

**Medical Care Collection Fund (MCCF) eBilling Compliance
Phase 3**

Work Effort Unique Identifying # 20140414

Business Requirements Document



October 2014

Revision History

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

Date	Description	Author
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10/29/14	Approved version	[REDACTED] Supervisory Program Analyst, OIT, VHA

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1. Purpose

The Business Requirements Document (BRD) is authored by the eBusiness Solutions Office (representing Veteran Health Administration [VHA] provider side needs) within VHA) Chief Business Office (CBO). It captures and describes the business needs as identified within the New Service Request (NSR) #20140414 Medical Care Collection Fund (MCCF) eBilling Compliance Phase 3¹. The BRD provides insight into the AS-IS and TO-BE business area, 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 does not state the development methodology. The intended audience for this document is the Office of Information and Technology (OI&T).

2. Overview

Changes within the Veterans Health Information Systems and Technology Architecture (VistA) are needed to support mandated additions/updates required by Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended by Public Law (P.L.) 111-148 The Patient Protection and Affordable Care Act (PPACA), Section 1104. These changes are needed to support X12 Electronic Data Interchange (EDI) transactions, which are defined by HIPAA Accredited Standards Committee X12 (ASC X12) standards² and include updates of data elements required within the 837 transactions.

These changes will update the VistA Integrated Billing (IB) and Accounts Receivable (AR) packages to ensure the ASC X12 5010 837 professional and institutional transactions transmitted meet the updated industry requirements. The changes/updates are required to continue VHA revenue flow and to not disrupt the current Revenue process flows.

Provisions of PPACA, Section 1104 are listed in order of effective date in the following table:

#	PPACA Provision	Adoption Date	Effective Date
1	Establish a unique Health Plan Identifier (HPID) to be used in electronic transaction standards	Not Applicable (NA)	11/1/2014 (Dual use period begins)
2	Adopt operating rules for health claims or equivalent encounter information [837, National Council for Prescription Drug Programs (NCPDP)], enrollment and disenrollment in a health plan (834), health plan premium payments (820), referral certification and authorization (278) transaction standards	7/1/2014	1/1/2016
3	Health plans to submit a notice of certification for operating rules for health claims or equivalent encounter information (837, NCPDP), enrollment and disenrollment in a health plan (834), health plan premium payments (820), referral certification and	NA	12/31/2015

¹ [REDACTED]

² Throughout the remainder of this document, the term “X12” is used to reference the standards developed by the ASC X12 standards organization.

#	PPACA Provision	Adoption Date	Effective Date
	authorization (278) transactions, and claims attachments (275)		
4	Establish a claim attachment (275) transaction standard and associated operating rules	1/1/2014	1/1/2016

3. Customer and Primary Stakeholders

[REDACTED], Deputy Chief Business Officer for the CBO, is the primary stakeholder for this request. Review [Appendix C](#) for the complete list of primary and secondary stakeholders.

4. Scope

Changes to VistA's IB package are requested by the VHA CBO Business Development Department to comply with the legislative changes mandated by the HIPAA as amended by the PPACA, P.L. 111-148, Section 1104. This includes the development and the ability to transmit updated 837 transactions, and to send all necessary X12 data elements needed to adjudicate claims for payment. Transmission of the data elements will assist with the revenue stream process for budgeting purposes. It also includes the ability to receive data from payers, where available

Revenue operation includes all processes that work together to support collection and use of insurance eligibility information, patient data, claims creation, and accounts receivable processing. This effort seeks to enhance the current local VistA IB package by associating and sending information mandated by X12 Industry standards.

Changes needed to eBilling software include 837 professional and institutional, including Electronic Medicare Remittance Advice (eMRA) and Fee Reimbursement Claims. These changes include but are not limited to:

- Need to assess the health care claim operating rules against the current eBilling processes to determine gaps.
- Ensure current ASC X12 837 transactions meet Implementation Guide requirements in order to comply with health care claims operating rules.
- Ensure that VistA systems comply with current National Uniform Claim Committee (NUCC) standards
- Ensure that VistA systems comply with current National Uniform Billing Committee (NUBC) standards
- Compliance with the mandate for Health Care Claims Attachments by transmitting attachments in industry compliant ASC X12.
- Evaluate Health Care Services Review transactions (ASC X12 278) in meeting industry compliance based upon experience with industry business partners. Ensure VHA systems allow for transmission and receipt of 278 transactions to streamline processes experienced with business partners.
- Ensure VHA systems are able to transmit, accept, store and view industry standard code lists and values as industry updates occur.

- To address the needs identified through business partner relationships where current transactions lack the ability to communicate with mandated business partners, such as Medicare. This includes streamlining processes and sunseting manual processes in order to transmit claims or where VHA does not have the ability to provide electronic transactions.
- Meet industry mandates for Universal Health Care Identifier to include the ability to store, display and transmit this identifier to various business partners.

5. Goals, Objectives and Outcome Measures

Goal/Objective and Desired Outcome	Impact/Benefit	Measurement
Transmit attachments to third party payers to provide supplemental information to assist in claims processing.	The mandated attachments will be utilized by payers to process health care claims. Staff will no longer have to print and mail or fax attachment information to payers.	<ul style="list-style-type: none"> • 95% of claim attachments will transmit from VistA to the third party payer in mandated industry format. • Local printing volumes will decrease by 95%.
Comply with submission of operating rules for authorizations/referrals/certifications to third party payers.	<ul style="list-style-type: none"> • Decrease volume of manual requests for authorizations/referrals/certifications by Utilization Review (UR) staff. • Industry adoption of ASC X12 278 transactions ensure claims process and pay in a timely manner. 	Submission and response of ASC X12 278 transactions 100% of the time.
Submit X12 compliant claims to third party payers.	VHA 837 Institutional/ Professional (I/P) will comply with new Operating Rule Guidance and the volume of claims rejecting for use of invalid codes will decrease.	Claims will process to third party payers with minimal rejection; that is, 95% of first time 837 I/P transactions will be accepted/ processed by payer.
View and store valid X12 codes throughout billing screens.	<ul style="list-style-type: none"> • End users will have ability to better understand Claims Adjustment Reason Codes (CARCs) and Remittance Advice Reason Codes (RARCs). • Meet mandates and provide further clarification on code use in the 837 transaction. 	<ul style="list-style-type: none"> • Ability to transmit X-12 codes and view X12 codes within VistA 100% of the time. • Decrease requests for support regarding reported CARCs and RARCs by 50%.
Store, view, transmit and receive Universal Healthcare Identifiers.	Ability to report one identifier for patient in order to meet mandates.	Meet mandate 100% of the time.
eBusiness eBilling Compliance	VHA 837 transactions and printed claims are compliant with HIPAA mandates and industry	95% of claims will process to third party payers with minimal

Goal/Objective and Desired Outcome	Impact/Benefit	Measurement
	setting partners (NUCC/NUBC).	rejection.

6. Enterprise Need/Justification

The PPACA was passed in March 2010 with the intent of implementing standardized operating rules and processes to increase the portability, efficiency and quality of health care services. As a federal entity and the nation's largest integrated health care provider, VHA is required to comply with all mandates. This legislation requires that health care providers structure health care operating information in a way that is universal amongst entities across the country.

Penalties for Non-Compliance

VHA provider-side penalties are stated in the HIPAA regulations for non-compliance. PPACA legislation includes Provisions on Penalty Fees (1104(b)(5)(j)) for non-compliance that apply strictly to the payer-side entity of VHA. However, the original transaction standard penalties under HIPAA still apply.

“Under the statute, failure to comply with standards may result in monetary penalties. The Secretary is required by statute to impose penalties of not more than \$100 per violation on any person who fails to comply with a standard, except that the total amount imposed on any one person in each calendar year may not exceed \$25,000 for violations of a single standard for a calendar year.”

Essentially, there is a cap of \$25,000 per year per violation. If this is interpreted as per transaction, the Department of Veterans Affairs (VA) could be penalized \$150,000 per year. However, there are some interpretations of the penalties which also include the lack of use of standard code sets which are defined. This interpretation could approach \$1,000,000 in penalties.

Impact to VHA

In addition to the potential for billions of dollars assessed in penalties for non-compliance, failure to implement EDI New Standards and Operating Rules according to the timeline set will result in the inability for VHA to exchange data with insurance payers according to the standards for data exchange, thereby resulting in a loss of revenue. Furthermore, the inability to exchange data according to the standards will result in a loss of business efficiency and ultimately a considerable failure to serve the Veteran population.

7. Requirements

7.1. Business Needs/Owner Requirements

Unique Identifier	Business Need/Requirement	Requirement Priority*
NEED1555 BN 1	Adhere to the Enterprise Level requirements as specifically addressed in Appendix E of this document.	

Unique Identifier	Business Need/Requirement	Requirement Priority*
NEED/ARCH Need 2	Utilize nationally standardized terminology for all use of trademark names.	
OWNR170 2.1	Provide the ability to express all content using nationally recognized reference and authoritative terminology standards (e.g., Logical Observation Identifiers, Names, and Codes [LOINC], Systematized Nomenclature of Medicine Clinical Terms [SNOMED CT], etc.).	High
OWNR8836 2.2	Provide the ability to record observations using standardized terms.	High
OWNR8837 2.3	Provide the ability for users to submit a request to Standards and Terminology Services (STS) for new standardized terms (e.g., via New Term Rapid Turnaround [NTRT] process).	High
	Provide the ability to express all content using Nationally recognized reference and authoritative terminology standards for all trademark names.	High
NEED/ARCH BN 3	Comply with Claims Attachment Phase 3 Operating Rules (January 2016 effective date).	High
OWNR 3.1	Provide the ability to receive a health care claim request for additional information in an industry standard format.	High
OWNR 3.1.1	Provide the ability for users to be alerted of the health care claim request.	High
OWNR 3.1.2	Provide the ability for users to track the health care claim request.	High
OWNR 3.1.3	Provide the ability for users to act on the health care claim request.	High
OWNR 3.2	Provide the ability for users to transmit a claims attachment in the industry standard format ASC X12.	High
OWNR 3.2.1	Provide the ability to attach administrative non VistA forms/documents Certificate of Medical Necessity(CMN).	High
OWNR 3.2.2	Provide the ability to transmit administrative non VistA forms/documents (CMN).	High
OWNR 3.3	Provide the ability to enter supplemental information regarding encounter in the attachment to transmit to business partner.	High
NEED/ARCH BN 4	Comply with Referrals/Authorizations/Certification Phase 3 Operating Rules (January 2016 effective date).	High
OWNR 4.1	Provide the ability to process referral/authorization/certification information for submission to UR staff.	High
OWNR 4.4	Provide the ability to obtain EDI referral certification and authorization transactions to third parties.	High

Unique Identifier	Business Need/Requirement	Requirement Priority*
OWNR 4.5	Provide the ability to transmit EDI referral certification and authorization transactions to third parties.	High
OWNR 4.6	Provide the ability to store EDI referral certification and authorization transactions to third parties.	High
OWNR 4.7	Provide the ability to streamline processes around Health Care Service Reviews submitted by VHA facilities.	High
OWNR 4.8	Provide the ability to streamline processes around Health Care Service Reviews received by VHA facilities.	High
OWNR 4.9	Provide the ability to streamline the Worklists for Revenue UR staff to eliminate the use of multiple systems or worklists.	High
NEED/ARCH BN 5	Ensure VHA 837 I/P are submitted in X12 compliant formats.	High
OWNR 5.1	Provide the ability to transmit X12 compliant professional 837s I/P.	High
OWNR 5.2	Provide the ability to store and display X12 compliant professional 837 information.	High
OWNR 5.3	Provide the ability to transmit HPID in compliant format with in professional 837 transactions.	High
OWNR 5.4	Provide the ability to transmit X12 compliant institutional 837s.	High
OWNR 5.5	Provide the ability to store and display X12 compliant institutional 837 information.	High
OWNR 5.6	Provide the ability to transmit HPID in compliant format with in institutional 837 transactions.	High
NEED/ARCH BN 6	Adhere to X12 Code Value Usage.	High
OWNR 6.1	Provide the ability to transmit X12 compliant professional 837s to include valid codes.	High
OWNR 6.2	Provide the ability to transmit X12 compliant institutional 837s to include valid codes.	
OWNR 6.3	Provide the ability in VistA to display for selection valid codes Present On Admission (POA).	High
OWNR 6.4	Provide the ability to display X12 compliant codes and code descriptions throughout billing screens, including codes received through eMRAs from Medicare.	High
NEED/ARCH BN 7	Comply with Universal Healthcare Identifier mandate.	High

Unique Identifier	Business Need/Requirement	Requirement Priority*
OWNR 7.1	Provide the ability to transmit X12 compliant professional 837s containing the Universal Healthcare Identifier.	High
OWNR 7.2	Provide the ability to transmit X12 compliant institutional 837s containing the Universal Healthcare Identifier.	
OWNR 7.2	Provide the ability to display Universal Healthcare Identifier on various screens for end users.	High
NEED/ARCH BN 8	eBusiness eBilling Compliance	High
OWNR 8.1	Ability to transmit all 837 I/P rate types electronically.	High
OWNR 8.1.1	Provide the ability to submit additional 837 rate types on professional claims, such as Workers Compensation transmission.	High
OWNR 8.1.2	Provide the ability to submit additional 837 rate types on institutional claims, such as Workers Compensation transactions	
OWNR 8.2	Provide the ability to enter multiple Medicare Will Not Reimburse (WNR) payers to submit additional claim types to Medicare Administrative Contractor (MAC) (i.e., Durable Medical Equipment [DME]/Skilled Nursing Facility [SNF]).	High
OWNR 8.2.1	Provide the ability to develop business rules associated with various Medicare Will Not Reimburse (WNR) payers to support additional claim types.	High
OWNR 8.3	Provide the ability for VistA to check for duplicate Medicare Remittance Advices (MRA) at Claims Adjustment Reason Codes (CARCs) code level.	High
OWNR 8.4	Provide the ability in VistA to identify multiple Health Care ClearingHouses (HCCHs) in responses/rejections received.	High
NEED/ARCH BN 9	Provide additional functionality for eBilling reports to track transactions to report metrics.	High
OWNR 9.1	Create VistA report for claims that are locally printed when claim is released/authorized.	High
OWNR 9.2	Provide the ability for management to view information on locally printed claims with detailed information.	High
OWNR 9.3	Provide the ability to enter and search by Payer ID within the View/Resubmit Claims – Live or Test (RCB report).	High
OWNR 9.4	Provide the ability to address service line level issues when combining procedure units.	High
OWNR 9.5	Provide the ability to ensure print order of service line items is functioning appropriately under revisions previously made.	High

Unique Identifier	Business Need/Requirement	Requirement Priority*
OWNR 10	Address implementation issues with International Classification of Diseases, Tenth Edition (ICD-10) compliance.	High
OWNR 10.1	Modify screens to display ICD-10 requirements.	High
OWNR 10.2	Modify fields to transmit ICD-10 to third party payers for professional claims.	High
OWNR 10.3	Modify fields to transmit ICD-10 to third party payers for institutional claims.	High
OWNR 11	Remove the VistA IB fatal error from 837 Professional claim when a patient has only one name in the Registration Package.	High
OWNR 12	Ability to update VistA and print all claims in industry standard formats.	High
OWNR 12.1	Provide the ability for VistA to print CMS 1500 in the current industry standard formats as reflected in NUCC.	High
OWNR 12.2	Provide the ability for VistA to store updated NUCC codes (to include definitions/form locator and terminology).	High
OWNR 12.3	Provide the ability for VistA to print UB04 in the current industry standard formats as reflected in NUBC.	High
OWNR 12.4	Provide the ability for VistA to store updated NUBC codes (to include definitions/form locator and terminology).	High

*All listed requirements are needed by the business community. The Priority is merely a mechanism to suggest a sense of urgency and order to the technical community if the requirements are to be parsed into phases. The order of importance begins with those that are designated as High priority.

7.2. Non-Functional Requirements

Functional requirements describe what a system must be able to perform—that is, the system behavior. All other requirements are non-functional. This section describes the non-functional requirements from a business need perspective.

Non-Functional Requirement Number	System Performance Reporting Requirements (Note: Each system developed by VA OIT <u>must</u> comply with the following mandatory requirements.)
	Include instrumentation to measure all performance metrics specified in the Non-Functional Requirements section of the BRD. At a minimum, systems will have the

	ability to measure reporting requirements for Responsiveness, Capacity, and Availability as defined in the non-functional requirements section of this document.
	Make the performance measurements available to the IT Performance Dashboard to enable display of “actual” system metrics to customers and IT staff.
	Operational Environment Requirements
	The primary and back-up sites for data storage shall be the same sites used for the VistA Integrated Billing (IB) packages.
	The system shall respond to user actions in 7 seconds or less in 95% of the attempts, and never more than 10 seconds.
	System response times and page load times shall be consistent with VistA Integrated Billing (IB) standards (for example My HealtheVet or HealtheVet).
	Maintenance, including maintenance of externally developed software incorporated into the IB application, shall be scheduled during off peak hours or in conjunction with relevant VistA maintenance schedules.
	Information about response time degradation resulting from unscheduled system outages and other events that degrade system functionality and/or performance shall be disseminated to the user community within 30 minutes of the occurrence. The notification shall include the information described in the current Automated Notification Reporting (ANR) template maintained by the VA Service Desk. The business impact must be noted.
	Provide a real-time monitoring solution during the maintenance windows or when technical issues/problems occur which may require a preventative back-up.
	Notification of scheduled maintenance periods that require the service to be offline or that may degrade system performance shall be disseminated to the user community a minimum of 48 hours prior to the scheduled event.
	When/if lapses in system/update availability occur, users would contact local Program Application Specialist (PAS) assigned to IB; contact OI&T assistance as needed; and enter standard VistA IB package Remedy ticket by calling National Support Desk.
	Documentation Requirements
	A technical training curriculum shall be developed and delivered to all levels of staff users.
	The training curriculum developed by the Program Office shall state the expected task completion time for primary and secondary users.
	Updates shall be made, as necessary, to the applicable user manuals and Operations and Maintenance (O&M) manuals related to the VistA IB application located on the VA Software Documentation Library. If no User or O&M documentation exists, it shall be produced.
	Implementation Requirements
	Technical Help Desk support for the application shall be provided for users to obtain assistance with IB.
	The IT solution shall be designed to comply with the applicable approved Enterprise Service Level Agreements (SLA).
	Implementation will require a system downtime of approximately 2-6 hours during installation.

	The implementation must be complete 30 days from patch release.
	Data Protection/Back-up/Archive Requirements
	Provide a back-up plan for when the system is brought off-line for maintenance or technical issues/problems.
	Data protection measures, such as back-up intervals and redundancy shall be consistent with systems categorized as Class I.
	User Access/Security Requirements
	Due to patient safety considerations, data protection measures such as backup intervals and/or redundancy shall be consistent with systems categorized as critical.
	Ensure the proposed solution meets all VHA Security, Privacy and Identity Management requirements including VA Handbook 6500. (See Enterprise Requirements Appendix).
	Data Protection/Back-up/Archive Requirements
	Based upon the criticality of the system, provide a back-up and data recovery process for when the system is brought off-line for maintenance or technical issues/problems.
	Data protection measures, such as back-up intervals and redundancy shall be consistent with systems categorized as mission critical (12 hour restoration). Business owners are required to state the mission criticality of the Information Technology (IT) services required in order to assist the planners and developers in determining best strategies for engineering an IT solution to meet their business objectives/needs. The business owner needs to state the criticality of the data and the impact to the business during a service disruption so appropriate technologies can be considered.
	Data Quality/Assurance Requirements
	A monitoring process shall be provided to ensure that data is accurate and up-to-date and provides accurate alerts for malfunctions while minimizing false alarms.
	User Access/Security Requirements
	Ensure the proposed solution meets all VHA Security, Privacy, and Identity Management requirements including VA Handbook 6500 (see Appendix E).
	User Interface/User Centered Design
	Adhere to good User Interface/User Centered Design (UI/UCD) principles as outlined in the Usability Appendix of the BRD.

7.2.1. User Access Levels

The table below defines the different levels of user access to the VistA IB application:

Name	Description	Integrated Billing (IB) Access	Accounts Receivable (AR) Access
Primary Users	Billing Staff	Full Access (IB security Keys maybe locked)	View access only
Primary Users	UR Nurses	Full Access to certification functionalities (View only for other IB access, IB security	View access only

Name	Description	Integrated Billing (IB) Access	Accounts Receivable (AR) Access
		keys maybe locked)	
Primary Users	Accounts Receivable Staff	View access only	Full Access (AR security keys maybe locked)
Secondary Users	Consolidated Patient Account Center (CPAC) Operations	View Access	View Access
Secondary Users	System Administrator	Full Access	Full Access

7.2.2. Performance, Capacity, and Availability Requirements

7.2.2.1. Performance

If this is a system modification, how many users does the current system support?
This is a system modification. However, the exact number of users of the current system is unknown. End users span the entire VHA third party insurance, billing, and accounts receivable operation as well as system support staff .
How many users will the new system (or system modification) support?
The new system modifications will support the entire VHA third party insurance, billing, accounts receivable and system support staff.
What is the predicted annual growth in the number of system users?
Although there is no way to predict the increase in staff, it has been determined that additional users would not have a negative impact on the system.

7.2.2.2. Capacity

What is the predicted size (average) of a typical business transaction?	
The predicted size of a typical business transaction is unknown by Business Subject Matter Experts (SMEs). This estimate can more appropriately be made by IT staff.	
What is the predicted number of transactions per hour (day, or other time period)?	
Claims:	
Monthly Commercial	851,572
Monthly ChampVA	19,375
Monthly Medicare (837s)	410,100
Monthly Total	1,281,047
MRA:	
Monthly Count(835s)	460,495
Monthly MRA/Medicare Claims	112%
Monthly Referral/Authorizations/Certifications are unknown until the release of PATCH # IB*2*517	

eBilling Build 2.

Monthly Attachments are unknown at this time

Is the transaction profile expected to change (grow) over time?

Yes. As the Referral/Authorization/Certification transaction is implemented under Patch Number IB*2*517, the volume of these transactions (X12 278s) is expected to grow. Currently, VHA does not submit these requests electronically and handles these by telephone and fax mechanisms.

What is the process for planning/adjusting capacity?

The future capacity of a typical business transaction is unknown by Business SMEs. This estimate can more appropriately be made by IT staff.

Does the update require a surge capacity that would be different from the base application?

No, there is not a requirement for surge capacity different from the base application.

7.2.2.3. Availability

Describe when the envisioned system will need to be available (business hours only, weekends, holidays, etc.) to support the business.

Required minimum availability would be during business hours, accommodating all time zones; however, the system is required to be available around the clock

Repository Unique ID (_____): The application must be available 24 hours a day, 7 days a week, consistent with VistA uptime at 99.99%.

7.3. Known Interfaces

This is the business community's best understanding of known interfaces and may not be a comprehensive listing. All required interfaces will be stated as Business Needs in [Section 7.1](#).

This operation has multiple internal and external interfaces. To implement the requirement modifications, changes to the Billing and possibly the Accounts Receivable modules and/or applications and interfaces of the VistA system will be required. External interfaces include, but are not limited to the following:

Name of Application	Description of Current Application	Interface Type	Existing Functionality	Deliverables
Gentran	Financial Services Center (FSC) Electronic Data Interchange processing is performed on the AITC mainframe using the Gentran system software	Automated	Yes	Ensure continued connectivity to FSC

Clearinghouses	Receives and transmits 270/271 transactions to health insurance payers	Automated	Yes	Ensure continued connectivity to Clearinghouses
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7.4. Related Projects or Work Efforts

- **NSR #20110503 - EDI New Standards and Operating Rules VHA Provider-Side Technical Compliance Requirements**

Provider Operating Rules (VA118-1001-0018) - eBilling System Modifications:

Section 1104 of PPACA requires HIPAA covered entities (such as VHA) to adopt standard operating rules for the electronic exchange and use of health information for the purposes of financial and administrative transactions. The standard operating rules will require changes in current EDI implementations.

- **NSR #20071217 - National Insurance File (NIF)/Health Plan Identifier (HPID)**

The HPID mandate falls under existing HIPAA legislation, as amended by PPACA. HIPAA called for Administrative Simplification. Section 1104 of the PPACA directs the Secretary of the Department of Health and Human Services (HHS) to implement new “operating rules” that will govern the exchange of health data transactions that were originally implemented under the Transactions and Code Sets Rule under the Administrative Simplification section of HIPAA. Therefore, this work is a prerequisite for effective implementation of the EDI New Standards and Operating Rules VHA Provider-Side Technical Compliance Requirements BRD (NSR#20110503³).

8. Other Considerations

8.1. Alternatives

Compliance with HIPAA as amended by the PPACA is mandatory and there are no alternatives.

8.2. Assumptions

It is assumed that related business processes will continue to function nationally within the CPAC business model and VHA healthcare system. It is also assumed that there will be some degree of end user and Product Support training required for proper use and understanding of new functionality.

³

[3](#)

8.3. Dependencies

The success of this project is dependent upon the final release of technical specifications and requirements in support of PPACA legislation as well as successful implementation and integration of the Referrals/Authorizations/Certifications (ASC X12 278) and the Claims Attachment (ASC X12 276) throughout the payer community.

8.4. Constraints

- The technological advancements incorporated must be implemented and tested prior to all training is rolled out.
- All activities must be completed prior to the compliance deadline enforced by the PPACA legislation.
- VHA must be certified as compliant with EDI New Standards and Operating Rules before implementing use of these standards nationally.

8.5. Business Risks and Mitigation

Business Risks	Mitigation
Implementation standards and operating rules for certain transactions, code sets, and identifiers are not yet finalized. If rules are not finalized by the anticipated by December 2014, VA will be unable to perform adequate process analysis to comprehensively document gaps in systems and application software, program interfaces, and business operation that must be addressed to meet compliance.	Process analysis must be performed once the final operating rules are released in December 2014. As a part of development, VHA would then need to verify the final operating rules against the affected transaction sets and provide testing and verification to ensure VHA met the mandates.
If contract resources cannot obtain access to the VHA Network in a timely fashion, then project schedule and each Program Management Accountability System (PMAS) milestone will be delayed by approximately 60 – 90 days (or more).	The Project Manager will utilize on-boarding processes that have been successful for other projects.
Use of certain transactions are not fully implemented across all third party payers	Fully engage with VHA business partners to ensure third party payers are implementing transactions and where no progress is made, file non-compliant notification to the Centers for Medicare and Medicaid Services (CMS).

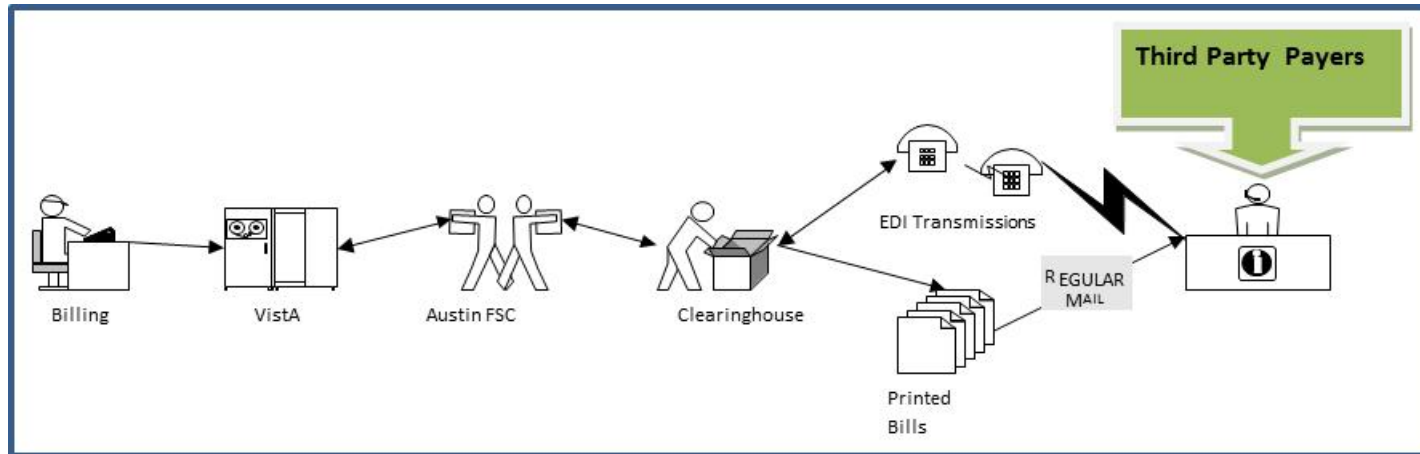
Appendix A References

The following references were used in the development of this BRD:

- HIPAA
 - HIPAA: New Transaction Standards (5010, D.0); Department of Health and Human Services 45 Code of Federal Regulations (CFR) Part 162 Health Insurance Reform; Modifications to the HIPAA; Final Rules
<http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf>
 - HIPAA: New Code Set (ICD-10); HHS Office of the Secretary, 45 CFR Part 162 [CMS-0013-F] RIN 0958-AN25 HIPAA Administrative Simplification: Modifications to Medical Data Code Set, Standards To Adopt ICD-10-Clinical Modification (ICD-10-CM), and ICD-10-Procedure Coding System (ICD-10-PCS)
<http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf>
- NSR #20140414 MCCF eBilling Compliance Phase 3
[REDACTED]
- Patient Protection and Affordable Care Act (PPACA)--"Health Care Reform" House of Representatives (H.R.) 3590, Section 1104--Administrative Simplification, Section 10109--Development of Standards for Financial and Administrative Transactions
 - Public Law 111-148, The Patient Protection and Affordable Care Act
<http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>
 - PPACA Compliance, Certification, and Penalties
https://www.cms.gov/Affordable-Care-Act/04_ComplianceCertificationandPenalties.asp
- VA Handbook 6500 – Information Security Program
[REDACTED]

Appendix B Models

The following depiction provides a description of the process in place today and in the future.



Appendix C Stakeholders, Users, and Workgroups

Stakeholders

Type of Stakeholder	Description	Responsibilities
Requester	██████████ EDI Transactions, eBusiness Solutions, CBO	Submitted request. Submits business requirements. Monitors progress of request. Contributes to BRD development.
Endorser	██████████ Deputy Chief Business Officer for Revenue Operations, CBO	Endorsed this request. Provides strategic direction to the program. Elicits executive support and funding. Monitors the progress and time lines.
Business Owner/Program Office	██████████ Director, eBusiness Solutions, CBO	Provide final approval of BRD with sign-off authority. Provide strategic direction to the program. Elicits executive support and funding. Monitors the progress and time lines.
Business Subject Matter Experts (SMEs)	<ul style="list-style-type: none"> • ██████████ Project Manager, eBilling • ██████████ Implementation Manager, eBilling • ██████████ Implementation Manager, eBilling 	Provide background on current system and processes. Describe features of current systems, including known problems. Identify features of enhancement.
Technical SMEs	<ul style="list-style-type: none"> • ██████████ Chief, Electronic Commerce Division, FSC • ██████████ Business Analyst, FSC 	Provide technical background information about the current software and requested enhancements.
User SMEs	<ul style="list-style-type: none"> • ██████████ Project Manager, eBilling • ██████████ Implementation Manager, eBilling • ██████████ Implementation Manager, eBilling 	Ensure that the enhancements will account for current business processes and existing software capabilities.

Stakeholder Support Team (BRD Development)

Type of Stakeholder	Description	Responsibilities
Security Requirements SME	██████████ Health Care Security Analyst, Health Care Security Requirements	Responsible for determining the Assessment and Authorization and other security requirements for the request.

Service Coordination SME	██████████ Management Analyst, Service Coordination	Responsible for ensuring all aspects of non-functional requirements have been accurately recorded for this request.
Applied Informatics Management (AIM) Health Enterprise Systems Manager (ESM) and Staff	██████████ Health ESM, Business Informatics Portfolio	Serve as the liaison between the Program Office (Business Owner) and Product Development throughout the lifecycle.
Strategic Investment Management (SIM), Requirements Development and Management (RDM)	██████████ Requirements Analyst	Responsible for working with all stakeholders to ensure the business requirements have been accurately recorded for this request.
Office of Information Technology, VHA	██████████ Jr., Supervisory Program Analyst, OIT, VHA	Representing the Office of Information & Technology

Primary and Secondary Users

Type of User	Description	Responsibilities
Primary Users	Billing Clerks and Associated staff [those employed by facilities and by CPACs]	Generate third party bills in VistA, monitor copayment responsibilities, enter non-VA providers into non-VA provider file; transmit or print claims.
Primary Users	Insurance Clerk Staff	Identify and review upcoming appointments to determine which patients required referral/authorization/certification.
Primary Users	Utilization Review Staff	Receive information on upcoming appointment and/or admissions to secure referral/authorization/certification.
Primary Users	AR Technicians	Ensure VHA claims are appropriately adjudicated by third party payers and post those payments in VistA, including amounts that offset veteran copayments Review CARCs and RARCs.
Secondary Users	CPAC Program Management Office (PMO)	Measure performance of billing staff in processing claims.
Secondary Users	Veterans Integrated Service Network (VISN) Business Implementation Managers, VAMC Revenue Coordinators	Oversee billing and collection activities at the VISN and Veterans Administration Medical Center (VAMC) level.
Secondary Users	CBO	Oversee revenue cycle operations, national payer relations and collections.
Secondary Users	VAMC Information Resource Managers (IRMs)	Provide on-site support for VistA system at each medical center.
Secondary Users	Product Support (PS)	Provide national user support.

Secondary Users	Emdeon Business Services	Receive VHA claims and transmit electronically or print/mail to third party payers.
Secondary Users	Quadramed	Interface with VistA IB to ensure clean claim submission to third party payers.

Appendix D Usability

User Experience encompasses the entire interaction between the user and the system. This includes direct interaction with the system as well as other interactions, understanding, awareness, perceptions, beliefs, feelings, and actions that result from that interaction. One key component of the user experience is the usability of 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).

In order for this application to achieve a good user experience for users who interact with it, the system must meet the requirements outlined in this section. These involve attributes of the application as well as the process that is required to achieve them.

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

- In accordance with the Office of the National Coordinator for Health Information Technology’s (ONCHIT) Meaningful Use (MU) 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 (NISTIR) 7741, ISO/International Electrochemical Commission (IEC) 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 (GUI) 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, Google-like, Lucene 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

Unique Identifier	Usability/User Interface Requirements
NONF2661	Left align content in table cells to facilitate quick visual scan.
NONF2662	Left align text for column headers to facilitate visual scan and make columns and content appear more organized.
NONF2663	Use mixed case instead of all caps whenever possible (e.g., dropdown list items, table data, table headers, hyperlinks, tab names). Limit the use of “all caps” throughout the application.
NONF2664	Simplify button labels. Re-label buttons to reflect standard terminology that is common in web interfaces and other applications (e.g., “Cancel”). Emphasize the action being performed in the most succinct way possible. Minimize redundancy in text/terminology that is used to convey the same action.
NONF2665	Left align page/section titles to anchor titles in consistent locations regardless of window sizing.
NONF2666	Labels for fields should be left aligned to facilitate quick visual scan and make forms and field groupings appear more organized.
NONF2667	Avoid using acronyms or abbreviations unless (a) they are widely understood/well known or (b) there is very limited space to display the full meaning. This supports naïve user understanding. If limited space results in using a non-common acronym/abbreviation, ensure it is specified within “Help” and/or as a tooltip.
NONF2668	Use colors such as red and green only for status driven content. Avoid using red for text/content, links, button labels, etc. This will reduce risk for user error, improve link discoverability, and facilitate understanding of differences in navigation/actions/content. It will also help users to isolate important status information (using red, green, etc.) from other less important information when viewing and processing information provided to them on a page.
NONF2669	Provide visual separation between the navigation space and the main content area.
NONF2670	Add field level validation and notification of missing information on the same page without launching a new window or navigating to another page.
NONF2671	Make all text hyperlinks appear consistent in style.
NONF2672	Make drop-down selection box widths appropriate for content and visual appeal.
NONF2673	Use standard and always visible radio buttons for “Yes/No” options instead of requiring the user to click in a drop down box and then click to select the “Yes” or “No” option.
NONF2674	Use standard date and time selection widgets. Where date and time are selected/picked from a standard widget, also provide direct data entry to support keyboard navigation. Enable field level validation immediately upon entry. Include instructional format text within the field entry box.
NONF2675	Provide standard sort behavior and visual indications on columns in all tables.
NONF2676	Define and adhere to a standard model for use and design of controls, buttons, hyperlinks, and navigation elements.
NONF2677	Ensure that text is sized to be readable (for example, by using the 007 Rule to assure text size is readable for users with 20/40 vision. The formula: Text height = .007 * distance between eyes and screen).

Unique Identifier	Usability/User Interface Requirements
NONF2678	Place common navigation elements in consistent locations.
NONF2679	Place critical information “above the fold” (i.e., in the top portion of the screen that is immediately viewable).
NONF2680	Use consistent screen flow models, elements, and terms to support similar workflows.
NONF2681	Use consistently named buttons when actions are the same (e.g., Add vs. Save vs. Submit).
NONF2682	Enable users to print views from where they are in the interface. Avoid requiring the user to “run a report” in order to print something that is viewable on the screen.
NONF2683	Provide field entry tool tips at the field location. Ensure consistency across the application in field labels, formats, location of tooltips, and tool tip text.
NONF2684	Provide visual indication of required fields.
NONF2685	Display field labels in close proximity to entry elements.
NONF2686	Use consistent elements to filter data.
NONF2687	Use consistent elements to sort data.
NONF2688	Use a consistent model for display, layout, and grouping of data entry fields.
NONF2689	Provide alternate row shading in lengthy tables of data, form elements, etc.
NONF2690	Ensure that icons are recognized by users.
NONF2691	Provide some “white space” between status icons in report views, white board views, etc.
NONF2692	Auto-populate default values in entry/selection fields when possible and appropriate.
NONF2693	Visually differentiate status icons from clickable icons, when appropriate.
NONF2694	Define and support the appropriate user tab sequence through fields in forms in order to support keyboard navigation when entering data in forms.
NONF2695	Define and adhere to standard action button placement on screens, forms, etc.
NONF2696	Visually distinguish the primary action button on a page.
NONF2697	Consistently use screen elements, action elements, workflow sequences within/across screens, language, etc.
NONF2698	Provide error messages in user-centric language with specific instructions on the meaning of the error and how to recover from it. Use error messages and method of display consistently across the interface.
NONF2699	Provide context-specific Help.
NONF2700	Do not use the term “sex” or any like abbreviations of that to represent gender.
NONF150	User acceptance testing personnel shall include billing staff, utilization review nursing staff, accounts receivable staff, and revenue collection management staff that are able to confirm acceptable changes to their workflow.
NONF133	User acceptance training and testing tools shall include user prompts to guide the use of the application so that minimal technical support is needed by the user.

Unique Identifier	Usability/User Interface Requirements
NONF70	A technical training curriculum shall be developed and delivered to all levels of staff users.
NONF151	The training curriculum shall state the expected training time for primary users and secondary users to become productive at using the new functionality of the IB application.
NONF152	A training curriculum, user manuals and other training tools shall be created/updated by VHA CBO eBusiness Solutions and then delivered to all levels of staff users at minimum 4-6 weeks in advance of the release of the software through nationwide teleconference calls, Live Meetings, Lync online meetings and PowerPoint presentations. The curriculum shall include all aspects of the revised IB software.
NONF69	The training curriculum shall state the expected task completion time for primary and secondary users.

Appendix E 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.

Unique ID	Requirement Type	Description
	Security	<p>All VA security requirements will be adhered to. Based on Federal Information Processing Standard (FIPS) 199 and National Institute of Standards and Technology (NIST) SP 800-60, recommended Security Categorization is Moderate.</p> <p>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.</p>
	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.
	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://www.ehealth.va.gov/508/resources_508.html 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.
	Executive Order	All executive order requirements will be adhered to.
	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.
	Terminology Services	Application/services shall reference the Standard Data Services (SDS) as the authoritative source to access non-clinical reference terminology.
	Terminology Services	Application/Services shall use the VA Enterprise Terminology Services (VETS) as the authoritative source to access clinical reference terminology.

Unique ID	Requirement Type	Description
	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 Information Technology Standards Panel (HITSP) Emergency Care Summary Document Using Integrating the Healthcare Enterprise (IHE) Emergency Department Encounter Summary (EDES) Component.
	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.

Appendix F Acronyms and Abbreviations

Term	Definition
AIM	Applied Informatics Management
ANR	Automated Notification Reporting
AR	Accounts Receivable
ASC X12	Accredited Standards Committee X12
BRD	Business Requirements Document
CARC	Claims Adjustment Reason Codes
CBO	Chief Business Office
CCD	Continuity of Care Document
CFR	Code of Federal Regulations
CMN	Certificate of Medical Necessity
CMS	Centers for Medicare and Medicaid Services
CPAC	Consolidated Patient Account Center
DME	Durable Medical Equipment
EDES	Emergency Department Encounter Summary
EDI	Electronic Data Interchange
eMRA	Electronic Medicare Remittance Advice
ESM	Enterprise Systems Manager
FIPS	Federal Information Processing Standard
FSC	Financial Services Center
GUI	Graphical User Interface
H.R.	House of Representatives
HCCH	Health Care ClearingHouses
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HITSP	Health Information Technology Standards Panel
HL7	Health Level 7
HPID	Health Plan Identifier
I/P	Institutional/Professional
IB	Integrated Billing
ICD-10	International Classification of Diseases, Tenth Edition
ICD-10-CM	ICD-10-Clinical Modification

Term	Definition
ICD-10-PCS	ICD-10-Procedure Coding System
IEC	International Electrochemical Commission
IHE	Integrating the Healthcare Enterprise
IRM	Information Resource Manager
ISO	International Organization for Standardization
IT	Information Technology
LOINC	Logical Observation Identifiers, Names, and Codes
MAC	Medicare Administrative Contractor
MCCF	Medical Care Collection Fund
MRA	Medicare Remittance Advice
MU	Meaningful Use
NA	Not Applicable
NCPDP	National Council for Prescription Drug Programs
NIF	National Insurance File
NIST	National Institute of Standards and Technology
NSR	New Service Request
NTRT	New Term Rapid Turnaround
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claim Committee
O&M	Operations and Maintenance
OI&T	Office of Information and Technology
ONCHIT	Office of the National Coordinator for Health Information Technology
P.L.	Public Law
PAS	Program Application Specialist
PMAS	Program Management Accountability System
PMO	Program Management Office
POA	Present On Admission
PPACA	Patient Protection and Affordable Care Act
PS	Product Support
RARC	Remittance Advice Reason Code
RCB	View/Resubmit Claims – Live or Test
RDM	Requirements Development and Management
SDS	Standard Data Services

Term	Definition
SIM	Strategic Investment Management
SLA	Service Level Agreement
SME	Subject Matter Expert
SNF	Skilled Nursing Facility
SNOMED CT	Systematized Nomenclature of Medicine Clinical Terms
STS	Standards and Terminology Services
UCD	User Centered Design
UI	User Interface
UI/UCD	User Interface/User Centered Design
UR	Utilization Review
VA	Department of Veterans Affairs
VAMC	Veterans Administration Medical Center
VETS	VA Enterprise Terminology Services
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information Systems and Technology Architecture
WNR	Will Not Reimburse

Appendix G Approval Signatures

The requirements defined in this document are the high level business requirements necessary to meet the strategic goals and operational plans of CBO. Further elaboration to these requirements will be done in more detailed artifacts.

Business Owner

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

Signed:

[REDACTED], Director eBusiness Solutions, Chief Business Office Date

[REDACTED]

Subject: RE: Approval of NSR Requirements and Architecture Package - NSR 20140414 Medical Care Collection Fund (MCCF) eBilling Compliance Phase 3

I accept this version of the Requirements and Architecture Package.

[REDACTED]

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.

Signed:

[REDACTED], Health ESM, Business Informatics Date

/es/ [REDACTED] (10/25/14)



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 during project planning as a result of technical reviews and feasibility.

Signed:

, Supervisory Program Analyst, OIT, VHA

Date

