Medical Care Collection Fund (MCCF)

eBilling Compliance Phase 3

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System Design Document

Patch IB\*2.0\*547



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| June 2015 | 3.0 | Updates to include approved CR001 | eBilling Development Team |
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Artifact Rationale

The System Design Document (SDD) is a dual-use document that provides the conceptual design as well as the as-built design. This document will be updated as the product is built, to reflect the as-built product. Per the Project Management Accountability System (PMAS) Guide, the SDD as a conceptual design is required prior to the Milestone 1 Review. (Sections 1, 2, 3, 4, 5, 7, 9 need to be populated, as applicable.) The as-built design for each delivery must be incorporated prior to the Milestone 2 Review. (The entire document needs to be populated or updated, as applicable.)

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# Introduction

The purpose of this System Design Document (SDD) is to outline the software design for the MCCF eBilling Compliance Phase 3 project related to Integrated Billing (IB) Patch IB\*2\*547.

The target audience for this SDD includes Office of Enterprise Development (OED), Product Development (PD), Product Support (PS), Software Quality Assurance (SQA), the Program Management Office (PMO), the Chief Business Office (CBO) Office, the Architecture and Engineering Review Board (AERB) and the software end-users.

## Purpose of the SDD

The purpose of this document is to describe in sufficient detail how the proposed system is to be constructed. The SDD translates the requirement specifications into a document from which the developers can create the actual system. It identifies the top-level system architecture and identifies hardware, software, communication, and interface components.

## Identification

The software that this SDD applies to is the Integrated Billing module, version 2.0, of the Veterans Health Information System and Technology Architecture (VistA) and Health Level Seven (HL7) version 2.6. It will use the following standards:

* American National Standards Institute (ANSI)
* International Organization for Standardization (ISO)
* Veterans Administration Standards and Conventions (VA SAC)

Refer to Appendix A for the standard Acronyms (Appendix A 4.1), Definitions (Appendix A 4.2) and References (Appendix A 4.3).

## Scope

This section describes the project scope which includes changes to the VistA IB module. IB is a software module within VistA that provides the ability for billing personnel to submit claims in either a paper or electronic format to third-party payers. The IB module uses data from other modules within VistA such as the Admission/Discharge and Transfer software, the Scheduling software, the Accounts Receivable (AR) software and the Registration software.

Table 1: Scope Inclusions

| Includes |
| --- |
| **Enter/Edit Billing Information**   * Make any necessary changes to the logic for determining Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) code service lines and revenue codes to ensure that identical codes either: * Combine and calculate the correct number of units – no Print Order * Do not combine – Print Order * Remove the fatal error that prevents the authorization of a claim for a patient with only a last name in the Patient file * Remove the obsolete Present on Admission (POA) code option of Blank/Exempt from POA Reporting |
| **Printed Claims**   * Add the ability to print the amount paid on a claim by the previous payer(s) in Box 29 of the CMS 1500 claim form when a secondary/tertiary claim is printed locally * Remove the printing of the admission date and time from the UB04 claim form (FL12/13) when an outpatient, institutional claim is printed locally |
| **Insurance Company Entry/Edit**   * Add the ability to define multiple Additional Primary Payer Identification numbers for an insurance company for the purpose of routing claims to different administrative contractors for both Medicare (WNR) and commercial [non-Medicare (WNR)] insurance companies |
| **Integrated Billing Site Parameters**   * Add a parameter that controls how long the VistA system will store American Standard Code (ASC) X12N Health Care Claim Request For Additional Information (277RFAI) transactions (default = infinity) * Add a parameter that controls how long an ASC X12N Health Care Claim Request For Additional Information (277RFAI) transaction will display on the ASC X12N Health Care Claim Request For Additional Information (277RFAI) work list * Add the ability to maintain a list of revenue codes that will be used to make some printed claims exempt from tracking |
| **Claims Status Awaiting Resolution (CSA)**   * Add the ability to view through CSA, which Health Care Clearing House (HCCH) sent a Claim Status (277RFAI) message for a claim |
| **Third Party Joint Inquiry (TPJI)**   * Add the ability to view through TPJI the Health Care Clearing House (HCCH) that sent a Claim Status (277RFAI) message for a claim when the message source is an HCCH * Modify the Electronic Explanation of Benefits (EEOB) view within the Claim Information action to display the Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) descriptions from the new AR EDI CARC DATA and AR EDI RARC DATA files (345 and 346) * Add the ability to view comments added to the RFAI Worklist for a claim |
| **EDI Menu For Electronic Bills ...**   * Modify the Electronic Explanation of Benefits (EEOB) to display the Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) descriptions from the new AR EDI CARC DATA and AR EDI RARC DATA files (345 and 346) from the following locations: * Print EOB [IBCE PRINT EOB] |
| **View/Resubmit Claims - Live or Test (RCB)**   * Add the ability to look up claims for an insurance company by Electronic Data Interchange (EDI) Payer ID in addition to the name of the insurance company * Add the ability to search for claims that were previously printed and transmit them via the test queue |
| **Medicare-equivalent Remittance Advice (MRA)/Medicare Management Worklist (MRW)**   * Modify the duplicate checking logic to use the line level Claims Adjustment Reason Codes (CARCs) as duplicate checking criteria in addition to existing criteria * Modify the EEOB view to display the CARCs and Remittance Advice Remark Codes (RARCs) descriptions from the new AR EDI CARC DATA and AR EDI RARC DATA files (345 and 346) from the following options: * Print MRA [IBCEM MRA REPORT PRINT] * View MRA EOB [IBCEM VIEW MRA EOB] * MRW [IBCE MRA MANAGEMENT] |
| **Billing Reports**   * Add the ability to track claims that are printed locally * Modify the View/Resubmit Claims – Live or Test option to allow the ability to sort by the electronic Payer identification number |
| **Copy and Cancel (CLON)**   * Modify the existing logic associated with copying a claim to ensure the Coordination of Benefits (COB) data associated with the cancelled claim is associated with the new copy |
| **COB Management Worklist (CBW)**   * Add the ability to search for claims on the COB Management Worklist by payer sequence * Modify the Electronic Explanation of Benefits (EEOB) to display the Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) descriptions from the new CARC and RARC files (344 and 345) from the following CBW actions: * Print EOB/MRA * View EOB |
| **Request For Additional Information Worklist**   * Add the ability to view and manage manually, requests for additional claim information (ASC X12N Health Care Claim Request For Additional Information (277RFAI) transactions) received from payers |
| **ASC X12N Health Care Claim (837) Transactions**   * Add the ability to transmit all claims with a Rate Type for which the insurer is responsible, in an ASC X12N Health Care Claim (837) transaction * Add the ability to transmit up to 25 procedures codes in an institutional ASC X12N Health Care Claim (837) transaction * Add the ability to transmit up to 12 e-Code diagnosis codes in an institutional ASC X12N Health Care Claim (837) transaction * Modify the ASC X12N Health Care Claim (837) layout to include maximum allowable data element lengths for the insurance fields whose lengths were increased by the eInsurance Patch IB\*2\*497 * Modify the ASC X12N Health Care Claim (837) layout to only transmit an admission date on inpatient claims |
| **ASC X12N Health Care Claim Request For Additional Information (277RFAI)**   * Add the ability to receive an ASC X12N Health Care Claim Request For Additional Information (277RFAI) in a batch process. |

Table 2: Scope Exclusions

| Excludes |
| --- |
| * BN 3.1.3: An analysis ONLY of the availability/accessibility within VistA of patient related data such as nursing notes, treatment plans and consultations that will potentially be used in the Health Level Seven (HL7) Clinical Documentation Architecture (CDA) within the X12N Health Care Claims Request for Additional Information (275) transaction |
| * BN 3.2: An analysis ONLY of the feasibility of meeting the requirements for a variety of Certificates of Medical Necessity by populating specific segments/data elements within the X12N Health Care Claims (837) Institutional and Professional transaction |

## Constraining Policies, Directives and Procedures

The constraining policies, directives, and procedures that are to be followed by this development effort include:

* The software language of MUMPS (M)
* Program Management Accountability System (PMAS) project management methodology
* ProPath v2.8
* The Veteran Administration’s Standards and Conventions (VA SAC).

The following standards apply to these development efforts:

* 835 - Health Care Claim Payment/Advice ASC X12 Standards for Electronic Data Exchange Technical Report Type 3 – May 2006
* 837 - P Health Care Claim: Professional ASC X12 Standards for Electronic Data Exchange Technical Report Type 3 – May 2006
* 837 - I Health Care Claim: Institutional ASC X12 Standards for Electronic Data Exchange Technical Report Type 3 – May 2006
* 277 Health Care Claim Request for Additional Information: ASC X12 Standard for Electronic Data Exchange Technical Report Type 3 – May 2006

## User Characteristics

The IB software is designed to be used by Billing supervisors, Billing clerks, Accounts Receivable supervisors and Accounts Receivable clerks as well as Utilization Review nurses and Insurance Verification personnel.

## Relationship to Other Documents and Plans

This enhancement is dependent on the following 2 VistA patches:

* IB\*2.0\*530 and PRCA\*4.5\*303: [**Uniform Use of CARC/RARC**](http://your_srver.domain.ext/warboard/anotebk.asp?proj=1693&Type=Active)
* IB\*2.0\*516: [**eBilling Claims Compliance**](http://your_srver.domain.ext/warboard/anotebk.asp?proj=1646&Type=Active)

This SDD and the companion Interface Control Documents (ICD) also contain relationships between the VistA IB module and the Financial Services Center (FSC) in Austin, TX.

## Definitions, Acronyms, and Abbreviations

### Definitions

Refer to Appendix A.

### Acronyms

Refer to Appendix A.

### References

Refer to Appendix A.

# Background

## Overview of the System

The IB module is designed to be used by Billing supervisors and Billing clerks as well as Utilization Review nurses and Insurance Verification personnel.

The IB module is an integrated part of the overall VistA system that exists at each site. The IB module communicates with other VistA modules such as Accounts Receivable, Appointment Scheduling, Admission/Discharge/Transfer, Claims Tracking, and the Charge Master. The IB module makes use of FileMan and MailMan. The IB module transmits flat file 837 Health Care Claim data to the FSC via MailMan. These are existing interfaces.

## Overview of the Business Process

The following features of the IB module will be affected by this development effort:

* Enter/Edit Billing Information
* Printed Claims
* Insurance Company Enter/Edit
* Patient Insurance
* Claims Status Awaiting Resolution (CSA)
* MRA Management Worklist
* Third Party Joint Inquiry (TPJI)
* Billing Reports
* Copy and Cancel (CLON)
* ASC X12N Health Care Claim Request For Additional Information (277RFAI) - The IB module already transmits and receives HL7 messages from FSC. This effort will add a new inbound HL7 message for the ASC X12N Health Care Claim Request For Additional Information (RFAI) (277RFAI) transactions to the existing interfaces with FSC.
* Request For Additional Information Worklist
* X12N 5010 Health Care Claim (837) - The IB module currently transmits Mailman messages to and receives Mailman messages from the Financial Services Center (FSC) in Austin, TX. The Claim Scrubber, a 3rd party piece of software developed by DSS, Inc., uses the 837 message format to communicate between Enter/Edit Billing Information and the scrubber. DSS will need to make changes to correspond to the changes made to the 837 map as part of this project.

Below is a high level view of the new ASC X12N Health Care Claim Request For Additional Information (277RFAI) process:



Figure 1: 277 (RFAI) Transaction Processing Diagram

## Business Benefits

This is an enhancement to the existing VA/Vista system, specifically the IB module.

A new HL7 message will be added to the system with this enhancement, the ASC X12N Health Care Claim Request For Additional Information (277RFAI). The IB module already transmits and receives HL7 messages from FSC. This effort will add a new inbound HL7 message for the ASC X12N Health Care Claim Request For Additional Information (RFAI) (277RFAI) transactions to the existing interfaces with FSC.

Please refer to the BRD for a discussion of the benefits: [MCCF eBilling Phase 3 TSPR](http://your_srver.domain.ext/warboard/anotebk.asp?proj=1724&Type=Active).

## Assumptions and Constraints

* Emdeon (HCCH) will provide resources to support both integration and site testing for this software development effort.
* FSC will provide resources to support both integration and site testing for this software development effort.
* HL7 will provide resources to support development, integration, and site testing for this software development effort.
* The Claim Scrubber, a 3rd party piece of software developed by DSS, Inc., uses the 837 message format to communicate between Enter/Edit Billing Information and the scrubber. DSS will need to make changes to correspond to the changes made to the 837 map as part of this project.
* At this time it is unknown when the payers will be implementing the 277 RFAI. Therefore it is likely that we will not have any real data to test this HL7 transaction during IOC.

### Design Assumptions

The constraining policies, directives, and procedures that are to be followed by this development effort include the Veteran Administration’s Standards and Conventions (VA SAC).

This design also assumes that the Uniform Use of CARC/RARC project patches PRCA\*4.5\*303 and IB\*2.0\*530 will be nationally released as the changes for this project build on the changes in those patches.

### Design Constraints

The constraints that exist for this development effort include the following:

* The software language of MUMPS (M)
* PMAS project management methodology
* ProPath v2.8
* National Release of CARC/RARC: PRCA\*4.5\*303 and IB\*2.0\*530
* HIPAA legislation, as amended by the PPACA.

The following standards apply to these development efforts:

* 835 - Health Care Claim Payment/Advice ASC X12 Standards for Electronic Data Exchange Technical Report Type 3 – May 2006
* 837 - P Health Care Claim: Professional ASC X12 Standards for Electronic Data Exchange Technical Report Type 3 – May 2006
* 837 - I Health Care Claim: Institutional ASC X12 Standards for Electronic Data Exchange Technical Report Type 3 – May 2006
* 277 Health Care Claim Request for Additional Information: ASC X12 Standard for Electronic Data Exchange Technical Report Type 3 – May 2006

### Design Trade-offs

There were no design trade-offs for this effort.

## Overview of the Significant Requirements

### Overview of Significant Functional Requirements

There are 15 different features of the IB module that will be affected by this project. Listed below are the 3 most significant changes. For additional information regarding these requirements, please refer to the Requirements Specification Document (RSD) located on the Technical Services Project Repository (TSPR):[MCCF eBilling Phase 3 TSPR](http://your_srver.domain.ext/warboard/anotebk.asp?proj=1724&Type=Active) *.*

Table 3: Significant Functional Requirements

| ID | Requirement |
| --- | --- |
| 2.6.14 System Feature: ASC X12N Health Care Claim Request For Additional Information (RFAI) (277RFAI) Transactions | The IB system shall provide the ability to receive an ASC X12N Health Care Claim Request For Additional Information (277RFAI) from FSC which includes the data specified in the 277 Health Care Claim Request for Additional Information: ASC X12 Standard for Electronic Data Exchange Technical Report Type 3 – May 2006 manual. Various work list functions will be created to allow the users to act on these requests. |
| 2.6.9 System Feature: Billing Reports | New reports for printed claims and unbilled amounts will be added with various search, sort, and print capabilities. |
| 2.6.10 System Feature: Copy and Cancel (CLON) | The IB system shall automatically copy the prior Coordination of Benefits (COB) payment data from previous payers to the new claim when users cancel and copy (CLON) a claim in certain situations. |

### Overview of Functional Workload / Performance Requirements

Most of the changes for the eBilling portion of the Medicare Care Collection Fund (MCCF) eBilling Compliance Phase 3 project will *not* make changes to the current workload of Integrated Billing personnel or the performance of VistA.

The most significant change will be the addition of the new ASC X12N transaction – Heath Care Claim Request for Additional Information (277 RFAI). The addition of this batched transaction will minimally affect the workload of the IB clerks and/or the AR clerks. Currently requests for additional clinical data to support claims for health care services come from either claim rejection or denial messages or contact by the payers, and they average about 85 per month, per facility. Now these requests will be a separate, batched HL7 transaction which will populate a worklist upon which the IB/AR staff will need to take action . The response to the 277RFAI requests will continue to be addressed by existing means such as Fax or mail.

Table 4: Workload/Performance Requirements

| ID | Requirement |
| --- | --- |
| 2.6.14 System Feature: ASC X12N Health Care Claim Request For Additional Information (RFAI) (277) Transactions | It is not known when and how many payers will implement the 277 transactions. If and when they do, IB staff will need to monitor and respond to the 277 work list. Currently each VA facility averages about 85 requests for additional information each month, with a high of 110 requests and a low of 71. The interface will be a batched process. |

### Overview of Operational Requirements

This project has no impact on the current Operational Requirements of the existing VistA system.

### Overview of the Technical Requirements

This project has no impact on the current Technical Requirements of the existing VistA system.

### Overview of the Security or Privacy Requirements

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

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

The HL7 interface to FSC is an existing interface to which a new transaction will be added.

### Overview of System Criticality and High Availability Requirements

The affected modules are integrated parts of the overall VistA system that exists at each site and will be subject to the normal availability, backup and recovery procedures.

### Single Sign-on Requirement

This enhancement is not impacted by the Single Sign-on Requirement of the existing VistA systems.

### Requirement for Use of Enterprise Portals

This enhancement is not impacted by the Use of Enterprise Portals Requirement of the existing VistA systems.

### Special Device Requirements

This enhancement is not impacted by the Special Device Requirement of the existing VistA systems.

## Legacy System Retirement

Nothing in this enhancement is being retired.

# Conceptual Design

This project does not require any changes to the conceptual design.

## Conceptual Application Design

This VistA enhancement does not require any changes to the conceptual design. The new HL7 transaction (277 RFAI) will accomplish the following:

* Receive, store and display ASC X12N Health Care Claim Request For Additional Information (277RFAI) transactions that come back from payers. These are batched requests.
* Provide the ability to manually respond to the ASC X12N Health Care Claim Request For Additional Information (277RFAI) transaction from the work list.

### Application Context

The following figure represents the context in which the new HL7 transaction will exist.



Figure 2: X12N 277 Response Application Context Diagram

Table 5: Application Context Description

**Object**

| ID | Name | Description | Interface Name | Interface System |
| --- | --- | --- | --- | --- |
| VistA | VistA | Veterans Health Information Systems and Technology Architecture Software application | VistA-FSC-interface | HL7 – uni-directional batched interface between FSC and VistA. |
| FSC | FSC | Financial Services Center – Austin, Texas | VistA-FSC-interface | HL7 – uni-directional batched interface between FSC and VistA. |

**Interfaces External to Office of Information and Technology (OI&T)**

| ID | Name | Related Object | Input Messages | Output Messages | External Party |
| --- | --- | --- | --- | --- | --- |
| FSC | FSC | FSC and HCCH | X12N 277 Response | X12N 277 Request | HCCH |

**Interfaces Internal to OI&T**

| ID | Name | Related Object | Input Messages | Output Messages | External Party |
| --- | --- | --- | --- | --- | --- |
| VistA | VistA | VistA and FSC | X12N 277 Request  (HL7 Message Type) | None |  |

**Externally Shared Data Stores**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ID | Name | Data Stored | Owner | Access |
| N/A | N/A | N/A | N/A | N/A |

### High-Level Application Design

This enhancement does not require any changes to the high-level application design of VistA.

### Application Locations

Table 6: Application Locations

| Application Component | Description | Location at Which Component is Run | Type |
| --- | --- | --- | --- |
| FSC | Provides EDI connectivity from VAMC to HCCH. Converts VistA HL7 messages to EDI X12. | Financial Services Center, Austin TX (FSC) | Software application |
| VistA | Integrated Billing module within the VistA system | VA Medical Centers (VAMC) Sites | Software application |

## Conceptual Data Design

### Project Conceptual Data Model

The Conceptual Data Model is found in the Entity Relationship Diagram (ERD), which will be placed here:[MCCF eBilling Phase 3 TSPR](http://your_srver.domain.ext/warboard/anotebk.asp?proj=1724&Type=Active)

### Database Information

Table 7: Database Inventory

| Database Name | Description | Type | Steward |
| --- | --- | --- | --- |
| File 36 | Insurance Company | New field for additional payer ID’s. | IB Application |
| File 350.9 | IB Site Parameters | New field for Primary Payer ID types | IB Application |
| File 350.9 | IB Site Parameters | New multiple to store Revenue Codes to exclude from Printed Claims Report | IB Application |
| File 350.9 | IB Site Parameters | Parameters for the new 277 RFAI interface including retention days, day before removing from work list, | Application |
| New FileMan File for 277 RFAI data | 277 RFAI Data transferred from the FSC to VistA | New file for use by Integrated Billing | IB Application |
| New FileMan Files for any tables/code sets/qualifiers needed by the 277 RFAI that do not already exist for use by 270/271 and 278. |  | New file for use by Integrated Billing.  Mostly qualifiers and descriptions pointed to by main 277 RFAI file. | Application |
| File 399 | Bill/Claims | New field for Claims Administrative Contractor | Application |
| New FileMan File | IB Claims Administrative Contractor | New File for Claims Administrative Contractor | Application |

### User Interface Data Mapping

This is an enhancement to existing VistA software which does not use a Graphical User Interface (GUI).

#### Application Screen Interface

##### Functional Requirement: Insurance Company Editor

**Insurance Company Editor** Apr 21, 2015@17:04:26 Page: 1 of 9

Insurance Company Information for: BLUE CROSS

Type of Company: Currently Active

Billing Parameters

Signature Required?: NO Type Of Coverage:

Reimburse?: WILL REIMBURSE Billing Phone:

Mult. Bedsections: Verification Phone:

One Opt. Visit: NO Precert Comp. Name:

Diff. Rev. Codes: Precert Phone:

Amb. Sur. Rev. Code:

Rx Refill Rev. Code:

Filing Time Frame:

EDI Parameters

Transmit?: YES-LIVE Insurance Type:

+ Enter ?? for more actions >>>

**BP Billing/EDI Param** IO Inquiry Office EA Edit All

MM Main Mailing Address AC Associate Companies AI (In)Activate Company

IC Inpt Claims Office ID Prov IDs/ID Param CC Change Insurance Co.

OC Opt Claims Office PA Payer DC Delete Company

PC Prescr Claims Of RE Remarks VP View Plans

AO Appeals Office SY Synonyms EX Exit

Figure 3: Insurance Company Editor Screen

##### Select Action: Next Screen// BP Billing/EDI Param

Table 8: Insurance Company Editor Screen Description

| Graphical User Interface (GUI) Field | Table (Database Table that field connects to) | Field (Field in Table that the GUI field connects to) | Comments |
| --- | --- | --- | --- |
| Insurance Company Editor | File #36 | To Be Determined (TBD) | New field(s) for additional payer ID’s. |

##### Functional Requirement: Designate Claims Administrative Contractor

IB,PATIENT MRA XX-XXX-XXXX BILL#: K101EUG - Inpat/UB04 SCREEN <10>

================================================================================

BILLING - SPECIFIC INFORMATION

[1] Bill Remarks

- FL-80 : UNSPECIFIED [NOT REQUIRED]

ICN/DCN(s) : UNSPECIFIED [NOT REQUIRED]

Auth/Referral : UNSPECIFIED [NOT REQUIRED]

Admitting Dx : 466.0 - ACUTE BRONCHITIS

PPS (DRG) : 0202 - BRONCHITIS & ASTHMA W CC/MCC

<2> Pt Reason f/Visit : UNSPECIFIED [NOT USED]

[3] Providers :

- ATTENDING : UNSPECIFIED

[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]

[5] Billing Provider : CHEYENNE VAMC

Taxonomy Code : 282N00000X

**[6] Alt Prim Payer IDs: UNSPECIFIED**

**[7]** Force MRA Sec Prt?: NO FORCED PRINT

**[8]** Provider ID Maint : (Edit Provider ID information)

<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT: 6

IB,PATIENT MRA XX-XX-XXXX BILL#: K101EU5 - Outpat/1500 SCREEN <10>

================================================================================

BILLING - SPECIFIC INFORMATION

[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]

Unable To Work To : UNSPECIFIED [NOT REQUIRED]

[2] ICN/DCN(s) : UNSPECIFIED [NOT REQUIRED]

Auth/Referral : UNSPECIFIED [NOT REQUIRED]

[3] Providers :

- RENDERING : UNSPECIFIED

[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]

Lab CLIA # : UNSPECIFIED [NOT REQUIRED]

Mammography Cert # : UNSPECIFIED [NOT REQUIRED]

[5] Chiropractic Data : UNSPECIFIED [NOT REQUIRED]

[6] CMS-1500 Box 19 : UNSPECIFIED [NOT REQUIRED]

[7] Billing Provider : CHEYENNE VAMC

Taxonomy Code : 282N00000X

**[8] Alt Prim Payer ID : UNSPECIFIED**

**[9]** Force MRA Sec Prt? : NO FORCED PRINT

**[10]** Provider ID Maint : (Edit Provider ID information)

<RET> to CONTINUE, 1-9 to EDIT, '^N' for screen N, or '^' to QUIT:8

Figure 4: Enter/Edit Billing Screens

Table 9: Enter/Edit Billing Screen Description

| Graphical User Interface (GUI) Field | Table (Database Table that field connects to) | Field (Field in Table that the GUI field connects to) | Comments |
| --- | --- | --- | --- |
| Enter/Edit Billing Screen | File #399 | TBD | New field for Claims Administrative Contractor |
| TBD | TBD | TBD | New File for Claims Administrative Contractor |

##### Functional Requirement: Request for Additional Information Worklist

Table 10: RFAI (277RFAI) Screen Description

| Graphical User Interface (GUI) Field | Table (Database Table that field connects to) | Field (Field in Table that the GUI field connects to) | Comments |
| --- | --- | --- | --- |
| TBD | TBD | TBD | 277 RFAI Data transferred from the FSC to VistA |
| TBD | TBD | TBD | New FileMan Files for any tables/code sets/qualifiers needed by the 277 RFAI that do not already exist for use by 270/271 and 278. |

##### Functional Requirement: Integrated Billing Site Parameters

Select System Manager's Integrated Billing Menu Option: enter/Edit IB Site Parameters

FACILITY NAME: ZZ DUP ALBANY//

FILE IN BACKGROUND: YES//

FILER UCI,VOL:

FILER HANG TIME: 2//

COPAY BACKGROUND ERROR GROUP:

COPAY EXEMPTION MAIL GROUP:

USE ALERTS:

MEANS TEST BILLING MAIL GROUP:

PER DIEM START DATE:

Figure 5: Integrated Billing Site Parameters Screen

Table 11: Integrated Billing Site Parameters Screen Description

| Graphical User Interface (GUI) Field | Table (Database Table that field connects to) | Field (Field in Table that the GUI field connects to) | Comments |
| --- | --- | --- | --- |
| Enter/Edit IB Site Parameters | File #350.9 | TBD | New field(s) for Primary Payer ID types & New multiple to store Revenue Codes to exclude from Printed Claims Report |
| Enter/Edit IB Site Parameters | File #350.9 | TBD | Parameters for the new 277 RFAI interface including retention days, day before removing from work list, |

#### Application Report Interface

This section is not applicable to this SDD because there are no application report changes for the data dictionary changes.

#### Unmapped Data Element

There are no unmapped data elements.

## Conceptual Infrastructure Design

This SDD contains enhancements that run on the existing VistA database and HL7 structure. As such, this section is not applicable to this SDD.

### System Criticality and High Availability

This section is not applicable to this SDD because this is not mission critical software and it falls under existing VistA procedures.

### Special Technology

This section is not applicable to this SDD because no special technology or devices are required.

### Technology Locations

Every existing nation-wide VistA site will use this new software.

### Conceptual Infrastructure Diagram

This SDD is for enhancements to the existing VistA infrastructure. No changes to the infrastructure are required, so this section is not applicable to this SDD.

# System Architecture

This is an enhancement to the existing VistA system and does not require changes to the System Architecture.

## Hardware Architecture

This section is not applicable to this SDD because it will use the existing VistA HL7 and VA network infrastructure.

## Software Architecture

This section is not applicable to this SDD because the enhancements use existing VistA MUMPS software without making any architectural changes.

## Network Architecture

This section is not applicable to this SDD because it will use the existing VistA HL7 messaging process.

## Service Oriented Architecture / ESS

This is an enhancement to the existing VistA system and does not require changes to the Enterprise Shared Services (ESS).

## Enterprise Architecture

This is an enhancement to the existing VistA system and does not require changes to the Enterprise Architecture.

# Data Design

Please refer to Section 3.2.1, Project Conceptual Data Model.

## DBMS Files

Please refer to Section 3.2.1 for the Project Conceptual Data model and Section 3.2.2 for Database Information.

## Non-DBMS Files

There are no Non-DBMS files for this VistA enhancement.

## Data View

The Conceptual Data Model is found in the ERD which will be placed here:[MCCF eBilling Phase 3 TSPR](http://your_srver.domain.ext/warboard/anotebk.asp?proj=1724&Type=Active)

# Detailed Design

## Hardware Detailed Design

VistA does not require any new hardware for this enhancement.

## Software Detailed Design

Please refer to Section 6.2.3 through Section 6.2.11, System Features for information on the detailed design of each software feature.

### Conceptual Design

Please refer to Section 6.2.3 through Section 6.2.11, System Features for information on the conceptual design of each software feature.

#### Product Perspective

The IB module communicates with other VistA modules such as Accounts Receivable (AR), Appointment Scheduling, Admission/Discharge/Transfer (ADT), Claims Processing and Tracking, Charge Master, and Insurance Verification (eIV). These are existing interfaces and no changes to their interaction will occur with this project.

***Note:*** *The X12 277 interface between VistA and FSC is a new interface link using the existing VistA HL7 messaging process.*

##### User Interfaces

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

##### Hardware Interfaces

There are no new hardware interfaces for this enhancement.

##### Software Interfaces

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

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

The following VistA software must be installed prior to the release of this product:

* Kernel V. 8.0
* MailMan V. 8.0
* VA FileMan V. 22.0
* Health Level Seven (HL7) V. 1.6
* Integrated Billing V. 2.0

##### Communications Interfaces

This project does not add or modify any existing communication interfaces. It does add a new batched transaction (277RFAI) to the existing Health Level Seven (HL7) V. 1.6 interface.

##### Memory Constraints

There are no memory constraints associated with this project.

##### Special Operations

There are no special operations associated with this project.

#### Product Features

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

**Integrated Billing**

* Enter/Edit Billing Information
* Printed Claims
* Insurance Company Entry/Edit
* Integrated Billing Site Parameters
* Claims Status Awaiting Resolution
* Third Party Joint Inquiry
* EDI Menu for Electronic Bills …
* View/Resubmit Claims – Live or Test
* Medicare-equivalent Remittance Advice (MRA)/Medicare Management Worklist (MRW)
* Billing Reports
* Copy and Cancel (CLON)/Correct Rejected/Denied Bill
* COB Management Worklist
* Request For Additional Information Worklist
* ASC X12N Health Care Claim (837) Transactions
* ASC X12N Health Care Claim Request For Additional Information (277RFAI)

#### User Characteristics

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

#### Dependencies and Constraints

1. Emdeon (HCCH) will provide resources to support both integration and site testing for this software development effort.
2. FSC will provide resources to support both integration and site testing for this software development effort.
3. The HL7 Team will provide approvals for the VistA and FSC interface.

### Specific Requirements

For a high level summary of the features and modifications that will be made to the eBilling module as part of this project, refer to Table 1 (Scope Inclusions) of Section 1.3 Scope.

#### Database Repository

No logical database design changes are necessary for this VistA enhancement.

#### System Features

This section covers the design for the Functional Requirements listed in Section 2.6 of the RSD.

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

###### Functional Requirement: Service Line issues – No Print Order

The IB system shall automatically combine any CPT/HCPCS procedures that have the exact same data elements and no Print Order and assign them the same revenue code with the combined number of units and monetary amounts. (BN 9.4, 9.5)

The current problem with the combining the procedures was introduced with IB\*2.0\*488.

**Design Element**

1. Remove changes from IBCF23 for combining procedures added in IB\*2.0\*488
2. Implement proper changes for procedures with greater than 999999999 units:

* After combination of procedures loop through the IBPO array and identify any entry with >999999999 units
* Split entry so that there is no single entry with >999999999 units.

###### Functional Requirement: Last Name Only

The IB system shall provide the ability for users to authorize a claim for a patient with only a last name in the Patient file (#1). (BN 11)

**Design Element**

This requirement consists of relaxing 1edit. The edit checking routines are in the IBCBB\* namespace. Only Patient name, not Subscriber name, was considered.

1. Both the wording and the check for IB300 need to be updated. Rewording Error Messages is typically done in the post install which in this case will be routine IBY547PO.

An example of updating an error message from patch IB\*2.0\*461:

UPDERR ; Update existing error code message for 350.8

N IBCODE,IBMESN,IBIEN,DIE,DIC,DA,DR,X,Y

;

S IBCODE="IB071",IBMESN="A claim must contain an ICD diagnosis."

S IBIEN=$O(^IBE(350.8,"C",IBCODE,0)) I 'IBIEN D MES^XPDUTL(">> IB ERROR

(#350.8) IB071 - Not Found, Error") Q

;

S DIE="^IBE(350.8,",DA=IBIEN,DR=".02////"\_IBMESN D ^DIE K DIE,DIC,DA,DR

D MES^XPDUTL(">> Updated IB ERROR (#350.8) Code IB071")

;

Q

The IB Error Message that needs updated:

IB300

Patient's first and last name must begin with an alpha character

Routine needing modification to relax edit:

ZL IBCBB9 ZP PARTB+17:PARTB+23

;

; First char of the pat's first and last name must be present and

; must be an alpha

K IBXDATA D F^IBCEF("N-PATIENT NAME",,,IBIFN)

S IBXDATA=$$NAME^IBCEFG1(IBXDATA)

I $S($G(IBXDATA)="":1,$E($P(IBXDATA,U))=" "!($E($P(IBXDATA,U))'?1A):1,$

E($P(IBXDATA,U,2))=" "!($E($P(IBXDATA,U,2))'?1A):1,1:0) S IBQUIT=$$IBER^IBCBB3(.

IBER,300) Q:IBQUIT

;

###### Functional Requirement: Present on Admission (POA) Code - Institutional

The IB system shall provide the ability for users to associate one of the following POA codes to a diagnosis on an inpatient, institutional claim:

* Y – Yes
* N – No
* U – No Information in the Record
* W – Clinically Undetermined (BN 6.3)

**Design Element**

1. Removing a code from a set of codes – In order to maintain the integrity of the database, the set of codes needs to be maintained as is. However, no new entries will be allowed to enter a 1 (Blank/Exemption). Something similar was done in IB\*2.0\*488 – Detailed below in this section.

What about existing entries that already exist in this file but have not been sent out or potentially even authorized. Authorized ones can be handled with instructions in the patch description for clearing the transmission queue.

**Note:** The data dictionary specifies DSS needs to be notified about this change. .

SELECT DIAGNOSIS FROM THE PTF RECORD TO INCLUDE ON THE BILL: X1-X2

YOU HAVE SELECTED X1,X2, TO BE ADDED TO THE BILL

IS THIS CORRECT? YES// ..

----------------- Existing Diagnoses for Bill -----------------

466.0 ACUTE BRONCHITIS (3)

253.5 DIABETES INSIPIDUS (6)

Edit POA indicators? NO// YES

466.0: ??

Enter the value that correctly indicates if this condition was present

at the time the patient was admitted.

Choose from:

Y Yes

N No

U No Information

W Clinically Undetermined

**1 Blank/Exempt from POA Reporting – Remove this selection**

Code invoking above prompt (no changes needed but helps with design understanding):

IBCSC4D

…

POAASK ; POA edit

N DIR,DIRUT,DUOUT,DTOUT,DX,ORD,X,Y

W !

S DIR("?")="Enter Yes to edit POA indicators."

S DIR("A")="Edit POA indicators"

S DIR(0)="YO",DIR("B")="NO" D ^DIR K DIR Q:Y'=1

S DIE="^IBA(362.3,",ORD="" F S ORD=$O(^IBA(362.3,"AO",IBIFN,ORD)) Q:OR

D="" D Q:$D(Y) ;

.S DA=$O(^IBA(362.3,"AO",IBIFN,ORD,"")),DX=$$GET1^DIQ(362.3,DA,.01),DR=

".04 "\_DX D ^DIE

.Q

K DA,DIE,DIR,DR

D CLEAN^DILF

Q

DD to be changed:

STANDARD DATA DICTIONARY #362.3 -- IB BILL/CLAIMS DIAGNOSIS FILE MAY 17,2015@13:03:42 PAGE 1

STORED IN ^IBA(362.3, (2133 ENTRIES) SITE: ALBANY CAMPUS DEVELOPMENT UCI: SERVER,SERVER

DATA NAME GLOBAL DATA

ELEMENT TITLE LOCATION TYPE

-----------------------------------------------------------------------------

362.3,.04 POA INDICATOR 0;4 SET

'Y' FOR Yes;

'N' FOR No;

'U' FOR No Information;

'W' FOR Clinically Undetermined;

**'1' FOR Blank/Exempt from POA Reportin**g;

LAST EDITED: OCT 10, 2008

HELP-PROMPT: Enter the value that correctly indicates if

this condition was present at the time the

patient was admitted.

DESCRIPTION: Enter the value that correctly indicates if

this condition was present at the time the

patient was admitted.

TECHNICAL DESCR: This is "Present On Admission" indicator.

Value of "1" instead of the actual blank is

required for 837 transmissions and QuadraMed

interface.

Example of similar change on IB\*2.0\*488 for removing something from selection in an existing SET OF CODES but maintaining the historical integrity of the field:

STANDARD DATA DICTIONARY #399 -- BILL/CLAIMS FILE

MAY 17,2015@13:08:58 PAGE 1

STORED IN ^DGCR(399, (728 ENTRIES) SITE: ALBANY CAMPUS DEVELOPMENT UCI: DEV

FEY,SERVER (VERSION 2.0)

DATA NAME GLOBAL DATA

ELEMENT TITLE LOCATION TYPE

-------------------------------------------------------------------------------

399,27 FORCE CLAIM TO PRINT TX;8 SET

'0' FOR NO FORCED PRINT;

'1' FOR FORCE LOCAL PRINT;

'2' FOR \*FORCE CLEARINGHOUSE PRINT;

LAST EDITED: MAR 14, 2014

HELP-PROMPT: Enter 0 to transmit the claim electronically to

the payer. Enter 1 to print the claim locally.

DESCRIPTION: This field determines whether a claim is

transmitted electronically (0) or printed

locally (1).

**SCREEN: S DIC("S")="I Y'=2"**

**EXPLANATION: Print to Clearinghouse is no longer an available option.**

WRITE AUTHORITY: ^

NOTES: TRIGGERED by the CURRENT BILL PAYER SEQUENCE

field of the BILL/CLAIMS File

TRIGGERED by the PRIMARY INSURANCE CARRIER

field of the BILL/CLAIMS File

TRIGGERED by the SECONDARY INSURANCE CARRIER

field of the BILL/CLAIMS File

TRIGGERED by the CURRENT BILL PAYER SEQUENCE

field of the BILL/CLAIMS File

TRIGGERED by the PRIMARY INSURANCE CARRIER

field of the BILL/CLAIMS File

The only Integration Agreement on that file does not mention that field.

Select INTEGRATION REFERENCES: 362.3 3824 INTEGRATED BILLING Private

DBIA3820-E IBA(362.3

DEVICE: ;132;9999 SSH VIRTUAL TERMINAL

INTEGRATION REFERENCE INQUIRY #3824 MAY 17,2015 14:50 PAGE 1

--------------------------------------------------------------------------------

3824 NAME: DBIA3820-E

CUSTODIAL PACKAGE: INTEGRATED BILLING Albany

SUBSCRIBING PACKAGE: ACCOUNTS RECEIVABLE Albany

USAGE: Private ENTERED: NOV 4,2002

STATUS: Pending EXPIRES:

DURATION: Till Otherwise Agr VERSION:

FILE: 362.3 ROOT: IBA(362.3

DESCRIPTION: TYPE: File

The Accounts Receivable package is requesting direct global read access to

file 362.3 IB BILL/CLAIMS DIAGNOSIS for the following fields listed below.

GLOBAL REFERENCE:

^IBA(362.3,

.01 DIAGNOSIS 0;1 Direct Global Read & w/Fileman

.02 BILL NUMBER 0;2 Direct Global Read & w/Fileman

.03 ORDER 0;3 Direct Global Read & w/Fileman

KEYWORDS: PRCA\*4.5\*179

MCCF

Data

Mart

Extract

VARI

Revenue

Information

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Press return to continue

Claims that are cloned or copied from existing claims may continue to have this value (“1”). The value will be removed as the claim is sent to FSC in the output 837. That is handled in design section 6.2.2.14.1.

###### Functional Requirement: Default Primary Payer ID – Institutional

The IB system shall use the EDI – Inst Payer Primary ID as the default value for the administrative contractor when an institutional claim is created. (BN 8.2)

**Design Element**

IB,PATIENT 56 XXX-XX-XXX BILL#: K101XXX - Inpat/UB04 SCREEN <10>

================================================================================

BILLING - SPECIFIC INFORMATION

[1] Bill Remarks

- FL-80 : UNSPECIFIED [NOT REQUIRED]

ICN/DCN(s) : UNSPECIFIED [NOT REQUIRED]

Auth/Referral : UNSPECIFIED [NOT REQUIRED]

Admitting Dx : 466.0 - ACUTE BRONCHITIS

PPS (DRG) : 0202 - BRONCHITIS & ASTHMA W CC/MCC

<2> Pt Reason f/Visit : UNSPECIFIED [NOT USED]

[3] Providers :

- ATTENDING : UNSPECIFIED

[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]

[5] Billing Provider : CHEYENNE VAMC

Taxonomy Code : 282N00000X

**[6] Alt Prim Payer IDs: UNSPECIFIED**

**[7]** Force MRA Sec Prt?: NO FORCED PRINT

**[8]** Provider ID Maint : (Edit Provider ID information)

<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT: 6

**Primary Payer - Alt Inst Prim Payer ID Type: ??**

**This is the Alternate Inst Primary Payer ID Type which is used**

**to identify an Alternate Inst Primary Payer ID for this payer.**

**If this value is unspecified, the EDI-Inst Primar**

**Choose from:**

**1 DME**

**2 Hospice 🡨 Just an example**

**Alt Inst Prim Payer ID Type: 1 DME**

**Alt Inst Prim Payer ID: 7766554432// ??🡨 Pull the ID from the Insurance Co file and let them enter a onetime ID if they want.**

**This is the Alternate Inst Prim Payer ID which is**

**used to route claims to an alternate administration**

**contractor for certain claims.**

**Secondary Payer – Alt Inst Prim Payer ID Type:**

**Tertiary Payer – Alt Inst Prim Payer ID Type: 🡨 Make prompt smart**

1. No changes are needed to any Billing Screens to actually create a default. The default will happen if nothing is done. However, the screen painting/display routine needs to be updated to display the new section (#6) with either the values entered or “UNSPECIFIED” for the administrator contractor is EN^IBCSC102. Also, routine IBCSCE, the billing screen editing driver, will need to be modified to allow editing of this new section and moving two other sections down.

Refer to section 6.2.2.2.1.6 for a further explanation and example as these to requirements are closely related.

###### Functional Requirement: Default Primary Payer ID – Professional

The IB system shall use the EDI – Prof Payer Primary ID as the default value for the administrative contractor when a professional claim is created. (BN 8.2)

**Design Element**

IB,PATIENT MRA XX-XX-XXXX BILL#: K101XXX - Outpat/1500 SCREEN <10>

================================================================================

BILLING - SPECIFIC INFORMATION

[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]

Unable To Work To : UNSPECIFIED [NOT REQUIRED]

[2] ICN/DCN(s) : UNSPECIFIED [NOT REQUIRED]

Auth/Referral : UNSPECIFIED [NOT REQUIRED]

[3] Providers :

- RENDERING : UNSPECIFIED

[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]

Lab CLIA # : UNSPECIFIED [NOT REQUIRED]

Mammography Cert # : UNSPECIFIED [NOT REQUIRED]

[5] Chiropractic Data : UNSPECIFIED [NOT REQUIRED]

[6] CMS-1500 Box 19 : UNSPECIFIED [NOT REQUIRED]

[7] Billing Provider : CHEYENNE VAMC

Taxonomy Code : 282N00000X

**[8] Alt Prim Payer ID : UNSPECIFIED**

**[9]** Force MRA Sec Prt? : NO FORCED PRINT

**[10]** Provider ID Maint : (Edit Provider ID information)

<RET> to CONTINUE, 1-9 to EDIT, '^N' for screen N, or '^' to QUIT:8

**Alt Prof Prim Payer ID Type: ??**

**This is the Alternate Prof Primary Payer ID Type which is used**

**to identify an Alternate Prof Primary Payer ID for this payer.**

**Choose from:**

**1 DME**

**2 Hospice**

**Alt Prof Prim Payer ID Type: 1 DME**

**Alt Prof Prim Payer ID: 7766554432// 🡨 Pull the ID from the Insurance Co file and let them enter a onetime ID if they want.**

1. No changes are needed to any Billing Screens to actually create a default. The default will happen if nothing is done. However, the screen painting/display routine needs to be updated to display the new section (#8) with either the values entered or “UNSPECIFIED” for the administrator contractor is EN^IBCSC102. Also, routine IBCSCE, the billing screen editing driver, will need to be modified to allow editing of this new section and moving two other sections down.

Refer to section 6.2.2.2.1.7 for a further explanation and example as these to requirements are closely related.

###### Functional Requirement: Designate Claims Administrative Contractor – Institutional

The IB system shall provide the ability for a user to change the default EDI - Inst Payer Primary ID to an additional institutional primary payer ID when creating an institutional claim. (BN 8.2)

**Design Element**

1. Need to create a 6 new fields in the Bills/Claims File (#399). The fields to be created are as follows:

* Field # 140 – Primary Payer – Alternate ID Type [M2;.01]
* Field # 141 – Secondary Payer – Alternate ID Type [M2;.02]
* Field # 142 – Tertiary Payer - Alternate ID Type [M2;.03]
* Field # 143 – Primary Payer – Alternate ID [M2;.04]
* Field # 144 – Secondary Payer – Alternate ID [M2;.05]
* Field # 145 – Tertiary Payer - Alternate ID [M2;.06]

These fields will be multi-functional. If the Bill/Claim is a “Professional” Bill/Claim then these fields will represent the Professional values. If the Bill/Claim is an “Institutional” Bill/Claim, then these fields will represent the Institutional values.

All should be defined as the default IDs (fields #3.02 and #3.04) is in the insurance company file (#36).

INPUT TRANSFORM: K:$L(X)>30!($L(X)<1)!($$UP^XLFSTR(X)["PRNT") X

1. Need to update the input template [IB SCREEN102] by inserting the Alt Prim Payer IDs field at section 6 and thus moving the remaining sections down a number. (Refer to the input template code and example below for how the update template will look. This will require numerous changes to the branching logic in the template as sections move down.

Editing Input Template "IB SCREEN102"

==========[ INSERT ]===========< (File 399) >===========[ <PF1>H=Help ]====

@105

S:IBDR20'["105" Y="@106"

BILLING PROVIDER TAXONOMY

D DISPTAX^IBCEP81($P($G(^DGCR(399,DA,"U3")),U,11),"Billing Provider")

I $P($G(^DGCR(399,DA,"U3")),U,11) N X,Y,DIR S DIR(0)="EA",DIR("A")="Press Return

🡸 Need to insert code here for the new “Alt Prim Payer IDs”

prompt for Institutional claims.

@106

S:IBDR20'["106" Y="@107"

I $$TEST^IBCEF84(DA) S Y="@1060"

I '$P($G(^DGCR(399,DA,"TX")),U,8),'$$TXMT^IBCEF4(DA) S Y="@1061"

I $$REQMRA^IBEFUNC(DA) S Y="@10611"

FORCE CLAIM TO PRINT//NO FORCED PRINT

S Y="@1069"

@1060

D MESSAGE^IBCEF84

S Y="@1069"

@10611

FORCE PRINT MRA SECONDARY//NO FORCED PRINT

S Y="@1069"

@1061

<=======T=======T=======T=======T=======T=======T=======T=======T=======T====

1. Build some intelligence into the logic. Only ask ID if users enter a type
2. Only ask for as many insurances as there are on the claim (Primary, Secondary, Tertiary)
3. Delete type if no ID defaulted or ID entered
4. Allow the Insurance company default to be overridden

IB,PATIENT M56 XX-XX-XXXX BILL#: K101XXX - Inpat/UB04 SCREEN <10>

================================================================================

BILLING - SPECIFIC INFORMATION

[1] Bill Remarks

- FL-80 : UNSPECIFIED [NOT REQUIRED]

ICN/DCN(s) : UNSPECIFIED [NOT REQUIRED]

Auth/Referral : UNSPECIFIED [NOT REQUIRED]

Admitting Dx : 466.0 - ACUTE BRONCHITIS

PPS (DRG) : 0202 - BRONCHITIS & ASTHMA W CC/MCC

<2> Pt Reason f/Visit : UNSPECIFIED [NOT USED]

[3] Providers :

- ATTENDING : UNSPECIFIED

[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]

[5] Billing Provider : CHEYENNE VAMC

Taxonomy Code : 282N00000X

**[6] Alt Prim Payer IDs: UNSPECIFIED 🡸 Display up to 3 IDs here**

**[7]** Force MRA Sec Prt?: NO FORCED PRINT

**[8]** Provider ID Maint : (Edit Provider ID information)

<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT: 6

**Primary Payer - Alt Inst Prim Payer ID Type: ??**

**This is the Alternate Inst Primary Payer ID Type which is used**

**to identify an Alternate Inst Primary Payer ID for this payer.**

**If this value is unspecified, the EDI-Inst Primar**

**Choose from:**

**1 DME**

**2 Hospice 🡨 Just an example, these values will be pulled from the new field in the #36 (Insurance Company file) for Institutional (field #15).**

**Alt Inst Prim Payer ID Type: 1 DME**

**Alt Inst Prim Payer ID: 7766554432// ?? 🡨 This value will be pulled from the new #355.98 file-the ID from the Insurance Co file and stored in the new field (#399,143)**

**This is the Alternate Inst Prim Payer ID which is**

**used to route claims to an alternate administration**

**contractor for certain claims.**

**Secondary Payer – Alt Inst Prim Payer ID Type: 🡨 This is the new (#399,141)field**

**Secondary Payer - Alt Inst Prim Payer ID: 7766554432// ?? 🡨 This value will be pulled from the new #355.98 file=the ID from the Insurance Co file and stored in the new field (#399,144)**

**Tertiary Payer – Alt Inst Prim Payer ID Type: 🡨 This is the new (#399,142)field**

**Tertiary Payer - Alt Inst Prim Payer ID: 7766554432// ?? 🡨 This value will be pulled from the new #355.98 file-the ID from the Insurance Co file and stored in the new field (#399,145)**

1. Need to update the routine EN^IBCSC102 by inserting code to handle the new section 6 for “Alt Inst Prim Payer ID” and thus moving the remaining sections down in the routine.
2. Update the Payer ID function to grab the correct IDs and make the Qualifier “PI” if one of these new IDs is used.

PIECE 1 RECORD ID 'CI5 ' 364.6[1818] 364.7[1518] 36

4.5[131] Length=4 Max Lines=0

>S IBXDATA=""

>I $D(IBXDATA) S IBXDATA="CI5 "

PIECE 2 Payer Primary ID Qualifier 364.6[1819] 364.7[1519] 36

4.5[5] Length=3 Max Lines=0

>Constant Value: ""

**>D CLEANUP^IBCEF78(.IBXSAVE),PAYERIDS^IBCEF78(IBXIEN,.IBXSAVE) S IBXDATA=$P($**

**G(IBXSAVE("CI\_PID",1)),U)**

PIECE 3 Payer Primary ID 364.6[1820] 364.7[1520] 36

4.5[5] Length=20 Max Lines=0

**>Constant Value: ""**

**>S IBXDATA=$P($G(IBXSAVE("CI\_PID",1)),U,2)**

###### Functional Requirement: Designate Claims Administrative Contractor – Professional

The IB system shall provide the ability for a user to change the default EDI - Prof Payer Primary ID to an additional professional primary payer ID when creating a professional claim. (BN 8.2)

**Design Element**

1. The 6 new fields in the Bills/Claims File (#399) for section 6.2.2.2.1.6 are the same fields that are being referenced here:

* Field # 140 – Primary Payer – Alternate ID Type [M2;.01]
* Field # 141 – Secondary Payer – Alternate ID Type [M2;.02]
* Field # 142 – Tertiary Payer - Alternate ID Type [M2;.03]
* Field # 143 – Primary Payer – Alternate ID [M2;.04]
* Field # 144 – Secondary Payer – Alternate ID [M2;.05]
* Field # 145 – Tertiary Payer - Alternate ID [M2;.06]

These fields will be multi-functional, meaning; if the Bill/Claim is a “Professional” Bill/Claim then these fields will represent the Professional values. If the Bill/Claim is an “Institutional” Bill/Claim, then these fields will represent the Institutional values.

All should be defined as the default IDs (fields #3.02 and #3.04) is in the insurance company file (#36)

INPUT TRANSFORM: K:$L(X)>30!($L(X)<1)!($$UP^XLFSTR(X)["PRNT") X

1. Need to update the input template [IB SCREEN10H] by inserting the Alt Prim Payer IDs field at section 8 and thus moving the remaining sections down a number. Refer to the input template code and example below for how the update template will look. This will require numerous changes to the branching logic in the template as sections move down.

Editing Input Template "IB SCREEN10H"

==========[ INSERT ]===========< (File 399) >==========[ <PF1>H=Help ]====

@106

S:IBDR20'["106" Y="@107"

FORM LOC 19-UNSPECIFIED DATA;T

D ASK19^IBCEU3(DA)

@107

S:IBDR20'["107" Y="@108"

BILLING PROVIDER TAXONOMY

D DISPTAX^IBCEP81($P($G(^DGCR(399,DA,"U3")),U,11),"Billing Provider")

I $P($G(^DGCR(399,DA,"U3")),U,11) N X,Y,DIR S DIR(0)="EA",DIR("A")="Press Return

🡸 Need to insert code here for the new “Alt Prim Payer IDs”

prompt for Professional claims.

@108

S:IBDR20'["108" Y="@109"

I $$TEST^IBCEF84(DA) S Y="@1080"

I '$P($G(^DGCR(399,DA,"TX")),U,8),'$$TXMT^IBCEF4(DA) S Y="@1082"

I $$REQMRA^IBEFUNC(DA) S Y="@10811"

FORCE CLAIM TO PRINT//NO FORCED PRINT

S Y="@1082"

@1080

D MESSAGE^IBCEF84

S Y="@1082"

<=======T=======T=======T=======T=======T=======T=======T=======T=======T====

1. Build some intelligence into the logic. Only ask ID if they enter a type.
2. Only ask for as many insurances as there are on the claim (Primary, Secondary, Tertiary)
3. Delete type if no ID defaulted or entered.
4. The Insurance company default can be overridden

IB,PATIENT MRA XX-XX-XXXX BILL#: K101XXX - Outpat/1500 SCREEN <10>

================================================================================

BILLING - SPECIFIC INFORMATION

[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]

Unable To Work To : UNSPECIFIED [NOT REQUIRED]

[2] ICN/DCN(s) : UNSPECIFIED [NOT REQUIRED]

Auth/Referral : UNSPECIFIED [NOT REQUIRED]

[3] Providers :

- RENDERING : UNSPECIFIED

[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]

Lab CLIA # : UNSPECIFIED [NOT REQUIRED]

Mammography Cert # : UNSPECIFIED [NOT REQUIRED]

[5] Chiropractic Data : UNSPECIFIED [NOT REQUIRED]

[6] CMS-1500 Box 19 : UNSPECIFIED [NOT REQUIRED]

[7] Billing Provider : CHEYENNE VAMC

Taxonomy Code : 282N00000X

**[8] Alt Prim Payer ID : UNSPECIFIED 🡸 Display up to 3 IDs here**

**[9]** Force MRA Sec Prt? : NO FORCED PRINT

**[10]** Provider ID Maint : (Edit Provider ID information)

<RET> to CONTINUE, 1-9 to EDIT, '^N' for screen N, or '^' to QUIT:8

**Alt Prof Prim Payer ID Type: ??**

**This is the Alternate Prof Primary Payer ID Type which is used**

**to identify an Alternate Prof Primary Payer ID for this payer.**

**Choose from:**

**1 DME**

**2 Hospice**

**Alt Prof Prim Payer ID Type: 1 DME**

**Alt Prof Prim Payer ID: 7766554432// 🡨 Just an example, these values will be pulled from the new field in the #36 (Insurance Company file) for Professional (field #16).**

**Alt Inst Prim Payer ID Type: 1 DME**

**Alt Inst Prim Payer ID: 7766554432// ?? 🡨 This value will be pulled from the new #355.98 file-the ID from the Insurance Co file and stored in the new field (#399,143)**

**This is the Alternate Prof Prim Payer ID which is**

**used to route claims to an alternate administration**

**contractor for certain claims.**

**Secondary Payer – Alt Prof Prim Payer ID Type: 🡨 This is the new (#399,141)field**

**Secondary Payer - Alt Prof Prim Payer ID: 7766554432// ?? 🡨 This value will be pulled from the new #355.98 file-the ID from the Insurance Co file and stored in the new field (#399,144)**

**Tertiary Payer – Alt Prof Prim Payer ID Type: 🡨 This is the new (#399,142)field**

**Tertiary Payer - Alt Prof Prim Payer ID: 7766554432// ?? 🡨 This value will be pulled from the new #355.98 file-the ID from the Insurance Co file and stored in the new field (#399,145)**

1. Need to update the routine EN^IBCSC10H by inserting code to handle the new section 8 for “Alt Prof Prim Payer ID” and thus move the remaining sections down in the routine.
2. Update the Payer ID function to grab the correct IDs and make the Qualifier “PI” if one of these new IDs is used.

PIECE 1 RECORD ID 'CI5 ' 364.6[1818] 364.7[1518] 36

4.5[131] Length=4 Max Lines=0

>S IBXDATA=""

>I $D(IBXDATA) S IBXDATA="CI5 "

PIECE 2 Payer Primary ID Qualifier 364.6[1819] 364.7[1519] 36

4.5[5] Length=3 Max Lines=0

>Constant Value: ""

**>D CLEANUP^IBCEF78(.IBXSAVE),PAYERIDS^IBCEF78(IBXIEN,.IBXSAVE) S IBXDATA=$P($**

**G(IBXSAVE("CI\_PID",1)),U)**

PIECE 3 Payer Primary ID 364.6[1820] 364.7[1520] 36

4.5[5] Length=20 Max Lines=0

**>Constant Value: ""**

**>S IBXDATA=$P($G(IBXSAVE("CI\_PID",1)),U,2)**

##### System Feature: Printed Claims

###### Functional Requirement: Amount Paid – CMS 1500 Form - Secondary

The IB System shall provide the ability to print the amount paid by the primary payer in Box 29 of the CMS 1500 form when a secondary claim is printed locally. (BN 12.1)

**Design Element**

1. The UB-04 currently prints the amount paid by previous payers. The output formatter fields governing Box 29 of the CMS 1500 form will be modified to imitate the corresponding fields on the UB-04 (^IBA(364.7,1344)) in the manner described below:

|  |  |
| --- | --- |
| Enhancement Category | ☐New ☒Modify ☐Delete ☐No Change |
| File Number and Name | #364.7, IB FORM FIELD CONTENT |
| IEN | 1198 |
| Data Element – Before | 5, N-GET FROM PREVIOUS EXTRACT |
| Data Element – After | **156**, N-PRIOR PAYMENTS (*This Data Element is already pulling the prior paid amount(s), if any, and totaling them in the variable* IBXSAVE(“PTOT”)*, which will then be used by this O.F. field to print in box 29.*) |
| Format Code – Before | S IBXSAVE("PAID")=0 K IBXDATA I $O(^TMP("IBXDATA",$J,IBXREC,""),-1)'>1 S IBXDATA=$$DOL^IBCEF77(IBXSAVE("PAID"),8) K IBXSAVE("PAID") |
| Format Code – After | **S IBXDATA=$$DOL^IBCEF77(IBXSAVE(“PTOT”),10)** |

###### Functional Requirement: Amount Paid – CMS 1500 Form – Tertiary

The IB System shall provide the ability to print the amount paid by the primary and secondary payers in Box 29 of the CMS 1500 form when a tertiary claim is printed locally. (BN 12.1)

**Design Element**

Please refer to the design for section 6.2.2.2.2.1.

###### Functional Requirement: Admission Date/Time – UB04 - Inpatient Only

The IB system shall provide the ability to print the Admission Date and Time in Form Locators 12 and 13 of the UB04 form for inpatient admissions only. (BN 12.3)

**Design Element**

|  |  |
| --- | --- |
| Enhancement Category | ☐New ☒Modify ☐Delete ☐No Change |
| File Number and Name | #364.7, IB FORM FIELD CONTENT |
| IEN | 1305 |
| Name | Admission Date (FL-12) |
| Format Code – Before | S IBXSAVE("ADTM")=$$TIME^IBCF3(IBXDATA), IBXDATA=$$DATE^IBCF2($P(IBXDATA,"."),,1) |
| Format Code – After | **K IBXDATA,IBXSAVE(“ADTM”) I $$INPAT^IBCEF(IBXIEN)** S IBXSAVE("ADTM")=$$TIME^IBCF3(IBXDATA), IBXDATA=$$DATE^IBCF2($P(IBXDATA,"."),,1) |

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

###### Functional Requirement: Additional EDI – Institutional Primary Payer IDs

The IB system shall provide the ability to define 0 - n additional primary payer IDs for an insurance company with the following data:

* Additional ID Type, and
* Additional ID (BN 8.2)

**Design Element**

**Note:** The design for 6.2.2.2.3.1-2, 6.2.2.2.4.5-6, and 6.2.2.2.1.4-7 are interrelated and should be reviewed together.

1. Need to create a new multiple field with 2 pieces in the Insurance File (#36). This new multi-field will be #36,15 and will have the following pieces:

* Alternate Institutional Payer Primary ID Type (.01)
* Alternate Institutional Payer Primary ID (.02)

The Alternate Institutional Payer Primary ID Type will be a pointer to the new IB Administrative Contractor Type file #355.98.

The Alternate Institutional Payer Primary ID will be a FREE TEXT field and allow for 1-30 characters. It will use the same code as the Payer Primary ID fields (#3.02 and #3.04) so as to prevent any PRNT values and locked by the same security key (see below):

INPUT TRANSFORM: K:$L(X)>30!($L(X)<1)!($$UP^XLFSTR(X)["PRNT") X

I $D(X) K:'$$EDIKEY^IBCNSC X

1. The system needs to automatically transmit the Qualifier = PI in CI5, Piece 2. The Alternate Institutional Payer Primary ID Type will not transmit – it is just used for selection in billing.

PIECE 1 RECORD ID '**CI5** ' 364.6[1818] 364.7[1518] 364.5[131] Length=4 Max Lines=0

>S IBXDATA=""

>I $D(IBXDATA) S IBXDATA="**CI5** "

PIECE 2 Payer Primary ID Qualifier 364.6[1819] 364.7[1519] 364.5[5] Length=3 Max Lines=0

>Constant Value: ""

>D CLEANUP^IBCEF78(.IBXSAVE),**PAYERIDS^IBCEF78(IBXIEN,.IBXSAVE)** **S IBXDATA=$P($G(IBXSAVE("CI\_PID",1)),U)**

1. As part of the [IBEDIT INS CO1] Input Template the new fields will be added to the process as depicted below:

Insurance Company Editor Apr 27, 2015@09:42:49 Page: 1 of 10

Insurance Company Information for: MEDICARE (WNR)

Type of Company: MEDICARE Currently Active

Billing Parameters

Signature Required?: NO Type Of Coverage: MEDICARE

Reimburse?: WILL NOT REIMBURSE Billing Phone: 972-766-5252

Mult. Bedsections: YES Verification Phone: 888-226-5511

One Opt. Visit: NO Precert Comp. Name:

Diff. Rev. Codes: Precert Phone: 800-655-1636

Amb. Sur. Rev. Code:

Rx Refill Rev. Code:

Filing Time Frame: WITHIN 1 YR FROM DOS

EDI Parameters

Transmit?: YES-LIVE Insurance Type: MEDICARE

+ Enter ?? for more actions >>>

BP Billing/EDI Param IO Inquiry Office EA Edit All

MM Main Mailing Address AC Associate Companies AI (In)Activate Company

IC Inpt Claims Office ID Prov IDs/ID Param CC Change Insurance Co.

OC Opt Claims Office PA Payer DC Delete Company

PC Prescr Claims Of RE Remarks VP View Plans

AO Appeals Office SY Synonyms EX Exit

Select Action: Next Screen// BP Billing/EDI Param

SIGNATURE REQUIRED ON BILL?: NO//

REIMBURSE?: WILL NOT REIMBURSE//

ALLOW MULTIPLE BEDSECTIONS: YES//

DIFFERENT REVENUE CODES TO USE:

ONE OPT. VISIT ON BILL ONLY: NO//

AMBULATORY SURG. REV. CODE:

PRESCRIPTION REFILL REV. CODE:

STANDARD FILING TIME FRAME:

FILING TIME FRAME: WITHIN 1 YR FROM DOS Replace

TYPE OF COVERAGE: MEDICARE//

BILLING PHONE NUMBER: 972-766-5252//

VERIFICATION PHONE NUMBER: 888-226-5511//

Are Precerts Processed by Another Insurance Co.?: NO

//

PRECERTIFICATION PHONE NUMBER: 800-655-1636//

EDI - Transmit?: YES-LIVE//

EDI - Inst Payer Primary ID: 12M30//

**EDI – Alt Inst Payer Primary ID Type: ??**

**This ID Type designates the type of claims which are**

**processed by a different Administration Contractor**

**than normal claims. It determines which Alternate**

**Institutional Payer Primary ID will be transmitted.**

**Choose from: 🡨 These choices will come from the IB Site Parameters**

**1 DME**

**EDI – Alt Inst Payer Primary ID Type: DME**

**EDI – Alt Inst Payer Primary ID: XYZABC 🡨 Do not allow PRNT values**

**EDI – Alt Inst Payer Primary ID Type:**

EDI - 1ST Inst Payer Sec. ID Qualifier: PAYER ID #//

EDI - 1ST Inst Payer Sec. ID: 670899//

EDI - 2ND Inst Payer Sec. ID Qualifier:

1. The [IBEDIT INS CO1] Input Template code will be modified as shown below:

Editing Input Template "IBEDIT INS CO1"

========[ INSERT ]==========< (File 36) >========[ <PF1>H=Help ]====

I '$G(DIPA("IBTX")) S Y="@17"

EDI ID NUMBER - INST;"EDI - Inst Payer Primary ID"

I X=$G(IBEDIKEY(4))!$$KCHK^XUSRB("IB EDI INSURANCE EDIT") S Y="@17211"

EDI ID NUMBER - INST////^S X=$G(IBEDIKEY(4))

I $$EDIKEY^IBCNSC()

S Y="@171"

@17211

**🡸 Code will be entered here to address the editing of the new “EDI – Alt Inst Payer Primary ID” and “EDI – Alt Inst Payer Primary ID Type” fields.**

I '$G(DIPA("IBTX")) S Y="@17"

EDI INST SECONDARY ID QUAL(1);"EDI - 1ST Inst Payer Sec. ID Qualifier"

I X=""&($G(IBEDIKEY(3,6))="")&$$KCHK^XUSRB("IB EDI INSURANCE EDIT") S Y="@1722"

I X=$G(IBEDIKEY(1,6))!$$KCHK^XUSRB("IB EDI INSURANCE EDIT") S Y="@17212"

EDI INST SECONDARY ID QUAL(1)////^S X=$G(IBEDIKEY(1,6))

EDI INST SECONDARY ID(1)////^S X=$G(IBEDIKEY(2,6))

I $$EDIKEY^IBCNSC()

S Y="@171"

@17212

I '$G(DIPA("IBTX")) S Y="@17"

EDI INST SECONDARY ID(1);"EDI - 1ST Inst Payer Sec. ID"

I X=$G(IBEDIKEY(2,6))!$$KCHK^XUSRB("IB EDI INSURANCE EDIT") S Y="@17213"

<=======T=======T=======T=======T=======T=======T=======T=======T=======T

###### Functional Requirement: Additional EDI – Professional Primary Payer IDs

The IB system shall provide the ability to define 0 – n additional professional primary payer IDs for an insurance company with the following data:

* Additional ID Type, and
* Additional ID (BN 8.2)

**Design Element**

**Note:** The design for 6.2.2.2.3.1-2, 6.2.2.2.4.5-6, and 6.2.2.2.1.4-7 are interrelated and should be reviewed together.

1. Need to create a new multiple field with 2 pieces in the Insurance File (#36). This new multi-field will be #36,16 and will have the following pieces:

* Alternate Professional Payer Primary ID Type (.01)
* Alternate Professional Payer Primary ID (.02)

The Alternate Professional Payer Primary ID Type will be a pointer to the new IB Administrative Contractor Type file #355.98

The Alternate Professional Payer Primary ID will be a FREE TEXT field and allow for 1-30 characters. It will use the same code as the Payer Primary ID fields (#3.02 and #3.04) and locked by the same security key so as to prevent any PRNT values (see below):

INPUT TRANSFORM: K:$L(X)>30!($L(X)<1)!($$UP^XLFSTR(X)["PRNT") X

I $D(X) K:'$$EDIKEY^IBCNSC X

1. The system needs to automatically transmit the Qualifier = PI in CI5, Piece 2. The Alternate Professional Payer Primary ID Type will not transmit – it is just used for selection in billing.

PIECE 1 RECORD ID '**CI5** ' 364.6[1818] 364.7[1518] 364.5[131] Length=4 Max Lines=0

>S IBXDATA=""

>I $D(IBXDATA) S IBXDATA="**CI5** "

PIECE 2 Payer Primary ID Qualifier 364.6[1819] 364.7[1519] 364.5[5] Length=3 Max Lines=0

>Constant Value: ""

>D CLEANUP^IBCEF78(.IBXSAVE),**PAYERIDS^IBCEF78(IBXIEN,.IBXSAVE)** **S IBXDATA=$P($G(IBXSAVE("CI\_PID",1)),U)**

1. As part of the [IBEDIT INS CO1] Input Template the new fields will be added to the process as depicted below:

Insurance Company Editor Apr 27, 2015@09:42:49 Page: 1 of 10

Insurance Company Information for: MEDICARE (WNR)

Type of Company: MEDICARE Currently Active

Billing Parameters

Signature Required?: NO Type Of Coverage: MEDICARE

Reimburse?: WILL NOT REIMBURSE Billing Phone: 972-766-5252

Mult. Bedsections: YES Verification Phone: 888-226-5511

One Opt. Visit: NO Precert Comp. Name:

Diff. Rev. Codes: Precert Phone: 800-655-1636

Amb. Sur. Rev. Code:

Rx Refill Rev. Code:

Filing Time Frame: WITHIN 1 YR FROM DOS

EDI Parameters

Transmit?: YES-LIVE Insurance Type: MEDICARE

+ Enter ?? for more actions >>>

BP Billing/EDI Param IO Inquiry Office EA Edit All

MM Main Mailing Address AC Associate Companies AI (In)Activate Company

IC Inpt Claims Office ID Prov IDs/ID Param CC Change Insurance Co.

OC Opt Claims Office PA Payer DC Delete Company

PC Prescr Claims Of RE Remarks VP View Plans

AO Appeals Office SY Synonyms EX Exit

Select Action: Next Screen// BP Billing/EDI Param

SIGNATURE REQUIRED ON BILL?: NO//

REIMBURSE?: WILL NOT REIMBURSE//

ALLOW MULTIPLE BEDSECTIONS: YES//

DIFFERENT REVENUE CODES TO USE:

ONE OPT. VISIT ON BILL ONLY: NO//

AMBULATORY SURG. REV. CODE:

PRESCRIPTION REFILL REV. CODE:

STANDARD FILING TIME FRAME:

FILING TIME FRAME: WITHIN 1 YR FROM DOS Replace

TYPE OF COVERAGE: MEDICARE//

BILLING PHONE NUMBER: 972-766-5252//

VERIFICATION PHONE NUMBER: 888-226-5511//

Are Precerts Processed by Another Insurance Co.?: NO

//

PRECERTIFICATION PHONE NUMBER: 800-655-1636//

EDI - Transmit?: YES-LIVE//

EDI - Inst Payer Primary ID: 12M30//

EDI – Alt Inst Payer Primary ID Type:

EDI – Alt Inst Payer Primary ID Type: DME

EDI – Alt Inst Payer Primary ID: XYZABC

EDI – Alt Inst Payer Primary ID Type:

EDI - 1ST Inst Payer Sec. ID Qualifier: PAYER ID #//

EDI - 1ST Inst Payer Sec. ID: 670899//

EDI - 2ND Inst Payer Sec. ID Qualifier:

EDI - Prof Payer Primary ID: SMWYO//

**EDI – Alt Prof Payer Primary ID Type:**

**This ID Type designates the type of claims which are**

**processed by a different Administration Contractor**

**than normal claims. It determines which Alternate**

**Institutional Payer Primary ID will be transmitted.**

**Choose from: 🡨 These choices will come from the IB Site Parameters**

**1 DME**

**EDI – Alt Prof Payer Primary ID: XYZABC 🡨 Do not allow PRNT values**

**EDI – Alt Prof Payer Primary ID Type:**

EDI - 1ST Prof Payer Sec. ID Qualifier: PAYER ID #//

EDI - 1ST Prof Payer Sec. ID: VA442//

EDI - 2ND Prof Payer Sec. ID Qualifier:

EDI - Insurance Type: MEDICARE//

1. The [IBEDIT INS CO1] Input Template code will be modified as shown below:

Editing Input Template "IBEDIT INS CO1"

==========[ INSERT ]============< (File 36) >==========[ <PF1>H=Help ]====

@1722

EDI ID NUMBER - PROF;"EDI - Prof Payer Primary ID"

I X=$G(IBEDIKEY(2))!$$KCHK^XUSRB("IB EDI INSURANCE EDIT") S Y="@17221"

EDI ID NUMBER - PROF////^S X=$G(IBEDIKEY(2))

I $$EDIKEY^IBCNSC()

S Y="@171"

@17221

**🡸 Code will be entered here to address the editing of the new “EDI – Alt Prof Payer Primary ID” and “EDI – Alt Prof Payer Primary ID Type” fields.**

I '$G(DIPA("IBTX")) S Y="@17"

EDI PROF SECONDARY ID QUAL(1);"EDI - 1ST Prof Payer Sec. ID Qualifier"

I X=""&($G(IBEDIKEY(7,6))="")&$$KCHK^XUSRB("IB EDI INSURANCE EDIT") S Y="@1723"

I X=$G(IBEDIKEY(5,6))!$$KCHK^XUSRB("IB EDI INSURANCE EDIT") S Y="@17222"

EDI PROF SECONDARY ID QUAL(1)////^S X=$G(IBEDIKEY(5,6))

EDI PROF SECONDARY ID(1)////^S X=$G(IBEDIKEY(6,6))

I $$EDIKEY^IBCNSC()

S Y="@171"

@17222

I '$G(DIPA("IBTX")) S Y="@17"

EDI PROF SECONDARY ID(1);"EDI - 1ST Prof Payer Sec. ID"

I X=$G(IBEDIKEY(6,6))!$$KCHK^XUSRB("IB EDI INSURANCE EDIT") S Y="@17223"

<=======T=======T

##### System Feature: Integrated Billing Site Parameters

###### Functional Requirement: Store ASC X12N Health Care Claim Request For Additional Information (RFAI) (277RFAI) Transactions

The IB system shall provide the ability for users to define the length of time for which ASC X12N Health Care Claim Request For Additional Information (RFAI) (277RFAI) transactions will be stored. (BN 3.1)

**Design Element**

**Note:** This screen shot applies to the next 4 requirements.

Claims Tracking Parameters Apr 27, 2015@13:50:19 Page: 1 of 2

Only authorized persons may edit this data.

Tracking Parameters Random Sample Parameters

Track Inpatient: INSURED AND UR ONLY Medicine Sample: 5

Track Outpatient: INSURED ONLY Medicine Admissions: 5

Track Rx: INSURED ONLY Surgery Sample: 5

Track Prosthetics: INSURED ONLY Surgery Admissions: 5

Reports Can Add CT: YES Psych Sample: 1

Psych Admissions: 5

General Parameters **Request For Additional Info**

Initialization Date: 01/01/94 **Save 277 RFAI:**

Use Admission Sheet: YES **Remove 277 RFAI from WL: 20 Days**

Header Line 1: CHEYENNE VAMC

Header Line 2: 2360 E. PERSHING BLVD

Header Line 3: CHEYENNE, WY

+ Enter ?? for more actions **\* Note HS is from Patch 517**

TP Tracking **HS HCSR** EX Exit

RS Random Sample **RI RFAI**

GP General EA Edit All

Select Action: Next Screen//RI

**Years to store 277 RFAI Transactions: 🡨 Default Forever**

**This is the number of years for which 277 RFAI transactions**

**will be saved in VistA.**

**Years to store 277 RFAI Transactions:**

**Days to wait to purge entry on RFAI Worklist Response: 20 Days// 🡨 Default 20**

**This is the number of days a 277 RFAI transaction will**

**remain on the RFAI Worklist unless specifically removed**

**by a user.**

**Days to wait to purge entry on RFAI Worklist Response: 20 Days//**

**Note:** It will be extremely, if not impossible, to avoid an overlap with Patch IB\*2\*517 - coordinate with 517 when adding to the IB Site Parameters.

1. New fields in 350.9 for RETENTION DAYS 277 RFAI and another for WORKLIST DAYS 277 RFAI.
2. New Protocol for action RI – RFAI (Protocol file 101 – use IBJP CT namespace).
3. Other tags on that menu use CTEDIT^IBJPC(parameter)
4. Update CT Protocol Menu (**IBJP CLAIMS TRACKING SCREEN**) to include the new protocol RI (above)
5. Update Protocol EA (Edit All) to include new fields (**Tag 0 in IBJPC**). It’s a DR string.
6. A nightly process to purge the file based on the new RETENTION DAYS 277FRAI field. If the parameter is not set, do not purge.

* Routine to perform the purge – Model after PURGE^IBTRHDE – the 278 purge being added in IB517.
* Something to kick it off/schedule it. Since this is part of CT, should it just be added to the 278 purge. Or added to the regular IB night job. I don’t see the purpose of added another stand-alone nightly event.

1. Display new fields in CT ListMan section (**BLD^IBJPC**)
2. Post Install to set new defaults – note: only one default is actually being set. (IPY547PO) – again IBY517PO can be used as an example.

###### Functional Requirement: Store ASC X12N Health Care Claim Request For Additional Information (RFAI) (277RFAI) Transactions - Default

The IB system shall set the ASC X12N Health Care Claim Request For Additional Information (RFAI) (277RFAI) transaction storage period to infinity when the software is installed. (BN 3.1)

**Design Element** Refer to 6.2.2.2.4.1

###### Functional Requirement: Display ASC X12N Health Care Claim Request For Additional Information (RFAI) (277RFAI) Transactions

The IB system shall provide the ability for users to define the length of time an ASC X12N Health Care Claim Request For Additional Information (RFAI) (277RFAI) transaction will remain on the work list before being automatically removed. (BN 3.1.1)

**Design Element** Refer to 6.2.2.2.4.1

###### Functional Requirement: Display ASC X12N Health Care Claim Request For Additional Information (RFAI) (277RFAI) Transactions – Default

The IB system shall set the ASC X12N Health Care Claim Request For Additional Information (RFAI) (277RFAI) transaction display period to twenty days when the software is installed. (BN 3.1.1)

**Design Element** Refer to 6.2.2.2.4.1

###### Functional Requirement: Additional Primary Payer ID Types

The IB system shall provide the ability for users to define Additional Primary Payer ID Types for additional primary payer IDs for the following Electronic Plan Types:

* MX – Medicare A or B, or
* Not MX – Medicare A or B (BN 3.1)

**Design Element**

**Note:** The design for 6.2.2.2.3.1-2, 6.2.2.2.4.5-6, and 6.2.2.2.1.4-7 are interrelated and should be reviewed together.

**Note:** This screen shot applies to the next 2 requirements:

IB Site Parameters Apr 27, 2015@13:12:45 Page: 4 of 5

Only authorized persons may edit this data.

+

EDI 837 Live Transmit Queue : MCT

EDI 837 Test Transmit Queue : MCT

Auto-Txmt Bill Frequency : Every Day

Hours To Auto-Transmit : 1130;1500;1700

Max # Bills Per Batch : 10

Only Allow 1 Ins Co/Claim Batch?: NO

Last Auto-Txmt Run Date : 04/27/15

Days To Wait To Purge Msgs : 15

Allow MRA Processing? : YES

Enable Automatic MRA Processing?: YES

Enable Auto Reg EOB Processing? : YES

**[17] Alt Prim Payer ID Typ-Medicare :**

**[18] Alt Prim Payer ID Typ-Commercial:**

**[19]** Are we using ClaimsManager? : NO

Is ClaimsManager working OK? : NO

**Note:** It will be extremely difficult or impossible to avoid an overlap with IB\*517

Also, coordinate with IB517 when adding things to IB Site Parameters

1. Create a new file (#355.98) to store the IB Administrative Contractor Types that will be referenced for the Alternate Primary Payer ID Types for both Medicare and Non-Medicare (Commercial). This file will contain records that have a .01 field for the Payer ID Type. The global containing these Payer ID Types is: ^IBA(355.98,…). It needs to be a new file because it is pointed to from the Site Parameters File (#350.9), the Insurance Company File (#36), and the Bill/Claims File (#399). Entries can only be added to this new file from Site Parameters.
2. Create a new multiple field (80.01) in file #350.9 to store the various Alternate Primary Payer ID Types for Medicare Plans pointing to the new IB Administrative Contractor File (#350.9).
3. New multiple field (80.02) in file #350.9 to store the various Alternate Primary Payer ID Types for Commercial Plans pointing to the new IB Administrative Contractor File (#350.9).
4. For action IB on the IBJP MCCR PARAMETERS MENU protocol the IB SITE PARAMETER SCREEN will include 2 new sections inserted before the section for “Are we using ClaimsManager?”, which will have its section number dropped down by 1 to section [19]. The 2 new sections will be [17] Alt Prim Payer ID Typ-Medicare and [18] Alt Prim Payer ID Typ-Commercial and need to be added to the existing display routine IBJPS2. Similar to the pay to providers, the display will only state how many entries are in the subfile from this main screen.
5. The routine ^IBJPS needs to be modified by inserting branching logic for sections 17 and 18 for the new multiples of file #350.9 similar to the Pay to provider (set 10) bolded in the code below. Both sets will branch to the same routine and ListMan template. The only difference will be the storage location of the data and the title on the ListMan screen which will be based on the set being edited.

EDIT(IBSET) ; edit IB Site Parameters

D FULL^VALM1

I IBSET'="" **D:IBSET=10 EN^IBJPS3 S:IBSET'=10 DR=$P($T(@IBSET),";;",2,999)**

I IBSET=8,$$ICD9SYS^IBACSV(DT)=30 S $P(DR,";",1)=7.05

;

I $G(DR)'="" S DIE="^IBE(350.9,",DA=1 D ^DIE K DA,DR,DIE,DIC,X,Y

D INIT^IBJPS S VALMBCK="R"

Q

1. When tag 17 or 18 is selected the following new ListMan screen IBJP ALT PRIM PAYER ID TYP-MEDICARE will be used to add or delete types to new multiples.

+ Enter ?? for more actions

EP Edit Set EX Exit

Select Action: Next Screen// **EP=17**

Alt Prim Payer ID Typ-Medicare Apr 27, 2015@13:17:44 Page: 1 of 1

Medicare (Electronic Payer Type = MX Medicare A or B)

1. DME **🡨 Default**

AT Add Medicare Type DT Delete Medicare Type EX Exit

Select Item(s): Quit//

This will require 1 ListMan template, 1 ListMan supporting routine, 1 protocol menu, and 3 new protocols described below.

Protocol 1 AT – Add Type - When a type is added to this field, if the Payer ID Type exists in the new IB Administrative Contractor Types file (#355.98), then it is simply added to the multi-field (80.01). If the Payer ID Type does not exist in the #355.98 file, it is both added into the #355.98 file and to the #350.9, 80.01 field. When a Payer ID Type is deleted from the multi-field (#350.9, 80.01) for the site, it does not get deleted from the #355.98 file. This option is the only place entries can be added to the new file (outside the post install).

Protocol 2 DT – Delete Type - When deleting entries from the IB Administrative Contractor Types file (#355.98), the user will be prevented from deleting an entry if the entry is currently in use in the Insurance Company file (#36). This will require a non-lookup cross reference on both multiples across the insurance company file (#36). The cross reference would need to be across both multiples or potentially have two cross references.

Protocol 3 EX – Exit – Standard for most IB worklists.

###### Functional Requirement: Additional Primary Payer ID Types - Default Values

The IB system shall create the Additional Primary Payer ID Type for Medicare (WNR) claims equal to Durable Medical Equipment (DME) when the software is installed. (BN 3.1)

**Design Element**

**Note:** The design for 6.2.2.2.3.1-2, 6.2.2.2.4.5-6, and 6.2.2.2.1.4-7 are interrelated and should be reviewed together.

1. The New File to store the IB Administrative Contractor Types (#355.98) needs to be populated with an entry for DME. The safest place to do this would be the post install routine, IBY547PO. Otherwise, if the file is delivered with its contents, erroneous entries from unit testing could be inadvertently be included.
2. The Post Install routine (IBY547PO) needs to include an initial default of DME for the new Alternate Primary Payer ID Type – Medicare IB Site Parameter (#350.9, 80.01). After the entry is added to file #355.98 for DME in the post install above, it can be added to the site parameter file multiple.

###### Functional Requirement: Printed Claims Report – Revenue Code Exclusions

The IB system shall provide the ability for users to define the revenue codes that will be excluded from the reporting of printed claims. (BN 9.1)

**Design Element**

**Note:** These requirements are related to the ones in 6.2.2.2.10.1-5.

**Note:** This screen shot applies to the next 2 requirements.

IB Site Parameters Apr 27, 2015@10:34:51 Page: 2 of 5

Only authorized persons may edit this data.

+

[5] Medical Center : CHEYENNE VAMC Default Division : CHEYENNE VAMR

MAS Service : BUSINESS OFFICE Billing Supervisor : WAITHE,MOSES

[6] Initiator Authorize: YES Xfer Proc to Sched : YES

Ask HINQ in MCCR : YES Use Non-PTF Codes : YES

Multiple Form Types: YES Use OP CPT screen : YES

[7] UB-04 Print IDs : YES UB-04 Address Col :

CMS-1500 Print IDs : YES CMS-1500 Addr Col : 40

CMS-1500 Auto Prter: UB-04 Auto Prter :

EOB Auto Prter : MRA Auto Prter :

**[8] Printed Claims Rev Code Excl: 13 defined**

**[9]** Default RX DX Cd : V68.1 (ICD-9) Default ASC Rev Cd : 490

Default RX CPT Cd : J8499 Default RX Rev Cd : 250

**[10]** Bill Signer Name : <No longer used> Federal Tax # : 83-0168494

Bill Signer Title : <No longer used>

+ Enter ?? for more actions

EP Edit Set EX Exit

Select Action: Next Screen//**EP=8**

**Excluded Revenue Codes Apr 27, 2015@10:41:46 Page: 1 of 1**

**1. 270 🡨 These are the default exclusions 270-279 and 290-299**

**2. 271**

**3. 272**

**4. 273**

**5. 274**

**6. 275**

**7. 276**

**8. 277**

**9. 278**

**10. 279**

**11. 290**

**12. 291**

**13. 292**

**+**

**AC Add Revenue Code DC Delete Revenue Code EX Exit**

**Select Item(s): Next Screen// AC Add Revenue Code**

**Revenue Code: ??**

**Enter a Revenue Code that will be used to exclude a**

**claim from the Locally Printed Claims Report.**

**Choose from:**

**100 ALL INCL R&B/ANC ALL-INCLUSIVE ROOM AND BOARD PLUS ANCILLARY**

**101 ALL INCL R&B ALL-INCLUSIVE ROOM AND BOARD**

**110 ROOM-BOARD/PVT GENERAL CLASSIFICATION**

**111 MED-SUR-GY/PVT MEDICAL/SURGICAL/GYN**

**112 OB/PVT OB**

**113 PEDS/PVT PEDIATRIC**

**114 PSYCH/PVT PSYCHIATRIC**

**115 HOSPICE/PVT HOSPICE**

**116 DETOX/PVT DETOXIFICATION**

**117 ONCOLOGY/PVT ONCOLOGY**

**118 REHAB/PVT REHABILITATION**

**119 OTHER/PVT OTHER**

**120 ROOM-BOARD/SEMI GENERAL CLASSIFICATION**

1. New field in file #350.9 for REVENUE CODE EXCLUSIONS. This field is defined as a multiple occurring pointer to the REVENUE CODE File #399.2, NON-LAYGO
2. Modify the ListMan screen for IB parameters at (**BLD^IBJPS1** and **BLD2^IBJPS2)** to add the new excluded revenue codes. Initially only display a count of entries followed by the word “defined”
3. Update Protocol EP (Edit Action) to include a new ListMan (in the IBJPS namespace ) call for revenue code exclusions. Pay-to-providers can be used as an example:

* Inside this new ListMan add Protocol AC (Add Revenue Code)
* Inside this new ListMan add Protocol DC (Delete Revenue Code)
* Inside this new ListMan add Protocol EX (Exit)
* Add a new Protocol Menu to house these new protocols and attach to the ListMan template

1. The DR strings that currently exist in (**IBJPS**) at tags 8 and higher, will all be incremented by 1 and become tags 9 and higher. This step will coordinate with **6.2.2.2.4.5-6** which is also adding additional sections to the Site Parameters
2. Modify JPS to call out to the new ListMan routine lie the pat to provider shown below:

EDIT(IBSET) ; edit IB Site Parameters

D FULL^VALM1

**I IBSET'="" D:IBSET=10 EN^IBJPS3 S:IBSET'=10 DR=$P($T(@IBSET),";;",2,999)**

I IBSET=8,$$ICD9SYS^IBACSV(DT)=30 S $P(DR,";",1)=7.05

;

I $G(DR)'="" S DIE="^IBE(350.9,",DA=1 D ^DIE K DA,DR,DIE,DIC,X,Y

D INIT^IBJPS S VALMBCK="R"

Q

###### Functional Requirement: Revenue Codes – Default Values

The IB system shall add the following revenue codes to the list of codes to be excluded from the printed claims report when the software is installed:

* 270 through 279
* 290 through 299 (BN 9.1)

**Design Element**

1. Set the default values in file #350.9 for REVENUE CODE EXCLUSIONS to all values from 270 through 279 and 290 through 299. This will be done with the post install routine (**IBY547PO**) by looping through file #399.2 and filing into the new multiple in file #350.9

##### System Feature: Claims Status Awaiting Resolution (CSA)

###### Functional Requirement: Health Care Clearing House – Claim Status Message Source

The IB system shall display the name of the Health Care Clearing House (HCCH) in CSA when the HCCH is the source of a claim status message (informational/rejection). (BN 8.4)

**Routines (Entry Points)**

| Routine Name | IBCE277 | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Enhancement Category | New | | Modify | Delete | | | No Change | | |
| Requirement Traceability Matrix | 2.6.5.1 | | | | | | | | |
| Related Options | IBCE CLAIMS STATUS AWAITING | | | | | | | | |
| **Related Routines** | Routines “Called By” | | | | Routines “Called” | | | | |
| IBCESRV | | | | ^%DT  $$FT^IBCEF  $$LAST364^IBCEF4 | | | | |
| Data Dictionary (DD) References | NONE | | | | | | | | |
| Related Protocols | NONE | | | | | | | | |
| Related Integration Control Registrations (ICRs) | NONE | | | | | | | | |
| Data Passing | Input | Output Reference | | | | Both | | Global Reference | Local |
| Input Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Output Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Current Logic | | | | | | | | | |
| IBCE277 ;ALB/TMP - 277 EDI CLAIM STATUS MESSAGE PROCESSING ;15-JUL-98  ;;2.0;INTEGRATED BILLING;\*\*137,155,368,403\*\*;21-MAR-94;Build 24  ;;Per VHA Directive 2004-038, this routine should not be modified.  Q  ; MESSAGE HEADER DATA STRING =  ; type of message^msg queue^msg #^bill #^REF NUM/Batch #^date/time  ;  HDR(ENTITY,ENTVAL,IBTYPE,IBD) ;Process header data  ; INPUT:  ; ENTITY = "BATCH" or "CLAIM" for batch/claim level messages respectively  ; ENTVAL = claim #  ; IBTYPE = the type of status msg this piece of the message represents  ; (837REC1, 837REJ1)  ; ^TMP("IBMSGH",$J,0) = header message text  ;  ; OUTPUT:  ; IBD array returned with processed data  ; "DATE" = Date/Time of status (Fileman format)  ; "MRA" = 1 if MRA, 0 if not "X12" = 1 if X12, 0 if not  ; "BATCH" = Batch ien for batch level calls  ; "SOURCE" = Source of message code^source name, if known  ;  ; ^TMP("IBMSG",$J,"BATCH",batch #,0)=MESSAGE HEADER DATA STRING  ; if batch level message  ; ,"D",0,1)=header record raw data  ; ,line #)=batch status message lines  ;  ; ^TMP("IBMSG",$J,"CLAIM",claim #,0)=MESSAGE HEADER DATA STRING  ; if claim level message  ; ,"D",0,1)=header record raw data  ; ,line #)=claim status message lines  ;  N DATA,IBD0,L,PC,X,Y  S IBD0=$G(^TMP("IBMSGH",$J,0)) Q:IBD0  S Y=0,L=1  ; Convert claim date/time  S X=$$DATE($P(IBD0,U,3))\_"@"\_$E($P(IBD0,U,4)\_"0000",1,4) I X S %DT="XTS" D ^%DT  ; populate IBD array  S IBD("DATE")=$S(Y>0:Y,1:""),IBD("MRA")=$P(IBD0,U,5),IBD("X12")=($P(IBD0,U,2)="X")  S IBD("SOURCE")=$P(IBD0,U,12,13),IBD("BATCH")=$P(IBD0,U,14)  I +$TR($P(IBD0,U,6,9),U) F PC=6:1:9 D  .I $P(IBD0,U,PC)'="" S DATA=$P("# Claims Submitted^# Claims Rejected^Total Charges Submitted^Total Charges Rejected",U,PC-5)\_": "\_$S(PC<8:+$P(IBD0,U,PC  ),1:$FNUMBER($P(IBD0,U,PC)/100,"",2))\_" "  .I $L($G(^TMP("IBMSG-H",$J,ENTITY,ENTVAL,L)))+$L(DATA)>70 S L=L+1 ; if data doesn't fit into current line, go to the next line  .S ^TMP("IBMSG-H",$J,ENTITY,ENTVAL,L)=$G(^TMP("IBMSG-H",$J,ENTITY,ENTVAL,L))\_DATA ; file this piece of data  .Q  ; file batch ref. number  S:IBD("BATCH")'="" L=L+1,^TMP("IBMSG-H",$J,ENTITY,ENTVAL,L)="Batch Reference Number: "\_IBD("BATCH")  I $TR($P(IBD0,U,10,13),U)'="" D  .S L=L+1  .; generate and file Payer Name / Payer Id line  .S DATA="Payer Name: "\_$S($P(IBD0,U,10)'="":$P(IBD0,U,10),1:"N/A")\_" Payer ID: "\_$S($P(IBD0,U,11)'="":$P(IBD0,U,11),1:"N/A")  .S ^TMP("IBMSG-H",$J,ENTITY,ENTVAL,L)=DATA  .I $P(IBD0,U,12)'=""!($P(IBD0,U,13)'="") D  **..; generate and file Message Source line**  **..S DATA="Source: "\_$S($P(IBD0,U,12)="Y":"Sent by payer",$P(IBD0,U,13)'="":"Sent by non-payer ("\_$P(IBD0,U,13)\_")",1:"UNKNOWN")**  **..S L=L+1,^TMP("IBMSG-H",$J,ENTITY,ENTVAL,L)=DATA**  ..Q  .Q  S ^TMP("IBMSG",$J,ENTITY,ENTVAL,0)=IBTYPE\_U\_$G(IBD("MSG#"))\_U\_$G(IBD("S UBJ"))\_U\_$$GETBILL(ENTVAL)\_U\_U\_IBD("DATE")\_U\_IBD("SOURCE")  ; file raw data  S ^TMP("IBMSG",$J,ENTITY,ENTVAL,"D",0,1)="##RAW DATA: "\_IBD0  Q  ; | | | | | | | | | |
| Modified Logic (Changes are in bold) | | | | | | | | | |
| No changes needed | | | | | | | | | |

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

###### Functional Requirement: TPJI – Claim Status Message Source

The IB system shall provide the ability for users to view the name of the Health Care Clearing House (HCCH) in TPJI when the HCCH is the source of a claim status message (informational/rejection). (BN 8.4)

**Routines (Entry Points):**

| Routine Name | IBJTED | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Enhancement Category | New | | Modify | Delete | | | No Change | | |
| Requirement Traceability Matrix | 2.6.6.1 | | | | | | | | |
| Related Options | IBJ THIRD PARTY JOINT INQUIRY | | | | | | | | |
| **Related Routines** | Routines “Called By” | | | | Routines “Called” | | | | |
| NONE | | | | $$LAST364^IBCEF4 HDR^IBJTU1  $$DAT1^IBOUTL  $$EXPAND^IBTRE  EN^VALM $$SETSTR^VALM1 CLEAR^VALM1  CNTRL^VALM10 $$FMTE^XLFDT  DISP^XQORM1 | | | | |
| Data Dictionary (DD) References | NONE | | | | | | | | |
| Related Protocols | IBJT EDI STATUS SCREEN | | | | | | | | |
| Related Integration Control Registrations (ICRs) | NONE | | | | | | | | |
| Data Passing | Input | Output Reference | | | | Both | | Global Reference | Local |
| Input Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Output Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| **Current Logic** | | | | | | | | | |
| E361(IBY) ; Bill Status Message  ; IBY = ien of entry in file 361  N IBZ,IBX,IBDT,IBT  K ^TMP($J,"RET-MSG")  S IBCH=0  S IBT="EDI Bill Status Messages"  D SET($J("",(80-$L(IBT))\2)\_IBT)  D CNTRL^VALM10(VALMCNT,((80-$L(IBT))\2)+1,$L(IBT),IORVON,IORVOFF)  I IBY S IBCH=1 D ; Find all messages rec'd for the bill  . N IBCH  . S IBDT="",IBCNT=0  . F S IBDT=+$O(^IBM(361,"ADR",IBIFN,IBDT),-1) Q:'IBDT S IBY=0 F S ID  .. N IBT1  .. S IBCNT=IBCNT+1  .. I IBCNT>1 D SET(" ")  .. S IBT1="---Message "\_IBCNT\_"---"  .. S IBT=$J("",32-($L(IBCNT)+1\2))\_IBT1  .. S IBD=$$SET1(IBT,"",1,80) D SET(IBD)  .. D CNTRL^VALM10(VALMCNT,(33-(($L(IBCNT)+1)\2)),$L(IBT1),IOINHI,IOINO)  .. S IBT=$J("",8)\_"Date Received: "\_$$FMTE^XLFDT(IBDT)  .. S IBD=$$SET1(IBT,"",1,49)  .. S IBT="Batch #: "\_$$EXPAND^IBTRE(361,.05,+$P($G(^IBA(364,+$P(IBX,U,)  .. D SET(IBD)  .. ;S IBT="Msg Generation Source: "\_$$EXPAND^IBTRE(361,.04,$P(IBX,U,4))  .. ;S IBD=$$SET1(IBT,"",1,40)  .. S IBT="Return Msg Id: "\_$P(IBX,U,6)  .. S IBD=$$SET1(IBT,"",9,40)  .. S IBT="Msg Severity: "\_$$EXPAND^IBTRE(361,.03,$P(IBX,U,3))  .. S IBD=$$SET1(IBT,IBD,45,35) D SET(IBD)  .. ;S IBT="Return Msg Id: "\_$P(IBX,U,6)  .. ;S IBD=$$SET1(IBT,"",9,40) D SET(IBD)  .. S (IBCH,IBCN)=0  **.. F S IBCN=$O(^IBM(361,IBY,1,IBCN)) Q:'IBCN S IBD=$$SET1(^(IBCN,0),)**  .. I 'IBCH S IBD=$$SET1(" No message text found","",1,25) D SET(IBD)  .. S IBT=$J("",31-($L(IBCNT)+1\2))\_"---Msg "\_IBCNT\_" Review---"  .. S IBD=$$SET1(IBT,"",1,80) D SET(IBD)  .. S IBCN=0 F S IBCN=$O(^IBM(361,IBY,2,IBCN)) Q:'IBCN S IBGS=$G(^(IBD  ... S IBT="Review Date: "\_$$DAT1^IBOUTL($P(IBGS,U),1)  ... S IBD=$$SET1(IBT,"",1,40)  ... ;S IBT="Reviewed By: "\_$P($G(^VA(200,+$P(IBGS,U,2),0)),U)  ... ;S IBD=$$SET1(IBT,IBD,49,29)  ... D SET(IBD)  ... S IBCH=0  ... S IBCN2=0 F S IBCN2=$O(^IBM(361,IBY,2,IBCN,1,IBCN2)) Q:'IBCN2 S )  D NONE(IBCH)  K ^TMP($J,"RET-MSG")  Q  ;  E364(IBZ) ; EDI Transmit Bill  ; IBZ = ien of entry in file 364  N IBY,IBT,IBX  S IBX=""  I IBZ S IBX=$G(^IBA(364,IBZ,0))  S IBT="Last EDI Transmission"  D SET($J("",(80-$L(IBT))\2)\_IBT)  D CNTRL^VALM10(VALMCNT,(80-$L(IBT)\2)+1,$L(IBT),IORVON,IORVOFF)  S IBT="Transmission Status: "\_$$EXPAND^IBTRE(364,.03,$P(IBX,U,3))  S IBD=$$SET1(IBT,"",3,79)  D SET(IBD)  S IBT="Status Date: "\_$$FMTE^XLFDT($P(IBX,U,4))  S IBD=$$SET1(IBT,"",11,38)  S IBT="Batch #: "\_$$EXPAND^IBTRE(364,.02,+$P(IBX,U,2))  S IBD=$$SET1(IBT,IBD,50,29)  D SET(IBD)  I $P(IBX,U,6) D  . S IBT="Resubmit Batch #: "\_$$EXPAND^IBTRE(364,.06,+$P(IBX,U,6))  . S IBD=$$SET1(IBT,"",6,30)  . D SET(IBD)  D SET("")  Q  ;  BLDQ ;  D SET(" ",0),SET("No EDI Status Messages Found For This Bill Entry.",0)  Q  ;  NONE(IBCH) ;  I 'IBCH D  . S IBD=$$SET1(" None","",1,10)  . D SET(IBD)  Q  ;  SET(X,CNT) ;  S VALMCNT=VALMCNT+1  S ^TMP("IBJTED",$J,VALMCNT,0)=X  Q:'$G(CNT)  S ^TMP("IBJTED",$J,"IDX",VALMCNT,CNT)=""  Q  ;  SET1(IBT,IBD,COL,WD) ;  S IBD=$$SETSTR^VALM1(IBT,IBD,COL,WD)  Q IBD  ; | | | | | | | | | |
| Modified Logic (Changes are in bold) | | | | | | | | | |
| No changes needed | | | | | | | | | |

###### Functional Requirement: RFAI Worklist Comments - TPJI

The IB system shall provide the ability for users to view the comments added in the RFAI Worklist by claim in the Comment History of TPJI. (BN 3.1.2)

**Routines (Entry Points):**

| Routine Name | IBJTTC | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Enhancement Category | New | | Modify | Delete | | | No Change | | |
| Requirement Traceability Matrix | 2.6.6.2 | | | | | | | | |
| Related Options | IBJ THIRD PARTY JOINT INQUIRY | | | | | | | | |
| Related Routines | Routines “Called By” | | | | Routines “Called” | | | | |
| IBCECOB6  IBJTA1  IBJTU6  IBJYL1 | | | | CLEAN^DILF  $$EXTERNAL^DILFD  $$GET1^DIQ  ^DIWP  HDR^IBJTU1  MCOM^PRCAMDA2  $$EN^RCDPAYER  ADD^RCDPAYER  $$N5^RCJIBFN1  N7^RCJIBFN1  $$STNO^RCJIBFN2  BCOM^RCJIBFN2  TRN^RCJIBFN2  EN^VALM  $$SETSTR^VALM1  CLEAR^VALM1  SET^VALM10  $$FMTE^XLFDT  DISP^XQORM1 | | | | |
| Data Dictionary (DD) References | NONE | | | | | | | | |
| Related Protocols | IBJT AR COMMENT HISTORY | | | | | | | | |
| Related Integration Control Registrations (ICRs) | None for this change. Existing ones on this routine are: IA 5549, IA 4051, & IA 5696. | | | | | | | | |
| Data Passing | Input | Output Reference | | | | Both | | Global Reference | Local |
| Input Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Output Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Current Logic | | | | | | | | | |
| BLD ;  N CMLN,CMSTR,X,IBCNT,IBZ,IB0,IBI,IBX,IBD,IBDATE,IBDUZ,IBRCT5,IBLN,IBSTR  ,IBK,IBJ,DIWL,DIWR,DIWF,COM  ; HIPAA 5010  N IB3611,FOUND  ;  S VALMCNT=0,IBLN=0  ;  ; Bill Comments (430,98)  K COM,^UTILITY($J,"W") D BCOM^RCJIBFN2(IBIFN) I $D(COM)>10 D  . S IBSTR="",IBD="AR BILL COMMENTS:" S IBSTR=$$SETLN(IBD,IBSTR,25,54),I  BLN=$$SET(IBSTR,IBLN)  . S IBSTR="",IBSTR=$$SETLN("--------------------------",IBSTR,25,54),IB  LN=$$SET(IBSTR,IBLN)  . ;  . S IBJ="" F S IBJ=$O(COM(IBJ)) Q:'IBJ S X=$G(COM(IBJ)) I X'="" S DIW  L=1,DIWR=54,DIWF="" D ^DIWP  . ;  . I $D(^UTILITY($J,"W")) S (IBK,IBCNT)=0 F S IBK=$O(^UTILITY($J,"W",1,  IBK)) Q:'IBK D  .. S IBD=$G(^UTILITY($J,"W",1,IBK,0)) S IBSTR=$$SETLN(IBD,IBSTR,25,54),  IBLN=$$SET(IBSTR,IBLN),IBSTR=""  . K ^UTILITY($J,"W")  ; AR profile of comment transactions (433: 5.02, 41, 86)  K ^TMP("RCJIB",$J),^UTILITY($J,"W") D TRN^RCJIBFN2(IBIFN)  ;  ;HIPAA 5010 - check if contact data has been added as a comment  I '$$CONTACT D  .;Check for payer contact data in all entries associated with the bill  # (IBIFN)  .S (FOUND,IB3611)=0 F S IB3611=$O(^IBM(361.1,"B",IBIFN,IB3611)) Q:'IB3  611 Q:FOUND S FOUND=$$EN^RCDPAYER(IB3611)  .Q:'FOUND ; payer contact data does not exist in any of the EOB entrie  s related to claim  .;Add canned text as a brief comment in file #433 which will serve as a  notice that contact data came from 835 ERA  .D ADD^RCDPAYER(IBIFN) ;IA 5549  .;Rebuild AR profile of comment transactions  .K ^TMP("RCJIB",$J),^UTILITY($J,"W") D TRN^RCJIBFN2(IBIFN)  ;  I $D(^TMP("RCJIB",$J)) S IBI="" F S IBI=$O(^TMP("RCJIB",$J,IBI)) Q:'IB  I D  . S IBX=$G(^TMP("RCJIB",$J,IBI)) I $$STNO^RCJIBFN2(+$P(IBX,U,3))'["COMM  ENT" Q  . S IBRCT5=$$N5^RCJIBFN1(IBI)  . S IBSTR="",IBLN=$$SET(IBSTR,IBLN)  . S IBD=$P(IBX,U,1) S IBSTR=$$SETLN(IBD,IBSTR,2,8)  . S IBD=$$DATE(+$P(IBX,U,2)) S IBSTR=$$SETLN(IBD,IBSTR,14,8)  . S IBD=$P(IBRCT5,U,1) S IBSTR=$$SETLN(IBD,IBSTR,25,30)  . S IBD="FOLLOW-UP DT: "\_$$DATE(+$P(IBRCT5,U,2)) S IBSTR=$$SETLN(IBD,IB  STR,57,22)  . S IBLN=$$SET(IBSTR,IBLN),IBSTR=""  .;HIPAA 5010 - check if this comment is contact data  .I $P(IBRCT5,U)["ERA Payer Contact Information" D  ..N CONTACT,PHONE,FAX,EMAIL,WEB,NAME,EXT,PAYER,HAVPAYER  ..;Display contact data IA 5549  ..; primary, secondary, and tertiary contact data need to be displayed.  Display of contact data  ..; should only occur for each unique payer at BILL (B) x-ref of IBM(36  1.1,"B",IBIFN).  ..; evaluation starts with the most recent entry.  ..; Contact data belonging to more than one payer can be distinguished  by payer name  ..S (HAVPAYER,IB3611)=""  ..F S IB3611=$O(^IBM(361.1,"B",IBIFN,IB3611),-1) Q:'IB3611 S CONTACT=  $$EN^RCDPAYER(IB3611) D  ...Q:'CONTACT  ...S PAYER=$P($G(^IBM(361.1,IB3611,0)),U,2),PAYER=$$EXTERNAL^DILFD(361.  1,.02,,PAYER) ;IA 4051  ...Q:PAYER=HAVPAYER ; payer contact data has already been displayed  ...S HAVPAYER=PAYER  ...S FAX=$P(CONTACT,U,5),EMAIL=$P(CONTACT,U,6),WEB=$P(CONTACT,U,3)  ...S PHONE=$P(CONTACT,U,4),EXT=$P(CONTACT,U,7),NAME=$P(CONTACT,U,2)  ...S IBD="Payer Name: "\_PAYER  ...S IBSTR=$$SETLN(IBD,IBSTR,25,78)  ...S IBLN=$$SET(IBSTR,IBLN),IBSTR=""  ...I NAME]"" D  ....S IBD="Contact Name: "\_NAME  ....S IBSTR=$$SETLN(IBD,IBSTR,25,78)  ....S IBLN=$$SET(IBSTR,IBLN),IBSTR=""  ...I PHONE]"" D  ....S IBD="Phone Number: "\_PHONE S:EXT]"" IBD=IBD\_" Ext: "\_EXT  ....S IBSTR=$$SETLN(IBD,IBSTR,25,78)  ....S IBLN=$$SET(IBSTR,IBLN),IBSTR=""  ...I FAX]"" D  ....S IBD="Facsimile Number: "\_FAX  ....S IBSTR=$$SETLN(IBD,IBSTR,25,78)  ....S IBLN=$$SET(IBSTR,IBLN),IBSTR=""  ...I EMAIL]"" D  ....S IBD="Email Address: "\_EMAIL  ....S IBSTR=$$SETLN(IBD,IBSTR,25,78)  ....S IBLN=$$SET(IBSTR,IBLN),IBSTR=""  ...I WEB]"" D  ....S IBD="Website Address:"\_$E(WEB,1,40)  ....S IBSTR=$$SETLN(IBD,IBSTR,25,78)  ....S IBLN=$$SET(IBSTR,IBLN),IBSTR="" Q:$L(WEB)<41  ....S IBSTR=$$SETLN($E(WEB,41,96),IBSTR,25,78)  ....S IBLN=$$SET(IBSTR,IBLN),IBSTR="" Q:$L(WEB)<97  ....S IBSTR=$$SETLN($E(WEB,97,115),IBSTR,25,78)  ....S IBLN=$$SET(IBSTR,IBLN),IBSTR=""  ...S IBLN=$$SET(IBSTR,IBLN)  . ;  . ; -- transaction comments (86)  . S X=$P($G(^TMP("RCJIB",$J,IBI)),U,6) I X'="" S DIWL=1,DIWR=54,DIWF=""  D ^DIWP  . ;  . ; -- comments (86 & 41)  . K COM D N7^RCJIBFN1(IBI) I $D(COM)>2 D  .. S IBJ="" F S IBJ=$O(COM(IBJ)) Q:'IBJ S X=$G(COM(IBJ)) I X'="" S DI  WL=1,DIWR=54,DIWF="" D ^DIWP  . ;  . I $D(^UTILITY($J,"W")) S (IBK,IBCNT)=0 F S IBK=$O(^UTILITY($J,"W",1,  IBK)) Q:'IBK D  .. S IBD=$G(^UTILITY($J,"W",1,IBK,0)) S IBSTR=$$SETLN(IBD,IBSTR,25,54),  IBLN=$$SET(IBSTR,IBLN),IBSTR=""  . K ^UTILITY($J,"W")  K ^TMP("RCJIB",$J),^UTILITY($J,"W")  ; MRA comments  ; check if we have any comments to display  I $D(^DGCR(399,IBIFN,"TXC","B")) D  .S IBLN=$$SET("",IBLN)  .S IBSTR="",IBSTR=$$SETLN("MRA REQUEST CLAIM COMMENTS",IBSTR,25,54),IBL  N=$$SET(IBSTR,IBLN)  .S IBSTR="",IBSTR=$$SETLN("--------------------------",IBSTR,25,54),IBL  N=$$SET(IBSTR,IBLN)  .; loop through all available comments  .S IBDATE="" F S IBDATE=$O(^DGCR(399,IBIFN,"TXC","B",IBDATE),-1) Q:IBD  ATE="" D  ..S IBZ=$O(^DGCR(399,IBIFN,"TXC","B",IBDATE,"")),IB0=^DGCR(399,IBIFN,"T  XC",IBZ,0),IBDUZ=$P(IB0,U,2)  ..;S IBLN=$$SET("",IBLN)  ..S IBSTR=""  ..S IBSTR=$$SETLN($$FMTE^XLFDT(IBDATE,"2Z"),IBSTR,14,8)  ..S IBSTR=$$SETLN($J("Entered by "\_$$GET1^DIQ(200,IBDUZ,.01),54),IBSTR,  25,54)  ..S IBLN=$$SET(IBSTR,IBLN),IBSTR=""  ..; loop through comment lines  ..S CMLN=0 F S CMLN=$O(^DGCR(399,IBIFN,"TXC",IBZ,1,CMLN)) Q:CMLN="" D  ...S X=^DGCR(399,IBIFN,"TXC",IBZ,1,CMLN,0) I X'="" S DIWL=1,DIWR=54,DIW  F="" D ^DIWP  ...Q  ..I $D(^UTILITY($J,"W")) S IBK=0 F S IBK=$O(^UTILITY($J,"W",1,IBK)) Q:  'IBK D  ...S CMSTR=$G(^UTILITY($J,"W",1,IBK,0)) S IBSTR=$$SETLN(CMSTR,IBSTR,25,  54),IBLN=$$SET(IBSTR,IBLN),IBSTR=""  ...Q  ..K ^UTILITY($J,"W")  ..Q  .;D CLEAN^DILF  .Q  D EOBC ; IB\*2.0\*432  D MDACMTS ; IB\*2.0\*447 BI  D CLEAN^DILF  ;  I IBLN=0 S IBLN=$$SET("",IBLN),IBLN=$$SET("No Comment Transactions Exis  t For This Account.",IBLN)  S VALMCNT=IBLN  Q  ; | | | | | | | | | |
| Modified Logic (Changes are in bold) | | | | | | | | | |
| BLD ;  N CMLN,CMSTR,X,IBCNT,IBZ,IB0,IBI,IBX,IBD,IBDATE,IBDUZ,IBRCT5,IBLN,IBSTR  ,IBK,IBJ,DIWL,DIWR,DIWF,COM  ; HIPAA 5010  N IB3611,FOUND  ;  S VALMCNT=0,IBLN=0  ;  ; Bill Comments (430,98)  K COM,^UTILITY($J,"W") D BCOM^RCJIBFN2(IBIFN) I $D(COM)>10 D  . S IBSTR="",IBD="AR BILL COMMENTS:" S IBSTR=$$SETLN(IBD,IBSTR,25,54),I  BLN=$$SET(IBSTR,IBLN)  . S IBSTR="",IBSTR=$$SETLN("--------------------------",IBSTR,25,54),IB  LN=$$SET(IBSTR,IBLN)  . ;  . S IBJ="" F S IBJ=$O(COM(IBJ)) Q:'IBJ S X=$G(COM(IBJ)) I X'="" S DIW  L=1,DIWR=54,DIWF="" D ^DIWP  . ;  . I $D(^UTILITY($J,"W")) S (IBK,IBCNT)=0 F S IBK=$O(^UTILITY($J,"W",1,  IBK)) Q:'IBK D  .. S IBD=$G(^UTILITY($J,"W",1,IBK,0)) S IBSTR=$$SETLN(IBD,IBSTR,25,54),  IBLN=$$SET(IBSTR,IBLN),IBSTR=""  . K ^UTILITY($J,"W")  ; AR profile of comment transactions (433: 5.02, 41, 86)  K ^TMP("RCJIB",$J),^UTILITY($J,"W") D TRN^RCJIBFN2(IBIFN)  ;  ;HIPAA 5010 - check if contact data has been added as a comment  I '$$CONTACT D  .;Check for payer contact data in all entries associated with the bill  # (IBIFN)  .S (FOUND,IB3611)=0 F S IB3611=$O(^IBM(361.1,"B",IBIFN,IB3611)) Q:'IB3  611 Q:FOUND S FOUND=$$EN^RCDPAYER(IB3611)  .Q:'FOUND ; payer contact data does not exist in any of the EOB entrie  s related to claim  .;Add canned text as a brief comment in file #433 which will serve as a  notice that contact data came from 835 ERA  .D ADD^RCDPAYER(IBIFN) ;IA 5549  .;Rebuild AR profile of comment transactions  .K ^TMP("RCJIB",$J),^UTILITY($J,"W") D TRN^RCJIBFN2(IBIFN)  ;  I $D(^TMP("RCJIB",$J)) S IBI="" F S IBI=$O(^TMP("RCJIB",$J,IBI)) Q:'IB  I D  . S IBX=$G(^TMP("RCJIB",$J,IBI)) I $$STNO^RCJIBFN2(+$P(IBX,U,3))'["COMM  ENT" Q  . S IBRCT5=$$N5^RCJIBFN1(IBI)  . S IBSTR="",IBLN=$$SET(IBSTR,IBLN)  . S IBD=$P(IBX,U,1) S IBSTR=$$SETLN(IBD,IBSTR,2,8)  . S IBD=$$DATE(+$P(IBX,U,2)) S IBSTR=$$SETLN(IBD,IBSTR,14,8)  . S IBD=$P(IBRCT5,U,1) S IBSTR=$$SETLN(IBD,IBSTR,25,30)  . S IBD="FOLLOW-UP DT: "\_$$DATE(+$P(IBRCT5,U,2)) S IBSTR=$$SETLN(IBD,IB  STR,57,22)  . S IBLN=$$SET(IBSTR,IBLN),IBSTR=""  .;HIPAA 5010 - check if this comment is contact data  .I $P(IBRCT5,U)["ERA Payer Contact Information" D  ..N CONTACT,PHONE,FAX,EMAIL,WEB,NAME,EXT,PAYER,HAVPAYER  ..;Display contact data IA 5549  ..; primary, secondary, and tertiary contact data need to be displayed.  Display of contact data  ..; should only occur for each unique payer at BILL (B) x-ref of IBM(36  1.1,"B",IBIFN).  ..; evaluation starts with the most recent entry.  ..; Contact data belonging to more than one payer can be distinguished  by payer name  ..S (HAVPAYER,IB3611)=""  ..F S IB3611=$O(^IBM(361.1,"B",IBIFN,IB3611),-1) Q:'IB3611 S CONTACT=  $$EN^RCDPAYER(IB3611) D  ...Q:'CONTACT  ...S PAYER=$P($G(^IBM(361.1,IB3611,0)),U,2),PAYER=$$EXTERNAL^DILFD(361.  1,.02,,PAYER) ;IA 4051  ...Q:PAYER=HAVPAYER ; payer contact data has already been displayed  ...S HAVPAYER=PAYER  ...S FAX=$P(CONTACT,U,5),EMAIL=$P(CONTACT,U,6),WEB=$P(CONTACT,U,3)  ...S PHONE=$P(CONTACT,U,4),EXT=$P(CONTACT,U,7),NAME=$P(CONTACT,U,2)  ...S IBD="Payer Name: "\_PAYER  ...S IBSTR=$$SETLN(IBD,IBSTR,25,78)  ...S IBLN=$$SET(IBSTR,IBLN),IBSTR=""  ...I NAME]"" D  ....S IBD="Contact Name: "\_NAME  ....S IBSTR=$$SETLN(IBD,IBSTR,25,78)  ....S IBLN=$$SET(IBSTR,IBLN),IBSTR=""  ...I PHONE]"" D  ....S IBD="Phone Number: "\_PHONE S:EXT]"" IBD=IBD\_" Ext: "\_EXT  ....S IBSTR=$$SETLN(IBD,IBSTR,25,78)  ....S IBLN=$$SET(IBSTR,IBLN),IBSTR=""  ...I FAX]"" D  ....S IBD="Facsimile Number: "\_FAX  ....S IBSTR=$$SETLN(IBD,IBSTR,25,78)  ....S IBLN=$$SET(IBSTR,IBLN),IBSTR=""  ...I EMAIL]"" D  ....S IBD="Email Address: "\_EMAIL  ....S IBSTR=$$SETLN(IBD,IBSTR,25,78)  ....S IBLN=$$SET(IBSTR,IBLN),IBSTR=""  ...I WEB]"" D  ....S IBD="Website Address:"\_$E(WEB,1,40)  ....S IBSTR=$$SETLN(IBD,IBSTR,25,78)  ....S IBLN=$$SET(IBSTR,IBLN),IBSTR="" Q:$L(WEB)<41  ....S IBSTR=$$SETLN($E(WEB,41,96),IBSTR,25,78)  ....S IBLN=$$SET(IBSTR,IBLN),IBSTR="" Q:$L(WEB)<97  ....S IBSTR=$$SETLN($E(WEB,97,115),IBSTR,25,78)  ....S IBLN=$$SET(IBSTR,IBLN),IBSTR=""  ...S IBLN=$$SET(IBSTR,IBLN)  . ;  . ; -- transaction comments (86)  . S X=$P($G(^TMP("RCJIB",$J,IBI)),U,6) I X'="" S DIWL=1,DIWR=54,DIWF=""  D ^DIWP  . ;  . ; -- comments (86 & 41)  . K COM D N7^RCJIBFN1(IBI) I $D(COM)>2 D  .. S IBJ="" F S IBJ=$O(COM(IBJ)) Q:'IBJ S X=$G(COM(IBJ)) I X'="" S DI  WL=1,DIWR=54,DIWF="" D ^DIWP  . ;  . I $D(^UTILITY($J,"W")) S (IBK,IBCNT)=0 F S IBK=$O(^UTILITY($J,"W",1,  IBK)) Q:'IBK D  .. S IBD=$G(^UTILITY($J,"W",1,IBK,0)) S IBSTR=$$SETLN(IBD,IBSTR,25,54),  IBLN=$$SET(IBSTR,IBLN),IBSTR=""  . K ^UTILITY($J,"W")  K ^TMP("RCJIB",$J),^UTILITY($J,"W")  ; MRA comments  ; check if we have any comments to display  I $D(^DGCR(399,IBIFN,"TXC","B")) D  .S IBLN=$$SET("",IBLN)  .S IBSTR="",IBSTR=$$SETLN("MRA REQUEST CLAIM COMMENTS",IBSTR,25,54),IBL  N=$$SET(IBSTR,IBLN)  .S IBSTR="",IBSTR=$$SETLN("--------------------------",IBSTR,25,54),IBL  N=$$SET(IBSTR,IBLN)  .; loop through all available comments  .S IBDATE="" F S IBDATE=$O(^DGCR(399,IBIFN,"TXC","B",IBDATE),-1) Q:IBD  ATE="" D  ..S IBZ=$O(^DGCR(399,IBIFN,"TXC","B",IBDATE,"")),IB0=^DGCR(399,IBIFN,"T  XC",IBZ,0),IBDUZ=$P(IB0,U,2)  ..;S IBLN=$$SET("",IBLN)  ..S IBSTR=""  ..S IBSTR=$$SETLN($$FMTE^XLFDT(IBDATE,"2Z"),IBSTR,14,8)  ..S IBSTR=$$SETLN($J("Entered by "\_$$GET1^DIQ(200,IBDUZ,.01),54),IBSTR,  25,54)  ..S IBLN=$$SET(IBSTR,IBLN),IBSTR=""  ..; loop through comment lines  ..S CMLN=0 F S CMLN=$O(^DGCR(399,IBIFN,"TXC",IBZ,1,CMLN)) Q:CMLN="" D  ...S X=^DGCR(399,IBIFN,"TXC",IBZ,1,CMLN,0) I X'="" S DIWL=1,DIWR=54,DIW  F="" D ^DIWP  ...Q  ..I $D(^UTILITY($J,"W")) S IBK=0 F S IBK=$O(^UTILITY($J,"W",1,IBK)) Q:  'IBK D  ...S CMSTR=$G(^UTILITY($J,"W",1,IBK,0)) S IBSTR=$$SETLN(CMSTR,IBSTR,25,  54),IBLN=$$SET(IBSTR,IBLN),IBSTR=""  ...Q  ..K ^UTILITY($J,"W")  ..Q  .;D CLEAN^DILF  .Q  **; call new line tag to display RFAI Claim Comments right after MRA REQUEST CLAIM COMMENTS \*IB\*2.0\*547**  **D RFAIC**  D EOBC ; IB\*2.0\*432  D MDACMTS ; IB\*2.0\*447 BI  D CLEAN^DILF  ;  I IBLN=0 S IBLN=$$SET("",IBLN),IBLN=$$SET("No Comment Transactions Exist For This Account.",IBLN)  S VALMCNT=IBLN  Q  ;  **RFAIC ; Display RFAI Claim Comments \*IB\*2.0\*547**  **I $D(^DGCR(399,IBIFN,"RFAI","B")) D ; not sure yet where RFAI comments will be stored**  **.S IBLN=$$SET("",IBLN)**  **.S IBSTR="",IBSTR=$$SETLN("RFAI CLAIM COMMENTS",IBSTR,25,54),I**  **BLN=$$SET(IBSTR,IBLN)**  **.S IBSTR="",IBSTR=$$SETLN("----------------------------",IBSTR,25,54),I**  **BLN=$$SET(IBSTR,IBLN)**  **.; loop through all available comments**  **.S IBDATE="" F S IBDATE=$O(^DGCR(399,IBIFN,"RFAI","B",IBDATE),-1) Q:IB**  **DATE="" D ; verify where RFAI claim comments to be stored.**  **..S IBZ=$O(^DGCR(399,IBIFN,"RFAI","B",IBDATE,"")),IB0=^DGCR(399,IBIFN,"**  **TXC2",IBZ,0),IBDUZ=$P(IB0,U,2)**  **..;S IBLN=$$SET("",IBLN)**  **..S IBSTR=""**  **..S IBSTR=$$SETLN($$FMTE^XLFDT(IBDATE,"2Z"),IBSTR,14,8)**  **..S IBSTR=$$SETLN($J("Entered by "\_$$GET1^DIQ(200,IBDUZ,.01),54),IBSTR,**  **25,54)**  **..S IBLN=$$SET(IBSTR,IBLN),IBSTR=""**  **..; loop through comment lines**  **..S CMLN=0 F S CMLN=$O(^DGCR(399,IBIFN,"RFAI",IBZ,1,CMLN)) Q:CMLN=""**  **D**  **...S X=^DGCR(399,IBIFN,"RFAI",IBZ,1,CMLN,0) I X'="" S DIWL=1,DIWR=54,DI**  **WF="" D ^DIWP**  **...Q**  **..I $D(^UTILITY($J,"W")) S IBK=0 F S IBK=$O(^UTILITY($J,"W",1,IBK)) Q:**  **'IBK D**  **...S CMSTR=$G(^UTILITY($J,"W",1,IBK,0)) S IBSTR=$$SETLN(CMSTR,IBSTR,25,**  **54),IBLN=$$SET(IBSTR,IBLN),IBSTR=""**  **...Q**  **..K ^UTILITY($J,"W")**  **..Q**  **.Q**  **Q**  **;** | | | | | | | | | |

###### Functional Requirement: EEOB Detail – CARC/RARC Descriptions

The IB system shall provide the ability for users to view the CARCs and RARCs descriptions from the new AR EDI CARC DATA and AR EDI RARC DATA files (345 and 346) when viewing the EEOB detail from Claim Information. (BN 6.4)

**Routines (Entry Points):**

| Routine Name | IBCECSA6 | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Enhancement Category | New | | Modify | Delete | | | No Change | | |
| Requirement Traceability Matrix | **2.6.6.3** | | | | | | | | |
| Related Options | IBJ THIRD PARTY JOINT INQUIRY | | | | | | | | |
| Related Routines | Routines “Called By” | | | | Routines “Called” | | | | |
| IBCAPR2  IBCECOB5  IBCECSA5  IBCECSA7  IBJTBA1 | | | | $$EXTERNAL^DILFD  $$PTRESPI^IBCECOB1  MIN^IBCECSA5  REMARK^IBCECSA5  ARCP^IBCECSA7  INSINF^IBCECSA7  LLVLA^IBCECSA7  RDATA^IBCECSA7  $$FT^IBCEF  $$INPAT^IBCEF  $$DAT1^IBOUTL  $$SETSTR^VALM1  EN^VALM2  $$RJ^XLFSTR | | | | |
| Data Dictionary (DD) References | NONE | | | | | | | | |
| Related Protocols | IBJT BILL CHARGES SCREEN | | | | | | | | |
| Related Integration Control Registrations (ICRs) | A new ICR will be created to access the AR files #345 & #346 (CARC & RARC). | | | | | | | | |
| Data Passing | Input | Output Reference | | | | Both | | Global Reference | Local |
| Input Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Output Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Current Logic | | | | | | | | | |
| CLVLA ;  N IBREC,IBFLG,GR,RSN,Z,I  S IB=$$SETSTR^VALM1("CLAIM LEVEL ADJUSTMENTS:","",1,50),IBSRC=$G(IBSRC)  D SET(IBSRC,IB,CNT,IBCNT)  I 'IBSRC D  . D CNTRL^VALM10(VALMCNT,1,24,IORVON,IORVOFF)  . S ^TMP("IBCECSD",$J,"X",4)=VALMCNT  S (Y,IBFLG)=0 F S Y=$O(^IBM(361.1,IBCNT,10,Y)) Q:'Y D  . S IBREC=$G(^IBM(361.1,IBCNT,10,Y,0)),GR=$P(IBREC,U,1)  . I GR="OA",$P($G(^IBM(361.1,IBCNT,10,Y,1,0)),U,4)=1,$D(^IBM(361.1,IBCN  T,10,Y,1,"B","AB3")) Q ; kludge  . S IBREC=$$EXTERNAL^DILFD(361.11,.01,"",GR),IBFLG=1  . D SET(IBSRC," GROUP CODE: "\_IBREC,CNT,IBCNT)  . S Z=0 F S Z=$O(^IBM(361.1,IBCNT,10,Y,1,Z)) Q:'Z D  .. S IBREC=$G(^IBM(361.1,IBCNT,10,Y,1,Z,0)),RSN=$P(IBREC,U,1)  .. I GR="OA",RSN="AB3" Q ; kludge  .. S IB=$$SETSTR^VALM1("REASON CODE: "\_RSN\_" "\_$P(IBREC,U,4),"",3,77)  .. D SET(IBSRC,IB,CNT,IBCNT)  .. S IB=$$SETSTR^VALM1("Amount: "\_$$A10($P(IBREC,U,2)),"",3,40)  .. S IB=$$SETSTR^VALM1("Quantity: "\_$P(IBREC,U,3),IB,41,38)  .. D SET(IBSRC,IB,CNT,IBCNT)  ;;;D:IBSRC SET(IBSRC,"",CNT,IBCNT) ;IB\*2.0\*488 (vd) REMOVED EXTRA BLA  NK LINE.  I 'IBFLG D SET(IBSRC," NONE",CNT,IBCNT)  Q  ; | | | | | | | | | |
| Modified Logic (Changes are in bold) | | | | | | | | | |
| CLVLA ;  N IBREC,IBFLG,GR,RSN,Z,I**,IBR**  S IB=$$SETSTR^VALM1("CLAIM LEVEL ADJUSTMENTS:","",1,50),IBSRC=$G(IBSRC)  D SET(IBSRC,IB,CNT,IBCNT)  I 'IBSRC D  . D CNTRL^VALM10(VALMCNT,1,24,IORVON,IORVOFF)  . S ^TMP("IBCECSD",$J,"X",4)=VALMCNT  S (Y,IBFLG)=0 F S Y=$O(^IBM(361.1,IBCNT,10,Y)) Q:'Y D  . S IBREC=$G(^IBM(361.1,IBCNT,10,Y,0)),GR=$P(IBREC,U,1)  . I GR="OA",$P($G(^IBM(361.1,IBCNT,10,Y,1,0)),U,4)=1,$D(^IBM(361.1,IBCN  T,10,Y,1,"B","AB3")) Q ; kludge  . S IBREC=$$EXTERNAL^DILFD(361.11,.01,"",GR),IBFLG=1  . D SET(IBSRC," GROUP CODE: "\_IBREC,CNT,IBCNT)  . S Z=0 F S Z=$O(^IBM(361.1,IBCNT,10,Y,1,Z)) Q:'Z D  .. S IBREC=$G(^IBM(361.1,IBCNT,10,Y,1,Z,0)),RSN=$P(IBREC,U,1)  .. I GR="OA",RSN="AB3" Q ; kludge  .. S IB=$$SETSTR^VALM1("REASON CODE: "\_RSN\_" "\_$P(IBREC,U,4),"",3,77)  .. D SET(IBSRC,IB,CNT,IBCNT)  **..; insert IA here to access full CARC/RARC description \*IB\*2.0\*547**  **An API will be written to take the reason code from the EOB and do a lookup on either file**  **345 or 346 using their B x-ref and then retrieving the word processing field that contains the full description (.04 field). Need to format that it can be more than 1 line.**  **.. S IBR=$$CARC^IBCECSA5(RSN,345,”IBR”)**  **.. F I=1:1:+IBR(0) S IB=$$SETSTR^VALM1(IBR(I),””,1,80) D SET(IBSRC,IB,CNT,IBCNT)**  .. S IB=$$SETSTR^VALM1("Amount: "\_$$A10($P(IBREC,U,2)),"",3,40)  .. S IB=$$SETSTR^VALM1("Quantity: "\_$P(IBREC,U,3),IB,41,38)  .. D SET(IBSRC,IB,CNT,IBCNT)  ;;;D:IBSRC SET(IBSRC,"",CNT,IBCNT) ;IB\*2.0\*488 (vd) REMOVED EXTRA BLA  NK LINE.  I 'IBFLG D SET(IBSRC," NONE",CNT,IBCNT)  Q  ; | | | | | | | | | |

| Routine Name | IBCECSA5 | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Enhancement Category | New | | Modify | Delete | | | No Change | | |
| Requirement Traceability Matrix | 2.6.6.3 | | | | | | | | |
| Related Options | IBJ THIRD PARTY JOINT INQUIRY | | | | | | | | |
| Related Routines | Routines “Called By” | | | | Routines “Called” | | | | |
| IBCECOB5  IBCECSA6  IBCECSA7 | | | | $$EXTERNAL^DILFD  ^DIWP  $$A10^IBCECSA6  BLD^IBCECSA6  SET^IBCECSA6  $$FT^IBCEF  $$INPAT^IBCEF  F^IBCEF  BLD^IBCEOB2  HDR^IBCEOB2  $$DAT1^IBOUTL  EN^VALM  $$SETSTR^VALM1  CLEAR^VALM1  CLEAN^VALM10  CNTRL^VALM10  $$LJ^XLFSTR  $$RJ^XLFSTR  DISP^XQORM1 | | | | |
| Data Dictionary (DD) References | NONE | | | | | | | | |
| Related Protocols | IBJT BILL CHARGES SCREEN | | | | | | | | |
| Related Integration Control Registrations (ICRs) | A new ICR will be created to access the AR files #345 & #346 (CARC & RARC). | | | | | | | | |
| Data Passing | Input | Output Reference | | | | Both | | Global Reference | Local |
| Input Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Output Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Current Logic | | | | | | | | | |
| MRALLA S IB=$$SETSTR^VALM1("LINE LEVEL ADJUSTMENTS:","",1,50)  D SET(IB)  I '$G(IBSRC) D  . D CNTRL^VALM10(VALMCNT,1,23,IORVON,IORVOFF)  . S ^TMP("IBCECSD",$J,"X",7)=VALMCNT  I '$D(^IBM(361.1,IBCNT,15,0)) D SET(" NONE") Q ; only if there is info  ;  ; look up all billed data  N IBZDATA,IBFORM,IBX2,IBX3,IBREC2,IBREC3,IBTX,IBT,IBRC,IBZ,IBTXL  S IBFORM=0 ; cms-1500  I $$FT^IBCEF(+IBREC)=3 S IBFORM=1 ; UB-04  D F^IBCEF("N-"\_$S(IBFORM:"UB-04",1:"HCFA 1500")\_" SERVICE LINE (EDI)","  IBZDATA",,+IBREC)  ;  S IBX=0 F S IBX=$O(^IBM(361.1,IBCNT,15,IBX)) Q:IBX<1 S IBREC1=^IBM(36  1.1,IBCNT,15,IBX,0) D  . NEW RVL  . D SET(" # SV DT REVCD PROC MOD UNITS BILLED DEDUCT COINS  ALLOW PYMT")  . S RVL=+$P(IBREC1,U,12) ; referenced Vista line#  . I 'RVL S RVL=IBX ; use the EOB line# if not there  . S IBT=$$RJ($P(IBREC1,"^"),3) ; line number  . S IBT=IBT\_" "\_$$RJ($$DAT1^IBOUTL($P($P(IBREC1,"^",16),".")),8) ; serv  ice date  . S IBT=IBT\_" "\_$$RJ($$EXTERNAL^DILFD(361.115,.1,"",$P(IBREC1,"^",10)),  6) ; revcd  . S IBT=IBT\_" "\_$$RJ($P(IBREC1,"^",4),5) ; procedure  . S IBT=IBT\_" "\_$$RJ($P($G(^IBM(361.1,IBCNT,15,IBX,2,1,0)),"^"),3)\_$S($  D(^IBM(361.1,IBCNT,15,IBX,2,2,0)):"+",1:" ") ; modifiers  . S IBT=IBT\_" "\_$$RJ($FN($P(IBREC1,"^",11),"",0),5) ; units  . S IBT=IBT\_" "\_$$RJ($FN($S(IBFORM:$P($G(IBZDATA(RVL)),"^",5),1:$P($G(I  BZDATA(RVL)),"^",8)\*$P($G(IBZDATA(RVL)),"^",9)),"",2),8) ; billed  . S IBT=IBT\_" "\_$$RJ($FN($P($G(^IBM(361.1,IBCNT,15,IBX,1,+$O(^IBM(361.1  ,IBCNT,15,IBX,1,"B","PR",0)),1,+$O(^IBM(361.1,IBCNT,15,IBX,1,+$O(^IBM(361.1,IBCN  T,15,IBX,1,"B","PR",0)),1,"B",1,0)),0)),"^",2),"",2),7) ; deduct  . S IBT=IBT\_" "\_$$RJ($FN($P($G(^IBM(361.1,IBCNT,15,IBX,1,+$O(^IBM(361.1  ,IBCNT,15,IBX,1,"B","PR",0)),1,+$O(^IBM(361.1,IBCNT,15,IBX,1,+$O(^IBM(361.1,IBCN  T,15,IBX,1,"B","PR",0)),1,"B",2,0)),0)),"^",2),"",2),6) ; coins  . S IBT=IBT\_" "\_$$RJ($FN($P(IBREC1,"^",13),"",2),8) ; allow  . S IBT=IBT\_" "\_$$RJ($FN($P(IBREC1,"^",3),"",2),8) ; payment  . D SET(IBT)  . S IBX2=0 F S IBX2=$O(^IBM(361.1,IBCNT,15,IBX,1,IBX2)) Q:IBX2<1 D  .. S IBREC2=^IBM(361.1,IBCNT,15,IBX,1,IBX2,0),IBX3=0  .. F S IBX3=$O(^IBM(361.1,IBCNT,15,IBX,1,IBX2,1,IBX3)) Q:IBX3<1 D  ... S IBREC3=^IBM(361.1,IBCNT,15,IBX,1,IBX2,1,IBX3,0)  ... ; line level adjustments; don't display kludges (esg 10/23/03)  ... I $P(IBREC2,U,1)="PR",$P(IBREC3,U,1)="AAA" Q  ... I $P(IBREC2,U,1)="OA",$P(IBREC3,U,1)="AB3" Q  ... I $P(IBREC2,U,1)="LQ" Q  ... S IBTX(1)="ADJ: "\_$P(IBREC2,"^")\_" "\_$P(IBREC3,"^")\_" "\_$P(IBREC3  ,"^",4) D TXT1(.IBTX,0,79) S IBT=0 F S IBT=$O(IBTX(IBT)) Q:IBT<1 D SET(IBTX(IB  T))  ... K IBTX  ... D SET("ADJ AMT: "\_$FN($P(IBREC3,"^",2),"",2))  . S IBRC=0  . F S IBRC=$O(^IBM(361.1,IBCNT,15,IBX,4,IBRC)) Q:'IBRC S IBREC2=$G(^(  IBRC,0)) I IBREC2 K IBTX,IBZ S IBTX(1)=" -REMARK CODE("\_+IBREC2\_"): ",IBTXL=$L(  IBTX(1)) D  .. S IBTX(1)=IBTX(1)\_$P(IBREC2,U,2)\_" "\_$P(IBREC2,U,3)  .. I $L(IBTX(1))>79 D  ... D TXT1(.IBTX,0,79) D SET(IBTX(1)) M IBZ=IBTX K IBTX S IBTX(1)="",IB  T=1 F S IBT=$O(IBZ(IBT)) Q:'IBT S IBTX(1)=IBTX(1)\_IBZ(IBT)\_" "  .. E D  ... S IBTXL=0  .. D TXT1(.IBTX,IBTXL,79) S IBT=0 F S IBT=$O(IBTX(IBT)) Q:IBT<1 D SET  (IBTX(IBT))  . D SET(" ")  D SET(" ")  Q  ; | | | | | | | | | |
| Modified Logic (Changes are in bold) | | | | | | | | | |
| MRALLA S IB=$$SETSTR^VALM1("LINE LEVEL ADJUSTMENTS:","",1,50)  D SET(IB)  I '$G(IBSRC) D  . D CNTRL^VALM10(VALMCNT,1,23,IORVON,IORVOFF)  . S ^TMP("IBCECSD",$J,"X",7)=VALMCNT  I '$D(^IBM(361.1,IBCNT,15,0)) D SET(" NONE") Q ; only if there is info  ;  ; look up all billed data  N IBZDATA,IBFORM,IBX2,IBX3,IBREC2,IBREC3,IBTX,IBT,IBRC,IBZ,IBTXL  S IBFORM=0 ; cms-1500  I $$FT^IBCEF(+IBREC)=3 S IBFORM=1 ; UB-04  D F^IBCEF("N-"\_$S(IBFORM:"UB-04",1:"HCFA 1500")\_" SERVICE LINE (EDI)","  IBZDATA",,+IBREC)  ;  S IBX=0 F S IBX=$O(^IBM(361.1,IBCNT,15,IBX)) Q:IBX<1 S IBREC1=^IBM(36  1.1,IBCNT,15,IBX,0) D  . NEW RVL  . D SET(" # SV DT REVCD PROC MOD UNITS BILLED DEDUCT COINS  ALLOW PYMT")  . S RVL=+$P(IBREC1,U,12) ; referenced Vista line#  . I 'RVL S RVL=IBX ; use the EOB line# if not there  . S IBT=$$RJ($P(IBREC1,"^"),3) ; line number  . S IBT=IBT\_" "\_$$RJ($$DAT1^IBOUTL($P($P(IBREC1,"^",16),".")),8) ; serv  ice date  . S IBT=IBT\_" "\_$$RJ($$EXTERNAL^DILFD(361.115,.1,"",$P(IBREC1,"^",10)),  6) ; revcd  . S IBT=IBT\_" "\_$$RJ($P(IBREC1,"^",4),5) ; procedure  . S IBT=IBT\_" "\_$$RJ($P($G(^IBM(361.1,IBCNT,15,IBX,2,1,0)),"^"),3)\_$S($  D(^IBM(361.1,IBCNT,15,IBX,2,2,0)):"+",1:" ") ; modifiers  . S IBT=IBT\_" "\_$$RJ($FN($P(IBREC1,"^",11),"",0),5) ; units  . S IBT=IBT\_" "\_$$RJ($FN($S(IBFORM:$P($G(IBZDATA(RVL)),"^",5),1:$P($G(I  BZDATA(RVL)),"^",8)\*$P($G(IBZDATA(RVL)),"^",9)),"",2),8) ; billed  . S IBT=IBT\_" "\_$$RJ($FN($P($G(^IBM(361.1,IBCNT,15,IBX,1,+$O(^IBM(361.1  ,IBCNT,15,IBX,1,"B","PR",0)),1,+$O(^IBM(361.1,IBCNT,15,IBX,1,+$O(^IBM(361.1,IBCN  T,15,IBX,1,"B","PR",0)),1,"B",1,0)),0)),"^",2),"",2),7) ; deduct  . S IBT=IBT\_" "\_$$RJ($FN($P($G(^IBM(361.1,IBCNT,15,IBX,1,+$O(^IBM(361.1  ,IBCNT,15,IBX,1,"B","PR",0)),1,+$O(^IBM(361.1,IBCNT,15,IBX,1,+$O(^IBM(361.1,IBCN  T,15,IBX,1,"B","PR",0)),1,"B",2,0)),0)),"^",2),"",2),6) ; coins  . S IBT=IBT\_" "\_$$RJ($FN($P(IBREC1,"^",13),"",2),8) ; allow  . S IBT=IBT\_" "\_$$RJ($FN($P(IBREC1,"^",3),"",2),8) ; payment  . D SET(IBT)  . S IBX2=0 F S IBX2=$O(^IBM(361.1,IBCNT,15,IBX,1,IBX2)) Q:IBX2<1 D  .. S IBREC2=^IBM(361.1,IBCNT,15,IBX,1,IBX2,0),IBX3=0  .. F S IBX3=$O(^IBM(361.1,IBCNT,15,IBX,1,IBX2,1,IBX3)) Q:IBX3<1 D  ... S IBREC3=^IBM(361.1,IBCNT,15,IBX,1,IBX2,1,IBX3,0)  ... ; line level adjustments; don't display kludges (esg 10/23/03)  ... I $P(IBREC2,U,1)="PR",$P(IBREC3,U,1)="AAA" Q  ... I $P(IBREC2,U,1)="OA",$P(IBREC3,U,1)="AB3" Q  ... I $P(IBREC2,U,1)="LQ" Q  ... S IBTX(1)="ADJ: "\_$P(IBREC2,"^")\_" "\_$P(IBREC3,"^")\_" "\_$P(IBREC3  ,"^",4) D TXT1(.IBTX,0,79) S IBT=0 F S IBT=$O(IBTX(IBT)) Q:IBT<1 D SET(IBTX(IB  T))  ... K IBTX  ... D SET("ADJ AMT: "\_$FN($P(IBREC3,"^",2),"",2))  . S IBRC=0  . F S IBRC=$O(^IBM(361.1,IBCNT,15,IBX,4,IBRC)) Q:'IBRC S IBREC2=$G(^(  IBRC,0)) I IBREC2 K IBTX,IBZ S IBTX(1)=" -REMARK CODE("\_+IBREC2\_"): ",IBTXL=$L(  IBTX(1)) D  **..; insert IA here to access full CARC/RARC description \*IB\*2.0\*547**  **An API will be written to take the reason code from the EOB and do a lookup on either file**  **345 or 346 using their B x-ref and then retrieving the word processing field that contains the full description (.04 field)**  .. S IBTX(1)=IBTX(1)\_$P(IBREC2,U,2)\_" "\_$P(IBREC2,U,3)  .. I $L(IBTX(1))>79 D  ... D TXT1(.IBTX,0,79) D SET(IBTX(1)) M IBZ=IBTX K IBTX S IBTX(1)="",IB  T=1 F S IBT=$O(IBZ(IBT)) Q:'IBT S IBTX(1)=IBTX(1)\_IBZ(IBT)\_" "  .. E D  ... S IBTXL=0  .. D TXT1(.IBTX,IBTXL,79) S IBT=0 F S IBT=$O(IBTX(IBT)) Q:IBT<1 D SET  (IBTX(IBT))  . D SET(" ")  D SET(" ")  Q  ;  **CARC(code,file,array) ; new CARC/RACR API for IB\*2.0\*547 – get IA#**  **; code=reason code to lookup in carc/rarc file**  **; file= file# to do lookup (either 345 or 346)**  **; array= subscripted array to return description data in:**  **; array(0) = number of lines total**  **; array(1)= first line of word processed description**  **; array(2)= 2nd line and so on**  **Use fileman lookup code to find ien from B x-ref**  **Then use DIQ to get word processing sub-field**  **S ARRAY=$$GET1^DIQ(file,ien\_",",4,"",ARRAY)**  **S ARRAY(0)=$P($G(^RC(345,IEN,1,0)),U,3)**  **Q ARRAY** | | | | | | | | | |

##### System Feature: EDI Menu for Electronic Bills

###### Functional Requirement: Print EOB With CARC/RARC Descriptions

The IB system shall provide the ability for users to print the CARCs and RARCs descriptions from the new AR EDI CARC DATA and AR EDI RARC DATA files (345 and 346) from the Print EOB [IBCE PRINT EOB] option. (BN 6.4)

**Design Element**

CLVLA^ IBCECSA6

.. S IB=$$SETSTR^VALM1("REASON CODE: "\_RSN\_" "\_$P(IBREC,U,4),"",3,77)

1. Replace $P(IBREC,U,4) with a call to retrieve description from file 345 or 346. Will need to be formatted over multiple lines to fit the report

 MRALLA^IBCECSA5

 ... S IBTX(1)="ADJ: "\_$P(IBREC2,"^")\_" "\_$P(IBREC3,"^")\_" "\_$P(IBREC3,"^",4) D TXT1(.IBTX,0,79) S IBT=0 F  S IBT=$O(IBTX(IBT)) Q:IBT<1 D SET(IBTX(IBT))

1. Replace $P(IBREC3,^,4) with a call to retrieve description from file 345 or 346. Will need to be formatted over multiple lines to fit the report
2. An ICR will be required

##### System Feature - View/Resubmit Claims - Live or Test (RCB)

###### Functional Requirement: View/Resubmit Claims - Live or Test (RCB) Look-up

The IB System shall provide the ability for users to look up claims in the View/Resubmit Claims - Live or Test option by Electronic Data Interchange (EDI) Payer ID. (BN 9.3)

**Database Information**

**(Describe new Field or field change here)**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| File Name and Number | INSURANCE COMPANY #36 | | | | | | | | | |
| Enhancement Category | New | Modify | | | | Delete | | No Change | | |
| Requirements Traceability Matrix | 2.6.8.1 | | | | | | | | | |
| Related Options | IBCE PREV TRANSMITTED CLAIMS | | | | | | | | | |
| Data Dictionary (DD) References | NONE | | | | | | | | | |
| Related Protocols | NONE | | | | | | | | | |
| Related Integration Control Registrations (ICRs) Agreements | NONE | | | | | | | | | |
| File Documentation | This file contains the names and addresses of insurance companies as needed by the local facility. The data in this file is NOT EDITABLE USING VA FILEMANAGER. If a new entry needs to be made or an existing entry changed the user must be assigned the appropriate MAS or IB module option. | | | | | | | | | |
| File Auditing, Security, and Archiving | DD ACCESS: #  WR ACCESS: D  DEL ACCESS: d  LAYGO ACCESS: d | | | | | | | | | |
| **Field Name** | EDI ID NUMBER - PROF | | | | | | | | | |
| Field Description | This is the ID number used to identify the Payer on professional claim transmissions. PRNT values are not valid Payer IDs. | | | | | | | | | |
| Field # | 3.02 | | | | | | | | | |
| Node # | 3 | | | | | | | | | |
| Piece # | 2 | | | | | | | | | |
| New Field | Yes | | | No | | | | | | |
| Data Type | Date/Time | | | Numeric | | | Set of Codes | | | Free Text |
| Pointer to a File | | | | | | Variable-Pointer | | | |
| Identifier | Yes | | | No | | | | | | |
| Uneditable Field | Yes | | | No | | | | | | |
| Mandatory Field | Yes | | | No | | | | | | |
| Field Documentation or Help Changes Necessary | Yes | | | No | | | | | | |
| Field Definition | We are adding a cross-reference to this field to allow users to lookup an Insurance Company entry by Primary EDI # within the RCB option only. | | | | | | | | | |
| Input/Output Transform | K:$L(X)>30!($L(X)<1)!($$UP^XLFSTR(X)["PRNT") X I $D(X) K:'$$EDIKEY^IBCNSC X | | | | | | | | | |
| Cross-Reference (id and type)  No cross reference | Regular | | Kwic | | Mnemonic | | | | Mumps | |
| Soundex | | Trigger | | Bulletin | | | |  | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| File Name and Number | INSURANCE COMPANY #36 | | | | | | | | | |
| Enhancement Category | New | Modify | | | | Delete | | No Change | | |
| Requirements Traceability Matrix | 2.6.8.1 | | | | | | | | | |
| Related Options | IBCE PREV TRANSMITTED CLAIMS | | | | | | | | | |
| Data Dictionary (DD) References | NONE | | | | | | | | | |
| Related Protocols | NONE | | | | | | | | | |
| Related Integration Control Registrations (ICRs) Agreements | NONE | | | | | | | | | |
| File Documentation | This file contains the names and addresses of insurance companies as needed by the local facility. The data in this file is NOT EDITABLE USING VA FILEMANAGER. If a new entry needs to be made or an existing entry changed the user must be assigned the appropriate MAS or IB module option. | | | | | | | | | |
| File Auditing, Security, and Archiving | DD ACCESS: #  WR ACCESS: D  DEL ACCESS: d  LAYGO ACCESS: d | | | | | | | | | |
| **Field Name** | EDI ID NUMBER - INST | | | | | | | | | |
| Field Description | This is the ID number used to identify the Payer on Institutional claim transmissions. PRNT values are not valid Payer IDs. | | | | | | | | | |
| Field # | 3.04 | | | | | | | | | |
| Node # | 3 | | | | | | | | | |
| Piece # | 4 | | | | | | | | | |
| New Field | Yes | | | No | | | | | | |
| Data Type | Date/Time | | | Numeric | | | Set of Codes | | | Free Text |
| Pointer to a File | | | | | | Variable-Pointer | | | |
| Identifier | Yes | | | No | | | | | | |
| Uneditable Field | Yes | | | No | | | | | | |
| Mandatory Field | Yes | | | No | | | | | | |
| Field Documentation or Help Changes Necessary | Yes | | | No | | | | | | |
| Field Definition | We are adding a look-up cross-reference to this field to allow users to lookup an Insurance Company entry by Primary EDI # within the RCB option only. | | | | | | | | | |
| Input/Output Transform | K:$L(X)>30!($L(X)<1)!($$UP^XLFSTR(X)["PRNT") X I $D(X) K:'$$EDIKEY^IBCNSC X | | | | | | | | | |
| Cross-Reference (id and type)  No cross reference | Regular | | Kwic | | Mnemonic | | | | Mumps | |
| Soundex | | Trigger | | Bulletin | | | |  | |

**Routines (Entry Points):**

| Routine Name | IBY547PO | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Enhancement Category | New | | Modify | Delete | | | No Change | | |
| Requirement Traceability Matrix | 2.6.8.1 | | | | | | | | |
| Related Options | KIDS post-install routine | | | | | | | | |
| Related Routines | Routines “Called By” | | | | Routines “Called” | | | | |
| KIDS | | | | XPDUTL  DIK | | | | |
| Data Dictionary (DD) References | File 36, fields 3.02 & 3.04 | | | | | | | | |
| Related Protocols | none | | | | | | | | |
| Related Integration Control Registrations (ICRs) | none | | | | | | | | |
| Data Passing | Input | Output Reference | | | | Both | | Global Reference | Local |
| Input Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Output Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Current Logic | | | | | | | | | |
| n/a (new post-install routine) | | | | | | | | | |
| Modified Logic (Changes are in bold) | | | | | | | | | |
| **IBY547PO ;ALB/GEF - Post install routine for patch 547 ; 7-MAY-15**  **;;2.0;INTEGRATED BILLING;\*\*547\*\*;21-MAR-94;Build 33**  **;;Per VA Directive 6402, this routine should not be modified.**  **;**  **; XPDUTL calls are DBIA#10141**  **;**  **POINDX ; POST-INSTALL comes here**  **; run triggers on new cross-refs for fields 3.02 & 8.04 (EDI PROF & INST)**  **D MES^XPDUTL("Setting new EDI cross-references in INSURANCE COMPANY file ")**  **N DIK,FLD**  **; file 36, top level**  **S DIK="^DIC(36,"**  **F FLD=3.02,3.04 S DIK(1)=FLD D ENALL^DIK**  **Q** | | | | | | | | | |

| Routine Name | IBCEPTC | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Enhancement Category | New | | Modify | Delete | | | No Change | | |
| Requirement Traceability Matrix | 2.6.8.1, 2.6.8.2 | | | | | | | | |
| Related Options | IBCE PREV TRANSMITTED CLAIMS | | | | | | | | |
| Related Routines | Routines “Called By” | | | | Routines “Called” | | | | |
| IBCEPTC3 | | | | ^%ZIS  HOME^%ZIS  ^%ZTLOAD  ^DIC  ^DIR  LIST^IBCEPTC0  RESUB^IBCEPTC3  $$FMADD^XLFDT  $$FMTE^XLFDT  $$UP^XLFSTR | | | | |
| Data Dictionary (DD) References | NONE | | | | | | | | |
| Related Protocols | IBCE VIEW PREV TRANS | | | | | | | | |
| Related Integration Control Registrations (ICRs) | NONE | | | | | | | | |
| Data Passing | Input | Output Reference | | | | Both | | Global Reference | Local |
| Input Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Output Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Current Logic | | | | | | | | | |
| IBCEPTC ;ALB/TMK - EDI PREVIOUSLY TRANSMITTED CLAIMS ; 4/12/05 11:15am  ;;2.0;INTEGRATED BILLING;\*\*296,320,348,349\*\*;21-MAR-94;Build 46  ;;Per VHA Directive 2004-038, this routine should not be modified.  ;  EN ; Main entrypoint  ; IBDT1,IBDT2 = last transmit date range to use  ; IBSORT = primary sort criteria to use B=BATCH #,I=INS CO NAME  ; IBFORM = form type to limit selection to U=UB-04,C=CMS-1500,B=BOTH  ; IBCRIT = the additional sort criteria needed  ; IBPTCCAN = whether or not to include cancelled claims  ; IBRCBFPC = whether or not to include force print @ clearinghouse  ; ^TMP("IB\_PREV\_CLAIM\_INS",$J) = 1 for specific ins co/null for all  ; ^($J,1,ien)="" for ien of each ins co selected  ; ^($J,2,payer ID,ien)="" if selected  ; IBREP = format output should be put in R=report,S=ListMan  ;  N DIR,DIC,X,Y,Z,Z0,Z1,IBHOW,IBACT,IBCT,IBREP,IBCRIT,IBDT1,IBDT2  N IBFORM,IBOK,IBQUIT,IBSORT,IBY,DTOUT,DUOUT,%ZIS,ZTSAVE,ZTRTN,ZTDESC  N POP,IBPAYER,EDI,INST,PROF,IBPTCCAN,DIROUT,DIRUT,DTOUT,DUOUT,IBRCBFPC  ;  Q1 ;  W !!,"\*\*\* Please Note \*\*\*"  W ?20,"2 '^' are needed to abort this option (^^)"  W !?20,"1 '^' brings you back to the previous prompt (^)"  W !  ;  S DIR(0)="SA^C:Claim;B:Batch;L:List",DIR("A")="Select By: (C)laim, (B)atch or see a (L)ist to pick from?: ",DIR("B")="List"  D ^DIR K DIR  I $D(DTOUT)!$D(DUOUT) G ENQ  S IBHOW=Y  I IBHOW="L" G Q1A  ;  S IBQUIT=0,IBCT=0  K ^TMP($J,IBHOW)  F D Q:IBQUIT  . I IBHOW="C" S DIR("A")="Select a"\_$S(IBCT:"nother",1:"")\_" Claim: ",DIR(0)="PA^364:AEMQZ",DIR("S")="I '$P(^(0),U,7),'$O(^IBA(364,""B"",+^(0),Y))"  . I IBHOW="B" S DIR("A")="Select a"\_$S(IBCT:"nother",1:"")\_" Batch: ",DIR(0)="PA^IBA(364.1,:AEMQ^W "" "",$P(^(0),U,3),"" Claims""",DIR("S")="I '$P(^(0),U,14)"  . S DIR("?")="^D SELDSP^IBCEPTC(IBHOW)"  . S:IBCT $P(DIR(0),U)=$P(DIR(0),U)\_"O" ; Optional prompt after one is selected  . D ^DIR K DIR  . I Y'>0 S IBQUIT=$S(X="^":2,X="^^":3,1:1) Q  . S IBY=$S(IBHOW="C":+Y,1:""),Y=$S(IBHOW="C":+Y(0),1:Y)  . I '$D(^TMP($J,IBHOW,+Y)) S IBCT=IBCT+1,^TMP($J,IBHOW,+Y)=IBY  ;  G:IBQUIT=3 ENQ  G:IBQUIT=2!'$O(^TMP($J,IBHOW,0)) Q1  S Z=0  I IBHOW="C" F S Z=$O(^TMP($J,"C",Z)) Q:'Z S ^TMP("IB\_PREV\_CLAIM\_SELEC T",$J,Z,0)=^TMP($J,"C",Z)  I IBHOW="B" S (Z,IBCT)=0 F S Z=$O(^TMP($J,"B",Z)) Q:'Z D  . S Z0=0 F S Z0=$O(^IBA(364,"C",Z,Z0)) Q:'Z0 S Z1=+$G(^IBA(364,Z0,0)) I Z1,'$D(^TMP("IB\_PREV\_CLAIM\_SELECT",$J,Z1,0)) S ^(0)=Z0,IBCT=IBCT+1  S ^TMP("IB\_PREV\_CLAIM\_SELECT",$J)=IBCT  D RESUB^IBCEPTC3  G ENQ  ;  Q1A K ^TMP("IB\_PREV\_CLAIM\_INS",$J)  S DIR(0)="SA^A:All Payers;S:Selected Payers"  S DIR("A")="Run for (A)ll Payers or (S)elected Payers?: " S DIR("B")="Selected Payers"  W !!,"PAYER SELECTION:" D ^DIR K DIR  I X="^^" G ENQ  I $D(DTOUT)!$D(DUOUT) G Q1  ;  I Y="A" S ^TMP("IB\_PREV\_CLAIM\_INS",$J)="" G Q2  ;  ; esg - 11/21/05 - patch 320 question  W !  S DIR(0)="Y",DIR("A")=" Include all payers with the same electronic Payer ID",DIR("B")="Yes" D ^DIR K DIR  I $D(DIROUT) G ENQ  I $D(DIRUT) G Q1A  S IBPAYER=Y  W !  ;  S ^TMP("IB\_PREV\_CLAIM\_INS",$J)=1  S IBQUIT=0  F D Q:IBQUIT  . S DIC(0)="AEMQ",DIC=36,DIC("A")=" Select Insurance Company: "  . I $O(^TMP("IB\_PREV\_CLAIM\_INS",$J,1,"")) S DIC("A")=" Select Another Insurance Company: "  . S DIC("W")="D INSLIST^IBCEMCA(Y)"  . D ^DIC K DIC ; lookup  . I X="^^" S IBQUIT=2 Q ; user entered "^^"  . I +Y'>0 S IBQUIT=1 Q ; user is done  . W !  . S ^TMP("IB\_PREV\_CLAIM\_INS",$J,1,+Y)=""  . I 'IBPAYER Q  . S EDI=$$UP^XLFSTR($G(^DIC(36,+Y,3)))  . S PROF=$P(EDI,U,2),INST=$P(EDI,U,4)  . I PROF'="",PROF'["PRNT" S ^TMP("IB\_PREV\_CLAIM\_INS",$J,2,PROF,+Y)=""  . I INST'="",INST'["PRNT" S ^TMP("IB\_PREV\_CLAIM\_INS",$J,2,INST,+Y)=""  . Q  ;  I IBQUIT=2 G ENQ  ;  I '$O(^TMP("IB\_PREV\_CLAIM\_INS",$J,1,0)) D G Q1A  . W \*7,!!?3,"No payers have been selected. Please try again."  . Q  ;  Q2 S DIR(0)="SA^C:CMS-1500;U:UB-04;B:Both",DIR("B")="Both"  S DIR("A")="Run for (U)B-04, (C)MS-1500 or (B)oth: "  W !!,"BILL FORM TYPE SELECTION:" D ^DIR K DIR  I X="^^" G ENQ  I $D(DTOUT)!$D(DUOUT) G Q1A  S IBFORM=Y  ;  Q3 S DIR(0)="DA^0:9999999:EPX",DIR("A")="Start with Date Last Transmitted: "  S DIR("?",1)="This is the earliest date on which a batch that you want to include on this",DIR("?",2)=" report was last transmitted. You may choose a maximum date range of 90 days.",DIR("?")=" "  W !!,"LAST BATCH TRANSMIT DATE RANGE SELECTION:" D ^DIR K DIR  I X="^^" G ENQ  I $D(DTOUT)!$D(DUOUT) G Q2  S IBDT1=Y  S IBDT2=$$FMADD^XLFDT(IBDT1,90) I IBDT2>DT S IBDT2=DT  S DIR("?",1)="This is the latest date on which a batch that you want to include on this",DIR("?",2)=" report was last transmitted. You may choose a maximum date range of 90 days.",DIR("?")=" "  S DIR("B")=$$FMTE^XLFDT(IBDT2,2),DIR(0)="DA^"\_IBDT1\_":"\_IBDT2\_":EPX"  S DIR("A")="Go to Date Last Transmitted:("\_$$FMTE^XLFDT(IBDT1,2)\_"-"\_$$ FMTE^XLFDT(IBDT2,2)\_"): " D ^DIR K DIR  I X="^^" G ENQ  I $D(DTOUT)!$D(DUOUT) G Q3  S IBDT2=Y  ;  Q4 ; Additional selection criteria  S DIR(0)="SAO^1:MRA Secondary Only;2:Primary Claims Only;3:Secondary Claims Only;4:Claims Previously Printed at Clearinghouse"  S DIR("A",1)="ADDITIONAL SELECTION CRITERIA:",DIR("A",2)=" ",DIR("A",3)  ="1 - MRA Secondary Only",DIR("A",4)="2 - Primary Cl  aims Only",DIR("A",5)="3 - Secondary Claims Only"  S DIR("A",6)="4 - Claims Sent to Print at Clearinghouse Only",DIR("A",7  )=" ",DIR("A")="Select Additional Limiting Criteria  (optional): "  S DIR("?")="Select one of the listed criteria to further limit the clai  ms to include"  W ! D ^DIR K DIR  I X="^^" G ENQ  I $D(DTOUT)!$D(DUOUT) G Q3  S IBCRIT=Y  ;  Q41 ; Ask user if they want to include cancelled claims  S DIR(0)="Y",DIR("B")="No",DIR("A")="Would you like to include cancelle  d claims"  W ! D ^DIR K DIR  I X="^^" G ENQ  I $D(DIRUT) G Q4  S IBPTCCAN=Y  ;  Q42 ; Include claims that are forced to print at clearinghouse?  S DIR(0)="Y",DIR("B")="No",DIR("A")="Would you like to include claims F  orced to Print at the Clearinghouse"  W ! D ^DIR K DIR  I X="^^" G ENQ  I $D(DIRUT) G Q41  S IBRCBFPC=Y  ;  Q5 S DIR("L",1)="Select one of the following: ",DIR("L",2)=" ",DIR("L",3)=  $J("",10)\_"1 Batch By Last Transmitted Date  (Claims within a Batch)",DIR("L",4)=$J("",10)\_"2 Current Payer (Insuranc  e Company)"  S DIR("L",5)=" "  S DIR(0)="SA^1:Batch By Last Transmitted Date (Claims within a Batch);2  :Current Payer (Insurance Company)",DIR("B")="Curren  t Payer"  S DIR("A")="Sort By: "  W ! D ^DIR K DIR  I X="^^" G ENQ  I $D(DTOUT)!$D(DUOUT) G Q42  S IBSORT=Y  ;  Q6 S DIR(0)="SA^R:Report;S:Screen List"  S DIR("A")="Do you want a (R)eport or a (S)creen List format?: "  S DIR("B")="Screen List"  W ! D ^DIR K DIR  I X="^^" G ENQ  I $D(DTOUT)!$D(DUOUT) G Q5  S IBREP=Y  ;  I IBREP="S" D LIST^IBCEPTC0 G ENQ  ;  Q7 ; Select device  F S IBACT=0 D DEVSEL(.IBACT) Q:IBACT  I IBACT=99 G ENQ  U IO  D LIST^IBCEPTC0  ;  ENQ K ^TMP("IB\_PREV\_CLAIM\_INS",$J),^TMP("IB\_PREV\_CLAIM\_SELECT",$J)  Q  ; | | | | | | | | | |
| Modified Logic (Changes are in bold) | | | | | | | | | |
| IBCEPTC ;ALB/TMK - EDI PREVIOUSLY TRANSMITTED CLAIMS ; 4/12/05 11:15am  ;;2.0;INTEGRATED BILLING;\*\*296,320,348,349**,547**\*\*;21-MAR-94;Build 46  ;;Per VHA Directive 2004-038, this routine should not be modified.  ;  EN ; Main **entry point**  ; IBDT1,IBDT2 = last transmit date range to use  ; IBSORT = primary sort criteria to use B=BATCH #,I=INS CO NAME  ; IBFORM = form type to limit selection to U=UB-04,C=CMS-1500,B=BOTH  ; IBCRIT = the additional sort criteria needed  ; IBPTCCAN = whether or not to include cancelled claims  ; IBRCBFPC = whether or not to include force print @ clearinghouse  ; ^TMP("IB\_PREV\_CLAIM\_INS",$J) = 1 for specific ins co/null for all  ; ^($J,1,ien)="" for ien of each ins co selected  ; ^($J,2,payer ID,ien)="" if selected  ; IBREP = format output should be put in R=report,S=ListMan  ;  N DIR,DIC,X,Y,Z,Z0,Z1,IBHOW,IBACT,IBCT,IBREP,IBCRIT,IBDT1,IBDT2**,IBLOC**  N IBFORM,IBOK,IBQUIT,IBSORT,IBY,DTOUT,DUOUT,%ZIS,ZTSAVE,ZTRTN,ZTDESC  N POP,IBPAYER,EDI,INST,PROF,IBPTCCAN,DIROUT,DIRUT,DTOUT,DUOUT,IBRCBFPC  ;  W !!,"\*\*\* Please Note \*\*\*"  W ?20,"2 '^' are needed to abort this option (^^)"  W !?20,"1 '^' brings you back to the previous prompt (^)"  W !  ; **IB\*2.0\*547 add new prompt for locally printed vs. transmitted claims**  **S DIR(0)="SA^P:Printed;T:Transmitted",DIR("A")="Run report for (P)rinted or (T)ransmitted claims?: ",DIR("B")="Transmitted"**  **D ^DIR K DIR**  **I $D(DTOUT)!$D(DUOUT) G ENQ**  **S IBHOW=Y**  **I IBHOW="T" G Q1**  **; Set a flag here to indicate user wants locally printed claims and use that to control how the rest of the prompts act.**  **S IBLOC=1**  **;**  **Q1 ;**  **W !**  **;**S DIR(0)="SA^C:Claim;B:Batch;L:List",DIR("A")="Select By: (C)laim, (B)atch or see a (L)ist to pick from?: ",DIR("B")="List"  **S DIR(0)=“SA^C:Claim;”\_$S(IBLOC:””,1:”B:Batch;")\_”L:List",DIR("A")="Select By: (C)laim “\_$S(IBLOC:””,1:” , (B)atch “)\_”or see a (L)ist to pick from?: " ,DIR("B")="List"**  D ^DIR K DIR  I $D(DTOUT)!$D(DUOUT) G ENQ  S IBHOW=Y  I IBHOW="L" G Q1A  ;  S IBQUIT=0,IBCT=0  K ^TMP($J,IBHOW)  F D Q:IBQUIT  . I IBHOW="C" S DIR("A")="Select a"\_$S(IBCT:"nother",1:"")\_" Claim: ",D  IR(0)="PA^364:AEMQZ",DIR("S")="I '$P(^(0),U,7),'$O(^  IBA(364,""B"",+^(0),Y))"  . I IBHOW="B" S DIR("A")="Select a"\_$S(IBCT:"nother",1:"")\_" Batch: ",D  IR(0)="PA^IBA(364.1,:AEMQ^W "" "",$P(^(0),U,3),"" C  laims""",DIR("S")="I '$P(^(0),U,14)"  . S DIR("?")="^D SELDSP^IBCEPTC(IBHOW)"  . S:IBCT $P(DIR(0),U)=$P(DIR(0),U)\_"O" ; Optional prompt after one is s  elected  . D ^DIR K DIR  . I Y'>0 S IBQUIT=$S(X="^":2,X="^^":3,1:1) Q  . S IBY=$S(IBHOW="C":+Y,1:""),Y=$S(IBHOW="C":+Y(0),1:Y)  . I '$D(^TMP($J,IBHOW,+Y)) S IBCT=IBCT+1,^TMP($J,IBHOW,+Y)=IBY  ;  G:IBQUIT=3 ENQ  G:IBQUIT=2!'$O(^TMP($J,IBHOW,0)) Q1  S Z=0  I IBHOW="C" F S Z=$O(^TMP($J,"C",Z)) Q:'Z S ^TMP("IB\_PREV\_CLAIM\_SELEC  T",$J,Z,0)=^TMP($J,"C",Z)  I IBHOW="B" S (Z,IBCT)=0 F S Z=$O(^TMP($J,"B",Z)) Q:'Z D  . S Z0=0 F S Z0=$O(^IBA(364,"C",Z,Z0)) Q:'Z0 S Z1=+$G(^IBA(364,Z0,0))  I Z1,'$D(^TMP("IB\_PREV\_CLAIM\_SELECT",$J,Z1,0)) S ^(  0)=Z0,IBCT=IBCT+1  S ^TMP("IB\_PREV\_CLAIM\_SELECT",$J)=IBCT  D RESUB^IBCEPTC3  G ENQ  ;  Q1A K ^TMP("IB\_PREV\_CLAIM\_INS",$J)  S DIR(0)="SA^A:All Payers;S:Selected Payers"  S DIR("A")="Run for (A)ll Payers or (S)elected Payers?: " S DIR("B")="Selected Payers"  W !!,"PAYER SELECTION:" D ^DIR K DIR  I X="^^" G ENQ  I $D(DTOUT)!$D(DUOUT) G Q1  ;  I Y="A" S ^TMP("IB\_PREV\_CLAIM\_INS",$J)="" G Q2  ;  ; esg - 11/21/05 - patch 320 question  W !  S DIR(0)="Y",DIR("A")=" Include all payers with the same electronic Payer ID",DIR("B")="Yes" D ^DIR K DIR  I $D(DIROUT) G ENQ  I $D(DIRUT) G Q1A  S IBPAYER=Y  W !  ;  S ^TMP("IB\_PREV\_CLAIM\_INS",$J)=1  S IBQUIT=0  F D Q:IBQUIT  . S DIC(0)="AEMQ",DIC=36,DIC("A")=" Select Insurance Company: "  . I $O(^TMP("IB\_PREV\_CLAIM\_INS",$J,1,"")) S DIC("A")=" Select Another  Insurance Company: "  . S DIC("W")="D INSLIST^IBCEMCA(Y)"  . **;**D ^DIC K DIC ; lookup  **.; IB\*2.0\*547 allow lookup by EDI#’s using new cross-ref**  **.S** **D="B^AEI^AEP" D MIX^DIC1 K DIC**  . I X="^^" S IBQUIT=2 Q ; user entered "^^"  . I +Y'>0 S IBQUIT=1 Q ; user is done  . W !  . S ^TMP("IB\_PREV\_CLAIM\_INS",$J,1,+Y)=""  . I 'IBPAYER Q  . S EDI=$$UP^XLFSTR($G(^DIC(36,+Y,3)))  . S PROF=$P(EDI,U,2),INST=$P(EDI,U,4)  . I PROF'="",PROF'["PRNT" S ^TMP("IB\_PREV\_CLAIM\_INS",$J,2,PROF,+Y)=""  . I INST'="",INST'["PRNT" S ^TMP("IB\_PREV\_CLAIM\_INS",$J,2,INST,+Y)=""  . Q  ;  I IBQUIT=2 G ENQ  ;  I '$O(^TMP("IB\_PREV\_CLAIM\_INS",$J,1,0)) D G Q1A  . W \*7,!!?3,"No payers have been selected. Please try again."  . Q  ;  Q2 S DIR(0)="SA^C:CMS-1500;U:UB-04;B:Both",DIR("B")="Both"  S DIR("A")="Run for (U)B-04, (C)MS-1500 or (B)oth: "  W !!,"BILL FORM TYPE SELECTION:" D ^DIR K DIR  I X="^^" G ENQ  I $D(DTOUT)!$D(DUOUT) G Q1A  S IBFORM=Y  ;  Q3 S DIR(0)="DA^0:9999999:EPX",DIR("A")="Start with Date Last Transmitted:  "  S DIR("?",1)="This is the earliest date on which a batch that you want to include on this",DIR("?",2)=" report was last transmitted. You may choose a maximum date range of 90 days.",DIR("?")=" "  **;**W !!,"LAST BATCH TRANSMIT DATE RANGE SELECTION:" D ^DIR K DIR  **W !!,"LAST “\_$S(IBLOC:”PRINT “, 1:”BATCH TRANSMIT “)\_” DATE RANGE SELECTION:" D ^DIR K DIR**  I X="^^" G ENQ  I $D(DTOUT)!$D(DUOUT) G Q2  S IBDT1=Y  S IBDT2=$$FMADD^XLFDT(IBDT1,90) I IBDT2>DT S IBDT2=DT  S DIR("?",1)="This is the latest date on which a batch that you want to include on this",DIR("?",2)=" report was last **“\_$S(IBLOC:”printed“,1:”**transmitted**”)\_”**. You may choose a maximum date range of 90 days.",DIR("?")=" "  S DIR("B")=$$FMTE^XLFDT(IBDT2,2),DIR(0)="DA^"\_IBDT1\_":"\_IBDT2\_":EPX"  S DIR("A")="Go to Date Last **“\_$S(IBLOC:”Printed”,1:”**Transmitted"**)\_**”(“\_$$FMTE^XLFDT(IBDT1,2)\_"-"\_$$  FMTE^XLFDT(IBDT2,2)\_"): " D ^DIR K DIR  I X="^^" G ENQ  I $D(DTOUT)!$D(DUOUT) G Q3  S IBDT2=Y  ;  Q4 ; Additional selection criteria  S DIR(0)="SAO^1:MRA Secondary Only;2:Primary Claims Only;3:Secondary Claims Only;4:Claims Previously Printed at Clearinghouse"  S DIR("A",1)="ADDITIONAL SELECTION CRITERIA:",DIR("A",2)=" ",DIR("A",3)="1 - MRA Secondary Only",DIR("A",4)="2 - Primary Claims Only",DIR("A",5)="3 - Secondary Claims Only"  S DIR("A",6)=**$S(IBLOC:””,1:**"4 - Claims Sent to Print at Clearinghouse Only"**)**,DIR("A",7)=" ",DIR("A")="Select Additional Limiting Criteria (optional): "  S DIR("?")="Select one of the listed criteria to further limit the claims to include"  W ! D ^DIR K DIR  I X="^^" G ENQ  I $D(DTOUT)!$D(DUOUT) G Q3  S IBCRIT=Y  ;  Q41 ; Ask user if they want to include cancelled claims  S DIR(0)="Y",DIR("B")="No",DIR("A")="Would you like to include cancelled claims"  W ! D ^DIR K DIR  I X="^^" G ENQ  I $D(DIRUT) G Q4  S IBPTCCAN=Y  ; **IB\*2.0\*547 skip next 2 questions if looking for locally printed claims**  **I IBLOC G Q6**  **;**  Q42 ; Include claims that are forced to print at clearinghouse?  S DIR(0)="Y",DIR("B")="No",DIR("A")="Would you like to include claims Forced to Print at the Clearinghouse"  W ! D ^DIR K DIR  I X="^^" G ENQ  I $D(DIRUT) G Q41  S IBRCBFPC=Y  ;  Q5 S DIR("L",1)="Select one of the following: ",DIR("L",2)=" ",DIR("L",3)=$J("",10)\_"1 Batch By Last Transmitted Date (Claims within a Batch)",DIR("L",4)=$J("",10)\_"2 Current Payer (Insurance Company)"  S DIR("L",5)=" "  S DIR(0)="SA^1:Batch By Last Transmitted Date (Claims within a Batch);2:Current Payer (Insurance Company)",DIR("B")="Current Payer"  S DIR("A")="Sort By: "  W ! D ^DIR K DIR  I X="^^" G ENQ  I $D(DTOUT)!$D(DUOUT) G Q42  S IBSORT=Y  ;  Q6 S DIR(0)="SA^R:Report;S:Screen List"  S DIR("A")="Do you want a (R)eport or a (S)creen List format?: "  S DIR("B")="Screen List"  W ! D ^DIR K DIR  I X="^^" G ENQ  I $D(DTOUT)!$D(DUOUT) G Q5  S IBREP=Y  ; **IB \*2.0\*547 call new SUB-routine for locally printed claims (field #27 = 1)**  **I IBREP="S" ,IBLOC D LOC^IBCEPT0 G ENQ**  I IBREP="S" D LIST^IBCEPTC0 G ENQ  ;  Q7 ; Select device  F S IBACT=0 D DEVSEL(.IBACT) Q:IBACT  I IBACT=99 G ENQ  U IO  D **$S(IBLOC:LOC^IBCEPT0,1:**LIST^IBCEPTC0**)**  ;  ENQ K ^TMP("IB\_PREV\_CLAIM\_INS",$J),^TMP("IB\_PREV\_CLAIM\_SELECT",$J)  Q  ; | | | | | | | | | |

###### Functional Requirement: View/Resubmit Claims - Live or Test (RCB) – Printed Claim Look-up

The IB System shall provide the ability for users to look up claims that were printed locally in the View/Resubmit Claims - Live or Test option by Electronic Data Interchange (EDI) option. (BN n/a)

**Routines (Entry Points):**

| Routine Name | IBCEPTC1 | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Enhancement Category | New | | Modify | Delete | | | No Change | | |
| Requirement Traceability Matrix | 2.6.8.2 | | | | | | | | |
| Related Options | IBCE PREV TRANSMITTED CLAIMS | | | | | | | | |
| Related Routines | Routines “Called By” | | | | Routines “Called” | | | | |
| IBCEPTC0  IBCEPTC2  IBCEPTC3 | | | | ^%ZISC  ^DIR  F^IBCEF  WRT^IBCEPTC2  $$FMTE^XLFDT  $$HTE^XLFDT | | | | |
| Data Dictionary (DD) References | NONE | | | | | | | | |
| Related Protocols | IBCE VIEW PREV TRANS | | | | | | | | |
| Related Integration Control Registrations (ICRs) | NONE | | | | | | | | |
| Data Passing | Input | Output Reference | | | | Both | | Global Reference | Local |
| Input Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Output Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Current Logic | | | | | | | | | |
| IBCEPTC1 ;ALB/TMK - EDI PREV TRANSMITTED CLAIMS REPORT OUTPUT ;01/20/05  ;;2.0;INTEGRATED BILLING;\*\*296,320\*\*;21-MAR-94  ;  RPT(IBSORT,IBDT1,IBDT2) ; Output transmitted claims report  ; global ^TMP("IB\_PREV\_CLAIM",$J,srt1,srt2,ien of entry file 364)=""  N IBDA,IBIFN,IBPAGE,IBSTOP,IBHDR,IBS1,IBS2,Z,IBZ,IBREP  S (IBPAGE,IBSTOP)=0,IBPAGE(0)="",IBPAGE(1)="",IBREP="R"  S IBHDR="Transmitted Claims Report for period covering "\_$$FMTE^XLFDT(I  BDT1,1)\_" thru "\_$$FMTE^XLFDT(IBDT2,1)\_$J("",14)\_$$HTE^XLFDT($H,"1M"),IBHDR=IBHD  R\_$J("",124-$L(IBHDR))\_"Page"  S IBS1="" F S IBS1=$O(^TMP("IB\_PREV\_CLAIM",$J,IBS1)) Q:IBS1="" D Q:I  BSTOP  . ; First level sort  . D:($Y+6)>IOSL!'IBPAGE HDR(IBHDR,IBSORT,.IBPAGE,.IBSTOP) Q:IBSTOP  . S IBPAGE(1)=IBS1,IBPAGE(0)="" ; Hold data for hdr repeated on new pg  . D HDR1(IBSORT,IBS1,.IBPAGE,.IBSTOP) Q:IBSTOP  . ;  . S IBPAGE(0)=1  . S IBS2="" F S IBS2=$O(^TMP("IB\_PREV\_CLAIM",$J,IBS1,IBS2)) Q:IBS2=""!  IBSTOP S IBDA=0 F S IBDA=$O(^TMP("IB\_PREV\_CLAIM",$J,IBS1,IBS2,IBDA)) Q:'IBDA!I  BSTOP D  .. S IBIFN=+$G(^IBA(364,+IBDA,0))  .. ;  .. D:($Y+5)>IOSL!'IBPAGE HDR(IBHDR,IBSORT,.IBPAGE,.IBSTOP) Q:IBSTOP  .. D WRT^IBCEPTC2(IBS1,IBS2,IBDA,IBIFN,IBSORT,IBREP,"",.IBPAGE,.IBSTOP)  Q:IBSTOP  . S IBPAGE(0)=""  ;  G:IBSTOP STOP  I 'IBPAGE D WRT^IBCEPTC2("NO PREVIOUSLY TRANSMITTED CLAIMS EXIST TO MAT  CH THE SEARCH CRITERIA SELECTED","",0,0,IBSORT,IBREP,IBHDR,0,0)  ;  I $E(IOST,1,2)["C-" K DIR S DIR(0)="E" D ^DIR K DIR  ;  STOP I $D(ZTQUEUED) S ZTREQ="@"  I '$D(ZTQUEUED) W ! D ^%ZISC  ;  Q  ;  HDR1(IBSORT,IBDATA,IBPAGE,IBSTOP) ; First level report sort headers  ; IBSORT = sort type  ; IBDATA = data at the 1st sort level  I ($Y+11)>IOSL D HDR(IBHDR,IBSORT,.IBPAGE,.IBSTOP) Q:IBSTOP  N Z,X,Y,Q  I IBSORT=1 D  . S Q="Batch Number: "\_$P(IBDATA,U,2)\_$S('$P(IBDATA,U,4):"",1:" \*\* Thi  s batch was rejected \*\*")\_$S('$P(IBDATA,U,3):"",1:" \*\* This batch was a test ba  tch \*\*")  . W !!,Q W:$G(IBPAGE(0)) $J("",120-$L(Q)),"(Continued)" W !,"Date Last  Transmitted: ",$$FMTE^XLFDT(99999999-IBDATA,1)  . S Z="",$P(Z,"=",133)="" W !,Z  . W !,"Claim # Form Type Seq Status A/R Current Payer",$J("",1  3),"Payer Address",$J("",17),"Other Payer(s) Patient Name",!  ;  I IBSORT=2 D  . N IBZ,IBIFN  . S IBIFN=""  . I IBDATA'="" S IBIFN=+$G(^TMP("IB\_PREV\_CLAIM",$J,IBDATA))  . S Q="Current Payer: "\_$P(IBDATA,U)  . D F^IBCEF("N-CURR INS CO FULL ADDRESS","IBZ",,IBIFN)  . S Q=Q\_" "\_$G(IBZ(1))\_$S($G(IBZ(1))'="":",",1:"")\_" "\_$G(IBZ(4))\_$S($  G(IBZ(4))'="":",",1:"")\_" "\_$P($G(^DIC(5,+$G(IBZ(5)),0)),U,2)  . W !!,Q  . I $G(IBPAGE(0)) D  .. I $L(Q)>119 S Q="" W !  .. W $J("",120-$L(Q)),"(Continued)"  . S Z="",$P(Z,"=",133)="" W !,Z  . W !,"Claim # Form Type Seq Status A/R Other Payer(s)",$J("  ",6),"Patient Name",$J("",10),"Last Transmit Batch Number",!  ;  Q  ;  HDR(IBHDR,IBSORT,IBPAGE,IBSTOP) ; Report header  ;  N Z,DIR,X,Y  I IBPAGE D Q:IBSTOP  . I $E(IOST,1,2)["C-" K DIR S DIR(0)="E" D ^DIR K DIR S IBSTOP=('Y) Q:I  BSTOP  . W @IOF  S IBPAGE=IBPAGE+1,Z=IBHDR\_$J(IBPAGE,4)  W !,Z  W !,"\*\* A claim may appear on this report multiple times if it has been  transmitted more than once. \*\*"  I IBSORT=2 D  . W !,"\*\* T indicates the claim was transmitted as a test claim prior t  o turning on EDI live for the payer. \*\*"  . W !,"\*\* R indicates that the batch was rejected. \*\*"  I IBPAGE>1,$G(IBPAGE(0)) D HDR1(IBSORT,IBPAGE(1),.IBPAGE,.IBSTOP)  Q  ; | | | | | | | | | |
| Modified Logic (Changes are in bold) | | | | | | | | | |
| IBCEPTC1 ;ALB/TMK - EDI PREV TRANSMITTED CLAIMS REPORT OUTPUT ;01/20/05  ;;2.0;INTEGRATED BILLING;\*\*296,320**,547**\*\*;21-MAR-94  **; add correct directive here**  ;  RPT(IBSORT,IBDT1,IBDT2) ; Output transmitted claims report  ; global ^TMP("IB\_PREV\_CLAIM",$J,srt1,srt2,ien of entry file 364)=""  N IBDA,IBIFN,IBPAGE,IBSTOP,IBHDR,IBS1,IBS2,Z,IBZ,IBREP  S (IBPAGE,IBSTOP)=0,IBPAGE(0)="",IBPAGE(1)="",IBREP="R"  S IBHDR=**$S(IBLOC:”Printed”,1:**"Transmitted**”)\_”**  Claims Report for period covering "\_$$FMTE^XLFDT(I  BDT1,1)\_" thru "\_$$FMTE^XLFDT(IBDT2,1)\_$J("",14)\_$$HTE^XLFDT($H,"1M"),IBHDR=IBHD  R\_$J("",124-$L(IBHDR))\_"Page"  S IBS1="" F S IBS1=$O(^TMP("IB\_PREV\_CLAIM",$J,IBS1)) Q:IBS1="" D Q:I  BSTOP  . ; First level sort  . D:($Y+6)>IOSL!'IBPAGE HDR(IBHDR,IBSORT,.IBPAGE,.IBSTOP) Q:IBSTOP  . S IBPAGE(1)=IBS1,IBPAGE(0)="" ; Hold data for hdr repeated on new pg  . D HDR1(IBSORT,IBS1,.IBPAGE,.IBSTOP) Q:IBSTOP  . ;  . S IBPAGE(0)=1  . S IBS2="" F S IBS2=$O(^TMP("IB\_PREV\_CLAIM",$J,IBS1,IBS2)) Q:IBS2=""!  IBSTOP S IBDA=0 F S IBDA=$O(^TMP("IB\_PREV\_CLAIM",$J,IBS1,IBS2,IBDA)) Q:'IBDA!I  BSTOP D  .. S IBIFN=+$G(^IBA(364,+IBDA,0))  .. ;  .. D:($Y+5)>IOSL!'IBPAGE HDR(IBHDR,IBSORT,.IBPAGE,.IBSTOP) Q:IBSTOP  .. D WRT^IBCEPTC2(IBS1,IBS2,IBDA,IBIFN,IBSORT,IBREP,"",.IBPAGE,.IBSTOP)  Q:IBSTOP  . S IBPAGE(0)=""  ;  G:IBSTOP STOP  I 'IBPAGE D WRT^IBCEPTC2("NO PREVIOUSLY **“$S(IBLOC:”PRINTED”,1:”**TRANSMITTED**”)\_”**  CLAIMS EXIST TO MATCH THE SEARCH CRITERIA SELECTED","",0,0,IBSORT,IBREP,IBHDR,0,0)  ;  I $E(IOST,1,2)["C-" K DIR S DIR(0)="E" D ^DIR K DIR  ;  STOP I $D(ZTQUEUED) S ZTREQ="@"  I '$D(ZTQUEUED) W ! D ^%ZISC  ;  Q  ;  HDR1(IBSORT,IBDATA,IBPAGE,IBSTOP) ; First level report sort headers  ; IBSORT = sort type  ; IBDATA = data at the 1st sort level  I ($Y+11)>IOSL D HDR(IBHDR,IBSORT,.IBPAGE,.IBSTOP) Q:IBSTOP  N Z,X,Y,Q  I IBSORT=1 D  . S Q=**$S(IBLOC:””,1:**"Batch Number: "\_$P(IBDATA,U,2)\_$S('$P(IBDATA,U,4):"",1:" \*\* This batch was rejected \*\*")\_$S('$P(IBDATA,U,3):"",1:" \*\* This batch was a test batch \*\*")**)**  . W !!,Q W:$G(IBPAGE(0)) $J("",120-$L(Q)),"(Continued)" W !,"Date Last **“\_$S(IBLOC:”Printed:”,1:”**Transmitted: "**)**,$$FMTE^XLFDT(99999999-IBDATA,1)  . S Z="",$P(Z,"=",133)="" W !,Z  . W !,"Claim # Form Type Seq Status A/R Current Payer",$J("",13),"Payer Address",$J("",17),"Other Payer(s) Patient Name",!  ;  I IBSORT=2 D  . N IBZ,IBIFN  . S IBIFN=""  . I IBDATA'="" S IBIFN=+$G(^TMP("IB\_PREV\_CLAIM",$J,IBDATA))  . S Q="Current Payer: "\_$P(IBDATA,U)  . D F^IBCEF("N-CURR INS CO FULL ADDRESS","IBZ",,IBIFN)  . S Q=Q\_" "\_$G(IBZ(1))\_$S($G(IBZ(1))'="":",",1:"")\_" "\_$G(IBZ(4))\_$S($ G(IBZ(4))'="":",",1:"")\_" "\_$P($G(^DIC(5,+$G(IBZ(5)),0)),U,2)  . W !!,Q  . I $G(IBPAGE(0)) D  .. I $L(Q)>119 S Q="" W !  .. W $J("",120-$L(Q)),"(Continued)"  . S Z="",$P(Z,"=",133)="" W !,Z  . W !,"Claim # Form Type Seq Status A/R Other Payer(s)",$J("",6),"Patient Name",$J("",10),"Last **“\_$S(IBLOC:”Printed”,1:”**Transmit Batch Number"**)**,!  ;  Q  ;  HDR(IBHDR,IBSORT,IBPAGE,IBSTOP) ; Report header  ;  N Z,DIR,X,Y  I IBPAGE D Q:IBSTOP  . I $E(IOST,1,2)["C-" K DIR S DIR(0)="E" D ^DIR K DIR S IBSTOP=('Y) Q:IBSTOP  . W @IOF  S IBPAGE=IBPAGE+1,Z=IBHDR\_$J(IBPAGE,4)  W !,Z  W**:IBLOC’=1** !,"\*\* A claim may appear on this report multiple times if it has been transmitted more than once. \*\*"  I IBSORT=2**,IBLOC’=1** D  . W !,"\*\* T indicates the claim was transmitted as a test claim prior to turning on EDI live for the payer. \*\*"  . W !,"\*\* R indicates that the batch was rejected. \*\*"  I IBPAGE>1,$G(IBPAGE(0)) D HDR1(IBSORT,IBPAGE(1),.IBPAGE,.IBSTOP)  Q  ; | | | | | | | | | |

| Routine Name | IBCEPTC0 | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Enhancement Category | New | | Modify | Delete | | | No Change | | |
| Requirement Traceability Matrix | 2.6.8.2,2.6.8.3 | | | | | | | | |
| Related Options | IBCE PREV TRANSMITTED CLAIMS | | | | | | | | |
| Related Routines | Routines “Called By” | | | | Routines “Called” | | | | |
| IBCEPTC | | | | $$COBN^IBCEF  $$FT^IBCEF  $$CURR^IBCEF2  $$MRASEC^IBCEF4  RPT^IBCEPTC1  EN^VALM  $$FMTE^XLFDT  $$UP^XLFSTR | | | | |
| Data Dictionary (DD) References | none | | | | | | | | |
| Related Protocols | IBCE VIEW PREV TRANS | | | | | | | | |
| Related Integration Control Registrations (ICRs) | none | | | | | | | | |
| Data Passing | Input | Output Reference | | | | Both | | Global Reference | Local |
| Input Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Output Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Current Logic | | | | | | | | | |
| N/A adding new sub-routine, not modifying existing | | | | | | | | | |
| Modified Logic (Changes are in bold) | | | | | | | | | |
| IBCEPTC0 ;ALB/ESG - EDI PREVIOUSLY TRANSMITTED CLAIMS CONT ; 12/19/05  ;;2.0;INTEGRATED BILLING;\*\*320,348**,547**\*\*;21-MAR-94;Build 5  ; **Insert new directive here**  Q  ;  **LOC ; new sub-routine for locally printed claims (use LIST & STORE tags as a guide)**  **; Use the existing AP x-ref to narrow down the list of claims by date, then check field 27 to see if it’s appropriate to put it on the report (1=LOCAL PRINT)**  **; variables pre-defined: IBREP,IBSORT,IBFORM,IBDT1,IBDT2,**  **; IBCRIT,IBPTCCAN,IBRCBFPC**  **; ^TMP("IB\_PREV\_CLAIM\_INS,$J) global**  **K ^TMP("IB\_PREV\_CLAIM",$J)**  **N IBBDA,IBBDA0,IBCURI,IBDA,IBDT,IBFT,IBIFN,IBS1,IBS2,IBDTX**  **N INCLUDE,EDI,PROF,INST,IB0,IBZ1,DATA,IB364,CURSEQ,IBZ,IBZDAT**  **I IBREP="R" N IBPAGE,IBSTOP,IBHDRDT S (IBPAGE,IBSTOP)=0**  **S IBDT=IBDT1-.1**  **F S IBDT=$O(^DGCR(399,”AP”,IBDT)) Q:'IBDT!(IBDT>IBDT2) S IBIFN=0 F**  **S IBIFN=$O(^DGCR(399,”AP”,IBDT,IBIFN)) Q:'IBIFN !($P($G(^DGCR(399,IBIFN,”TX”)),U,8)’=1 D**  **. S IB0=$G(^DGCR(399,IBIFN,0))**  **.S IBFT=$$FT^IBCEF(IBIFN) ; form type of claim**  **.I IBFORM'="B",$S(IBFT=3:IBFORM="C",IBFT=2:IBFORM="U",1:1) Q**  **.S IBCURI=$$CURR^IBCEF2(IBIFN) I 'IBCURI G STOREX ; current ins ien**  **.S EDI=$$UP^XLFSTR($G(^DIC(36,IBCURI,3))) ; 3 node EDI data**  **.S PROF=$P(EDI,U,2),INST=$P(EDI,U,4) ; payer IDs**  **.;**  **.; screen for user selected insurance companies/payers**  **.I +$G(^TMP("IB\_PREV\_CLAIM\_INS",$J)) D I 'INCLUDE Q**  **.. S INCLUDE=0**  **. .I $D(^TMP("IB\_PREV\_CLAIM\_INS",$J,1,IBCURI)) S INCLUDE=1 Q**  **. .I '$D(^TMP("IB\_PREV\_CLAIM\_INS",$J,2)) Q**  **. .I PROF'="",$D(^TMP("IB\_PREV\_CLAIM\_INS",$J,2,PROF)) S INCLUDE=1 Q**  **. .I INST'="",$D(^TMP("IB\_PREV\_CLAIM\_INS",$J,2,INST)) S INCLUDE=1 Q**  **. .Q**  **.;**  **.I IBCRIT=1,'$$MRASEC^IBCEF4(IBIFN) Q**  **.I IBCRIT=2,($$COBN^IBCEF(IBIFN)>1) Q**  **.I IBCRIT=3,($$COBN^IBCEF(IBIFN)=1) Q**  **.I IBCRIT=4,'$P($G(^DGCR(399,IBIFN,"TX")),U,7) Q**  **.;**  **.; skip cancelled claims conditionally**  **.I $P(IB0,U,13)=7,'IBPTCCAN Q**  **;**  **.S IBS1=$S(IBSORT=1:(99999999-IBDTX)\_U\_U\_U\_ +$P(IBBDA0,U,5),1:$P($G(^DIC(36,+IBCURI,0)),U)\_U\_+IBCURI)**  **.S IBS2=$S(IBSORT=1:$P(IB0,U,1),1:99999999-IBDTX)**  **.;**  **.; Meets all selection criteria - extract to sort global**  **.S:IBS1="" IBS1=" " S:IBS2="" IBS2=" "**  **.I '$D(^TMP("IB\_PREV\_CLAIM",$J,IBS1)) S ^TMP("IB\_PREV\_CLAIM",$J,IBS1)=$S**  **(IBSORT=1:$$FMTE^XLFDT(IBDTX,"1"),1:IBIFN)**  **.S ^TMP("IB\_PREV\_CLAIM",$J,IBS1,IBS2,IBIFN)=IBTYP**  **;**  **I IBREP="R" D RPT^IBCEPTC1(IBSORT,IBDT1,IBDT2) G END ; Output report**  **;**  **D EN^VALM($S(IBSORT=1:”IBCE VIEW LOC PRINT”) ; List Manager, new one for sort =2**  **;**  **END K ^TMP("IB\_PREV\_CLAIM",$J),^TMP("IB\_PREV\_CLAIM\_INS",$J)**  **Q** | | | | | | | | | |

Table 12: Templates

| Templates | Description | | | |
| --- | --- | --- | --- | --- |
| Template Name | IBCE VIEW LOC PRINT | | | |
| Enhancement Category | New | Modify | Delete | No Change |
| RSD | 2.6.8.2 | | | |
| Template Type | Sort | Input | Print | Other |
| Related Options | IBCE VIEW PREV TRANS | | | |

| Related Routines | Routines “Called By” | Routines “Called” |
| --- | --- | --- |
|  | IBCEPTC0 | NONE |

| Routines | Description |
| --- | --- |
| Data Dictionary (DD) References | NONE |
| Global References | ^TMP("IB\_PREV\_CLAIM\_LIST",$J) |

TYPE OF LIST: PROTOCOL RIGHT MARGIN: 126

TOP MARGIN: 7 BOTTOM MARGIN: 19

OK TO TRANSPORT?: OK USE CURSOR CONTROL: YES

ENTITY NAME: CLAIM PROTOCOL MENU: IBCE VIEW LOC PRINT MENU

SCREEN TITLE: PREVIOUSLY PRINTED CLAIMS

ALLOWABLE NUMBER OF ACTIONS: 1 AUTOMATIC DEFAULTS: YES

HIDDEN ACTION MENU: VALM HIDDEN ACTIONS

ARRAY NAME: ^TMP("IB\_PREV\_CLAIM\_LIST",$J)

ITEM NAME: CLAIM COLUMN: 7

WIDTH: 9 DISPLAY TEXT: Claim #

SCROLL LOCK: YES

ITEM NAME: FORM COLUMN: 17

WIDTH: 4 DISPLAY TEXT: Form

ITEM NAME: TYPE COLUMN: 22

WIDTH: 5 DISPLAY TEXT: Type

ITEM NAME: SEQ COLUMN: 27

WIDTH: 3 DISPLAY TEXT: Seq

ITEM NAME: STATUS COLUMN: 32

WIDTH: 11 DISPLAY TEXT: Status

ITEM NAME: OTHER\_PAYERS COLUMN: 51

WIDTH: 18 DISPLAY TEXT: Other Payer(s)

ITEM NAME: LAST\_PRINT COLUMN: 93

WIDTH: 13 DISPLAY TEXT: Last Printed

ITEM NAME: NUMBER COLUMN: 1

WIDTH: 6 DISPLAY TEXT: #

ITEM NAME: ARSTAT COLUMN: 44

WIDTH: 4 DISPLAY TEXT: A/R

ITEM NAME: PATIENTNAME COLUMN: 71

WIDTH: 18 DISPLAY TEXT: Patient Name

EXIT CODE: D EXIT^IBCEPTC2 HEADER CODE: D HDR^IBCEPTC2

HELP CODE: Q ENTRY CODE: D INIT^IBCEPTC2

Table 13: Protocols

| Protocols | Activities | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Protocol Name** | IBCE VIEW LOC PRINT MENU |  | | |  | | |  | | |
| **Enhancement Category** | New | Modify | | | Delete | | | No Change | | |
| **Associated Protocols** | NONE | | | | | | | | | |
| **Data Passing** | Input | | Output | | | Both | Global Reference  Local Reference | | | |
| **Item Text Description** | N/A | | | | | | | | | |
| **Protocol Type** | Action  Limited Protocol | | | Menu  Extended Action | | | | | Protocol  Dialog | Protocol Menu  Other |
| **Associated Routine** |  | | | | | | | | | |

|  |
| --- |
| Current Entry Action Logic |
| N/A (NEW) |

|  |
| --- |
| **Modified Entry Action Logic (Changes are in bold)**  **NAME: IBCE VIEW LOC PRINT MENU**  **ITEM TEXT: PREVIOUSLY PRINTED CLAIMS MENU**  **TYPE: menu PACKAGE: INTEGRATED BILLING**  **DESCRIPTION: This is the menu that contains the actions for the resubmission**  **of previously transmitted claims. The list is generated by the user using a**  **combination of sort and selection criteria.**  **COLUMN WIDTH: 35 MNEMONIC WIDTH: 2**  **ITEM: IBCE VIEW PREV TRANS EXIT SEQUENCE: 90**  **ITEM: IBCE VIEW PREV TRANS SELECT SEQUENCE: 10**  **ITEM: IBCE VIEW PREV TRANS RESUB SEQUENCE: 20**  **ITEM: IBCE VIEW PREV TRANS SEQUENCE: 60**  **ITEM: IBCE VIEW PREV TRANS REPORT SEQUENCE: 85**  **HEADER: D SHOW^VALM MENU PROMPT: Action:** |

|  |
| --- |
| Current Exit Action Logic |
| N/A (NEW) |

|  |
| --- |
| Modified Exit Action Logic (Changes are in bold) |
| N/A |

| Routine Name | IBCEPTC2 | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Enhancement Category | New | | Modify | Delete | | | No Change | | |
| Requirement Traceability Matrix | 2.6.8.2 & 2.6.8.3 | | | | | | | | |
| Related Options | IBCE PREV TRANSMITTED CLAIMS | | | | | | | | |
| Related Routines | Routines “Called By” | | | | Routines “Called” | | | | |
| IBCEPTC1 | | | | $$EXTERNAL^DILFD  $$INPAT^IBCEF  F^IBCEF  HDR^IBCEPTC1  $$FO^IBCNEUT1  $$BILL^RCJIBFN2  CLEAR^VALM1 $$FMTE^XLFDT | | | | |
| Data Dictionary (DD) References | NONE | | | | | | | | |
| Related Protocols | IBCE VIEW PREV TRANS | | | | | | | | |
| Related Integration Control Registrations (ICRs) | NONE | | | | | | | | |
| Data Passing | Input | Output Reference | | | | Both | | Global Reference | Local |
| Input Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Output Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Current Logic | | | | | | | | | |
| IBCEPTC2 ;ALB/TMK - EDI PREVIOUSLY TRANSMITTED CLAIMS LIST MGR ;01/20/05  ;;2.0;INTEGRATED BILLING;\*\*296,320,348,349\*\*;21-MAR-94;Build 46  ;;Per VHA Directive 2004-038, this routine should not be modified.  ; IA 3337 for file 430.3  ;  HDR ;  K VALMHDR  S VALMHDR(1)="\*\* A claim may appear multiple times if transmitted more  than once. \*\*"  ;  I $G(IBSORT)=1 D  . S VALMHDR(2)="Claims Selected: "\_+$G(^TMP("IB\_PREV\_CLAIM\_SELECT",$J))  \_" (marked with \*)"  . Q  ;  I $G(IBSORT)=2 D  . S VALMHDR(2)="\*\* T = Test Claim \*\* R = Batch Rejected"  . S VALMHDR(3)="Claims Selected: "\_+$G(^TMP("IB\_PREV\_CLAIM\_SELECT",$J))  \_" (marked with \*)"  . Q  ;  Q  ;  INIT ;  S VALMCNT=0,VALMBG=1  D BLD  Q  ;  BLD ; Build display lines  N IBDA,IBS1,IBS2,IBIFN,IB0,IBX,IBCNT,IBLEV1,IBBDA  K ^TMP("IB\_PREV\_CLAIM\_LIST",$J),^TMP("IB\_PREV\_CLAIM\_SELECT",$J),^TMP("I  B\_PREV\_CLAIM\_BATCH",$J)  S IBCNT=0  I $O(^TMP("IB\_PREV\_CLAIM",$J,""))="" D G BLDQ  . S IBX=" \*\* NO PREVIOUSLY TRANSMITTED CLAIMS EXIST FOR SEARCH CRITERIA  SELECTED \*\*"  . D WRT(IBX,"",0,0,"","S","",.IBCNT,0)  ;  S IBS1="" F S IBS1=$O(^TMP("IB\_PREV\_CLAIM",$J,IBS1)) Q:IBS1="" D  . ; First level sort  . ; for sort by batch, display batch ID and transmit date  . I IBSORT=1 D  .. S IBLEV1=" Batch: "\_$P(IBS1,U,2)\_" Last Transmitted: "\_$G(^TMP("IB  \_PREV\_CLAIM",$J,IBS1))  .. S IBBDA=+$O(^IBA(364.1,"B",$P(IBS1,U,2),0))  .. I $P(IBS1,U,3) S IBLEV1=IBLEV1\_" \*\* Test"  .. I $P(IBS1,U,4) S IBLEV1=IBLEV1\_" \*\* Rejected"  .. Q  . ;  . ; for sort by payer, display ins co name and payer address  . I IBSORT=2 D  .. S IBLEV1=" "\_$P(IBS1,U)\_" "\_$$CURRINS(+$G(^TMP("IB\_PREV\_CLAIM",$J,  IBS1)),0)  .. Q  . ;  . ; output sort header line  . D WRT(IBLEV1,"",0,0,IBSORT,"S","",IBCNT,0) ; Add header line  . ;  . I IBSORT=1,IBBDA S ^TMP("IB\_PREV\_CLAIM\_BATCH",$J,IBBDA)=VALMCNT  . S IBS2="" F S IBS2=$O(^TMP("IB\_PREV\_CLAIM",$J,IBS1,IBS2)) Q:IBS2=""  S IBDA=0 F S IBDA=$O(^TMP("IB\_PREV\_CLAIM",$J,IBS1,IBS2,IBDA)) Q:'IBDA D  .. N IBX,IBTEST  .. S IBIFN=+$G(^IBA(364,+IBDA,0)),IB0=$G(^DGCR(399,IBIFN,0))  .. S IBX=$P(^TMP("IB\_PREV\_CLAIM",$J,IBS1,IBS2,IBDA),U,1)  .. I IBX=1 S IBTEST=0 ; live 364 transmission  .. I IBX=2 S IBTEST=1 ; test 364 transmission  .. I IBX=3 S IBTEST=1 ; test 361.4 transmission  .. D WRT(IBS1,IBS2,IBDA,IBIFN,IBSORT,"S","",.IBCNT,0,IBTEST)  .. I IBSORT=1,IBBDA S ^TMP("IB\_PREV\_CLAIM\_BATCH",$J,IBBDA,VALMCNT)=IBIF  N\_U\_IBCNT  .. Q  . Q  ;  BLDQ Q  ; | | | | | | | | | |
| Modified Logic (Changes are in bold) | | | | | | | | | |
| IBCEPTC2 ;ALB/TMK - EDI PREVIOUSLY TRANSMITTED CLAIMS LIST MGR ;01/20/05  ;;2.0;INTEGRATED BILLING;\*\*296,320,348,349\*\*;21-MAR-94;Build 46  ;;Per VHA Directive 2004-038, this routine should not be modified.  ; IA 3337 for file 430.3  ;  HDR ;  K VALMHDR  S VALMHDR(1)=**$S(IBLOC:””,1:**"\*\* A claim may appear multiple times if transmitted more than once. \*\*"**)**  ;  I $G(IBSORT)=1 D  . S VALMHDR(2)="Claims Selected: "\_+$G(^TMP("IB\_PREV\_CLAIM\_SELECT",$J))  \_" (marked with \*)"  . Q  ;  I $G(IBSORT)=2 D  . S VALMHDR(2)=**$S(IBLOC:””,1:**"\*\* T = Test Claim \*\* R = Batch Rejected"**)**  . S VALMHDR(3)="Claims Selected: "\_+$G(^TMP("IB\_PREV\_CLAIM\_SELECT",$J))  \_" (marked with \*)"  . Q  ;  Q  ;  INIT ;  S VALMCNT=0,VALMBG=1  D BLD  Q  ;  BLD ; Build display lines  N IBDA,IBS1,IBS2,IBIFN,IB0,IBX,IBCNT,IBLEV1,IBBDA  K ^TMP("IB\_PREV\_CLAIM\_LIST",$J),^TMP("IB\_PREV\_CLAIM\_SELECT",$J),^TMP("I  B\_PREV\_CLAIM\_BATCH",$J)  S IBCNT=0  I $O(^TMP("IB\_PREV\_CLAIM",$J,""))="" D G BLDQ  . S IBX=" \*\* NO PREVIOUSLY **“\_$S(IBLOC:”PRINTED”,1:”**TRANSMITTED**”)\_”** CLAIMS EXIST FOR SEARCH CRITERIA SELECTED \*\*"  . D WRT(IBX,"",0,0,"","S","",.IBCNT,0)  ;  S IBS1="" F S IBS1=$O(^TMP("IB\_PREV\_CLAIM",$J,IBS1)) Q:IBS1="" D  . ; First level sort  . ; for sort by batch, display batch ID and transmit date  . I IBSORT=1 D  .. S IBLEV1=" Batch: "\_$P(IBS1,U,2)\_" Last Transmitted: "\_$G(^TMP("IB \_PREV\_CLAIM",$J,IBS1))  .. S IBBDA=+$O(^IBA(364.1,"B",$P(IBS1,U,2),0))  .. I $P(IBS1,U,3) S IBLEV1=IBLEV1\_" \*\* Test"  .. I $P(IBS1,U,4) S IBLEV1=IBLEV1\_" \*\* Rejected"  .. Q  . ;  . ; for sort by payer, display ins co name and payer address  . I IBSORT=2 D  .. S IBLEV1=" "\_$P(IBS1,U)\_" "\_$$CURRINS(+$G(^TMP("IB\_PREV\_CLAIM",$J, IBS1)),0)  .. Q  . ;  . ; output sort header line  . D WRT(IBLEV1,"",0,0,IBSORT,"S","",IBCNT,0) ; Add header line  . ;  . I IBSORT=1,IBBDA S ^TMP("IB\_PREV\_CLAIM\_BATCH",$J,IBBDA)=VALMCNT  . S IBS2="" F S IBS2=$O(^TMP("IB\_PREV\_CLAIM",$J,IBS1,IBS2)) Q:IBS2=""  S IBDA=0 F S IBDA=$O(^TMP("IB\_PREV\_CLAIM",$J,IBS1,IBS2,IBDA)) Q:'IBDA D  .. N IBX,IBTEST  .. S IBIFN=+$G(^IBA(364,+IBDA,0)),IB0=$G(^DGCR(399,IBIFN,0))  .. S IBX=$P(^TMP("IB\_PREV\_CLAIM",$J,IBS1,IBS2,IBDA),U,1)  .. I IBX=1 S IBTEST=0 ; live 364 transmission  .. I IBX=2 S IBTEST=1 ; test 364 transmission  .. I IBX=3 S IBTEST=1 ; test 361.4 transmission  .. D WRT(IBS1,IBS2,IBDA,IBIFN,IBSORT,"S","",.IBCNT,0,IBTEST)  .. I IBSORT=1,IBBDA S ^TMP("IB\_PREV\_CLAIM\_BATCH",$J,IBBDA,VALMCNT)=IBIF  N\_U\_IBCNT  .. Q  . Q  ;  BLDQ Q | | | | | | | | | |

###### Functional Requirement: View/Resubmit Claims - Live or Test (RCB) – Printed Claim Test Queue

The IB System shall provide the ability for users to transmit previously printed claims to the test queue only from the View/Resubmit Claims - Live or Test option by Electronic Data Interchange (EDI) option. (BN n/a)

**Routines (Entry Points):**

| Routine Name | IBCEPTC3 | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Enhancement Category | New | | Modify | Delete | | | No Change | | |
| Requirement Traceability Matrix | 2.6.8.3 | | | | | | | | |
| Related Options | IBCE PREV TRANSMITTED CLAIMS | | | | | | | | |
| Related Routines | Routines “Called By” | | | | Routines “Called” | | | | |
| IBCEPTC | | | | HOME^%ZIS  ^DIC  ^DIK  ^DIR  $$ADDTBILL^IBCB1  EN1^IBCE837B  $$LAST364^IBCEF4  UPDEDI^IBCEM  DEVSEL^IBCEPTC  RPT^IBCEPTC1  FULL^VALM1  EN^VALM2 | | | | |
| Data Dictionary (DD) References | NONE | | | | | | | | |
| Related Protocols | IBCE VIEW PREV TRANS | | | | | | | | |
| Related Integration Control Registrations (ICRs) | NONE | | | | | | | | |
| Data Passing | Input | Output Reference | | | | Both | | Global Reference | Local |
| Input Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Output Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Current Logic | | | | | | | | | |
| IBCEPTC3 ;ALB/ESG - EDI PREVIOUSLY TRANSMITTED CLAIMS ACTIONS ;12/19/05  ;;2.0;INTEGRATED BILLING;\*\*320\*\*;21-MAR-94  ;  Q  ;  SELBATCH ; Select a batch to resubmit  ; Assumes IBSORT is defined  N DIC,DIR,X,Y,Z,IBQ,IBZ,IBI,IBDX,IBASK,IBOK,IBY,DTOUT,DUOUT  D FULL^VALM1  I IBSORT'=1 D G SELBQ  . S DIR(0)="EA",DIR("A",1)="This action is not available unless you chose to sort by batch",DIR("A")="Press return to continue: "  . W ! D ^DIR K DIR  S DIC="^IBA(364.1,",DIC(0)="AEMQ",DIC("S")="I $D(^TMP(""IB\_PREV\_CLAIM\_B ATCH"",$J,+Y))"  D ^DIC K DIC  I Y'>0 G SELBQ  S IBY=+Y,VALMBG=+$G(^TMP("IB\_PREV\_CLAIM\_BATCH",$J,IBY))  ;  S (IBOK,IBASK)=1  I $G(^TMP("IB\_PREV\_CLAIM\_BATCH",$J,IBY,"SEL")) D G:'IBOK SELBQ  . S DIR(0)="YA",DIR("A",1)="This batch was previously selected.",DIR("A")="Do you want to de-select all claims in this batch?: ",DIR("B")="No"  . W ! D ^DIR K DIR  . I $D(DTOUT)!$D(DUOUT) S IBOK=0 Q  . I Y S IBASK=0 K ^TMP("IB\_PREV\_CLAIM\_BATCH",$J,IBY,"SEL")  ;  S IBQ=0 ; last screen row# for claim  F S IBQ=$O(^TMP("IB\_PREV\_CLAIM\_BATCH",$J,IBY,IBQ)) Q:'IBQ D  . S IBZ=$G(^(IBQ)) ; IBIFN^selection#  . S Z=$P(IBZ,U,2) ; selection#  . S IBDX=$G(^TMP("IB\_PREV\_CLAIM\_LIST\_DX",$J,+Z)) ; 1st screen row# for claim^364 ien  . S IBI=$P(IBDX,U,2) ; 364 ien  . D MARK(+IBZ,Z,+IBDX,IBI,IBASK,.VALMHDR)  ;  I IBASK S ^TMP("IB\_PREV\_CLAIM\_BATCH",$J,IBY,"SEL")=1  ;  SELBQ S VALMBCK="R"  Q  ;  MARK(IBIFN,IBZ,IBQ,IBI,IBASK,VALMHDR) ; Mark claim as selected for resubmit  ; Returns VALMHDR killed if any selections/de-selections made  N DIR,X,Y  I $D(^TMP("IB\_PREV\_CLAIM\_SELECT",$J,IBIFN)) D Q  . S Y=1  . I IBASK D  .. S DIR(0)="YA",DIR("B")="No",DIR("A",1)="Claim "\_$P($G(^DGCR(399,IBIFN,0)),U)\_" for entry # "\_IBZ\_" has already been selected",DIR("A")="Do you want to de-select it?: " W ! D ^DIR K DIR  . I Y=1 K ^TMP("IB\_PREV\_CLAIM\_SELECT",$J,IBIFN) S $E(^TMP("IB\_PREV\_CLAI  M\_LIST",$J,IBQ,0),6)="",^TMP("IB\_PREV\_CLAIM\_SELECT",$J)=^TMP("IB\_PREV\_CLAIM\_SELECT",$J)-1 K VALMHDR  ;  S ^TMP("IB\_PREV\_CLAIM\_SELECT",$J,IBIFN)=IBQ,^TMP("IB\_PREV\_CLAIM\_SELECT"  ,$J,IBIFN,0)=IBI,^TMP("IB\_PREV\_CLAIM\_SELECT",$J)=$G(^TMP("IB\_PREV\_CLAIM\_SELECT",$J))+1  S $E(^TMP("IB\_PREV\_CLAIM\_LIST",$J,IBQ,0),6)="\*" K VALMHDR  Q  ;  VIEW ; View claims selected  N IBCT,IBQUIT,DIR,X,Y,Z,Z0  D FULL^VALM1  I '$O(^TMP("IB\_PREV\_CLAIM\_SELECT",$J,0)) D G VIEWQ  . S DIR(0)="EA",DIR("A")="No claims have been selected - Press return to continue " D ^DIR K DIR  W @IOF  S (IBQUIT,IBCT)=0  W !,+^TMP("IB\_PREV\_CLAIM\_SELECT",$J)," claims selected:"  S Z="" F S Z=$O(^TMP("IB\_PREV\_CLAIM\_SELECT",$J,Z)) Q:'Z S Z0=+$G(^(Z)) D  . Q:'$D(^TMP("IB\_PREV\_CLAIM\_LIST",$J,Z0,0))  . S IBCT=IBCT+1  . I '(IBCT#15) S IBQUIT=0 D Q:IBQUIT  .. S DIR(0)="E" D ^DIR K DIR  .. I 'Y S IBQUIT=1  . W !," ",$E(^TMP("IB\_PREV\_CLAIM\_LIST",$J,Z0,0),7,47)  ;  G:IBQUIT VIEWQ  S DIR(0)="E" D ^DIR K DIR  ;  VIEWQ S VALMBCK="R"  Q  ;  RESUB ; Resubmit selected claims  N DIR,X,Y,IBIFN,IB364,Z1,IBTYPPTC,DIRUT,DIROUT,DTOUT,DUOUT,IBFSKIP,IBAB  ORT  D FULL^VALM1  I '$O(^TMP("IB\_PREV\_CLAIM\_SELECT",$J,0)) D G RESUBQ  . N DIR,X,Y  . S DIR(0)="EA",DIR("A")="No claims have been selected - Press return to continue " D ^DIR K DIR  ;  ; Ask user if resubmit as production or as test  S DIR(0)="SA^P:Production;T:Test Only"  S DIR("A")="Resubmit Claims: "  S DIR("B")="Production"  S DIR("?",1)=" Select Production to resubmit the claims to the payer for payment."  S DIR("?")=" Select Test to resubmit the claims as Test claims only."  W ! D ^DIR K DIR  I $D(DIRUT) G RESUBQ  S IBTYPPTC="TEST"  I Y="P" S IBTYPPTC="PRODUCTION"  ;  S DIR(0)="YA",DIR("B")="No"  S DIR("A",1)="You are about to resubmit "\_+^TMP("IB\_PREV\_CLAIM\_SELECT",  $J)\_" claims as "\_IBTYPPTC\_" claims."  S DIR("A")="Are you sure you want to continue?: "  W ! D ^DIR K DIR  I Y'=1 G RESUBQ  ;  ; OK to proceed and resubmit  W !!,"Resubmission in process ... "  ;  ; loop thru selected claims and set into scratch globals  S IBFSKIP=0  KILL ^TMP("IBRCBOLD",$J)  S IBIFN=0 F S IBIFN=$O(^TMP("IB\_PREV\_CLAIM\_SELECT",$J,IBIFN)) Q:'IBIFN  S Z1=+$G(^(IBIFN)),IB364=+$G(^(IBIFN,0)) I IB364 D  . ;  . I IBTYPPTC="TEST" D  .. S ^TMP("IBEDI\_TEST\_BATCH",$J,IB364)=""  .. S ^TMP("IBRESUBMIT",$J,IB364)=""  .. I Z1 D MARK(IBIFN,"",Z1,IB364,0,.VALMHDR)  .. Q  . ;  . I IBTYPPTC="PRODUCTION" D  .. I '$$TXOK(IBIFN) S IBFSKIP=IBFSKIP+1 Q ; transmission not allowed  .. N Y S Y=$$ADDTBILL^IBCB1(IBIFN) ; new entry in file 364 - "X" status  .. I '$P(Y,U,3) Q ; quit if new entry didn't get added  .. S ^TMP("IBSELX",$J,+Y)=""  .. S ^TMP("IBRCBOLD",$J,IB364)="" ; save list of old transmit bills  .. I Z1 D MARK(IBIFN,"",Z1,IB364,0,.VALMHDR)  .. Q  . ;  . Q  ;  ; set top level of scratch globals based on test or production  I IBTYPPTC="TEST" S ^TMP("IBRESUBMIT",$J)="^^0^1",^TMP("IBEDI\_TEST\_BATC  H",$J)=1  E KILL ^TMP("IBRESUBMIT",$J),^TMP("IBEDI\_TEST\_BATCH",$J),^TMP("IBONE",  $J) S ^TMP("IBSELX",$J)=0  ;  ; resubmit call  D EN1^IBCE837B("","","",.IBABORT)  ;  ; if user aborted at the last minute, then get rid of the new entries  ; in file 364 that were added for production claim sending  I IBABORT D  . N IB,DIK,DA  . S IB=0 F S IB=$O(^TMP("IBSELX",$J,IB)) Q:'IB S DIK="^IBA(364,",DA=IB D ^DIK  . Q  ;  ; update EDI files for the old transmit bills  I 'IBABORT D  . N IB  . S IB=0 F S IB=$O(^TMP("IBRCBOLD",$J,IB)) Q:'IB D UPDEDI^IBCEM(IB,"R")  . Q  ;  ; cleanup  K ^TMP("IBEDI\_TEST\_BATCH",$J),^TMP("IBRESUBMIT",$J),^TMP("IBSELX",$J),^  TMP("IBRCBOLD",$J)  I '$O(^TMP("IB\_PREV\_CLAIM\_SELECT",$J,0)) K ^TMP("IB\_PREV\_CLAIM\_SELECT",  $J)  S DIR(0)="EA"  S DIR("A",1)="Selected claims have been resubmitted as "\_IBTYPPTC\_"."  I IBFSKIP D  . S DIR("A",2)="Please note: Some claims were not eligible to be resubmitted as live claims."  . S DIR("A",3)=" These claims are still indicated as being selected."  . Q  I IBABORT K DIR("A") S DIR("A",1)="No claims were resubmitted."  S DIR("A")="Press return to continue "  W ! D ^DIR K DIR  K VALMHDR  ;  RESUBQ ;  S VALMBCK="R"  Q  ; | | | | | | | | | |
| Modified Logic (Changes are in bold) | | | | | | | | | |
| IBCEPTC3 ;ALB/ESG - EDI PREVIOUSLY TRANSMITTED CLAIMS ACTIONS ;12/19/05  ;;2.0;INTEGRATED BILLING;\*\*320**,547**\*\*;21-MAR-94  ; **Add new VA directive here \*\*\***  Q  ;  SELBATCH ; Select a batch to resubmit  ; Assumes IBSORT is defined  N DIC,DIR,X,Y,Z,IBQ,IBZ,IBI,IBDX,IBASK,IBOK,IBY,DTOUT,DUOUT  D FULL^VALM1  **; IB\*2.0\*547 Do not allow batch resubmit of locally printed claims**  **I IBLOC'=1 D G SELBQ**  **. S DIR(0)="EA",DIR("A",1)="This action is not available for Locally Printed Claims",DIR("A")="Press return to continue: "**  I IBSORT'=1 D G SELBQ  . S DIR(0)="EA",DIR("A",1)="This action is not available unless you chose to sort by batch",DIR("A")="Press return to continue: "  . W ! D ^DIR K DIR  S DIC="^IBA(364.1,",DIC(0)="AEMQ",DIC("S")="I $D(^TMP(""IB\_PREV\_CLAIM\_B ATCH"",$J,+Y))"  D ^DIC K DIC  I Y'>0 G SELBQ  S IBY=+Y,VALMBG=+$G(^TMP("IB\_PREV\_CLAIM\_BATCH",$J,IBY))  ;  S (IBOK,IBASK)=1  I $G(^TMP("IB\_PREV\_CLAIM\_BATCH",$J,IBY,"SEL")) D G:'IBOK SELBQ  . S DIR(0)="YA",DIR("A",1)="This batch was previously selected.",DIR("A")="Do you want to de-select all claims in this batch?: ",DIR("B")="No"  . W ! D ^DIR K DIR  . I $D(DTOUT)!$D(DUOUT) S IBOK=0 Q  . I Y S IBASK=0 K ^TMP("IB\_PREV\_CLAIM\_BATCH",$J,IBY,"SEL")  ;  S IBQ=0 ; last screen row# for claim  F S IBQ=$O(^TMP("IB\_PREV\_CLAIM\_BATCH",$J,IBY,IBQ)) Q:'IBQ D  . S IBZ=$G(^(IBQ)) ; IBIFN^selection#  . S Z=$P(IBZ,U,2) ; selection#  . S IBDX=$G(^TMP("IB\_PREV\_CLAIM\_LIST\_DX",$J,+Z)) ; 1st screen row# for claim^364 ien  . S IBI=$P(IBDX,U,2) ; 364 ien  . D MARK(+IBZ,Z,+IBDX,IBI,IBASK,.VALMHDR)  ;  I IBASK S ^TMP("IB\_PREV\_CLAIM\_BATCH",$J,IBY,"SEL")=1  ;  SELBQ S VALMBCK="R"  Q  ;  MARK(IBIFN,IBZ,IBQ,IBI,IBASK,VALMHDR) ; Mark claim as selected for resubmit  ; Returns VALMHDR killed if any selections/de-selections made  N DIR,X,Y  I $D(^TMP("IB\_PREV\_CLAIM\_SELECT",$J,IBIFN)) D Q  . S Y=1  . I IBASK D  .. S DIR(0)="YA",DIR("B")="No",DIR("A",1)="Claim "\_$P($G(^DGCR(399,IBIFN,0)),U)\_" for entry # "\_IBZ\_" has already been selected",DIR("A")="Do you want to de-select it?: " W ! D ^DIR K DIR  . I Y=1 K ^TMP("IB\_PREV\_CLAIM\_SELECT",$J,IBIFN) S $E(^TMP("IB\_PREV\_CLAI M\_LIST",$J,IBQ,0),6)="",^TMP("IB\_PREV\_CLAIM\_SELECT",$J)=^TMP("IB\_PREV\_CLAIM\_SELECT",$J)-1 K VALMHDR  ;  S ^TMP("IB\_PREV\_CLAIM\_SELECT",$J,IBIFN)=IBQ,^TMP("IB\_PREV\_CLAIM\_SELECT"  ,$J,IBIFN,0)=IBI,^TMP("IB\_PREV\_CLAIM\_SELECT",$J)=$G(^TMP("IB\_PREV\_CLAIM\_SELECT",$J))+1  S $E(^TMP("IB\_PREV\_CLAIM\_LIST",$J,IBQ,0),6)="\*" K VALMHDR  Q  ;  VIEW ; View claims selected  N IBCT,IBQUIT,DIR,X,Y,Z,Z0  D FULL^VALM1  I '$O(^TMP("IB\_PREV\_CLAIM\_SELECT",$J,0)) D G VIEWQ  . S DIR(0)="EA",DIR("A")="No claims have been selected - Press return to continue " D ^DIR K DIR  W @IOF  S (IBQUIT,IBCT)=0  W !,+^TMP("IB\_PREV\_CLAIM\_SELECT",$J)," claims selected:"  S Z="" F S Z=$O(^TMP("IB\_PREV\_CLAIM\_SELECT",$J,Z)) Q:'Z S Z0=+$G(^(Z)) D  . Q:'$D(^TMP("IB\_PREV\_CLAIM\_LIST",$J,Z0,0))  . S IBCT=IBCT+1  . I '(IBCT#15) S IBQUIT=0 D Q:IBQUIT  .. S DIR(0)="E" D ^DIR K DIR  .. I 'Y S IBQUIT=1  . W !," ",$E(^TMP("IB\_PREV\_CLAIM\_LIST",$J,Z0,0),7,47)  ;  G:IBQUIT VIEWQ  S DIR(0)="E" D ^DIR K DIR  ;  VIEWQ S VALMBCK="R"  Q  ;  RESUB ; Resubmit selected claims  N DIR,X,Y,IBIFN,IB364,Z1,IBTYPPTC,DIRUT,DIROUT,DTOUT,DUOUT,IBFSKIP,IBAB  ORT  D FULL^VALM1  I '$O(^TMP("IB\_PREV\_CLAIM\_SELECT",$J,0)) D G RESUBQ  . N DIR,X,Y  . S DIR(0)="EA",DIR("A")="No claims have been selected - Press return to continue " D ^DIR K DIR  ;  ; Ask user if resubmit as production or as test  S DIR(0)="SA^P:Production;T:Test Only"  S DIR("A")="Resubmit Claims: "  S DIR("B")="Production"  S DIR("?",1)=" Select Production to resubmit the claims to the payer for payment."  S DIR("?")=" Select Test to resubmit the claims as Test claims only."  **; IB\*2.0\*547 Only allow locally printed claims to resubmit as Test**  W ! **I IBLOC’=1** D ^DIR K DIR  I $D(DIRUT) G RESUBQ  S IBTYPPTC="TEST"  I **IBLOC’=1,**Y="P" S IBTYPPTC="PRODUCTION"  ;  S DIR(0)="YA",DIR("B")="No"  S DIR("A",1)="You are about to resubmit "\_+^TMP("IB\_PREV\_CLAIM\_SELECT",  $J)\_" claims as "\_IBTYPPTC\_" claims."  S DIR("A")="Are you sure you want to continue?: "  W ! D ^DIR K DIR  I Y'=1 G RESUBQ  ;  ; OK to proceed and resubmit  W !!,"Resubmission in process ... "  ;  ; loop thru selected claims and set into scratch globals  S IBFSKIP=0  KILL ^TMP("IBRCBOLD",$J)  S IBIFN=0 F S IBIFN=$O(^TMP("IB\_PREV\_CLAIM\_SELECT",$J,IBIFN)) Q:'IBIFN  S Z1=+$G(^(IBIFN)),IB364=+$G(^(IBIFN,0)) I IB364 D  . ;  . I IBTYPPTC="TEST" D  .. S ^TMP("IBEDI\_TEST\_BATCH",$J,IB364)=""  .. S ^TMP("IBRESUBMIT",$J,IB364)=""  .. I Z1 D MARK(IBIFN,"",Z1,IB364,0,.VALMHDR)  .. Q  . ;  . I IBTYPPTC="PRODUCTION" D  .. I '$$TXOK(IBIFN) S IBFSKIP=IBFSKIP+1 Q ; transmission not allowed  .. N Y S Y=$$ADDTBILL^IBCB1(IBIFN) ; new entry in file 364 - "X" status  .. I '$P(Y,U,3) Q ; quit if new entry didn't get added  .. S ^TMP("IBSELX",$J,+Y)=""  .. S ^TMP("IBRCBOLD",$J,IB364)="" ; save list of old transmit bills  .. I Z1 D MARK(IBIFN,"",Z1,IB364,0,.VALMHDR)  .. Q  . ;  . Q  ;  ; set top level of scratch globals based on test or production  I IBTYPPTC="TEST" S ^TMP("IBRESUBMIT",$J)="^^0^1",^TMP("IBEDI\_TEST\_BATC  H",$J)=1  E KILL ^TMP("IBRESUBMIT",$J),^TMP("IBEDI\_TEST\_BATCH",$J),^TMP("IBONE",  $J) S ^TMP("IBSELX",$J)=0  ;  ; resubmit call  D EN1^IBCE837B("","","",.IBABORT)  ;  ; if user aborted at the last minute, then get rid of the new entries  ; in file 364 that were added for production claim sending  I IBABORT D  . N IB,DIK,DA  . S IB=0 F S IB=$O(^TMP("IBSELX",$J,IB)) Q:'IB S DIK="^IBA(364,",DA=IB D ^DIK  . Q  ;  ; update EDI files for the old transmit bills  I 'IBABORT D  . N IB  . S IB=0 F S IB=$O(^TMP("IBRCBOLD",$J,IB)) Q:'IB D UPDEDI^IBCEM(IB,"R")  . Q  ;  ; cleanup  K ^TMP("IBEDI\_TEST\_BATCH",$J),^TMP("IBRESUBMIT",$J),^TMP("IBSELX",$J),^  TMP("IBRCBOLD",$J)  I '$O(^TMP("IB\_PREV\_CLAIM\_SELECT",$J,0)) K ^TMP("IB\_PREV\_CLAIM\_SELECT",$J)  S DIR(0)="EA"  S DIR("A",1)="Selected claims have been resubmitted as "\_IBTYPPTC\_"."  I IBFSKIP D  . S DIR("A",2)="Please note: Some claims were not eligible to be resubmitted as live claims."  . S DIR("A",3)=" These claims are still indicated as being selected."  . Q  I IBABORT K DIR("A") S DIR("A",1)="No claims were resubmitted."  S DIR("A")="Press return to continue "  W ! D ^DIR K DIR  K VALMHDR  ;  RESUBQ ;  S VALMBCK="R"  Q  ; | | | | | | | | | |

##### System Feature: Medicare-equivalent Remittance Advice (MRA)/Medicare Management Worklist (MRW)

###### Functional Requirement: Duplicate Medicare-equivalent Remittance Advice – Line Level

The IB system shall compare the line level (Record 45) Claims Adjustment Reason Codes (CARC) in an inbound X12N Health Care Claim Payment/Advice (835) from a Medicare (WNR) payer to determine when an MRA is a duplicate of an existing MRA. (BN 8.3)

**Design Element**

In routine DUP^IBCEOB:

1. Check to see if data is from EOB or MRA.
2. EOB– No change
3. MRA Logic:

* Build array of CARC reason codes from the incoming messages Record 45,
* Loop through the existing MRAs on file and build an array of the CARC Reason codes from Record 45.
* Compare the arrays to see if there are any differences.
* If no differences – **S DUP=IBEOB and exit the subroutine**
* Exit the subroutine and file the new MRA

###### Functional Requirement: Duplicate Medicare-equivalent Remittance Advice – Claim Level

The IB system shall compare the claim level (Record 20) Claims Adjustment Reason Codes (CARC) in an inbound X12N Health Care Claim Payment/Advice (835) from a Medicare (WNR) payer to determine when an MRA is a duplicate of an existing MRA. (BN 8.3)

**Design Element**

In routine DUP^IBCEOB:

Check to see if data is from an EOB or an MRA.

1. EOB– No change
2. MRA Logic:
3. Build array of CARC reason codes from the incoming messages Record 20,
4. Loop through the existing MRAs on file and build an array of the CARC Reason codes from Record 20.
5. Compare the arrays to see if there are any differences.
6. If no differences – **S DUP=IBEOB and exit the subroutine**
7. Exit the subroutine and file the new MRA

###### Functional Requirement: EEOB View – CARC/RARC

The IB system shall provide the ability for users to display the CARC and RARC descriptions from the new AR EDI CARC DATA and AR EDI RARC DATA files (345 and 346) from the following options:

* Print MRA [IBCEM MRA REPORT PRINT]
* View MRA EOB [IBCEM VIEW MRA EOB]
* MRW [IBCE MRA MANAGEMENT] (BN 6.4)

**Design Element**

An ICR will need to be created and approved for using files 345 and 346.

1. IBCEM MRA REPORT PRINT
2. IBCEMRAA – Use data from Files 345 and 346.
3. IBCEM VIEW MRA EOB
4. IBCEMVU – Use data from files 345 and 346.
5. IBCE MRA MANAGEMENT
6. MRALLA^ IBCECSA5 – Use data from files 345 and 346.

##### System Feature: Billing Reports

###### Functional Requirement: Printed Claims Report – Create

The IB system shall provide the ability for users to create a report of claims with a STATUS equal to PRNT/TX and FORCE CLAIM TO PRINT equal to FORCE LOCAL PRINT in the Bill/Claim file (#399) that contains the following data when available for each claim:

* Timeframe of Report
* Station Number - Claim Number
* Division
* Insurance Company (destination payer)
* Form type
* Type Of Plan
* Rate Type
* Revenue Code(s)
* Authorizing Biller
* Summary Information:
* Percentage of total claims that were printed locally
* Number of claims that were printed locally (BN 9.1)

**Design Element**

Select Billing Supervisor Menu <TEST ACCOUNT> Option: tpb Third Party Billing Menu

ADPR Print Bill Addendum Sheet

AUTH Authorize Bill Generation

BILL Enter/Edit Billing Information

CANC Cancel Bill

CLA Multiple CLAIMSMANAGER Claim Send

CLON Copy and Cancel

CRD Correct Rejected/Denied Bill

DLST Delete Auto Biller Results

GEN Print Bill

INQU Patient Billing Inquiry

LIST Print Auto Biller Results

PRNT Print Authorized Bills

RETN Return Bill Menu ...

VCB View Cancelled Bill

VIEW View Bills Pending Transmission

VIST Outpatient Visit Date Inquiry

**PCR Printed Claims Report**

Select Third Party Billing Menu <TEST ACCOUNT> Option: **PCR Printed Claims Report**

**Run Report for (C)PAC or (T)RICARE/CHAMPVA: CPAC// 🡨 Default CPAC**

**Run Report for (A)ll or (S)elected Divisions: All// S elected 🡨 Default ALL**

**Division: CHEYENNE VAMC**

**Division:**

**Earliest Printed Date: T-7// 🡨 Default - 7**

**Latest Printed Date: T// 🡨 Default Today**

**Sort Report By: Authorizing Biller//?? 🡨 Default Biller**

**This determines the criteria by which the claims will**

**be displayed.**

**Choose from:**

**I Insurance Company**

**B Authorizing Biller**

**R Rate Type**

**F Form Type**

**P Type of Plan**

**This is a 132 column report.**

**Device: HOME//0;132**

Printed Claim Report XX/XX/XXXX – XX/XX/XXXX Page 1XXXXX of XXXXXX

Run for: CPAC, Divisions: CHEYENNE VAMC

Sorted by: Biller

IB,CLERK 33 **🡨Include Station Number before claim**

Claim # Type RateType PlanType Division Biller RevCode

InsuranceCo

-----------------------------------------------------------------------------------------------------------------------------------

442-K100XXX I/I REIMBRSIBLE INS. PPO CHEYENNE VAMC IB,XXXXXXXXXXXXXXXX 270,324,299

ABERDEEN HEALTH CARE SERV PO BOX 4000 ABERDEEN,SD

442-K101XXX O/I XXXXXXX XXXXXX XXXXX HMO CHEYENNE VAMC IB,XXXXXXXXXXXXXXXX 270,277,299

ADVENTIST RISK MANAGEMENT PO BOX 4759 SILVER SPRING,MD

442-K101XXX O/P REIMBRSIBLE INS. Major Medical CHEYENNE VAMC IB,XXXXXXXXXXXXXXXX 277,324,271,272

BLUE CROSS/BS AL (PHARMAC PO BOX 2294 BIRMINGHAM,AL

**Design Element**

1. Add new **PCR Printed Claims** **Repor**t **[IB PRINTED CLAIMS REPORT]** option to the Third Party Billing menu. They will continue to be in alphabetical order unless all are numbered.

NAME: **IB THIRD PARTY BILLING MENU** MENU TEXT: Third Party Billing Menu

TYPE: menu CREATOR: CURRO,MARY ANNE

PACKAGE: INTEGRATED BILLING

DESCRIPTION: This menu contains the options necessary to create, edit,

review, authorize, print, and cancel third party bills.

ITEM: IB AUTHORIZE BILL GENERATION SYNONYM: AUTH

ITEM: IB EDIT BILLING INFO SYNONYM: BILL

ITEM: IB CANCEL BILL SYNONYM: CANC

ITEM: IB COPY AND CANCEL SYNONYM: CLON

ITEM: IB PRINT BILL SYNONYM: GEN

ITEM: IB RETURN BILL MENU SYNONYM: RETN

ITEM: IB OUTPT VISIT DATE INQUIRY SYNONYM: VIST

ITEM: IB OUTPUT FULL INQ BY BILL NO SYNONYM: INQU

ITEM: IB OUTPUT AUTO BILLER SYNONYM: LIST

ITEM: IB CLEAN AUTO BILLER LIST SYNONYM: DLST

ITEM: IB BATCH PRINT BILLS SYNONYM: PRNT

ITEM: IB PRINT BILL ADDENDUM SYNONYM: ADPR

ITEM: IBCE VIEW PENDING BILL SYNONYM: VIEW

ITEM: IBCI MULTIPLE CLAIM SEND SYNONYM: CLA

ITEM: IB CORRECT REJECTED/DENIED SYNONYM: CRD

**ITEM: IB PRINTED CLAIMS REPORT SYNONYM: PCR**

TIMESTAMP: 62509,35647 TIMESTAMP OF PRIMARY MENU: 58555,35785

UPPERCASE MENU TEXT: THIRD PARTY BILLING MENU

1. New routine **^IBCEMSRP** to gather the required filtering information and launch the **Printed Claims Report.**

* Prompt for (C)PAC or (T)RICARE/CHAMPVA, with CPAC set as the default.
* Prompt for (A)ll or (S)elected Divisions, with All as the default.  Provide a lookup into MEDICAL CENTER DIVISION File #40.8.
* Prompt for **Earliest Printed Date**, with Today-7 as the default.
* Prompt for **Latest Printed Date**, with default set to Today.
* Prompt **Sort Report By**, with Authorized Biller as the default.  Choose from the following list:
* I  Insurance Company
* B  Authorizing Biller
* R  Rate Type
* F  Form Type
* P  Type of Plan
* Call the line tag **SRCH** to locate the printed claims selected by the user.
* Call the new sort and print routine **^IBCEMSR6** to sort in the order the user has chosen, and to format and print the Printed Claims Report.
* Delete ^TMP($J,"IBCEMSRP") as part of the clean-up at exit.

1. New routine and tag **SRCH^IBCEMSRP** to search BILL/CLAIMS File #399 for entries that match the following criteria and place the required fields in ^TMP($J,"IBCEMSRP":

* Drive the user-specified date range corresponding to field EVENT DATE (399,.03) cross reference (D) .
* Verify the status is equal to PRNT/TX and FORCE CLAIM TO PRINT equal to FORCE LOCAL PRINT in STATUS (399,.13) .
* All or Selected divisions
* CPAC or CHAMPVA/TRICARE
* CPAC Inclusions
  + - 1. Exclude claim if it contains a revenue code listed in the REVENUE CODE EXCLUSIONS File #350.9 described in6.2.2.2.4.7
      2. Include if destination payer is not equal to US Labor Department and one of the following Rate Type, Who’s Responsible combinations exist:

|  |  |
| --- | --- |
| DENTAL | PATIENT |
| HUMANITARIAN | PATIENT |
| INTERAGENCY | OTHER (INSTITUTIONS) |
| MEANS TEST | PATIENT |
| MEDICARE ESRD | OTHER (INSTITUTIONS) |
| NO FAULT INS. | INSURER |
| REIMBURSABLE INS. | INSURER |
| SHARING AGREEMENT | OTHER (INSTITUTIONS) |
| CATEGORY C | PATIENT |

* + - 1. Include Type of Plan from the list located in 6.2.2.2.10.4.
* CHAMPVA/TRICARE Inclusions

1. Exclude claim if it contains a revenue code listed in the REVENUE CODE EXCLUSIONS File #350.9 described in6.2.2.2.4.8
2. Include if destination payer is not equal to US Labor Department and one of the following Rate Type, Who’s Responsible combinations exist:

|  |  |
| --- | --- |
| CHAMPVA REIMB. INS. | INSURER |
| CHAMPVA | INSURER |
| TRICARE REIMB.INS. | INSURER |
| TRICARE | INSURER |

1. Include Type of Plan from the list located in 6.2.2.2.10.5

* Keep a counter for total claims and another counter for claims printed locally in ^TMP($J,"IBCEMSRP", to provide the summary information at the end of the **Printed Claims Report**

1. New routine **^IBCEMSR6** to sort the selected data in ^TMP($J,"IBCEMSRP" based on one of the following sort options:

* Insurance Company
* Authorizing Biller - this selection will be the default
* Rate Type
* Form Type
* Type of Plan

1. New routine **^IBCEMSR7** to drive through ^TMP($J,"IBCEMSRP"  and format to the provided report layout shown above.  This report will be 132 characters wide and can be queued. It will contain summary data at the end of the report to show the percentage of claims printed locally, along with the number of printed claims.

###### Functional Requirement: Printed Claims Report – Search

The IB system shall provide the ability for users to create a report of claims with a STATUS equal to PRNT/TX and FORCE CLAIM TO PRINT equal to FORCE LOCAL PRINT in the Bill/Claim file (#399) based on the following criteria:

* A user-specified date range and
* All or selected divisions and
* CPAC or CHAMPVA/TRICARE (BN 9.2)

**Design Element** Refer to 6.2.2.2.10.1

###### Functional Requirement: Printed Claims Report – Sort

The IB system shall provide the ability for users to sort a report of claims with a STATUS equal to PRNT/TX and FORCE CLAIM TO PRINT equal to FORCE LOCAL PRINT in the Bill/Claim file (#399) based on the following criteria:

* Insurance Company
* Authorizing Biller
* Rate Type
* Form Type
* Type of Plan (BN 9.2)

**Design Element** Refer to 6.2.2.2.10.1

###### Functional Requirement: Printed Claims Report – Inclusions CPAC

The IB system shall include locally printed claims from the Printed Claims report based on the following inclusion criteria when the report search criteria equals CPAC:

* Claim does not contains one or more revenue codes equal to 270 – 279 and/or 290 – 299
* Destination payer is not equal to US Labor Department and
* Rate Type is one of the following and:
* DENTAL Who’s Responsible: PATIENT
* HUMANITARIAN Who’s Responsible: PATIENT
* INTERAGENCY Who's Responsible: OTHER (INSTITUTION)
* MEANS TEST Who's Responsible: PATIENT
* MEDICARE ESRD Who's Responsible: OTHER (INSTITUTION)
* NO FAULT INS. Who's Responsible: INSURER
* REIMBURSABLE INS. Who's Responsible: INSURER
* SHARING AGREEMENT Who's Responsible: OTHER (INSTITUTION)
* CATEGORY C Who's Responsible: PATIENT
* Type of Plan is one of the following:
* ACCIDENT AND HEALTH INSURANCE MAJOR MEDICAL
* AUTOMOBILE MAJOR MEDICAL
* CARVE-OUT MAJOR MEDICAL
* CATASTROPHIC INSURANCE MAJOR MEDICAL
* COMPREHENSIVE MAJOR MEDICAL MAJOR MEDICAL
* HEALTH MAINTENANCE ORGANIZ MAJOR MEDICAL
* INCOME PROTECTION (INDEMNITY) INDEMNITY
* INDIVIDUAL PRACTICE ASSOCATION (IPA) MAJOR MEDICAL
* INPATIENT (BASIC HOSPITAL) MAJOR MEDICAL
* LABS, PROCEDURES, X-RAY, ETC. (ONLY) ALL OTHER
* MANAGED CARE SYSTEM (MCS) MAJOR MEDICAL
* MEDI-CAL MEDICAIDE
* MEDICAID MEDICAIDE
* MEDICAL EXPENSE (OPT/PROF) MAJOR MEDICAL
* MEDICARE SECONDARY (B EXC) MAJOR MEDICAL
* MEDICARE SECONDARY (NO B EXC) MAJOR MEDICAL
* MEDICARE SUPPLEMENTAL MAJOR MEDICAL
* MEDICARE/MEDICAID (MEDI-CAL) MEDICARE
* MEDIGAP PLAN A MEDICARE SUPPLEMENTAL
* MEDIGAP PLAN B MEDICARE SUPPLEMENTAL
* MEDIGAP PLAN C MEDICARE SUPPLEMENTAL
* MEDIGAP PLAN D MEDICARE SUPPLEMENTAL
* MEDIGAP PLAN F MEDICARE SUPPLEMENTAL
* MEDIGAP PLAN G MEDICARE SUPPLEMENTAL
* MEDIGAP PLAN K MEDICARE SUPPLEMENTAL
* MEDIGAP PLAN L MEDICARE SUPPLEMENTAL
* MEDIGAP PLAN M MEDICARE SUPPLEMENTAL
* MEDIGAP PLAN N MEDICARE SUPPLEMENTAL
* MENTAL HEALTH ALL OTHER
* POINT OF SERVICE HMO
* PREFERRED PROVIDER ORGANIZATION (PPO) PPO
* PREPAID GROUP PRACTICE PLAN HMO
* PRESCRIPTION PRESCRIPTION
* RETIREE MAJOR MEDICAL
* SPECIAL CLASS INSURANCE MAJOR MEDICAL
* SPECIAL RISK INSURANCE MAJOR MEDICAL
* SPECIFIED DISEASE INSURANCE MAJOR MEDICAL
* SURGICAL EXPENSE INSURANCE MAJOR MEDICAL (BN 9.1)

**Design Element** Refer to 6.2.2.2.10.1

###### Functional Requirement – Printed Claims Report – Inclusions – TRICARE/CHAMPVA

The IB system shall include locally printed claims from the Printed Claims report based on the following criteria when the report search criteria is equal to TRICARE/CHAMPVA:

* Claim does not contains one or more revenue codes equal to 270 – 279 and/or 290 – 299
* Destination payer is not equal to US Labor Department and
* Rate Type is one of the following and:
* CHAMPVA REIMB. INS. Who's Responsible: INSURER
* CHAMPVA Who's Responsible: INSURER
* TRICARE REIMB. INS. Who's Responsible: INSURER
* TRICARE Who's Responsible: INSURER
* Type of Plan is one of the following:
* TRICARE CHAMPUS
* TRICARE SUPPLEMENTAL MAJOR MEDICAL
* CHAMPVA MAJOR MEDICAL (BN 9.1)

**Design Element** Refer to 6.2.2.2.10.1

###### Functional Requirement: Re-generate Unbilled Amount Report – Search

The IB system shall provide the ability for users to search the Re-generate Unbilled Amount Detailed Report by the following:

* All Divisions, or
* Select Divisions (BN 14.1)

**Design Element**

Patch IB\*2.0\*516 modified this report in two significant ways: a) the user can now choose to include all Divisions in the report or only specified Divisions; b) the results of the report – whether all Divisions are included or only specified Divisions – are now always sorted by Division. This current patch will make both of those optional.

Before asking the user to select whether to run the report for all Divisions or specified Divisions, the user will be asked whether to search by Division.

* If the user answers ‘no’ (do not search by Division), then data for all Divisions will be included in the report, and the results will not sort by Division.
* If the user answer ‘yes’ (search by Division), then the user will be asked whether to include data for all Divisions or specified Divisions. Furthermore, the user will be given the option of sorting the results by Patient Name across any and all Divisions or sorting first by Division and then by Patient Name within each Division. (Please see the design for section 6.2.2.2.10.7 for additional description on sorting by Patient Name.)

As the report gathers the data for the report, it currently sorts by Division, then by inpatient/outpatient/prescription, then by Patient Name, finally by date. With this patch, the Division will be defaulted to ‘999999’ when the users opt not to search by Division. All Divisions will be included in the report, but the data will not be sorted by Division.

For more detail on how the searching and sorting of the report will be modified, please see the design described in section 6.2.2.2.10.7 below.

**Routines (Entry Points):**

| **Routine Name** | **IBTUBO** | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Enhancement Category | New | Modify | | Delete | | | | No Change | | |
| RTM | 2.6.10.6. | | | | | | | | | |
| Related Options | IBT RE-GEN UNBILLED REPORT (Re-Generate Unbilled Amounts Report) | | | | | | | | | |
| Related Routines | Routines “Called By” | | | | | Routines “Called” | | | | |
|  | ^IBTUB  ^IBTUBAV1 | | | | | ^%ZIS  ^%ZTLOAD  ^DIC  DT^DICRW  ^DIR  ^IBJD  ^IBJDE  ^IBOUTL  ^IBTUBOA  ^IBTUBOU | | | | |
| Routines | | | Activities | | | | | | | |
| Data Dictionary (DD) References | | | N/A | | | | | | | |
| Related Protocols | | | N/A | | | | | | | |
| Related Integration Control Registrations (ICRs) | | | N/A | | | | | | | |
| Data Passing | | | Input | | Output Reference | | Both | | Global Reference | Local |
| Input Attribute Name and Definition | | | Name:  Definition: N/A | | | | | | | |
| Output Attribute Name and Definition | | | Name:  Definition: N/A | | | | | | | |
| Current Logic | | | | | | | | | | |
| IBTUBO ;ALB/AAS - UNBILLED AMOUNTS - GENERATE UNBILLED REPORTS ;29-SEP-94  ;;2.0;INTEGRATED BILLING;\*\*19,31,32,91,123,159,192,235,248,155,516\*\*;21-MAR-94  ;;Per VA Directive 6402, this routine should not be modified.  ;  % ; - Entry point for manual option.  N IBBDT,IBCOMP,IBDET,IBEDT,IBOPT,IBPRT,IBTIMON,IBQUIT,IBSEL  S IBQUIT=0 D:'$D(DT) DT^DICRW  W !!,"Re-Generate Unbilled Amounts Report",!  ;  ; - Ask to re-compile Unbilled Amounts data.  S DIR(0)="Y",DIR("B")="NO"  S DIR("A")="Do you want to store Unbilled Amounts figures"  S DIR("?",1)="Enter 'YES' if you wish to store the Unbilled Amounts summary"  S DIR("?",2)="figures in your system for a specific month/year in the past."  S DIR("?",3)="Once stored, these figures will be available for inquirythrough"  S DIR("?",4)="the View Unbilled Amounts option [IBT VIEW UNBILLED AMOUNTS]."  S DIR("?",5)="These summary figures are normally calculated and stored"  S DIR("?",6)="automatically by the system at the beginning of each month for"  S DIR("?",7)="the previous month."  S DIR("?",8)=" "  S DIR("?",9)="If you enter 'NO', the Unbilled Amounts summary figures will"  S DIR("?",10)="NOT be stored in your system, and the report may be runfor"  S DIR("?")="any date range."  D ^DIR K DIR G:$D(DIRUT) END S IBCOMP=Y  ;  ; IB\*2.0\*516 - Added ability to sort by Division  ;  K ^TMP($J,"IBTUB"),^TMP($J,"IBTUB-DIV")  I IBCOMP G RDATE  ;  DIV ; division  W !!  S DIR(0)="SA^A:All Divisions;S:Selected Divisions"  S DIR("A")="Include All Divisions or Selected Divisions? "  S DIR("B")="All"  D ^DIR K DIR  I $D(DIROUT)!$D(DIRUT) Q ;Timeout or User "^"  I Y="A" G DIVX  ;  W !  F D I IBQUIT S IBQUIT=IBQUIT-1 Q  . S DIC=40.8,DIC(0)="AEMQ",DIC("A")=" Select Division: "  . I $O(^TMP($J,"IBTUB-DIV","")) S DIC("A")=" Select Another Division: "  . D ^DIC K DIC ; lookup  . I X="^^" S IBQUIT=2 Q ; user entered ^^  . I +Y'>0 S IBQUIT=1 Q ; user is done  . S ^TMP($J,"IBTUB-DIV",+Y)=$P(Y,U,2)  . Q  ;  I IBQUIT G END ;User "^" out of the selection  ;  I '$O(^TMP($J,"IBTUB-DIV","")) D G DIV  . W \*7,!!?3,"No divisions have been selected. Please try again."  . Q  ;  DIVX ; Exit Division selection.  ;  ; - Select date(s) to build report.  … | | | | | | | | | | |
| Modified Logic (Changes are in bold) | | | | | | | | | | |
| IBTUBO ;ALB/AAS - UNBILLED AMOUNTS - GENERATE UNBILLED REPORTS ;29-SEP-94  ;;2.0;INTEGRATED BILLING;\*\*19,31,32,91,123,159,192,235,248,155,516\*\*;21-MAR-94  ;;Per VA Directive 6402, this routine should not be modified.  ;  % ; - Entry point for manual option.  N IBBDT,IBCOMP,IBDET,IBEDT,IBOPT,IBPRT**,IBSBD**,IBTIMON,IBQUIT,IBSEL  S IBQUIT=0 D:'$D(DT) DT^DICRW  W !!,"Re-Generate Unbilled Amounts Report",!  ;  ; - Ask to re-compile Unbilled Amounts data.  S DIR(0)="Y",DIR("B")="NO"  S DIR("A")="Do you want to store Unbilled Amounts figures"  S DIR("?",1)="Enter 'YES' if you wish to store the Unbilled Amounts summary"  S DIR("?",2)="figures in your system for a specific month/year in the past."  S DIR("?",3)="Once stored, these figures will be available for **inquiry through**"  S DIR("?",4)="the View Unbilled Amounts option [IBT VIEW UNBILLED AMOUNTS]."  S DIR("?",5)="These summary figures are normally calculated and stored"  S DIR("?",6)="automatically by the system at the beginning of each month for"  S DIR("?",7)="the previous month."  S DIR("?",8)=" "  S DIR("?",9)="If you enter 'NO', the Unbilled Amounts summary figures will"  S DIR("?",10)="NOT be stored in your system, and the report may be **run for**"  S DIR("?")="any date range."  D ^DIR K DIR G:$D(DIRUT) END S IBCOMP=Y  ;  ; IB\*2.0\*516 - Added ability to sort by Division  ;  K ^TMP($J,"IBTUB"),^TMP($J,"IBTUB-DIV")  I IBCOMP G RDATE  ;  ;  **Before asking the user whether to include all Divisions or selected Divisions, the report will first ask the user whether to search by Division. The prompt will appear in this manner:**  **Search by Division?: NO//??**  **This opt allows you to search for all unbilled amounts**  **or to search for unbilled amounts in only one or more**  **divisions.**  **Choose from:**  **N NO**  **Y YES**  **The following prompt – ‘Include All Divisions or Selected Divisions?’ – will be presented to the user only if the user answered ‘Yes’ to the ‘Search by Division?’ prompt.**  **When the report is compiled, the inclusion/exclusion of data for a given Division is governed by the temporary global ^TMP($J,“IBTUB-DIV”,Division). If this global exists, then only the Divisions included on this list will be included on the report. If this global does not exist, then all Divisions will be included.**  **The software will also set a flag – IBSBD, for sort by division – to be ‘0’ if the user answered ‘No’ and ‘1’ if the user answered ‘Yes’ (possible reset below, at the new question ‘Sort by’). As the data for the report is compiled, that flag will be used to either sort by Division or not, according to the user’s answer at the ‘Search by Division?’ prompt and the ‘Sort by’ prompt, detailed in section 6.2.2.2.10.7 below.**  ;  DIV ; division  W !!  S DIR(0)="SA^A:All Divisions;S:Selected Divisions"  S DIR("A")="Include All Divisions or Selected Divisions? "  S DIR("B")="All"  D ^DIR K DIR  I $D(DIROUT)!$D(DIRUT) Q ;Timeout or User "^"  I Y="A" G DIVX  ;  W !  F D I IBQUIT S IBQUIT=IBQUIT-1 Q  . S DIC=40.8,DIC(0)="AEMQ",DIC("A")=" Select Division: "  . I $O(^TMP($J,"IBTUB-DIV","")) S DIC("A")=" Select Another Division: "  . D ^DIC K DIC ; lookup  . I X="^^" S IBQUIT=2 Q ; user entered ^^  . I +Y'>0 S IBQUIT=1 Q ; user is done  . S ^TMP($J,"IBTUB-DIV",+Y)=$P(Y,U,2)  . Q  ;  I IBQUIT G END ;User "^" out of the selection  ;  I '$O(^TMP($J,"IBTUB-DIV","")) D G DIV  . W \*7,!!?3,"No divisions have been selected. Please try again."  . Q  ;  DIVX ; Exit Division selection.  ;  ; - Select date(s) to build report.  … | | | | | | | | | | |

###### Functional Requirement: Re-generate Unbilled Amount Report – Sort

The IB system shall provide the ability for users to sort the Re-generate Unbilled Amount Detailed Report by the following:

* Division
* Patient name (alphabetical) (BN 14.1)

**Routines (Entry Points):**

| Routine Name | IBTUBO | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Enhancement Category | New | Modify | | Delete | | | No Change | | |
| RTM | 2.6.10.7. | | | | | | | | |
| Related Options | IBT RE-GEN UNBILLED REPORT (Re-Generate Unbilled Amounts Report) | | | | | | | | |
| Related Routines | Routines “Called By” | | | | | Routines “Called” | | | |
|  | ^IBTUB  ^IBTUBAV1 | | | | | ^%ZIS  ^%ZTLOAD  ^DIC  DT^DICRW  ^DIR  ^IBJD  ^IBJDE  ^IBOUTL  ^IBTUBOA  ^IBTUBOU | | | |
| Routines | | | Activities | | | | | | |
| Data Dictionary (DD) References | | | N/A | | | | | | |
| Related Protocols | | | N/A | | | | | | |
| Related Integration Control Registrations (ICRs) | | | N/A | | | | | | |
| Data Passing | | | Input | | Output Reference | | Both | Global Reference | Local |
| Input Attribute Name and Definition | | | Name:  Definition: N/A | | | | | | |
| Output Attribute Name and Definition | | | Name:  Definition: N/A | | | | | | |
| Current Logic | | | | | | | | | |
| DET ; - Ask to print detail report.  S DIR(0)="Y",DIR("B")="NO" W !  S DIR("A")="Print detail report with the Unbilled Amounts summary"  S DIR("?",1)="Answer YES if you want a detailed listing of the patients"  S DIR("?",2)="and events that are unbilled. Answer NO if you just want"  S DIR("?")="the summary, or '^' to quit this option."  D ^DIR K DIR G:$D(DIRUT) END S IBDET=Y G:'IBDET QUE  ;  ; Ask to include REQUEST MRA Status  S DIR(0)="YA",DIR("A")="Do you want to include MRA claims?: ",DIR("B")="NO" W ! D ^DIR K DIR G:$D(DIRUT) END  S IBINMRA=+Y  ;  ; - Select device to print.  W !!,"This report takes a while to run, so you should queue it to run"  W !,"after normal business hours."  W !!,"You will need a 132 column printer for this report!",!  S %ZIS="QM" D ^%ZIS G END:POP,QUE:$D(IO("Q"))  ;  U IO G STR | | | | | | | | | |
| Modified Logic (Changes are in bold) | | | | | | | | | |
| DET ; - Ask to print detail report.  S DIR(0)="Y",DIR("B")="NO" W !  S DIR("A")="Print detail report with the Unbilled Amounts summary"  S DIR("?",1)="Answer YES if you want a detailed listing of the patients"  S DIR("?",2)="and events that are unbilled. Answer NO if you just want"  S DIR("?")="the summary, or '^' to quit this option."  D ^DIR K DIR G:$D(DIRUT) END S IBDET=Y G:'IBDET QUE  ;  ; Ask to include REQUEST MRA Status  S DIR(0)="YA",DIR("A")="Do you want to include MRA claims?: ",DIR("B")="NO" W ! D ^DIR K DIR G:$D(DIRUT) END  S IBINMRA=+Y  ;  **If the user answered ‘Yes’ to the question ‘Search by Division?’ above (being added as part of this patch), then before prompting the user for a device, the report will ask the user whether to sort by Patient Name or Division. The prompt will appear in this manner:**  **Sort by: Patient Name// ??**  **This determines whether the unbilled amounts are displayed**  **in alphabetical order of patient name or in alphabetical**  **order of patient name within a division.**    **Choose from:**  **N Patient Name**  **D Division**  **If the user opts to sort by Division, then the IBSBD flag will be set to ‘1’. If the user opts to sort by Patient Name, then the IBSBD flag will be reset to ‘0’. As the report is compiled, the IBSBD flag will be used to govern whether to include Division as a sort level.**  ; - Select device to print.  W !!,"This report takes a while to run, so you should queue it to run"  W !,"after normal business hours."  W !!,"You will need a 132 column printer for this report!",!  S %ZIS="QM" D ^%ZIS G END:POP,QUE:$D(IO("Q"))  ;  U IO G STR | | | | | | | | | |

| Routine Name | IBTUBO1 | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Enhancement Category | New | Modify | | Delete | No Change | | | | |
| RTM | 2.6.10.6. and 2.6.10.7. | | | | | | | | |
| Related Options | IBT RE-GEN UNBILLED REPORT (Re-Generate Unbilled Amounts Report) | | | | | | | | |
| Related Routines | Routines “Called By” | | | | | Routines “Called” | | | |
|  | ^IBTUBOA | | | | | ^DIQ  ^IBAMTS1  ^IBAMTS2  ^IBCRCI  ^IBTUBOU  ^ICPTCOD  ^SDOE  ^VASITE | | | |
| Routines | | | Activities | | | | | | |
| Data Dictionary (DD) References | | | N/A | | | | | | |
| Related Protocols | | | N/A | | | | | | |
| Related Integration Control Registrations (ICRs) | | | N/A | | | | | | |
| Data Passing | | | Input | | Output Reference | | Both | Global Reference | Local |
| Input Attribute Name and Definition | | | Name:  Definition: N/A | | | | | | |
| Output Attribute Name and Definition | | | Name:  Definition: N/A | | | | | | |
| Current Logic | | | | | | | | | |
| IBTUBO1 ;ALB/AAS - UNBILLED AMOUNTS - GENERATE UNBILLED REPORTS ;29-SEP-94  ;;2.0;INTEGRATED BILLING;\*\*19,31,32,91,123,159,247,155,277,339,399,516\*\*;21-MAR-94;Build 8  ;;Per VA Directive 6402, this routine should not be modified.  ;  OPT(IBOE,IBQUERY) ; - Has the outpatient encounter been billed?  ; Input: IBOE=pointer to outpatient encounter in file #409.68  ; (NOTE: this value may be null)  ; IBQUERY (Passed by reference)=flag that is incremented when  ; the Scheduling query API is invoked  ; \*Pre-set variables: DFN=patient IEN, IBDT=event date, IBRT=bill rate,  ; IBEDT=End of reporting period date.  ; IBX=ien of CLAIMS TRACKING entry file 356  ;  I '$G(DFN)!('$G(IBDT))!('$G(IBRT))!'$G(IBX) G OPTQ  N IBCN,IBCPT,IBCPTSUM,IBCT,IBDATA,IBDAY,IBDIV,IBFL,IBNAME  N IBQUIT,IBNCF,IBTCHRG,IBXX,IBYD,IBYY,IBZ,IBMRA  ;  ; - Check to be sure the encounter is billable.  I $$INPT^IBAMTS1(DFN,IBDT\1\_.2359) G OPTQ ; Became inpatient same day.  I $G(IBOE),$$ENCL^IBAMTS2(IBOE)["1" G OPTQ ; "ao^ir^sc^swa^mst^hnc^cv^shad" encounter.  S IBDAY=$E(IBDT,1,7),IBNAME=$P($G(^DPT(DFN,0)),U),IBQUIT="",IBNCF=0  ;  ; - Determine the encounter division.  S IBDIV=+$P($$GETOE^SDOE(IBOE),U,11) S:'IBDIV IBDIV=+$$PRIM^VASITE()  ; IB\*2.0\*516 - Added ability to sort by Division.  I $D(^TMP($J,"IBTUB-DIV")),'$D(^TMP($J,"IBTUB-DIV",IBDIV)) G OPTQ ; Not a selected Division  ;  ; - If no encounter, see if add/edits or registrations are not billable.  I '$G(IBOE) D NOOE G:IBQUIT OPTQ  ;  ; - If encounter was dated prior to Reasonable Charges (9/1/99) and  ; the claim was not authorized before end of reporting period, add  ; encounter Tort Rate to Unbilled Outpatient Amount  I IBDAY<2990901 D PRERC,SETUB:'IBQUIT G OPTQ  I '$G(IBOE) G OPTQ ; If still no encounter, quit.  ;  ; - If encounter was made after start of Reasonable Charges (9/1/99)  ; and any of the encounter's procedure codes have no corresponding  ; inst. or prof. claims that were not authorized before end of the  ; reporting period, add the charges for the procedures to the  ; Unbilled Outpatient Amount.  ;  ; - Gather all procedures associated with the encounter.  D GETCPT^SDOE(IBOE,"IBYY") G:'$G(IBYY) OPTQ ; Check CPT qty.  ;  ; - Build array of all billable encounter procedures.  S IBXX=0 F S IBXX=$O(IBYY(IBXX)) Q:'IBXX D  . ;  . ; - Get procedure pointer and code.  . S IBZ=+IBYY(IBXX),IBCN=$P($$CPT^ICPTCOD(IBZ),"^",2)  . ;  . ; - Ignore LAB services for vets with Medicare Supplemental coverage.  . I IBCN>79999,IBCN<90000 Q  . ;  . ; - Get the institutional/professional charge components.  . S IBCPT(IBZ,1)=+$$BICOST^IBCRCI(IBRT,3,IBDAY,"PROCEDURE",IBZ,"",IBDIV,"",1)  . S IBCPT(IBZ,2)=+$$BICOST^IBCRCI(IBRT,3,IBDAY,"PROCEDURE",IBZ,"",IBDIV,"",2)  . ;  . ; - Eliminate components without a charge.  . S IBCPTSUM(IBZ)=+$G(IBCPT(IBZ,1))+$G(IBCPT(IBZ,2))  . I 'IBCPT(IBZ,1) K IBCPT(IBZ,1)  . I 'IBCPT(IBZ,2) K IBCPT(IBZ,2)  . Q  ;  I '$D(IBCPT) G OPTQ ; Quit if no billable procedures remain.  ;  ; - Look at all of the vet's bills for the day and eliminate  ; from the array those procedures that have been billed.  S IBXX=0  F S IBXX=$O(^DGCR(399,"AOPV",DFN,IBDAY,IBXX)) Q:'IBXX D  . ;  . ; - Perform general checks on the claim.  . S IBDATA=$$CKBIL^IBTUBOU(IBXX) Q:IBDATA=""  . I $P(IBDATA,U,2)=2 S IBMRA(IBXX)=IBDATA ; MRA request  . S IBNCF=IBNCF+1  . ;  . ; If Compile/Store & Not authorized/MRA requested before reporting period - Quit.  . I $G(IBCOMP),$S('$G(IBMRA(IBXX)):$P(IBDATA,U,3),1:$P(IBDATA,U,6))>IBEDT Q  . ;  . ; - The episode has been billed. Check the revenue code multiple for  . ; all procedures billed on the claim.  . S IBYY=0  . F S IBYY=$O(^DGCR(399,IBXX,"RC",IBYY)) Q:'IBYY S IBYD=^(IBYY,0) D  . . ;  . . ; - Get the procedure code and charge type for the revenue code.  . . S IBZ=$P(IBYD,U,6)  . . S IBCT=$S($P(IBYD,U,12):$P(IBYD,U,12),1:$P(IBDATA,U,4))  . . S IBTCHRG=$P(IBYD,U,4)  . . I 'IBZ!('IBCT) Q ; Can't determine code/charge type for procedure.  . . I $G(IBMRA(IBXX))'="" S:$D(IBCPT(IBZ)) IBCPT("MRA",IBZ,IBCT)=1 Q  . . ; Delete procedure from unbilled procedures array.  . . I $G(IBTCHRG)'<$G(IBCPTSUM(IBZ)) K IBCPT(IBZ) Q  . . I $D(IBCPT(IBZ,IBCT)) K IBCPT(IBZ,IBCT) Q  . . K IBCPT(IBZ)  . . Q  . Q  ;  ; - Again, quit if no billable procedures remain.  I '$D(IBCPT) G OPTQ  ;  … | | | | | | | | | |
| Modified Logic (Changes are in bold) | | | | | | | | | |
| IBTUBO1 ;ALB/AAS - UNBILLED AMOUNTS - GENERATE UNBILLED REPORTS ;29-SEP-94  ;;2.0;INTEGRATED BILLING;\*\*19,31,32,91,123,159,247,155,277,339,399,516\*\*;21-MAR-94;Build 8  ;;Per VA Directive 6402, this routine should not be modified.  ;  OPT(IBOE,IBQUERY) ; - Has the outpatient encounter been billed?  ; Input: IBOE=pointer to outpatient encounter in file #409.68  ; (NOTE: this value may be null)  ; IBQUERY (Passed by reference)=flag that is incremented when  ; the Scheduling query API is invoked  ; \*Pre-set variables: DFN=patient IEN, IBDT=event date, IBRT=bill rate,  ; IBEDT=End of reporting period date.  ; IBX=ien of CLAIMS TRACKING entry file 356  ;  I '$G(DFN)!('$G(IBDT))!('$G(IBRT))!'$G(IBX) G OPTQ  N IBCN,IBCPT,IBCPTSUM,IBCT,IBDATA,IBDAY,IBDIV,IBFL,IBNAME  N IBQUIT,IBNCF,IBTCHRG,IBXX,IBYD,IBYY,IBZ,IBMRA  ;  ; - Check to be sure the encounter is billable.  I $$INPT^IBAMTS1(DFN,IBDT\1\_.2359) G OPTQ ; Became inpatient same day.  I $G(IBOE),$$ENCL^IBAMTS2(IBOE)["1" G OPTQ ; "ao^ir^sc^swa^mst^hnc^cv^shad" encounter.  S IBDAY=$E(IBDT,1,7),IBNAME=$P($G(^DPT(DFN,0)),U),IBQUIT="",IBNCF=0  ;  **Note: There is no change to the logic which checks whether or not to include a given Division. If that global exists, then data will be included only for the Divisions listed in that global. If the global ^TMP($J,“IBTUB-DIV”) does not exist, then data for all Divisions will be included.**  ; - Determine the encounter division.  S IBDIV=+$P($$GETOE^SDOE(IBOE),U,11) S:'IBDIV IBDIV=+$$PRIM^VASITE()  ; IB\*2.0\*516 - Added ability to sort by Division.  I $D(^TMP($J,"IBTUB-DIV")),'$D(^TMP($J,"IBTUB-DIV",IBDIV)) G OPTQ ; Not a selected Division  ;  ; - If no encounter, see if add/edits or registrations are not billable.  I '$G(IBOE) D NOOE G:IBQUIT OPTQ  ;  ; - If encounter was dated prior to Reasonable Charges (9/1/99) and  ; the claim was not authorized before end of reporting period, add  ; encounter Tort Rate to Unbilled Outpatient Amount  I IBDAY<2990901 D PRERC,SETUB:'IBQUIT G OPTQ  I '$G(IBOE) G OPTQ ; If still no encounter, quit.  ;  ; - If encounter was made after start of Reasonable Charges (9/1/99)  ; and any of the encounter's procedure codes have no corresponding  ; inst. or prof. claims that were not authorized before end of the  ; reporting period, add the charges for the procedures to the  ; Unbilled Outpatient Amount.  ;  ; - Gather all procedures associated with the encounter.  D GETCPT^SDOE(IBOE,"IBYY") G:'$G(IBYY) OPTQ ; Check CPT qty.  ;  ; - Build array of all billable encounter procedures.  S IBXX=0 F S IBXX=$O(IBYY(IBXX)) Q:'IBXX D  . ;  . ; - Get procedure pointer and code.  . S IBZ=+IBYY(IBXX),IBCN=$P($$CPT^ICPTCOD(IBZ),"^",2)  . ;  . ; - Ignore LAB services for vets with Medicare Supplemental coverage.  . I IBCN>79999,IBCN<90000 Q  . ;  . ; - Get the institutional/professional charge components.  . S IBCPT(IBZ,1)=+$$BICOST^IBCRCI(IBRT,3,IBDAY,"PROCEDURE",IBZ,"",IBDIV,"",1)  . S IBCPT(IBZ,2)=+$$BICOST^IBCRCI(IBRT,3,IBDAY,"PROCEDURE",IBZ,"",IBDIV,"",2)  . ;  . ; - Eliminate components without a charge.  . S IBCPTSUM(IBZ)=+$G(IBCPT(IBZ,1))+$G(IBCPT(IBZ,2))  . I 'IBCPT(IBZ,1) K IBCPT(IBZ,1)  . I 'IBCPT(IBZ,2) K IBCPT(IBZ,2)  . Q  ;  I '$D(IBCPT) G OPTQ ; Quit if no billable procedures remain.  ;  ; - Look at all of the vet's bills for the day and eliminate  ; from the array those procedures that have been billed.  S IBXX=0  F S IBXX=$O(^DGCR(399,"AOPV",DFN,IBDAY,IBXX)) Q:'IBXX D  . ;  . ; - Perform general checks on the claim.  . S IBDATA=$$CKBIL^IBTUBOU(IBXX) Q:IBDATA=""  . I $P(IBDATA,U,2)=2 S IBMRA(IBXX)=IBDATA ; MRA request  . S IBNCF=IBNCF+1  . ;  . ; If Compile/Store & Not authorized/MRA requested before reporting period - Quit.  . I $G(IBCOMP),$S('$G(IBMRA(IBXX)):$P(IBDATA,U,3),1:$P(IBDATA,U,6))>IBEDT Q  . ;  . ; - The episode has been billed. Check the revenue code multiple for  . ; all procedures billed on the claim.  . S IBYY=0  . F S IBYY=$O(^DGCR(399,IBXX,"RC",IBYY)) Q:'IBYY S IBYD=^(IBYY,0) D  . . ;  . . ; - Get the procedure code and charge type for the revenue code.  . . S IBZ=$P(IBYD,U,6)  . . S IBCT=$S($P(IBYD,U,12):$P(IBYD,U,12),1:$P(IBDATA,U,4))  . . S IBTCHRG=$P(IBYD,U,4)  . . I 'IBZ!('IBCT) Q ; Can't determine code/charge type for procedure.  . . I $G(IBMRA(IBXX))'="" S:$D(IBCPT(IBZ)) IBCPT("MRA",IBZ,IBCT)=1 Q  . . ; Delete procedure from unbilled procedures array.  . . I $G(IBTCHRG)'<$G(IBCPTSUM(IBZ)) K IBCPT(IBZ) Q  . . I $D(IBCPT(IBZ,IBCT)) K IBCPT(IBZ,IBCT) Q  . . K IBCPT(IBZ)  . . Q  . Q  ;  ; - Again, quit if no billable procedures remain.  I '$D(IBCPT) G OPTQ  ;  **Before adding this record to the report, conditionally reset the Division (IBDIV) to 999999. The IBSBD flag will be set to ‘1’ if the user wishes for the report to be sorted by Division, ‘0’ otherwise.**  **; If the IBSBD flag is not set, then reset the Division to be**  **; 999999. This data will still be included, but the report**  **; will not be sorted by Division.**  **;**  **I ‘IBSBD S IBDIV=99999999**  **;**  … | | | | | | | | | |

| Routine Name | IBTUBO2 | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Enhancement Category | New | Modify | | Delete | | | | No Change | | |
| RTM | 2.6.10.6. and 2.6.10.7 | | | | | | | | | |
| Related Options | IBT RE-GEN UNBILLED REPORT (Re-Generate Unbilled Amounts Report) | | | | | | | | | |
| Related Routines | Routines “Called By” | | | | | Routines “Called” | | | | |
|  | ^IBTUBOA | | | | | ^DIQ  ^IBCRCC  ^IBCRCI  ^IBCRU3  ^IBRXUTL  ^IBTUBOU  ^VASITE | | | | |
| Routines | | | Activities | | | | | | | |
| Data Dictionary (DD) References | | | N/A | | | | | | | |
| Related Protocols | | | N/A | | | | | | | |
| Related Integration Control Registrations (ICRs) | | | N/A | | | | | | | |
| Data Passing | | | Input | | Output Reference | | Both | | Global Reference | Local |
| Input Attribute Name and Definition | | | Name:  Definition:N/A | | | | | | | |
| Output Attribute Name and Definition | | | Name:  Definition:N/A | | | | | | | |
| Current Logic | | | | | | | | | | |
| IBTUBO2 ;ALB/AAS - UNBILLED AMOUNTS - GENERATE UNBILLED REPORTS ;03 Aug 2004 8:21 AM  ;;2.0;INTEGRATED BILLING;\*\*19,31,32,91,123,159,192,155,309,347,437,516\*\*;21-MAR-94;Build 11  ;;Per VA Directive 6402, this routine should not be modified.  ;  INPT(DGPM) ; - Check if inpatient episode has bills or final bill; if not,  ; ^TMP($J,"IBTUB",DIVISION,"INPT",NAME@@DFN,DATE,IBX)=bill status  ; ^TMP($J,"IBTUB",DIVISION,"INPT\_MRA",NAME@@DFN,DATE,IBX)=1 if MRA request  ; \*Pre-set variables: DFN=patient IEN, DGPM=pointer to file #405,  ; IBDT=event date, IBRT=bill rate,  ; IBEDT=reporting period date  ;  I '$G(DFN)!('$G(DGPM))!('$G(IBDT))!('$G(IBRT)) G INPTQ  N IBIP,IBDATA,IBNAME,IBNCF,IBXX,X,Y,IBMRA,IBDIV,IBWARD  S IBNAME=$P($G(^DPT(DFN,0)),U)  ;  ; Get Division. Default to main Division if not in Ward location  S IBWARD=$$GET1^DIQ(405,DGPM\_",",.06,"I") ;Determine Ward location.  S IBDIV=$$GET1^DIQ(42,IBWARD\_",",.015,"I") I IBDIV="" S IBDIV=$$PRIM^VASITE()  I $D(^TMP($J,"IBTUB-DIV")),'$D(^TMP($J,"IBTUB-DIV",IBDIV)) G INPTQ ; Not a selected Division  ;  I $D(^TMP($J,"IBTUB",IBDIV,"INPT",IBNAME\_"@@"\_DFN,IBDT)) G INPTQ  ;  I $P($G(^DGPM(DGPM,0)),U,11) G INPTQ ; Admitted for SC condition.  I $$SC^IBTUBOU($P($G(^DGPM(DGPM,0)),U,16)) G INPTQ ; Check PTF for SC.  S (IBIP(1),IBIP(2))=0 ; Set claim flags.  ;  ; - Check patient's claims.  S (IBNCF,X)=0  F S X=$O(^DGCR(399,"C",DFN,X)) Q:'X D Q:IBIP(1)&(IBIP(2))  . S IBDATA=$$CKBIL^IBTUBOU(X,1) Q:IBDATA=""  . ;  . ; The admission date on the bill is different from the Event date.  . I $P(IBDATA,U,5)'=$P(IBDT,".") Q  . S IBNCF=IBNCF+1 ; Increment the number of bills on file for episode  . ;  . ; If Compile/Store & Not authorized before reporting period - Quit.  . I $G(IBCOMP),$S($P(IBDATA,U,2)'=2:$P(IBDATA,U,3),1:$P(IBDATA,U,6))>IBEDT Q  . ;  . S IBIP($P(IBDATA,U,4))=$S($P(IBDATA,U,2)'=2:1,1:2) ; Episode billed for inst/prof bill type  . Q  ;  I IBIP(1)=1 G:IBIP(2)=1!(IBDT<2990901) INPTQ ; Episode is billed.  ;  ; - Add to episodes missing inst./prof. bills.  S (IBXX,IBMRA)=""  ;  I IBIP(1)'=1 D  . I 'IBIP(1) D  . . S IBUNB(IBDIV,"EPISM-I")=$G(IBUNB(IBDIV,"EPISM-I"))+1  . . S IBUNB("EPISM-I")=$G(IBUNB("EPISM-I"))+1  . . I IBDET S IBXX="I"  . . Q  . I $G(IBXTRACT) S IB(1)=IB(1)+1 ; For DM extract.  . I IBIP(1)=2 D  . . S IBUNB(IBDIV,"EPISM-I-MRA")=$G(IBUNB(IBDIV,"EPISM-I-MRA"))+1  . . S IBUNB("EPISM-I-MRA")=$G(IBUNB("EPISM-I-MRA"))+1  . . I IBDET S IBMRA="I"  . . Q  . Q  ;  I IBIP(2)'=1,IBDT'<2990901 D  . I 'IBIP(2) D  . . S IBUNB(IBDIV,"EPISM-P")=$G(IBUNB(IBDIV,"EPISM-P"))+1  . . S IBUNB("EPISM-P")=$G(IBUNB("EPISM-P"))+1  . . I IBDET S IBXX=$S(IBXX="I":"I,P",1:"P")  . . Q  . I $G(IBXTRACT) S IB(3)=IB(3)+1 ; For DM extract.  . I IBIP(2)=2 D  . . S IBUNB(IBDIV,"EPISM-P-MRA")=$G(IBUNB(IBDIV,"EPISM-P-MRA"))+1  . . S IBUNB("EPISM-P-MRA")=$G(IBUNB("EPISM-P-MRA"))+1  . . I IBDET S IBMRA=$S(IBMRA="I":"I,P",1:"P")  . . Q  . Q  ;  I 'IBIP(1)!'IBIP(2) S IBUNB(IBDIV,"EPISM-A")=$G(IBUNB(IBDIV,"EPISM-A"))+1 ; Number of Admissions missing claims  I IBIP(1)=2!(IBIP(2)=2) S IBUNB(IBDIV,"EPISM-A-MRA")=$G(IBUNB(IBDIV,"EPISM-A-MRA"))+1  I $G(IBXTRACT) S IB(5)=IB(5)+1 ; For DM extract.  ;  I '$G(IBINMRA),IBIP(1)=2 G:IBIP(2)=1 INPTQ  I '$G(IBINMRA),IBIP(2)=2 G:IBIP(1)=1 INPTQ  ;  ; - Set global for report.  I $S($G(IBINMRA):1,1:IBXX'="") S ^TMP($J,"IBTUB",IBDIV,"INPT",IBNAME\_"@@"\_DFN,IBDT,IBX)=IBNCF\_U\_IBXX\_U\_U\_U\_$$HOSP^IBTUBOU(DGPM)  I IBMRA'="",$G(IBINMRA) S ^TMP($J,"IBTUB",IBDIV,"INPT\_MRA",IBNAME\_"@@"\_DFN,IBDT,IBX)=1\_U\_IBMRA  ;  INPTQ Q  ;  RX(IBRX) ; - Check if prescription has been billed; if not,  ; ^TMP($J,"IBTUB",DIVISION,"RX",NAME@@DFN,DATE@RX#,IBX)=bill status^drug name^  ; original fill date  ; ^TMP($J,"IBTUB",DIVISION,"RX\_MRA",NAME@@DFN,DATE@RX#,IBX)=1 if reqMRA  ;  ; \*Pre-set variables: DFN=patient IEN, IBDT=refill date,  ; IBRT=bill rate, IBRX=pointer to file #52,  ; IBEDT=reporting period date  I '$G(DFN)!('$G(IBDT))!('$G(IBRT))!('$G(IBRX)) G RXQ  N IBDATA,IBDAY,IBDRX,IBFL,IBFLG,IBOFD,IBNAME,IBND,IBNO,IBNCF,RX,X,RXDT,IBMRA,IBCO,IBCLIN,IBDIV  ;  ; - Be sure prescription has an RX#.  S IBND=$$RXZERO^IBRXUTL(DFN,IBRX),IBNO=$P(IBND,U) G:IBNO="" RXQ  ;  ; - Retrieve the Prescription Original Fill Date  S IBOFD=$$FILE^IBRXUTL(IBRX,22)\1  ;  S IBDAY=$E(IBDT,1,7),IBDRX=IBDAY\_"@@"\_IBNO,IBNAME=$P($G(^DPT(DFN,0)),U)  ;  ; Get Division from Clinic associated with Rx. Default to VAMC  S IBCLIN=$$FILE^IBRXUTL(IBRX,5)  S IBDIV=$$GET1^DIQ(44,IBCLIN\_",",3.5,"I") I IBDIV="" S IBDIV=999999  I $D(^TMP($J,"IBTUB-DIV")),'$D(^TMP($J,"IBTUB-DIV",IBDIV)) G RXQ ; Nota selected Division  ;  … | | | | | | | | | | |
| Modified Logic (Changes are in bold) | | | | | | | | | | |
| IBTUBO2 ;ALB/AAS - UNBILLED AMOUNTS - GENERATE UNBILLED REPORTS ;03 Aug 2004 8:21 AM  ;;2.0;INTEGRATED BILLING;\*\*19,31,32,91,123,159,192,155,309,347,437,516\*\*;21-MAR-94;Build 11  ;;Per VA Directive 6402, this routine should not be modified.  ;  INPT(DGPM) ; - Check if inpatient episode has bills or final bill; if not,  ; ^TMP($J,"IBTUB",DIVISION,"INPT",NAME@@DFN,DATE,IBX)=bill status  ; ^TMP($J,"IBTUB",DIVISION,"INPT\_MRA",NAME@@DFN,DATE,IBX)=1 if MRA request  ; \*Pre-set variables: DFN=patient IEN, DGPM=pointer to file #405,  ; IBDT=event date, IBRT=bill rate,  ; IBEDT=reporting period date  ;  I '$G(DFN)!('$G(DGPM))!('$G(IBDT))!('$G(IBRT)) G INPTQ  N IBIP,IBDATA,IBNAME,IBNCF,IBXX,X,Y,IBMRA,IBDIV,IBWARD  S IBNAME=$P($G(^DPT(DFN,0)),U)  ;  **Note: There is no change to the logic which checks whether or not to include a given Division. If that global exists, then data will be included only for the Divisions listed in that global. If the global ^TMP($J,“IBTUB-DIV”) does not exist, then data for all Divisions will be included.**  ; Get Division. Default to main Division if not in Ward location  S IBWARD=$$GET1^DIQ(405,DGPM\_",",.06,"I") ;Determine Ward location.  S IBDIV=$$GET1^DIQ(42,IBWARD\_",",.015,"I") I IBDIV="" S IBDIV=$$PRIM^VASITE()  I $D(^TMP($J,"IBTUB-DIV")),'$D(^TMP($J,"IBTUB-DIV",IBDIV)) G INPTQ ; Not a selected Division  ;  **Before adding this record to the report, conditionally reset the Division (IBDIV) to 999999. The IBSBD flag will be set to ‘1’ if the user wishes for the report to be sorted by Division, ‘0’ otherwise.**  **; If the IBSBD flag is not set, then reset the Division to be**  **; 999999. This data will still be included, but the report**  **; will not be sorted by Division.**  **;**  **I ‘IBSBD S IBDIV=99999999**  **;**  I $D(^TMP($J,"IBTUB",IBDIV,"INPT",IBNAME\_"@@"\_DFN,IBDT)) G INPTQ  ;  I $P($G(^DGPM(DGPM,0)),U,11) G INPTQ ; Admitted for SC condition.  I $$SC^IBTUBOU($P($G(^DGPM(DGPM,0)),U,16)) G INPTQ ; Check PTF for SC.  S (IBIP(1),IBIP(2))=0 ; Set claim flags.  ;  ; - Check patient's claims.  S (IBNCF,X)=0  F S X=$O(^DGCR(399,"C",DFN,X)) Q:'X D Q:IBIP(1)&(IBIP(2))  . S IBDATA=$$CKBIL^IBTUBOU(X,1) Q:IBDATA=""  . ;  . ; The admission date on the bill is different from the Event date.  . I $P(IBDATA,U,5)'=$P(IBDT,".") Q  . S IBNCF=IBNCF+1 ; Increment the number of bills on file for episode  . ;  . ; If Compile/Store & Not authorized before reporting period - Quit.  . I $G(IBCOMP),$S($P(IBDATA,U,2)'=2:$P(IBDATA,U,3),1:$P(IBDATA,U,6))>IBEDT Q  . ;  . S IBIP($P(IBDATA,U,4))=$S($P(IBDATA,U,2)'=2:1,1:2) ; Episode billed for inst/prof bill type  . Q  ;  I IBIP(1)=1 G:IBIP(2)=1!(IBDT<2990901) INPTQ ; Episode is billed.  ;  ; - Add to episodes missing inst./prof. bills.  S (IBXX,IBMRA)=""  ;  I IBIP(1)'=1 D  . I 'IBIP(1) D  . . S IBUNB(IBDIV,"EPISM-I")=$G(IBUNB(IBDIV,"EPISM-I"))+1  . . S IBUNB("EPISM-I")=$G(IBUNB("EPISM-I"))+1  . . I IBDET S IBXX="I"  . . Q  . I $G(IBXTRACT) S IB(1)=IB(1)+1 ; For DM extract.  . I IBIP(1)=2 D  . . S IBUNB(IBDIV,"EPISM-I-MRA")=$G(IBUNB(IBDIV,"EPISM-I-MRA"))+1  . . S IBUNB("EPISM-I-MRA")=$G(IBUNB("EPISM-I-MRA"))+1  . . I IBDET S IBMRA="I"  . . Q  . Q  ;  I IBIP(2)'=1,IBDT'<2990901 D  . I 'IBIP(2) D  . . S IBUNB(IBDIV,"EPISM-P")=$G(IBUNB(IBDIV,"EPISM-P"))+1  . . S IBUNB("EPISM-P")=$G(IBUNB("EPISM-P"))+1  . . I IBDET S IBXX=$S(IBXX="I":"I,P",1:"P")  . . Q  . I $G(IBXTRACT) S IB(3)=IB(3)+1 ; For DM extract.  . I IBIP(2)=2 D  . . S IBUNB(IBDIV,"EPISM-P-MRA")=$G(IBUNB(IBDIV,"EPISM-P-MRA"))+1  . . S IBUNB("EPISM-P-MRA")=$G(IBUNB("EPISM-P-MRA"))+1  . . I IBDET S IBMRA=$S(IBMRA="I":"I,P",1:"P")  . . Q  . Q  ;  I 'IBIP(1)!'IBIP(2) S IBUNB(IBDIV,"EPISM-A")=$G(IBUNB(IBDIV,"EPISM-A"))+1 ; Number of Admissions missing claims  I IBIP(1)=2!(IBIP(2)=2) S IBUNB(IBDIV,"EPISM-A-MRA")=$G(IBUNB(IBDIV,"EPISM-A-MRA"))+1  I $G(IBXTRACT) S IB(5)=IB(5)+1 ; For DM extract.  ;  I '$G(IBINMRA),IBIP(1)=2 G:IBIP(2)=1 INPTQ  I '$G(IBINMRA),IBIP(2)=2 G:IBIP(1)=1 INPTQ  ;  ; - Set global for report.  I $S($G(IBINMRA):1,1:IBXX'="") S ^TMP($J,"IBTUB",IBDIV,"INPT",IBNAME\_"@@"\_DFN,IBDT,IBX)=IBNCF\_U\_IBXX\_U\_U\_U\_$$HOSP^IBTUBOU(DGPM)  I IBMRA'="",$G(IBINMRA) S ^TMP($J,"IBTUB",IBDIV,"INPT\_MRA",IBNAME\_"@@"\_DFN,IBDT,IBX)=1\_U\_IBMRA  ;  INPTQ Q  ;  RX(IBRX) ; - Check if prescription has been billed; if not,  ; ^TMP($J,"IBTUB",DIVISION,"RX",NAME@@DFN,DATE@RX#,IBX)=bill status^drug name^  ; original fill date  ; ^TMP($J,"IBTUB",DIVISION,"RX\_MRA",NAME@@DFN,DATE@RX#,IBX)=1 if reqMRA  ;  ; \*Pre-set variables: DFN=patient IEN, IBDT=refill date,  ; IBRT=bill rate, IBRX=pointer to file #52,  ; IBEDT=reporting period date  I '$G(DFN)!('$G(IBDT))!('$G(IBRT))!('$G(IBRX)) G RXQ  N IBDATA,IBDAY,IBDRX,IBFL,IBFLG,IBOFD,IBNAME,IBND,IBNO,IBNCF,RX,X,RXDT,IBMRA,IBCO,IBCLIN,IBDIV  ;  ; - Be sure prescription has an RX#.  S IBND=$$RXZERO^IBRXUTL(DFN,IBRX),IBNO=$P(IBND,U) G:IBNO="" RXQ  ;  ; - Retrieve the Prescription Original Fill Date  S IBOFD=$$FILE^IBRXUTL(IBRX,22)\1  ;  S IBDAY=$E(IBDT,1,7),IBDRX=IBDAY\_"@@"\_IBNO,IBNAME=$P($G(^DPT(DFN,0)),U)  ;  **Note: There is no change to the logic which checks whether or not to include a given Division. If that global exists, then data will be included only for the Divisions listed in that global. If the global ^TMP($J,“IBTUB-DIV”) does not exist, then data for all Divisions will be included.**  ; Get Division from Clinic associated with Rx. Default to VAMC  S IBCLIN=$$FILE^IBRXUTL(IBRX,5)  S IBDIV=$$GET1^DIQ(44,IBCLIN\_",",3.5,"I") I IBDIV="" S IBDIV=999999  I $D(^TMP($J,"IBTUB-DIV")),'$D(^TMP($J,"IBTUB-DIV",IBDIV)) G RXQ ; Nota selected Division  ;  **Before adding this record to the report, conditionally reset the Division (IBDIV) to 999999. The IBSBD flag will be set to ‘1’ if the user wishes for the report to be sorted by Division, ‘0’ otherwise.**  **; If the IBSBD flag is not set, then reset the Division to be**  **; 999999. This data will still be included, but the report**  **; will not be sorted by Division.**  **;**  **I ‘IBSBD S IBDIV=99999999**  **;**  … | | | | | | | | | | |

| Routine Name | IBTUBUL | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Enhancement Category | New | Modify | | Delete | | | | No Change | | |
| RTM | 2.6.10.6. and 2.6.10.7. | | | | | | | | | |
| Related Options | IBT RE-GEN UNBILLED REPORT (Re-Generate Unbilled Amounts Report) | | | | | | | | | |
| Related Routines | Routines “Called By” | | | | | Routines “Called” | | | | |
|  | ^IBTUB  ^IBTUBAV  ^IBTUBO3 | | | | | ^DIQ  ^IBOUTL  ^IBTUBOU  ^VASITE  ^XMD | | | | |
| Routines | | | Activities | | | | | | | |
| Data Dictionary (DD) References | | | N/A | | | | | | | |
| Related Protocols | | | N/A | | | | | | | |
| Related Integration Control Registrations (ICRs) | | | N/A | | | | | | | |
| Data Passing | | | Input | | Output Reference | | Both | | Global Reference | Local |
| Input Attribute Name and Definition | | | Name:  Definition:N/A | | | | | | | |
| Output Attribute Name and Definition | | | Name:  Definition:N/A | | | | | | | |
| Current Logic | | | | | | | | | | |
| BULL ; - Create and send bulletin.  ;  I '$O(IBUNB(0)) Q ; Quit out if no data.  ;  N I,IBDIV,IBGRP,IBT,IBTOTAL,IBX,IDX,X,XMDUZ,XMN,XMSUB,XMTEXT,XMY,XMZ  S XMSUB="UNBILLED AMOUNTS SUMMARY REPORT"\_$S($G(IBTEST):" (TEST)",1:"")  ;  D BULL1  ;  S IBDIV=0  F S IBDIV=$O(IBUNB(IBDIV)) Q:'IBDIV D BULL2  ;  D BULL3,SEND  ;  Q | | | | | | | | | | |
| Modified Logic (Changes are in bold) | | | | | | | | | | |
| BULL ; - Create and send bulletin.  ;  I '$O(IBUNB(0)) Q ; Quit out if no data.  ;  N I,IBDIV,IBGRP,IBT,IBTOTAL,IBX,IDX,X,XMDUZ,XMN,XMSUB,XMTEXT,XMY,XMZ  S XMSUB="UNBILLED AMOUNTS SUMMARY REPORT"\_$S($G(IBTEST):" (TEST)",1:"")  ;  D BULL1  ;  **I IBSBD** S IBDIV=0 F S IBDIV=$O(IBUNB(IBDIV)) Q:'IBDIV D BULL2  ;  D BULL3,SEND  ;  Q | | | | | | | | | | |

###### Functional Requirement: Re-generate Unbilled Amount Summary - Order

The IB system shall provide the ability for users to view the summary totals before the division totals when users select to sort the Re-generate Unbilled Amount Summary by division. (BN 14.1)

Display the grand total summary section only if the user opted to sort by Division and there is data for more than one Division.

**Routines (Entry Points):**

| Routine Name | IBTUBUL | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Enhancement Category | New | Modify | | Delete | | | | No Change | | |
| RTM | 2.6.10.6., 2.6.10.7. and 2.6.10.8 | | | | | | | | | |
| Related Options | IBT RE-GEN UNBILLED REPORT (Re-Generate Unbilled Amounts Report) | | | | | | | | | |
| Related Routines | Routines “Called By” | | | | | Routines “Called” | | | | |
|  | ^IBTUB  ^IBTUBAV  ^IBTUBO3 | | | | | ^DIQ  ^IBOUTL  ^IBTUBOU  ^VASITE  ^XMD | | | | |
| Routines | | | Activities | | | | | | | |
| Data Dictionary (DD) References | | | N/A | | | | | | | |
| Related Protocols | | | N/A | | | | | | | |
| Related Integration Control Registrations (ICRs) | | | N/A | | | | | | | |
| Data Passing | | | Input | | Output Reference | | Both | | Global Reference | Local |
| Input Attribute Name and Definition | | | Name:  Definition: N/A | | | | | | | |
| Output Attribute Name and Definition | | | Name:  Definition: N/A | | | | | | | |
| Current Logic | | | | | | | | | | |
| IBTUBUL ;ALB/AAS - UNBILLED AMOUNTS ;29-SEP-94  ;;2.0;INTEGRATED BILLING;\*\*19,123,159,217,155,356,516\*\*;21-MAR-94  ;;Per VA Directive 6402, this routine should not be modified.  ;  ; IB\*2.0\*516 - Added sort by Division. Because some of the totals  ; can be done by Division and some cannot, portions of the report  ; were reorganized.  ;  TEST ; - Create and send test bulletin.  N IBBDT,IBEDT,IBSEL,IBTEST  S IBBDT=DT,IBEDT=DT,IBSEL="1,2,3",IBTEST=1  D TESTV  ;  BULL ; - Create and send bulletin.  ;  I '$O(IBUNB(0)) Q ; Quit out if no data.  ;  N I,IBDIV,IBGRP,IBT,IBTOTAL,IBX,IDX,X,XMDUZ,XMN,XMSUB,XMTEXT,XMY,XMZ  S XMSUB="UNBILLED AMOUNTS SUMMARY REPORT"\_$S($G(IBTEST):" (TEST)",1:"")  ;  D BULL1  ;  S IBDIV=0  F S IBDIV=$O(IBUNB(IBDIV)) Q:'IBDIV D BULL2  ;  D BULL3,SEND  ;  Q  ;  BULL1 ; Header for entire report.  ;  S IDX=1  S IBX=$P($$SITE^VASITE,U,2,3)  S IBT(IDX)="SUMMARY UNBILLED AMOUNTS FOR "\_$P(IBX,U)\_" ("\_$P(IBX,U,2)\_").",IDX=IDX+1  S IBT(IDX)="PERIOD: FROM "\_$$DAT1^IBOUTL(IBBDT)\_" TO "\_$$DAT1^IBOUTL(IBEDT),IDX=IDX+1  ;  I $G(IBDET) S IBT(IDX)="DETAILED REPORT PRINTED TO '"\_IO\_"'",IDX=IDX+1  I $G(IBCOMP) S IBT(IDX)="UNBILLED AMOUNTS FIGURES STORED FOR "\_$$DAT2^IBOUTL(IBTIMON),IDX=IDX+1  ;  Q  ;  BULL2 ; Totals for one Division.  ;  I IBDIV=999999 S IBDIVHDR="UNKNOWN"  E S IBDIVHDR=$$GET1^DIQ(40.8,IBDIV\_",",.01)\_" ("\_$$GET1^DIQ(40.8,IBDIV\_",",1)\_")"  S IBT(IDX)="",IDX=IDX+1  S IBT(IDX)=" DIVISION: "\_IBDIVHDR,IDX=IDX+1  S IBT(IDX)="",IDX=IDX+1  ;  I $G(IBTEST) S IBT(IDX)=" \*\*\* TEST DATA, TEST DATA \*\*\*",IDX=IDX+1  ;  I IBSEL[1 D  . S X=$$INPAVG^IBTUBOU(IBTIMON)  . S IBT(IDX+1)=" Inpatient Care:"  . S IBT(IDX+2)=" Number of Unbilled Inpatient Admissions : "\_$J(+$G(IBUNB(IBDIV,"EPISM-A")),11)  . S IBT(IDX+3)=" Number of MRA Unbilled Inpt Admissions : "\_$J(+$G(IBUNB(IBDIV,"EPISM-A-MRA")),11)  . S IBT(IDX+4)=" Number of Inpt. Institutional Cases : "\_$J(+$G(IBUNB(IBDIV,"EPISM-I")),11)  . S IBT(IDX+5)=" Average Inpt. Institutional Bill Amount : "\_$J($P(X,"^"),11,2)  . S IBT(IDX+6)=" Number of Inpt. Professional Cases : "\_$J(+$G(IBUNB(IBDIV,"EPISM-P")),11)  . S IBT(IDX+7)=" Average Inpt. Professional Bill Amount : "\_$J($P(X,"^",2),11,2)  . S IBT(IDX+8)=" Total Unbilled Inpatient Care : "\_$J($G(IBUNB(IBDIV,"UNBILIP")),11,2)  . S IBT(IDX+9)=" Total MRA Unbilled Inpatient Care : "\_$J($G(IBUNB(IBDIV,"UNBILIP-MRA")),11,2)  . S IBT(IDX+10)="",IDX=IDX+10  . Q  ;  I IBSEL[2 D  . S IBT(IDX+1)=" Outpatient Care:"  . S IBT(IDX+2)=" Number of Unbilled Outpatient Cases : "\_$J(+$G(IBUNB(IBDIV,"ENCNTRS")),11)  . S IBT(IDX+3)=" Number of Unbilled CPT Codes : "\_$J(+$G(IBUNB(IBDIV,"CPTMS-I"))+$G(IBUNB(IBDIV,"CPTMS-P")),11)  . S IBT(IDX+4)=" Number of MRA Unbilled CPT Codes : "\_$J(+$G(IBUNB(IBDIV,"CPTMS-I-MRA"))+$G(IBUNB(IBDIV,"CPTMS-P-MRA")),11)  . S IBT(IDX+5)=" Total Unbilled Outpatient Care : "\_$J($G(IBUNB(IBDIV,"UNBILOP")),11,2)  . S IBT(IDX+6)=" Total MRA Unbilled Outpatient Care : "\_$J($G(IBUNB(IBDIV,"UNBILOP-MRA")),11,2)  . S IBT(IDX+7)="",IDX=IDX+7  . Q  ;  I IBSEL[3 D  . S IBT(IDX+1)=" Prescriptions:"  . S IBT(IDX+2)=" Number of Unbilled Prescriptions : "\_$J(+$G(IBUNB(IBDIV,"PRESCRP")),11)  . S IBT(IDX+3)=" Number of MRA Unbilled Prescriptions : "\_$J(+$G(IBUNB(IBDIV,"PRESCRP-MRA")),11)  . S IBT(IDX+4)=" Total Unbilled Prescriptions : "\_$J($G(IBUNB(IBDIV,"UNBILRX")),11,2)  . S IBT(IDX+5)=" Total MRA Unbilled Prescriptions : "\_$J($G(IBUNB(IBDIV,"UNBILRX-MRA")),11,2)  . S IBT(IDX+6)="",IDX=IDX+6  . Q  ;  ; Accumulate grand totals.  ;  S IBTOTAL("EPISM-A")=$G(IBTOTAL("EPISM-A"))+$G(IBUNB(IBDIV,"EPISM-A"))  S IBTOTAL("EPISM-A-MRA")=$G(IBTOTAL("EPISM-A-MRA"))+$G(IBUNB(IBDIV,"EPISM-A-MRA"))  S IBTOTAL("EPISM-I")=$G(IBTOTAL("EPISM-I"))+$G(IBUNB(IBDIV,"EPISM-I"))  S IBTOTAL("EPISM-P")=$G(IBTOTAL("EPISM-P"))+$G(IBUNB(IBDIV,"EPISM-P"))  S IBTOTAL("UNBILIP")=$G(IBTOTAL("UNBILIP"))+$G(IBUNB(IBDIV,"UNBILIP"))  S IBTOTAL("UNBILIP-MRA")=$G(IBTOTAL("UNBILIP-MRA"))+$G(IBUNB(IBDIV,"UNBILIP-MRA"))  S IBTOTAL("ENCNTRS")=$G(IBTOTAL("ENCNTRS"))+$G(IBUNB(IBDIV,"ENCNTRS"))  ;  S IBTOTAL("CPTMS")=$G(IBTOTAL("CPTMS"))+$G(IBUNB(IBDIV,"CPTMS-I"))+$G(IBUNB(IBDIV,"CPTMS-P"))  S IBTOTAL("CPTMS-MRA")=$G(IBTOTAL("CPTMS-MRA"))+$G(IBUNB(IBDIV,"CPTMS-I-MRA"))+$G(IBUNB(IBDIV,"CPTMS-P-MRA"))  ;  S IBTOTAL("UNBILOP")=$G(IBTOTAL("UNBILOP"))+$G(IBUNB(IBDIV,"UNBILOP"))  S IBTOTAL("UNBILOP-MRA")=$G(IBTOTAL("UNBILOP-MRA"))+$G(IBUNB(IBDIV,"UNBILOP-MRA"))  S IBTOTAL("PRESCRP")=$G(IBTOTAL("PRESCRP"))+$G(IBUNB(IBDIV,"PRESCRP"))  S IBTOTAL("PRESCRP-MRA")=$G(IBTOTAL("PRESCRP-MRA"))+$G(IBUNB(IBDIV,"PRESCRP-MRA"))  S IBTOTAL("UNBILRX")=$G(IBTOTAL("UNBILRX"))+$G(IBUNB(IBDIV,"UNBILRX"))  S IBTOTAL("UNBILRX-MRA")=$G(IBTOTAL("UNBILRX-MRA"))+$G(IBUNB(IBDIV,"UNBILRX-MRA"))  ;  Q  ;  BULL3 ; Grand totals across all Divisions and concluding notes.  ;  S IBT(IDX)="",IDX=IDX+1  S IBT(IDX)=" GRAND TOTALS",IDX=IDX+1  S IBT(IDX)="",IDX=IDX+1  ;  I IBSEL[1 D  . S X=$$INPAVG^IBTUBOU(IBTIMON)  . S IBT(IDX+1)=" Inpatient Care:"  . S IBT(IDX+2)=" Number of Unbilled Inpatient Admissions : "\_$J(+$G(IBTOTAL("EPISM-A")),11)  . S IBT(IDX+3)=" Number of MRA Unbilled Inpt Admissions : "\_$J(+$G(IBTOTAL("EPISM-A-MRA")),11)  . S IBT(IDX+4)=" Number of Inpt. Institutional Cases : "\_$J(+$G(IBTOTAL("EPISM-I")),11)  . S IBT(IDX+5)=" Average Inpt. Institutional Bill Amount : "\_$J($P(X,"^"),11,2)  . S IBT(IDX+6)=" Number of Inpt. Professional Cases : "\_$J(+$G(IBTOTAL("EPISM-P")),11)  . S IBT(IDX+7)=" Average Inpt. Professional Bill Amount : "\_$J($P(X,"^",2),11,2)  . S IBT(IDX+8)=" Total Unbilled Inpatient Care : "\_$J($G(IBTOTAL("UNBILIP")),11,2)  . S IBT(IDX+9)=" Total MRA Unbilled Inpatient Care : "\_$J($G(IBTOTAL("UNBILIP-MRA")),11,2)  . S IBT(IDX+10)="",IDX=IDX+10  . Q  ;  I IBSEL[2 D  . S IBT(IDX+1)=" Outpatient Care:"  . S IBT(IDX+2)=" Number of Unbilled Outpatient Cases : "\_$J(+$G(IBTOTAL("ENCNTRS")),11)  . S IBT(IDX+3)=" Number of Unbilled CPT Codes : "\_$J(+$G(IBTOTAL("CPTMS")),11)  . S IBT(IDX+4)=" Number of MRA Unbilled CPT Codes : "\_$J(+$G(IBTOTAL("CPTMS-MRA")),11)  . S IBT(IDX+5)=" Total Unbilled Outpatient Care : "\_$J($G(IBTOTAL("UNBILOP")),11,2)  . S IBT(IDX+6)=" Total MRA Unbilled Outpatient Care : "\_$J($G(IBTOTAL("UNBILOP-MRA")),11,2)  . S IBT(IDX+7)="",IDX=IDX+7  . Q  ;  I IBSEL[3 D  . S IBT(IDX+1)=" Prescriptions:"  . S IBT(IDX+2)=" Number of Unbilled Prescriptions : "\_$J(+$G(IBTOTAL("PRESCRP")),11)  . S IBT(IDX+3)=" Number of MRA Unbilled Prescriptions : "\_$J(+$G(IBTOTAL("PRESCRP-MRA")),11)  . S IBT(IDX+4)=" Total Unbilled Prescriptions : "\_$J($G(IBTOTAL("UNBILRX")),11,2)  . S IBT(IDX+5)=" Total MRA Unbilled Prescriptions : "\_$J($G(IBTOTAL("UNBILRX-MRA")),11,2)  . S IBT(IDX+6)="",IDX=IDX+6  . Q  ;  I IBSEL="1,2,3" D  . S IBT(IDX+1)=" Total Unbilled Amount (all care) : "\_$J($G(IBUNB("UNBILTL")),11,2)  . S IBT(IDX+2)=" Total MRA Unbilled Amount (all care) : "\_$J($G(IBUNB("UNBILTL-MRA")),11,2)  . S IDX(IDX+3)="",IDX=IDX+3  . Q  ;  S IBT(IDX+1)="",IDX=IDX+1  ;  I IBSEL[1 D  . S IBT(IDX+1)="Note: Average bill Amount is based on Bills Authorized during the 12"  . S IBT(IDX+2)=" months preceding the month of this report."  . S IDX=IDX+2  . Q  ;  S IBT(IDX+1)="Note: Number of cases is insured cases in Claims Tracking that are"  S IBT(IDX+2)=" not billed (or bill not authorized/req MRA) but appear to be billable."  ;  Q | | | | | | | | | | |
| Modified Logic (Changes are in bold) | | | | | | | | | | |
| IBTUBUL ;ALB/AAS - UNBILLED AMOUNTS ;29-SEP-94  ;;2.0;INTEGRATED BILLING;\*\*19,123,159,217,155,356,516\*\*;21-MAR-94  ;;Per VA Directive 6402, this routine should not be modified.  ;  ; IB\*2.0\*516 - Added sort by Division. Because some of the totals  ; can be done by Division and some cannot, portions of the report  ; were reorganized.  ;  TEST ; - Create and send test bulletin.  N IBBDT,IBEDT,IBSEL,IBTEST  S IBBDT=DT,IBEDT=DT,IBSEL="1,2,3",IBTEST=1  D TESTV  ;  BULL ; - Create and send bulletin.  ;  I '$O(IBUNB(0)) Q ; Quit out if no data.  ;  N I,IBDIV,IBGRP,IBT,IBTOTAL,IBX,IDX,X,XMDUZ,XMN,XMSUB,XMTEXT,XMY,XMZ  S XMSUB="UNBILLED AMOUNTS SUMMARY REPORT"\_$S($G(IBTEST):" (TEST)",1:"")  ;  D BULL1  ;  **D SUMMARY**  **;**  S IBDIV=0  F S IBDIV=$O(IBUNB(IBDIV)) Q:'IBDIV D BULL2  ;  D BULL3,SEND  ;  Q  ;  **;**  **SUMMARY ; Compile the grand totals, print summary section.**  **;**  **N IBCNT**  **S IBCNT=0**  **;**  **; Count how many Divisions have data. If there is**  **; not more than one, then Quit out – do not print**  **; the grand total summary section.**  **;**  **S IBDIV=0**  **F S IBDIV=$O(IBUNB(IBDIV)) Q:’IBDIV S IBCNT=IBCNT+1**  **I IBCNT<2 Q**  **;**  **; Accumulate grand totals.**  **;**  **S IBDIV=0**  **F S IBDIV=$O(IBUNB(IBDIV)) Q:’IBDIV D**  **. S IBTOTAL("EPISM-A")=$G(IBTOTAL("EPISM-A"))+$G(IBUNB(IBDIV,"EPISM-A"))**  **. S IBTOTAL("EPISM-A-MRA")=$G(IBTOTAL("EPISM-A-MRA"))+$G(IBUNB(IBDIV,"EPISM-A-MRA"))**  **. S IBTOTAL("EPISM-I")=$G(IBTOTAL("EPISM-I"))+$G(IBUNB(IBDIV,"EPISM-I"))**  **. S IBTOTAL("EPISM-P")=$G(IBTOTAL("EPISM-P"))+$G(IBUNB(IBDIV,"EPISM-P"))**  **. S IBTOTAL("UNBILIP")=$G(IBTOTAL("UNBILIP"))+$G(IBUNB(IBDIV,"UNBILIP"))**  **. S IBTOTAL("UNBILIP-MRA")=$G(IBTOTAL("UNBILIP-MRA"))+$G(IBUNB(IBDIV,"UNBILIP-MRA"))**  **. S IBTOTAL("ENCNTRS")=$G(IBTOTAL("ENCNTRS"))+$G(IBUNB(IBDIV,"ENCNTRS"))**  **. ;**  **. S IBTOTAL("CPTMS")=$G(IBTOTAL("CPTMS"))+$G(IBUNB(IBDIV,"CPTMS-I"))+$G(IBUNB(IBDIV,"CPTMS-P"))**  **. S IBTOTAL("CPTMS-MRA")=$G(IBTOTAL("CPTMS-MRA"))+$G(IBUNB(IBDIV,"CPTMS-I-MRA"))+$G(IBUNB(IBDIV,"CPTMS-P-MRA"))**  **. ;**  **. S IBTOTAL("UNBILOP")=$G(IBTOTAL("UNBILOP"))+$G(IBUNB(IBDIV,"UNBILOP"))**  **. S IBTOTAL("UNBILOP-MRA")=$G(IBTOTAL("UNBILOP-MRA"))+$G(IBUNB(IBDIV,"UNBILOP-MRA"))**  **. S IBTOTAL("PRESCRP")=$G(IBTOTAL("PRESCRP"))+$G(IBUNB(IBDIV,"PRESCRP"))**  **. S IBTOTAL("PRESCRP-MRA")=$G(IBTOTAL("PRESCRP-MRA"))+$G(IBUNB(IBDIV,"PRESCRP-MRA"))**  **. S IBTOTAL("UNBILRX")=$G(IBTOTAL("UNBILRX"))+$G(IBUNB(IBDIV,"UNBILRX"))**  **. S IBTOTAL("UNBILRX-MRA")=$G(IBTOTAL("UNBILRX-MRA"))+$G(IBUNB(IBDIV,"UNBILRX-MRA"))**  **. ;**  **. Q**  **;**  **; Display grand totals.**  **;**  **S IBT(IDX)="",IDX=IDX+1**  **S IBT(IDX)=" GRAND TOTALS",IDX=IDX+1**  **S IBT(IDX)="",IDX=IDX+1**  **;**  **I IBSEL[1 D**  **. S X=$$INPAVG^IBTUBOU(IBTIMON)**  **. S IBT(IDX+1)=" Inpatient Care:"**  **. S IBT(IDX+2)=" Number of Unbilled Inpatient Admissions : "\_$J(+$G(IBTOTAL("EPISM-A")),11)**  **. S IBT(IDX+3)=" Number of MRA Unbilled Inpt Admissions : "\_$J(+$G(IBTOTAL("EPISM-A-MRA")),11)**  **. S IBT(IDX+4)=" Number of Inpt. Institutional Cases : "\_$J(+$G(IBTOTAL("EPISM-I")),11)**  **. S IBT(IDX+5)=" Average Inpt. Institutional Bill Amount : "\_$J($P(X,"^"),11,2)**  **. S IBT(IDX+6)=" Number of Inpt. Professional Cases : "\_$J(+$G(IBTOTAL("EPISM-P")),11)**  **. S IBT(IDX+7)=" Average Inpt. Professional Bill Amount : "\_$J($P(X,"^",2),11,2)**  **. S IBT(IDX+8)=" Total Unbilled Inpatient Care : "\_$J($G(IBTOTAL("UNBILIP")),11,2)**  **. S IBT(IDX+9)=" Total MRA Unbilled Inpatient Care : "\_$J($G(IBTOTAL("UNBILIP-MRA")),11,2)**  **. S IBT(IDX+10)="",IDX=IDX+10**  **. Q**  **;**  **I IBSEL[2 D**  **. S IBT(IDX+1)=" Outpatient Care:"**  **. S IBT(IDX+2)=" Number of Unbilled Outpatient Cases : "\_$J(+$G(IBTOTAL("ENCNTRS")),11)**  **. S IBT(IDX+3)=" Number of Unbilled CPT Codes : "\_$J(+$G(IBTOTAL("CPTMS")),11)**  **. S IBT(IDX+4)=" Number of MRA Unbilled CPT Codes : "\_$J(+$G(IBTOTAL("CPTMS-MRA")),11)**  **. S IBT(IDX+5)=" Total Unbilled Outpatient Care : "\_$J($G(IBTOTAL("UNBILOP")),11,2)**  **. S IBT(IDX+6)=" Total MRA Unbilled Outpatient Care : "\_$J($G(IBTOTAL("UNBILOP-MRA")),11,2)**  **. S IBT(IDX+7)="",IDX=IDX+7**  **. Q**  **;**  **I IBSEL[3 D**  **. S IBT(IDX+1)=" Prescriptions:"**  **. S IBT(IDX+2)=" Number of Unbilled Prescriptions : "\_$J(+$G(IBTOTAL("PRESCRP")),11)**  **. S IBT(IDX+3)=" Number of MRA Unbilled Prescriptions : "\_$J(+$G(IBTOTAL("PRESCRP-MRA")),11)**  **. S IBT(IDX+4)=" Total Unbilled Prescriptions : "\_$J($G(IBTOTAL("UNBILRX")),11,2)**  **. S IBT(IDX+5)=" Total MRA Unbilled Prescriptions : "\_$J($G(IBTOTAL("UNBILRX-MRA")),11,2)**  **. S IBT(IDX+6)="",IDX=IDX+6**  **. Q**  **;**  **Q**  ;  BULL1 ; Header for entire report.  ;  S IDX=1  S IBX=$P($$SITE^VASITE,U,2,3)  S IBT(IDX)="SUMMARY UNBILLED AMOUNTS FOR "\_$P(IBX,U)\_" ("\_$P(IBX,U,2)\_").",IDX=IDX+1  S IBT(IDX)="PERIOD: FROM "\_$$DAT1^IBOUTL(IBBDT)\_" TO "\_$$DAT1^IBOUTL(IBEDT),IDX=IDX+1  ;  I $G(IBDET) S IBT(IDX)="DETAILED REPORT PRINTED TO '"\_IO\_"'",IDX=IDX+1  I $G(IBCOMP) S IBT(IDX)="UNBILLED AMOUNTS FIGURES STORED FOR "\_$$DAT2^IBOUTL(IBTIMON),IDX=IDX+1  ;  Q  ;  BULL2 ; Totals for one Division.  ;  **; IBDIV may be 999999 for two reasons – either data was**  **; found for which the Division could not be determined,**  **; in which case the Division will be displayed as ‘UNKNOWN’,**  **; or the user opted NOT to sort by Division, in which**  **; case all the data is beneath the 999999 Division and**  **; the Division should be displayed as ‘ALL’.**  **;**  I IBDIV=999999 S IBDIVHDR=**$S(‘IBSBD:”ALL”,1:"UNKNOWN")**  E S IBDIVHDR=$$GET1^DIQ(40.8,IBDIV\_",",.01)\_" ("\_$$GET1^DIQ(40.8,IBDIV\_",",1)\_")"  S IBT(IDX)="",IDX=IDX+1  S IBT(IDX)=" DIVISION: "\_IBDIVHDR,IDX=IDX+1  S IBT(IDX)="",IDX=IDX+1  ;  I $G(IBTEST) S IBT(IDX)=" \*\*\* TEST DATA, TEST DATA \*\*\*",IDX=IDX+1  ;  I IBSEL[1 D  . S X=$$INPAVG^IBTUBOU(IBTIMON)  . S IBT(IDX+1)=" Inpatient Care:"  . S IBT(IDX+2)=" Number of Unbilled Inpatient Admissions : "\_$J(+$G(IBUNB(IBDIV,"EPISM-A")),11)  . S IBT(IDX+3)=" Number of MRA Unbilled Inpt Admissions : "\_$J(+$G(IBUNB(IBDIV,"EPISM-A-MRA")),11)  . S IBT(IDX+4)=" Number of Inpt. Institutional Cases : "\_$J(+$G(IBUNB(IBDIV,"EPISM-I")),11)  . S IBT(IDX+5)=" Average Inpt. Institutional Bill Amount : "\_$J($P(X,"^"),11,2)  . S IBT(IDX+6)=" Number of Inpt. Professional Cases : "\_$J(+$G(IBUNB(IBDIV,"EPISM-P")),11)  . S IBT(IDX+7)=" Average Inpt. Professional Bill Amount : "\_$J($P(X,"^",2),11,2)  . S IBT(IDX+8)=" Total Unbilled Inpatient Care : "\_$J($G(IBUNB(IBDIV,"UNBILIP")),11,2)  . S IBT(IDX+9)=" Total MRA Unbilled Inpatient Care : "\_$J($G(IBUNB(IBDIV,"UNBILIP-MRA")),11,2)  . S IBT(IDX+10)="",IDX=IDX+10  . Q  ;  I IBSEL[2 D  . S IBT(IDX+1)=" Outpatient Care:"  . S IBT(IDX+2)=" Number of Unbilled Outpatient Cases : "\_$J(+$G(IBUNB(IBDIV,"ENCNTRS")),11)  . S IBT(IDX+3)=" Number of Unbilled CPT Codes : "\_$J(+$G(IBUNB(IBDIV,"CPTMS-I"))+$G(IBUNB(IBDIV,"CPTMS-P")),11)  . S IBT(IDX+4)=" Number of MRA Unbilled CPT Codes : "\_$J(+$G(IBUNB(IBDIV,"CPTMS-I-MRA"))+$G(IBUNB(IBDIV,"CPTMS-P-MRA")),11)  . S IBT(IDX+5)=" Total Unbilled Outpatient Care : "\_$J($G(IBUNB(IBDIV,"UNBILOP")),11,2)  . S IBT(IDX+6)=" Total MRA Unbilled Outpatient Care : "\_$J($G(IBUNB(IBDIV,"UNBILOP-MRA")),11,2)  . S IBT(IDX+7)="",IDX=IDX+7  . Q  ;  I IBSEL[3 D  . S IBT(IDX+1)=" Prescriptions:"  . S IBT(IDX+2)=" Number of Unbilled Prescriptions : "\_$J(+$G(IBUNB(IBDIV,"PRESCRP")),11)  . S IBT(IDX+3)=" Number of MRA Unbilled Prescriptions : "\_$J(+$G(IBUNB(IBDIV,"PRESCRP-MRA")),11)  . S IBT(IDX+4)=" Total Unbilled Prescriptions : "\_$J($G(IBUNB(IBDIV,"UNBILRX")),11,2)  . S IBT(IDX+5)=" Total MRA Unbilled Prescriptions : "\_$J($G(IBUNB(IBDIV,"UNBILRX-MRA")),11,2)  . S IBT(IDX+6)="",IDX=IDX+6  . Q  ;  Q  ;  BULL3 ; **Concluding notes.**  ;  I IBSEL="1,2,3" D  . S IBT(IDX+1)=" Total Unbilled Amount (all care) : "\_$J($G(IBUNB("UNBILTL")),11,2)  . S IBT(IDX+2)=" Total MRA Unbilled Amount (all care) : "\_$J($G(IBUNB("UNBILTL-MRA")),11,2)  . S IDX(IDX+3)="",IDX=IDX+3  . Q  ;  S IBT(IDX+1)="",IDX=IDX+1  ;  I IBSEL[1 D  . S IBT(IDX+1)="Note: Average bill Amount is based on Bills Authorized during the 12"  . S IBT(IDX+2)=" months preceding the month of this report."  . S IDX=IDX+2  . Q  ;  S IBT(IDX+1)="Note: Number of cases is insured cases in Claims Tracking that are"  S IBT(IDX+2)=" not billed (or bill not authorized/req MRA) but appear to be billable."  ;  Q | | | | | | | | | | |

##### System Feature: Copy and Cancel (CLON)

###### Functional Requirement: Copy and Cancel – COB Data

The IB system shall automatically copy the prior Coordination of Benefits (COB) payment data from previous payers to the new claim when users cancel and copy a claim in the following situations:

* Primary commercial claim with Explanation of Benefits (EOB) with payment – primary COB/no copy
* Secondary commercial claim with EOB without payment – primary and secondary COB/copy
* Secondary commercial claim with EOB with payment – primary and secondary COB/copy
* Secondary commercial claim with no EOB – primary COB/no secondary COB/copy primary
* Primary Medicare claim with MRA with payment – Primary COB/no copy
* Secondary Medicare claim with MRA without payment – primary and secondary COB/copy
* Secondary Medicare claim with MRA with payment – primary and secondary COB/copy
* Secondary Medicare claim with no MRA – primary COB/no secondary COB/copy primary (BN 13.1)

Further clarification from the customer: When transmitting a CLONed secondary or tertiary claim, the system shall continue to not send COB data for the current payer but **continue to send the COB data for all prior payers**. Transmitting a cloned secondary claim should include COB data from the primary claim and transmitting a cloned tertiary claim should include COB data from the primary and secondary claims.

**Routines (Entry Points):**

| Routine Name | IBCCC2 | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Enhancement Category | New | | Modify | Delete | | | | No Change | |
| Requirement Traceability Matrix | 2.6.11.1 | | | | | | | | |
| Related Options | IB COPY AND CANCEL | | | | | | | | |
| Related Routines | Routines “Called By” | | | | Routines “Called” | | | | |
| IBCC  IBCB11  IBCCC1  IBCCCB  IBNCPDP5 | | | | FILE^DICN  ^DIE  IX1^DIK  RECALL^DILFD  FORCEPRT^IBCAPP  ^IBCB1  ^IBCCC3  COPYB^IBCDC  $$COB^IBCEF  $$COBN^IBCEF  $$FT^IBCEF  $$GETNPI^IBCEF73A  $$CHK^IBCEMU1  FTPRV^IBCEU5  BILL^IBCRBC  ^IBCSC1  ^IBCSCU  CPTMOD26^IBCU73  PROC^IBCU7A  $$GETSPEC^IBEFUNC  $$MCRWNR^IBEFUNC  $$REQMRA^IBEFUNC  $$MOD^ICPTMOD | | | | |
| Data Dictionary (DD) References | NONE | | | | | | | | |
| Related Protocols | NONE | | | | | | | | |
| Related Integration Control Registrations (ICRs) | NONE | | | | | | | | |
| Data Passing | Input | Output Reference | | | | Both | Global Reference | | Local |
| Input Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Output Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Current Logic | | | | | | | | | |
| IBCCC2 ;ALB/AAS - CANCEL AND CLONE A BILL - CONTINUED ;6/6/03 9:56am  ;;2.0;INTEGRATED BILLING;\*\*80,106,124,138,51,151,137,161,182,211,245,15  5,296,320,348,349,371,400,433,432,447,516\*\*;21-MAR-94;Build 123  ;;Per VA Directive 6402, this routine should not be modified.  ;  ;MAP TO DGCRCC2  ;  ;STEP 5 - get remainder of data to move and store in MCCR then x-ref  ;STEP 6 - go to screens, come out to IBB1 or something like that  ;  STEP5 S IBIFN1=$P(^DGCR(399,IBIFN,0),"^",15) G END:$S(IBIFN1="":1,'$D(^DGCR(3  99,IBIFN1,0)):1,1:0)  ; NOTE: any new or changed data nodes may also need to be updated in IBNCPDP5  ;move pure data nodes  ; MRD;IB\*2.0\*516 - Added "In7" nodes.  F I="I1","I17","I2","I27","I3","I37","M1" I $D(^DGCR(399,IBIFN1,I)) S ^ DGCR(399,IBIFN,I)=^DGCR(399,IBIFN1,I)  ;  ;move top level data node. ;Do not move 'TX' node EXCEPT piece 8 (added with IB\*2.0\*432)  ;F I="U","U1","U2","U3","UF2","UF3","UF31","C","M" I $D(^DGCR(399,IBIFN1,I)) S IBND(I)=^(I) D @I  ; add new data nodes introduced with IB\*2.0\*432  F I="TX","U","U1","U2","U3","U4","U5","U6","U7","U8","UF2","UF3","UF31","UF32","C","M" I $D(^DGCR(399,IBIFN1,I)) S IBND(I)=^(I) D @I  ;  ;move multiple level data  ;F I="CC","OC","OP","OT","RC","CP","CV","PRV" I $D(^DGCR(399,IBIFN1,I,0)) D @I  ; add new data nodes introduced with IB\*2.0\*447 BI  F I="CC","OC","OP","OT","RC","CP","CV","PRV","U9" I $D(^DGCR(399,IBIFN1,I,0)) D @I  ;  ; IB\*2.0\*432 ADDED IBSILENT flag so that this can be processed in background  D FTPRV^IBCEU5(IBIFN,$G(IBSILENT)) ; Ask change prov type if form type not the same  D COBCHG(IBIFN,,.IBCOB)  ;  D ^IBCCC3 ; copy table files (362.3)  ;  S I=$G(^DGCR(399,IBIFN1,0)) I $P(I,U,13)=7,$P(I,U,20)=1 D COPYB^IBCDC(I BIFN1,IBIFN) ; update auto bill files  D PRIOR(IBIFN) ; add new bill to previous bills in series, primary/secondary  ;  I +$G(IBCTCOPY) N IBAUTO S IBAUTO=1 D PROC^IBCU7A(IBIFN),BILL^IBCRBC(IB  IFN),CPTMOD26^IBCU73(IBIFN) D RECALL^DILFD(399,IBIFN\_",",DUZ) G END  ;  STEP6 N IBGOEND  ; need to kill CRD flag prior to entering billing screens in case a copy for corresponding claim is needed  K IBCNCRD  ; don't call IB bill edit screens if this is non-MRA background processing  I $G(IBSTSM)=1 G END  I '$G(IBCE("EDI"))!$G(IBCE("EDI","NEW")),'$G(IBCEAUTO) D IBSCEDT G END:  $G(IBGOEND)  ;  ;  END K DFN,IB,IBA,IBA2,IBAD,IBADD1,IBBNO,IBCAN,IBCCC,IBDA,IBDPT,IBDR,IBDT,IB  I,IBI1,IBIDS,IBIFN,IBIFN1,IBND,IBQUIT,IBU,IBUN,IBARST,IBCOB,IBCNCOPY,IBCBCOPY,IB  CNCRD,IBKEY  K IBV,IBV1,IBW,IBWW,IBYN,IBZZ,PRCASV,PRCAERCD,PRCAERR,PRCASVC,PRCAT,IBB  T,IBCH,IBNDS,IBOA,IBREV,IBX,DGXRF1,VAEL,VAERR,IBAC,IBCCC,IBDD1,IBIN,DGREV,DGREV00,DGREVHDR,IBCHK  K IBBS,IBLS,DGPCM,IBIP,IBND0,IBNDU,IBO,IBPTF,IBST,IBUC,IBDD,D,%,%DT,DIC  ,VA,VADM,X,X1,X2,X3,X4,Y,I,J,K,DGRVRCAL,DDH,DGACTDT,DGAMNT,DGBR,DGBRN,DGBSI,DGBSLOS,IBA1,IBOD,IBINS,IBN,IBPROC,DGFUNC,DGIFN  Q  ;  ;  IBSCEDT ; call the IB bill edit screens and validate the data  N IBV,IBPAR,IBAC,IBHV,IBH,IBCIREDT  ; if the user came from CBW->PC and this is a non-MRA claim w/a paper EOB, set force print flag IB\*2.0\*432  ; also, if the user came from CBW->PC and this is a non-MRA claim and the only EEOB we have has filing errors, set force print flagon't copy value codes from inpatient inst to inpatient prof billsadd new 1 node  . F K=1:1:5 S $P(^DGCR(399,IBIFN,I,J,1),"^",K)=$P(IBND("CP1"),"^",K)  . ; esg - 11/2/06 - IB\*2\*348 - 50.09 field was added - AUX piece [9]  . I IBND("CP-AUX")'="" F K=1:1:9 S $P(^DGCR(399,IBIFN,I,J,"AUX"),"^",K) =$P(IBND("CP-AUX"),"^",K)  . ; IB\*2.0\*432 add new LNPRV multiple  . I $D(^DGCR(399,IBIFN1,I,J,"LNPRV",0)) S ^DGCR(399,IBIFN,I,J,"LNPRV",0 )=^DGCR(399,IBIFN1,I,J,"LNPRV",0) D  .. S K=0 F S K=$O(^DGCR(399,IBIFN1,I,J,"LNPRV",K)) Q:'K D  ... S ^DGCR(399,IBIFN,I,J,"LNPRV",K,0)=^DGCR(399,IBIFN1,I,J,"LNPRV",K,0)  . I $D(^DGCR(399,IBIFN1,I,J,"MOD",0)) S ^DGCR(399,IBIFN,I,J,"MOD",0)=^D GCR(399,IBIFN1,I,J,"MOD",0) D  .. S K=0 F S K=$O(^DGCR(399,IBIFN1,I,J,"MOD",K)) Q:'K D  ... I $G(IBNOTC),$P($$MOD^ICPTMOD(+$P($G(^DGCR(399,IBIFN1,I,J,"MOD",K,0  )),U,2),"I"),U,2)="TC" Q ; Don't copy TC modifier from inst to prof billdded for new data elements in IB\*2.0\*447 BI  M ^DGCR(399,IBIFN,I)=^DGCR(399,IBIFN1,I)  Q  ;  COB S J=0 F S J=$O(IBCOB(I,J)) Q:'J S $P(^DGCR(399,IBIFN,I),U,J)=IBCOB(I,J)  Q  ;  FILE N DIC,DIE,DR,DA,X,Y,DLAYGO,DD,DO  I '$D(^DGCR(399,IBIFN,"CP",0)) S DIC("P")=$$GETSPEC^IBEFUNC(399,304)  S DIC(0)="L",DLAYGO=399,DA(1)=IBIFN,DIC="^DGCR(399,"\_DA(1)\_",""CP""," Q:X="" D FILE^DICN K DO,DD Q:+Y<1 S DA=+Y  S DIE="^DGCR(399,"\_DA(1)\_",""CP"",",DR="1///"\_DGPROCDT D ^DIE  K DGPROCDT  Q  ;  INDEX ;index entire file (set logic)  N IBMAED D SAVERC(IBIFN,.IBMAED) ; IB\*2.0\*447 BI - Save the value of piece 16 of each RC node before re-indexing.  S DIK="^DGCR(399,",DA=IBIFN D IX1^DIK K DA,DIK  D RESTRC(IBIFN,.IBMAED) ; IB\*2.0\*447 BI - Restore the value of piece 16 of each RC node before re-indexing.  Q  ;  PRIOR(IBIFN) ; set Secondary/Tertiary Bill #s on prior bills, if the bill is cancelled remove it from prior bills  N IBSEQ,IBSEQN,IBM1,I,IBIFN1  S IBSEQ=$$COB^IBCEF(IBIFN)  S IBSEQN=$S(IBSEQ="S":6,IBSEQ="T":7,1:"") Q:'IBSEQN  ;  S IBM1=$G(^DGCR(399,IBIFN,"M1")) I +$P(^DGCR(399,IBIFN,0),U,13)=7 S IBIFN=""  F I=5,6 I I<IBSEQN S IBIFN1=+$P(IBM1,U,I) I +IBIFN1,$D(^DGCR(399,+IBIF  N1,0)) S $P(^DGCR(399,IBIFN1,"M1"),U,IBSEQN)=IBIFN  Q  ; | | | | | | | | | |
| Modified Logic (Changes are in bold) | | | | | | | | | |
| IBCCC2 ;ALB/AAS - CANCEL AND CLONE A BILL - CONTINUED ;6/6/03 9:56am  ;;2.0;INTEGRATED BILLING;\*\*80,106,124,138,51,151,137,161,182,211,245,15  5,296,320,348,349,371,400,433,432,447,516\*\*;21-MAR-94;Build 123  ;;Per VA Directive 6402, this routine should not be modified.  ;  ;MAP TO DGCRCC2  ;  ;STEP 5 - get remainder of data to move and store in MCCR then x-ref  ;STEP 6 - go to screens, come out to IBB1 or something like that  ;  STEP5 S IBIFN1=$P(^DGCR(399,IBIFN,0),"^",15) G END:$S(IBIFN1="":1,'$D(^DGCR(3  99,IBIFN1,0)):1,1:0)  ; NOTE: any new or changed data nodes may also need to be updated in IBNCPDP5  ;move pure data nodes  ; MRD;IB\*2.0\*516 - Added "In7" nodes.  F I="I1","I17","I2","I27","I3","I37","M1" I $D(^DGCR(399,IBIFN1,I)) S ^ DGCR(399,IBIFN,I)=^DGCR(399,IBIFN1,I)  ;  ;move top level data node. ;Do not move 'TX' node EXCEPT piece 8 (added with IB\*2.0\*432)  ;F I="U","U1","U2","U3","UF2","UF3","UF31","C","M" I $D(^DGCR(399,IBIFN1,I)) S IBND(I)=^(I) D @I  ; add new data nodes introduced with IB\*2.0\*432  F I="TX","U","U1","U2","U3","U4","U5","U6","U7","U8","UF2","UF3","UF31","UF32","C","M" I $D(^DGCR(399,IBIFN1,I)) S IBND(I)=^(I) D @I  ;  ;move multiple level data  ;F I="CC","OC","OP","OT","RC","CP","CV","PRV" I $D(^DGCR(399,IBIFN1,I,0)) D @I  ; add new data nodes introduced with IB\*2.0\*447 BI  F I="CC","OC","OP","OT","RC","CP","CV","PRV","U9" I $D(^DGCR(399,IBIFN1,I,0)) D @I  ;  ; IB\*2.0\*432 ADDED IBSILENT flag so that this can be processed in background  D FTPRV^IBCEU5(IBIFN,$G(IBSILENT)) ; Ask change prov type if form type not the same  D COBCHG(IBIFN,,.IBCOB)  ;  D ^IBCCC3 ; copy table files (362.3)  ;  S I=$G(^DGCR(399,IBIFN1,0)) I $P(I,U,13)=7,$P(I,U,20)=1 D COPYB^IBCDC(I BIFN1,IBIFN) ; update auto bill files  D PRIOR(IBIFN) ; add new bill to previous bills in series, primary/secondary  ;  I +$G(IBCTCOPY) N IBAUTO S IBAUTO=1 D PROC^IBCU7A(IBIFN),BILL^IBCRBC(IB  IFN),CPTMOD26^IBCU73(IBIFN) D RECALL^DILFD(399,IBIFN\_",",DUZ) G END  ;  STEP6 N IBGOEND  ; need to kill CRD flag prior to entering billing screens in case a copy for corresponding claim is needed  K IBCNCRD  ; don't call IB bill edit screens if this is non-MRA background processing  I $G(IBSTSM)=1 G END  I '$G(IBCE("EDI"))!$G(IBCE("EDI","NEW")),'$G(IBCEAUTO) D IBSCEDT G END:  $G(IBGOEND)  ;  ;  END K DFN,IB,IBA,IBA2,IBAD,IBADD1,IBBNO,IBCAN,IBCCC,IBDA,IBDPT,IBDR,IBDT,IB  I,IBI1,IBIDS,IBIFN,IBIFN1,IBND,IBQUIT,IBU,IBUN,IBARST,IBCOB,IBCNCOPY,IBCBCOPY,IB  CNCRD,IBKEY  K IBV,IBV1,IBW,IBWW,IBYN,IBZZ,PRCASV,PRCAERCD,PRCAERR,PRCASVC,PRCAT,IBB  T,IBCH,IBNDS,IBOA,IBREV,IBX,DGXRF1,VAEL,VAERR,IBAC,IBCCC,IBDD1,IBIN,DGREV,DGREV00,DGREVHDR,IBCHK  K IBBS,IBLS,DGPCM,IBIP,IBND0,IBNDU,IBO,IBPTF,IBST,IBUC,IBDD,D,%,%DT,DIC  ,VA,VADM,X,X1,X2,X3,X4,Y,I,J,K,DGRVRCAL,DDH,DGACTDT,DGAMNT,DGBR,DGBRN,DGBSI,DGBSLOS,IBA1,IBOD,IBINS,IBN,IBPROC,DGFUNC,DGIFN  Q  ;  ;  IBSCEDT ; call the IB bill edit screens and validate the data  N IBV,IBPAR,IBAC,IBHV,IBH,IBCIREDT  ; if the user came from CBW->PC and this is a non-MRA claim w/a paper EOB, set force print flag IB\*2.0\*432  ; also, if the user came from CBW->PC and this is a non-MRA claim and the only EEOB we have has filing errors, set force print flagon't copy value codes from inpatient inst to inpatient prof billsadd new 1 node  . F K=1:1:5 S $P(^DGCR(399,IBIFN,I,J,1),"^",K)=$P(IBND("CP1"),"^",K)  . ; esg - 11/2/06 - IB\*2\*348 - 50.09 field was added - AUX piece [9]  . I IBND("CP-AUX")'="" F K=1:1:9 S $P(^DGCR(399,IBIFN,I,J,"AUX"),"^",K) =$P(IBND("CP-AUX"),"^",K)  . ; IB\*2.0\*432 add new LNPRV multiple  . I $D(^DGCR(399,IBIFN1,I,J,"LNPRV",0)) S ^DGCR(399,IBIFN,I,J,"LNPRV",0 )=^DGCR(399,IBIFN1,I,J,"LNPRV",0) D  .. S K=0 F S K=$O(^DGCR(399,IBIFN1,I,J,"LNPRV",K)) Q:'K D  ... S ^DGCR(399,IBIFN,I,J,"LNPRV",K,0)=^DGCR(399,IBIFN1,I,J,"LNPRV",K,0)  . I $D(^DGCR(399,IBIFN1,I,J,"MOD",0)) S ^DGCR(399,IBIFN,I,J,"MOD",0)=^D GCR(399,IBIFN1,I,J,"MOD",0) D  .. S K=0 F S K=$O(^DGCR(399,IBIFN1,I,J,"MOD",K)) Q:'K D  ... I $G(IBNOTC),$P($$MOD^ICPTMOD(+$P($G(^DGCR(399,IBIFN1,I,J,"MOD",K,0  )),U,2),"I"),U,2)="TC" Q ; Don't copy TC modifier from inst to prof billdded for new data elements in IB\*2.0\*447 BI  M ^DGCR(399,IBIFN,I)=^DGCR(399,IBIFN1,I)  Q  ;  COB S J=0 F S J=$O(IBCOB(I,J)) Q:'J S $P(^DGCR(399,IBIFN,I),U,J)=IBCOB(I,J)  Q  ;  FILE N DIC,DIE,DR,DA,X,Y,DLAYGO,DD,DO  I '$D(^DGCR(399,IBIFN,"CP",0)) S DIC("P")=$$GETSPEC^IBEFUNC(399,304)  S DIC(0)="L",DLAYGO=399,DA(1)=IBIFN,DIC="^DGCR(399,"\_DA(1)\_",""CP""," Q:X="" D FILE^DICN K DO,DD Q:+Y<1 S DA=+Y  S DIE="^DGCR(399,"\_DA(1)\_",""CP"",",DR="1///"\_DGPROCDT D ^DIE  K DGPROCDT  Q  ;  INDEX ;index entire file (set logic)  N IBMAED D SAVERC(IBIFN,.IBMAED) ; IB\*2.0\*447 BI - Save the value of piece 16 of each RC node before re-indexing.  S DIK="^DGCR(399,",DA=IBIFN D IX1^DIK K DA,DIK  D RESTRC(IBIFN,.IBMAED) ; IB\*2.0\*447 BI - Restore the value of piece 16 of each RC node before re-indexing.  Q  ;  PRIOR(IBIFN) ; set Secondary/Tertiary Bill #s on prior bills, if the bill is cancelled remove it from prior bills  **; ib\*2.0\*547: Make sure this code handles these scenarios:**  **;** **When transmitting a CLONed secondary or tertiary claim, the system shall continue to not send COB data for the current payer but continue to send the COB data for all prior payers.  Ie. transmitting a cloned secondary claim should include COB data from the primary claim and transmitting a cloned tertiary claim should include COB data from the primary and secondary claims. The transmit process relies on the data in piece 5,6 & 7 of the M1 node**  **;**  N IBSEQ,IBSEQN,IBM1,I,IBIFN1  S IBSEQ=$$COB^IBCEF(IBIFN)  S IBSEQN=$S(IBSEQ="S":6,IBSEQ="T":7,1:"") Q:'IBSEQN  ;  S IBM1=$G(^DGCR(399,IBIFN,"M1")) I +$P(^DGCR(399,IBIFN,0),U,13)=7 S IBIFN=""  F I=5,6 I I<IBSEQN S IBIFN1=+$P(IBM1,U,I) I +IBIFN1,$D(^DGCR(399,+IBIF  N1,0)) S $P(^DGCR(399,IBIFN1,"M1"),U,IBSEQN)=IBIFN  Q  ; | | | | | | | | | |

| Routine Name | IBCEU1 | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Enhancement Category | New | | Modify | Delete | | | | No Change | |
| Requirement Traceability Matrix | 2.6.11.1 | | | | | | | | |
| Related Options | IB COPY AND CANCEL | | | | | | | | |
| Related Routines | Routines “Called By” | | | | Routines “Called” | | | | |
| IBCCCB  IBCECOB2  IBCEU0  IBCEU6 | | | | $$FT^IBCEF  ALLPAYID^IBCEF2  ID^IBCEF2  $$DOLLAR^IBCEFG1  $$SPLIT^IBCEMU1  $$MCRONBIL^IBEFUNC  $$PTRESPI^IBCECOB1  $$COB^IBCEF | | | | |
| Data Dictionary (DD) References | NONE | | | | | | | | |
| Related Protocols | NONE | | | | | | | | |
| Related Integration Control Registrations (ICRs) | NONE | | | | | | | | |
| Data Passing | Input | Output Reference | | | | Both | Global Reference | | Local |
| Input Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Output Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Current Logic | | | | | | | | | |
| IBCEU1 ;ALB/TMP - EDI UTILITIES FOR EOB PROCESSING ;10-FEB-99  ;;2.0;INTEGRATED BILLING;\*\*137,155,296,349,371,432,473\*\*;21-MAR-94;Build 29  ;;Per VHA Directive 2004-038, this routine should not be modified.  ;  CCOB1(IBIFN,NODE,SEQ) ; Extract Claim level COB data  ; for a bill IBIFN  ; NODE = the file 361.1 node(s) to be returned, separated by commas  ; SEQ = the specific insurance sequence you want returned. If not =  ; 1, 2, or 3, all are returned  ; Returns IBXDATA(COB,n,node) where COB = COB insurance sequence,  ; n is the entry number in file 361.1 and node is the node requested  ; = the requested node's data  ;  N IB,IBN,IBBILL,IBS,A,B,C,IBCURR,IBMRAF,Z  ;  K IBXDATA  ;  S:$G(NODE)="" NODE=1  S IB=$P($G(^DGCR(399,IBIFN,"M1")),U,5,7)  S IBCURR=$$COB^IBCEF(IBIFN)  S IBMRAF=$$MCRONBIL^IBEFUNC(IBIFN)  ;  S:"123"'[$G(SEQ) SEQ=""  ;  F B=1:1:3 S IBBILL=$P(IB,U,B) I IBBILL S C=0 F S C=$O(^IBM(361.1,"B",IBBILL,C)) Q:'C D  . I '$$EOBELIG(C,IBMRAF,IBCURR) Q ; eob not eligible for secondary claim  . S IBS=$P($G(^IBM(361.1,C,0)),U,15) ; insurance sequence  . I $S('$G(SEQ):1,1:SEQ=IBS) D  .. F Z=1:1:$L(NODE,",") D  ... S A=$P(NODE,",",Z)  ... Q:A=""  ... S IBN=$G(^IBM(361.1,C,A))  ... ; Start IB\*2.0\*473 BI Added to null patient responsibility in OI1  ... ; if the data is contained at the line level to be sent in LCOB.  ... ; Perform the following for only OI1.19 using the dictionary 364.6 IEN.  ... S:+$G(IBX0)=2204&($$LPREXIST(C))&(A=1) $P(IBN,U,2)=""  ... ; End IB\*2.0\*473  ... I $TR(IBN,U)'="" S IBXDATA(IBS,C,A)=IBN  ;  Q  ;  CCAS1(IBIFN,SEQ) ; Extract all MEDICARE COB claim level adjustment data  ; for a bill IBIFN (subfile 361.11 in file 361.1)  ; SEQ = the specific insurance sequence you want returned. If not =  ; 1, 2, or 3, all are returned  ; Returns IBXDATA(COB,n) where COB = COB insurance sequence,  ; n is the entry number in file 361.1 and  ; = the 0-node of the subfile entry (361.11)  ; and IBXDATA(COB,n,m) where m is a sequential # and  ; = this level's 0-node  N IB,IBA,IBS,IB0,IB00,IBBILL,B,C,D,E  ;  S IB=$P($G(^DGCR(399,IBIFN,"M1")),U,5,7)  S:"123"'[$G(SEQ) SEQ=""  ;  F B=1:1:3 S IBBILL=$P(IB,U,B) I IBBILL S C=0 F S C=$O(^IBM(361.1,"B",IBBILL,C)) Q:'C D  . I '$$EOBELIG(C) Q ; eob not eligible for secondary claim  . S IBS=$P($G(^IBM(361.1,C,0)),U,15) ; insurance sequence  . I $S('$G(SEQ):1,1:SEQ=IBS) D  .. S (IBA,D)=0 F S D=$O(^IBM(361.1,C,10,D)) Q:'D S IB0=$G(^(D,0)) D  ... S IBXDATA(IBS,D)=IB0  ... S (IBA,E)=0  ... F S E=$O(^IBM(361.1,C,10,D,1,E)) Q:'E S IB00=$G(^(E,0)) D  .... S IBA=IBA+1  .... I $TR(IB00,U)'="" S IBXDATA(IBS,D,IBA)=IB00  ;  Q  ;  SEQ(A) ; Translate sequence # A into corresponding letter representation  S A=$E("PST",A)  I $S(A'="":"PST"'[A,1:1) S A="P"  Q A  ;  EOBTOT(IBIFN,IBCOBN) ; Total all EOB's for a bill's COB sequence  ; Function returns the total of all EOB's for a specific COB seq  ; IBIFN = ien of bill in file 399  ; IBCOBN = the # of the COB sequence you want EOB/MRA total for (1-3)  ;  N Z,Z0,IBTOT  S IBTOT=0  I $O(^IBM(361.1,"ABS",IBIFN,IBCOBN,0)) D  . ; Set up prior payment field here from MRA/EOB(s)  . S (IBTOT,Z)=0  . F S Z=$O(^IBM(361.1,"ABS",IBIFN,IBCOBN,Z)) Q:'Z D  .. ; HD64841 IB\*2\*371 - total up the payer paid amounts  .. S IBTOT=IBTOT+$P($G(^IBM(361.1,Z,1)),U,1)  Q IBTOT  ;  ;  LCOBOUT(IBXSAVE,IBXDATA,COL) ; Output the line adjustment reasons COB  ; line # data for an electronic claim  ; IBXSAVE,IBXDATA = arrays holding formatter information for claim -  ; pass by reference  ; COL = the column in the 837 flat file being output for LCAS record  N LINE,COBSEQ,RECCT,GRPCD,SEQ,RCCT,RCPC,DATA,RCREC,SEQLINE K IBXDATA  S (LINE,RECCT)=0  S RCPC=(COL#3) S:'RCPC RCPC=3  S RCREC=$S(COL'<4:COL-1\3,1:0)  ;S RCREC=$S(COL'<4:COL+5\6-1,1:0)  F S LINE=$O(IBXSAVE("LCOB",LINE)) Q:'LINE D  . S COBSEQ=0  . F S COBSEQ=$O(IBXSAVE("LCOB",LINE,"COB",COBSEQ)) Q:'COBSEQ S SEQLIN  E=0 F S SEQLINE=$O(IBXSAVE("LCOB",LINE,"COB",COBSEQ,SEQLINE)) Q:'SEQLINE S GRPCD="" F S GRPCD=$O(IBXSAVE("LCOB",LINE,"COB",COBSEQ,SEQLINE,GRPCD)) Q:GRPCD="" D  .. S RECCT=RECCT+1  .. ;IB\*2.0\*432/TAZ Added payer sequence in piece 22 of LCAS record (parameter Z)  .. I COL="Z" S IBXDATA(RECCT)=$E("PST",COBSEQ) I RECCT>1 D ID^IBCEF2(RE  CCT,"LCAS")  .. I COL=2 S IBXDATA(RECCT)=LINE,DATA=LINE D:RECCT>1 ID^IBCEF2(RECCT,"L  CAS")  .. I COL=3 S IBXDATA(RECCT)=$TR(GRPCD," ")  .. S (SEQ,RCCT)=0  .. F S SEQ=$O(IBXSAVE("LCOB",LINE,"COB",COBSEQ,SEQLINE,GRPCD,SEQ)) Q:'  SEQ I $TR($G(IBXSAVE("LCOB",LINE,"COB",COBSEQ,SEQLINE,GRPCD,SEQ)),U)'="" D  ... S RCCT=RCCT+1  ... Q:COL'<4&(RCCT'=RCREC)&(RCCT'>6)  ... S DATA=$S(COL=2:LINE,COL=3:$TR(GRPCD," "),1:$P($G(IBXSAVE("LCOB",LI NE,"COB",COBSEQ,SEQLINE,GRPCD,SEQ)),U,RCPC))  ... I COL'<4,RCCT=RCREC S:DATA'="" IBXDATA(RECCT)=DATA Q  ... I RCCT>6 S RCCT=1,RECCT=RECCT+1 D:COL=2 ID^IBCEF2(RECCT,"LCAS") I D  ATA'="",$S(COL'>3:1,1:RCCT=RCREC) S IBXDATA(RECCT)=DATA  Q  ;  CCOBOUT(IBXSAVE,IBXDATA,COL) ; Output the claim adjustment reasons COB  ; data for an electronic claim  ; IBXSAVE,IBXDATA = arrays holding formatter information for claim -  ; pass by reference  ; COL = the column in the 837 flat file being output for CCAS record  N COBSEQ,RECCT,GRPSEQ,SEQ,RCPC,RCCT,RCREC,DATA K IBXDATA  S RECCT=0  S RCPC=(COL#3) S:'RCPC RCPC=3  S RCREC=$S(COL'<4:COL+5\6-1,1:0)  S COBSEQ=0  F S COBSEQ=$O(IBXSAVE("CCAS",COBSEQ)) Q:'COBSEQ S GRPSEQ="" F S GRPSEQ=$O(IBXSAVE("CCAS",COBSEQ,GRPSEQ)) Q:GRPSEQ="" D  . S RECCT=RECCT+1  . I COL=2 S IBXDATA(RECCT)=COBSEQ D:RECCT>1 ID^IBCEF2(RECCT,"CCAS")  . I COL=3 S IBXDATA(RECCT)=$P($G(IBXSAVE("CCAS",COBSEQ,GRPSEQ)),U)  . S (SEQ,RCCT)=0  . F S SEQ=$O(IBXSAVE("CCAS",COBSEQ,GRPSEQ,SEQ)) Q:'SEQ I $TR($G(IBXSA  VE("CCAS",COBSEQ,GRPSEQ,SEQ)),U)'="" D  .. S RCCT=RCCT+1  .. Q:COL'<4&(RCCT'=RCREC)&(RCCT'>6)  .. S DATA=$S(COL=2:COBSEQ,COL=3:$P($G(IBXSAVE("CCAS",COBSEQ,GRPSEQ)),U),1:$P($G(IBXSAVE("CCAS",COBSEQ,GRPSEQ,SEQ)),U,RCPC))  .. I COL'<4,RCCT=RCREC S:DATA'="" IBXDATA(RECCT)=DATA Q  .. I RCCT>6 S RCCT=1,RECCT=RECCT+1 D:COL=2 ID^IBCEF2(RECCT,"CCAS") I DA  TA'="",$S(COL'>3:1,1:RCCT=RCREC) S IBXDATA(RECCT)=DATA  Q  ;  COBOUT(IBXSAVE,IBXDATA,CL) ; build LCOB segment data  ; The IBXSAVE array used here is built by INS-2, then LCOB-1.9  ; This is basically the 361.115, but all the piece numbers here in this  ; local array are one higher than the pieces in subfile 361.115.  N Z,M,N,P,PCCL  S (N,Z)=0  F S Z=$O(IBXSAVE("LCOB",Z)) Q:'Z D  . S M=0 F S M=$O(IBXSAVE("LCOB",Z,"COB",M)) Q:'M D  .. S P=0 F S P=$O(IBXSAVE("LCOB",Z,"COB",M,P)) Q:'P D  ... S N=N+1  ... I CL="Z" S IBXDATA(N)=$E("PST",M) Q  ... S PCCL=$P($G(IBXSAVE("LCOB",Z,"COB",M,P)),U,CL)  ... ;IB\*2.0\*432/TAZ - If the revenue code is blank for the EOB get it from the Primary Level  ... I PCCL="",CL=11 S PCCL=$P($G(IBXSAVE("LCOB",Z)),U)  ... S:PCCL'="" IBXDATA(N)=PCCL  Q  ;  ;IB\*2.0\*432/TAZ - XCOBOUT is the original code which did not capture all the LCOB records.  XCOBOUT(IBXSAVE,IBXDATA,CL) ; build LCOB segment data  ; The IBXSAVE array used here is built by INS-2, then LCOB-1.9  ; This is basically the 361.115, but all the piece numbers here in this  ; local array are one higher than the pieces in subfile 361.115.  N Z,M,N,P,PCCL  S (N,Z,P)=0 F S Z=$O(IBXSAVE("LCOB",Z)) Q:'Z D  . S N=N+1  . S M=$O(IBXSAVE("LCOB",Z,"COB",""),-1) Q:'M  . S P=$O(IBXSAVE("LCOB",Z,"COB",M,""),-1) Q:'P  . ;IB\*2.0\*432/TAZ Added Payer Sequence to piece 18 of the LCOB record  . I CL="Z" S IBXDATA(N)=$E("PST",M) Q  . S PCCL=$P($G(IBXSAVE("LCOB",Z,"COB",M,P)),U,CL)  . S:PCCL'="" IBXDATA(N)=PCCL  . Q  Q  ;  COBPYRID(IBXIEN,IBXSAVE,IBXDATA) ; cob insurance company payer id  N CT,N,NUM,Z  K IBXDATA  I '$D(IBXSAVE("LCOB")) G COBPYRX  ;  ;IB\*2.0\*432/TAZ - Replaced following code with loop to insure that all LCOB records have the Payer ID  ;D ALLPAYID^IBCEF2(IBXIEN,.NUM,1)  ;S NUM=$G(NUM(1))  ;S NUM=$E(NUM\_$J("",5),1,5)  ;S (CT,N)=0  ;F S N=$O(IBXSAVE("LCOB",N)) Q:'N S CT=CT+1,IBXDATA(CT)=NUM  ;  D ALLPAYID^IBCEF2(IBXIEN,.NUM)  S (CT,N)=0  F S N=$O(IBXSAVE("LCOB",N)) Q:'N D  . S Z=0  . F S Z=$O(IBXSAVE("LCOB",N,"COB",Z)) Q:'Z D  .. S CT=CT+1,IBXDATA(CT)=$G(NUM(Z))  COBPYRX ;  Q  ;  EOBELIG(IBEOB,IBMRAF,IBCURR) ; EOB eligibility for secondary claim  ; Function to decide if EOB entry in file 361.1 (ien=IBEOB) is  ; eligible to be included for secondary claim creation process  ; The EOB is not eligible if the review status is not 3, or if there  ; is no insurance sequence indicator, or if the EOB has been DENIED  ; and the patient responsibility for that EOB is $0 and that EOB is  ; not a split EOB. Split EOB's need to be included (IB\*2\*371).  ;  ; 432 - added new flag IBMRAF to indicate if we need to check only MRA's or all EOB's  ; IBMRAF = 1 if only need MRA EOB's  ;  NEW ELIG,IBDATA,PTRESP  S ELIG=0  ; IB\*2.0\*432/TAZ Get current Payer sequence if not passed in.  I '$G(IBCURR) S IBCURR=$$COB^IBCEF(IBIFN)  I '$G(IBEOB) G EOBELIGX  S IBDATA=$G(^IBM(361.1,IBEOB,0))  I $G(IBMRAF)=1,$P(IBDATA,U,4)'=1 G EOBELIGX ; Only MRA EOB's for now if flag = 1  I $D(^IBM(361.1,IBEOB,"ERR")) G EOBELIGX ; filing error  I $P(IBDATA,U,16)'=3 G EOBELIGX ; review status - accepted-complete  I '$P(IBDATA,U,15) G EOBELIGX ; insurance sequence must exist  ; IB\*2.0\*432/TAZ Don't send EOB data for current payer  I $P(IBDATA,U,15)=IBCURR G EOBELIGX ; Don't send EOB data for current payer (this is for retransmits)  S PTRESP=$P($G(^IBM(361.1,IBEOB,1)),U,2) ; Pt Resp Amount for 1500s  I $$FT^IBCEF(+IBDATA)=3 S PTRESP=$$PTRESPI^IBCECOB1(IBEOB) ; for UBs  I PTRESP'>0,$P(IBDATA,U,13)=2,'$$SPLIT^IBCEMU1(IBEOB) G EOBELIGX ;  Denied & No Pt. Resp. & not a split MRA  ;  S ELIG=1  EOBELIGX ;  Q ELIG  ; | | | | | | | | | |
| Modified Logic (Changes are in bold) | | | | | | | | | |
| IBCEU1 ;ALB/TMP - EDI UTILITIES FOR EOB PROCESSING ;10-FEB-99  ;;2.0;INTEGRATED BILLING;\*\*137,155,296,349,371,432,473\*\*;21-MAR-94;Build 29  ;;Per VHA Directive 2004-038, this routine should not be modified.  ;  CCOB1(IBIFN,NODE,SEQ) ; Extract Claim level COB data  ; for a bill IBIFN  ; NODE = the file 361.1 node(s) to be returned, separated by commas  ; SEQ = the specific insurance sequence you want returned. If not =  ; 1, 2, or 3, all are returned  ; Returns IBXDATA(COB,n,node) where COB = COB insurance sequence,  ; n is the entry number in file 361.1 and node is the node requested  ; = the requested node's data  ;  N IB,IBN,IBBILL,IBS,A,B,C,IBCURR,IBMRAF,Z  ;  K IBXDATA  ;  S:$G(NODE)="" NODE=1  S IB=$P($G(^DGCR(399,IBIFN,"M1")),U,5,7)  S IBCURR=$$COB^IBCEF(IBIFN)  S IBMRAF=$$MCRONBIL^IBEFUNC(IBIFN)  ;  S:"123"'[$G(SEQ) SEQ=""  ;  F B=1:1:3 S IBBILL=$P(IB,U,B) I IBBILL S C=0 F S C=$O(^IBM(361.1,"B",IBBILL,C)) Q:'C D  **; ib\*2.0\*547: Make sure this code handles these scenarios:**  **;** **When transmitting a CLONed secondary or tertiary claim, the system shall continue to not send COB data for the current payer but continue to send the COB data for all prior payers.  Ie. transmitting a cloned secondary claim should include COB data from the primary claim and transmitting a cloned tertiary claim should include COB data from the primary and secondary claims. The transmit process relies on the data in piece 5,6 & 7 of the M1 node**  . I '$$EOBELIG(C,IBMRAF,IBCURR) Q ; eob not eligible for secondary claim  . S IBS=$P($G(^IBM(361.1,C,0)),U,15) ; insurance sequence  . I $S('$G(SEQ):1,1:SEQ=IBS) D  .. F Z=1:1:$L(NODE,",") D  ... S A=$P(NODE,",",Z)  ... Q:A=""  ... S IBN=$G(^IBM(361.1,C,A))  ... ; Start IB\*2.0\*473 BI Added to null patient responsibility in OI1  ... ; if the data is contained at the line level to be sent in LCOB.  ... ; Perform the following for only OI1.19 using the dictionary 364.6 IEN.  ... S:+$G(IBX0)=2204&($$LPREXIST(C))&(A=1) $P(IBN,U,2)=""  ... ; End IB\*2.0\*473  ... I $TR(IBN,U)'="" S IBXDATA(IBS,C,A)=IBN  ;  Q  ;  CCAS1(IBIFN,SEQ) ; Extract all MEDICARE COB claim level adjustment data  ; for a bill IBIFN (subfile 361.11 in file 361.1)  ; SEQ = the specific insurance sequence you want returned. If not =  ; 1, 2, or 3, all are returned  ; Returns IBXDATA(COB,n) where COB = COB insurance sequence,  ; n is the entry number in file 361.1 and  ; = the 0-node of the subfile entry (361.11)  ; and IBXDATA(COB,n,m) where m is a sequential # and  ; = this level's 0-node  N IB,IBA,IBS,IB0,IB00,IBBILL,B,C,D,E  ;  S IB=$P($G(^DGCR(399,IBIFN,"M1")),U,5,7)  S:"123"'[$G(SEQ) SEQ=""  ;  F B=1:1:3 S IBBILL=$P(IB,U,B) I IBBILL S C=0 F S C=$O(^IBM(361.1,"B",IBBILL,C)) Q:'C D  .**; ib\*2.0\*547: Make sure this code handles these scenarios:**  **.;** **When transmitting a CLONed secondary or tertiary claim, the system shall continue to not send COB data for the current payer but continue to send the COB data for all prior payers.  Ie. transmitting a cloned secondary claim should include COB data from the primary claim and transmitting a cloned tertiary claim should include COB data from the primary and secondary claims. The transmit process relies on the data in piece 5,6 & 7 of the M1 node**  . I '$$EOBELIG(C) Q ; eob not eligible for secondary claim  . S IBS=$P($G(^IBM(361.1,C,0)),U,15) ; insurance sequence  . I $S('$G(SEQ):1,1:SEQ=IBS) D  .. S (IBA,D)=0 F S D=$O(^IBM(361.1,C,10,D)) Q:'D S IB0=$G(^(D,0)) D  ... S IBXDATA(IBS,D)=IB0  ... S (IBA,E)=0  ... F S E=$O(^IBM(361.1,C,10,D,1,E)) Q:'E S IB00=$G(^(E,0)) D  .... S IBA=IBA+1  .... I $TR(IB00,U)'="" S IBXDATA(IBS,D,IBA)=IB00  ;  Q  ;  SEQ(A) ; Translate sequence # A into corresponding letter representation  S A=$E("PST",A)  I $S(A'="":"PST"'[A,1:1) S A="P"  Q A  ;  EOBTOT(IBIFN,IBCOBN) ; Total all EOB's for a bill's COB sequence  ; Function returns the total of all EOB's for a specific COB seq  ; IBIFN = ien of bill in file 399  ; IBCOBN = the # of the COB sequence you want EOB/MRA total for (1-3)  ;  N Z,Z0,IBTOT  S IBTOT=0  I $O(^IBM(361.1,"ABS",IBIFN,IBCOBN,0)) D  . ; Set up prior payment field here from MRA/EOB(s)  . S (IBTOT,Z)=0  . F S Z=$O(^IBM(361.1,"ABS",IBIFN,IBCOBN,Z)) Q:'Z D  .. ; HD64841 IB\*2\*371 - total up the payer paid amounts  .. S IBTOT=IBTOT+$P($G(^IBM(361.1,Z,1)),U,1)  Q IBTOT  ;  ;  LCOBOUT(IBXSAVE,IBXDATA,COL) ; Output the line adjustment reasons COB  ; line # data for an electronic claim  ; IBXSAVE,IBXDATA = arrays holding formatter information for claim -  ; pass by reference  ; COL = the column in the 837 flat file being output for LCAS record  N LINE,COBSEQ,RECCT,GRPCD,SEQ,RCCT,RCPC,DATA,RCREC,SEQLINE K IBXDATA  S (LINE,RECCT)=0  S RCPC=(COL#3) S:'RCPC RCPC=3  S RCREC=$S(COL'<4:COL-1\3,1:0)  ;S RCREC=$S(COL'<4:COL+5\6-1,1:0)  F S LINE=$O(IBXSAVE("LCOB",LINE)) Q:'LINE D  . S COBSEQ=0  . F S COBSEQ=$O(IBXSAVE("LCOB",LINE,"COB",COBSEQ)) Q:'COBSEQ S SEQLIN  E=0 F S SEQLINE=$O(IBXSAVE("LCOB",LINE,"COB",COBSEQ,SEQLINE)) Q:'SEQLINE S GRPCD="" F S GRPCD=$O(IBXSAVE("LCOB",LINE,"COB",COBSEQ,SEQLINE,GRPCD)) Q:GRPCD="" D  .. S RECCT=RECCT+1  .. ;IB\*2.0\*432/TAZ Added payer sequence in piece 22 of LCAS record (parameter Z)  .. I COL="Z" S IBXDATA(RECCT)=$E("PST",COBSEQ) I RECCT>1 D ID^IBCEF2(RE  CCT,"LCAS")  .. I COL=2 S IBXDATA(RECCT)=LINE,DATA=LINE D:RECCT>1 ID^IBCEF2(RECCT,"L  CAS")  .. I COL=3 S IBXDATA(RECCT)=$TR(GRPCD," ")  .. S (SEQ,RCCT)=0  .. F S SEQ=$O(IBXSAVE("LCOB",LINE,"COB",COBSEQ,SEQLINE,GRPCD,SEQ)) Q:'  SEQ I $TR($G(IBXSAVE("LCOB",LINE,"COB",COBSEQ,SEQLINE,GRPCD,SEQ)),U)'="" D  ... S RCCT=RCCT+1  ... Q:COL'<4&(RCCT'=RCREC)&(RCCT'>6)  ... S DATA=$S(COL=2:LINE,COL=3:$TR(GRPCD," "),1:$P($G(IBXSAVE("LCOB",LI NE,"COB",COBSEQ,SEQLINE,GRPCD,SEQ)),U,RCPC))  ... I COL'<4,RCCT=RCREC S:DATA'="" IBXDATA(RECCT)=DATA Q  ... I RCCT>6 S RCCT=1,RECCT=RECCT+1 D:COL=2 ID^IBCEF2(RECCT,"LCAS") I D  ATA'="",$S(COL'>3:1,1:RCCT=RCREC) S IBXDATA(RECCT)=DATA  Q  ;  CCOBOUT(IBXSAVE,IBXDATA,COL) ; Output the claim adjustment reasons COB  ; data for an electronic claim  ; IBXSAVE,IBXDATA = arrays holding formatter information for claim -  ; pass by reference  ; COL = the column in the 837 flat file being output for CCAS record  N COBSEQ,RECCT,GRPSEQ,SEQ,RCPC,RCCT,RCREC,DATA K IBXDATA  S RECCT=0  S RCPC=(COL#3) S:'RCPC RCPC=3  S RCREC=$S(COL'<4:COL+5\6-1,1:0)  S COBSEQ=0  F S COBSEQ=$O(IBXSAVE("CCAS",COBSEQ)) Q:'COBSEQ S GRPSEQ="" F S GRPSEQ=$O(IBXSAVE("CCAS",COBSEQ,GRPSEQ)) Q:GRPSEQ="" D  . S RECCT=RECCT+1  . I COL=2 S IBXDATA(RECCT)=COBSEQ D:RECCT>1 ID^IBCEF2(RECCT,"CCAS")  . I COL=3 S IBXDATA(RECCT)=$P($G(IBXSAVE("CCAS",COBSEQ,GRPSEQ)),U)  . S (SEQ,RCCT)=0  . F S SEQ=$O(IBXSAVE("CCAS",COBSEQ,GRPSEQ,SEQ)) Q:'SEQ I $TR($G(IBXSA  VE("CCAS",COBSEQ,GRPSEQ,SEQ)),U)'="" D  .. S RCCT=RCCT+1  .. Q:COL'<4&(RCCT'=RCREC)&(RCCT'>6)  .. S DATA=$S(COL=2:COBSEQ,COL=3:$P($G(IBXSAVE("CCAS",COBSEQ,GRPSEQ)),U),1:$P($G(IBXSAVE("CCAS",COBSEQ,GRPSEQ,SEQ)),U,RCPC))  .. I COL'<4,RCCT=RCREC S:DATA'="" IBXDATA(RECCT)=DATA Q  .. I RCCT>6 S RCCT=1,RECCT=RECCT+1 D:COL=2 ID^IBCEF2(RECCT,"CCAS") I DA  TA'="",$S(COL'>3:1,1:RCCT=RCREC) S IBXDATA(RECCT)=DATA  Q  ;  COBOUT(IBXSAVE,IBXDATA,CL) ; build LCOB segment data  ; The IBXSAVE array used here is built by INS-2, then LCOB-1.9  ; This is basically the 361.115, but all the piece numbers here in this  ; local array are one higher than the pieces in subfile 361.115.  N Z,M,N,P,PCCL  S (N,Z)=0  F S Z=$O(IBXSAVE("LCOB",Z)) Q:'Z D  . S M=0 F S M=$O(IBXSAVE("LCOB",Z,"COB",M)) Q:'M D  .. S P=0 F S P=$O(IBXSAVE("LCOB",Z,"COB",M,P)) Q:'P D  ... S N=N+1  ... I CL="Z" S IBXDATA(N)=$E("PST",M) Q  ... S PCCL=$P($G(IBXSAVE("LCOB",Z,"COB",M,P)),U,CL)  ... ;IB\*2.0\*432/TAZ - If the revenue code is blank for the EOB get it from the Primary Level  ... I PCCL="",CL=11 S PCCL=$P($G(IBXSAVE("LCOB",Z)),U)  ... S:PCCL'="" IBXDATA(N)=PCCL  Q  ;  ;IB\*2.0\*432/TAZ - XCOBOUT is the original code which did not capture all the LCOB records.  XCOBOUT(IBXSAVE,IBXDATA,CL) ; build LCOB segment data  ; The IBXSAVE array used here is built by INS-2, then LCOB-1.9  ; This is basically the 361.115, but all the piece numbers here in this  ; local array are one higher than the pieces in subfile 361.115.  N Z,M,N,P,PCCL  S (N,Z,P)=0 F S Z=$O(IBXSAVE("LCOB",Z)) Q:'Z D  . S N=N+1  . S M=$O(IBXSAVE("LCOB",Z,"COB",""),-1) Q:'M  . S P=$O(IBXSAVE("LCOB",Z,"COB",M,""),-1) Q:'P  . ;IB\*2.0\*432/TAZ Added Payer Sequence to piece 18 of the LCOB record  . I CL="Z" S IBXDATA(N)=$E("PST",M) Q  . S PCCL=$P($G(IBXSAVE("LCOB",Z,"COB",M,P)),U,CL)  . S:PCCL'="" IBXDATA(N)=PCCL  . Q  Q  ;  COBPYRID(IBXIEN,IBXSAVE,IBXDATA) ; cob insurance company payer id  N CT,N,NUM,Z  K IBXDATA  I '$D(IBXSAVE("LCOB")) G COBPYRX  ;  ;IB\*2.0\*432/TAZ - Replaced following code with loop to insure that all LCOB records have the Payer ID  ;D ALLPAYID^IBCEF2(IBXIEN,.NUM,1)  ;S NUM=$G(NUM(1))  ;S NUM=$E(NUM\_$J("",5),1,5)  ;S (CT,N)=0  ;F S N=$O(IBXSAVE("LCOB",N)) Q:'N S CT=CT+1,IBXDATA(CT)=NUM  ;  D ALLPAYID^IBCEF2(IBXIEN,.NUM)  S (CT,N)=0  F S N=$O(IBXSAVE("LCOB",N)) Q:'N D  . S Z=0  . F S Z=$O(IBXSAVE("LCOB",N,"COB",Z)) Q:'Z D  .. S CT=CT+1,IBXDATA(CT)=$G(NUM(Z))  COBPYRX ;  Q  ;  EOBELIG(IBEOB,IBMRAF,IBCURR) ; EOB eligibility for secondary claim  ; Function to decide if EOB entry in file 361.1 (ien=IBEOB) is  ; eligible to be included for secondary claim creation process  ; The EOB is not eligible if the review status is not 3, or if there  ; is no insurance sequence indicator, or if the EOB has been DENIED  ; and the patient responsibility for that EOB is $0 and that EOB is  ; not a split EOB. Split EOB's need to be included (IB\*2\*371).  ;  ; 432 - added new flag IBMRAF to indicate if we need to check only MRA's or all EOB's  ; IBMRAF = 1 if only need MRA EOB's  ;  NEW ELIG,IBDATA,PTRESP  S ELIG=0  ; IB\*2.0\*432/TAZ Get current Payer sequence if not passed in.  I '$G(IBCURR) S IBCURR=$$COB^IBCEF(IBIFN)  I '$G(IBEOB) G EOBELIGX  S IBDATA=$G(^IBM(361.1,IBEOB,0))  I $G(IBMRAF)=1,$P(IBDATA,U,4)'=1 G EOBELIGX ; Only MRA EOB's for now if flag = 1  I $D(^IBM(361.1,IBEOB,"ERR")) G EOBELIGX ; filing error  I $P(IBDATA,U,16)'=3 G EOBELIGX ; review status - accepted-complete  I '$P(IBDATA,U,15) G EOBELIGX ; insurance sequence must exist  ; IB\*2.0\*432/TAZ Don't send EOB data for current payer  I $P(IBDATA,U,15)=IBCURR G EOBELIGX ; Don't send EOB data for current payer (this is for retransmits)  S PTRESP=$P($G(^IBM(361.1,IBEOB,1)),U,2) ; Pt Resp Amount for 1500s  I $$FT^IBCEF(+IBDATA)=3 S PTRESP=$$PTRESPI^IBCECOB1(IBEOB) ; for UBs  I PTRESP'>0,$P(IBDATA,U,13)=2,'$$SPLIT^IBCEMU1(IBEOB) G EOBELIGX ;  Denied & No Pt. Resp. & not a split MRA  ;  S ELIG=1  EOBELIGX ;  Q ELIG  ; | | | | | | | | | |

| Routine Name | IBCEU6 | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Enhancement Category | New | | Modify | Delete | | | | No Change | |
| Requirement Traceability Matrix | 2.6.11.1 | | | | | | | | |
| Related Options | IB COPY AND CANCEL | | | | | | | | |
| Related Routines | Routines “Called By” | | | | Routines “Called” | | | | |
| IBCEF11  IBCEF22 | | | | $$COB^IBCEF  $$EOBELIG^IBCEU1  $$MCRONBIL^IBEFUNC | | | | |
| Data Dictionary (DD) References | NONE | | | | | | | | |
| Related Protocols | NONE | | | | | | | | |
| Related Integration Control Registrations (ICRs) | NONE | | | | | | | | |
| Data Passing | Input | Output Reference | | | | Both | Global Reference | | Local |
| Input Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Output Attribute Name and Definition | Name:  Definition: | | | | | | | | |
| Current Logic | | | | | | | | | |
| IBCEU6 ;ALB/ESG - EDI UTILITIES FOR EOB PROCESSING ;29-JUL-2003  ;;2.0;INTEGRATED BILLING;\*\*155,371,432\*\*;21-MAR-94;Build 192  ;;Per VHA Directive 2004-038, this routine should not be modified.  Q  ;  COBLINE(IBIFN,IBI,IBXDATA,SORT,IBXTRA) ; Extract all COB data for line item  ; from file 361.1 (EOB), subfile 15 into IBXDATA(IBI,"COB",n)  ;  ; IBIFN = bill entry #  ; IBI = VistA outbound line item #  ; IBXDATA = array returned with COB line item data/pass by reference  ; SORT = flag that determines whether the data should be sorted for  ; output for the 837 record ('PR' group always there and has  ; a reason code for deductible first and co-insurance second -  ; even if they are 0).  ; 1 = sort, 0 = no sort needed  ;  ; Returns IBXDATA(IBI,"COB",COB,n) with COB data for each line item  ; found in an accepted EOB for the bill and = the '0' node data of  ; file 361.115 (LINE LEVEL ADJUSTMENTS)  ; -- AND --  ; IBXDATA(IBI,"COB",COB,n,z,p)=  ; the data on the '0' node for each subordinate entry of file  ; 361.11511 (REASONS) (Only first 3 pieces for 837 output)  ; z = this is either piece 1 of the 0-node for subfile  ; 361.1151 (ADJUSTMENTS)  ; OR  ; for the 837 COB 'sorted' output, this will be ' PR'  ; for the forced/extracted entries for deductible  ; and co-insurance so they are always output first  ; The space needs to be stripped off on output  ; -- AND --  ; IBXTRA = array returned if passed by reference if line is found  ; associated with line IBI due to bundling/unbundling  ; IBXTRA("ALL",x,paid procedure)=COB SEQ ^ seq # corresponding  ; to subscript n in IBXDATA(,"COB",COB,n  ; (x = line #-original proc-service dt)  ;  ;IB\*2.0\*432/TAZ - Added loop to extract data from all associated EOBs.  ;  N IB,IBBILL,IBCURR  S IBCURR=$$COB^IBCEF(IBIFN)  S IBMRAF=$$MCRONBIL^IBEFUNC(IBIFN)  S IB=$P($G(^DGCR(399,IBIFN,"M1")),U,5,7)  ;  F B=1:1:3 S IBBILL=$P(IB,U,B) I IBBILL D COB1(IBBILL,.IBXDATA,IBMRAF,IBCURR)  Q  ;  COB1(IBIFN,IBXDATA,IBMRAF,IBCURR) ; Process the EOB  ;  N A,B,B1,C,D,IBDATA,IB0,IB00,IBA,IBB,IBDED,IBCOI,IBS,IBN,IBDT  ;  ; If multiple EOB's reference this line for the same COB sequence,  ; extract only the last one marked accepted containing this line item  .  ;  S A=0  F S A=$O(^IBM(361.1,"B",IBIFN,A)) Q:'A D  .  . I '$$EOBELIG^IBCEU1(A,IBMRAF,IBCURR) Q ; eob not eligible for secondary claim  . I '$D(^IBM(361.1,A,15,"AC",IBI)) Q ; this EOB does not reference VistA line# IBI  . S IBA=0  . S IBDATA=$G(^IBM(361.1,A,0))  . S IBS=$P(IBDATA,U,15) ; insurance sequence#  . S IBN=+$O(IBXDATA(IBI,"COB",IBS,0))  . I IBN D Q:IBN ; check for later EOB  .. I $G(IBDT(IBI,IBS)),IBDT(IBI,IBS)<$P(IBDATA,U,6) K IBDT(IBI,IBS),IBX  DATA(IBI,"COB",IBS) S IBN=0  . ;  . S IBDT(IBI,IBS)=$P(IBDATA,U,6)  . S B=0  . F S B=$O(^IBM(361.1,A,15,"AC",IBI,B)) Q:'B S IB0=$G(^IBM(361.1,A,15 ,B,0)),IB0=IB0\_U\_IBDT(IBI,IBS) D  .. Q:$TR(IB0,U)=""  .. S IBA=IBA+1,IBXDATA(IBI,"COB",IBS,IBA)=IBI\_U\_IB0  .. ;  .. ; capture the modifiers (361.1152)  .. I $D(^IBM(361.1,A,15,B,2)) M IBXDATA(IBI,"COBMOD")=^IBM(361.1,A,15,B,2)  .. I $P(IB0,U,15)'="" D ;Line involved in bundling/unbundling  ... N Z0 S Z0=IBI\_"-"\_$P(IB0,U,15)\_"-"\_$P(IB0,U,16)  ... S IBXTRA("ALL",Z0,$P(IB0,U,4))=IBS\_U\_IBA,$P(IBXDATA(IBI,"COB",IBS,IBA),U)=""  .. S C=0,(IBDED(IBA),IBCOI(IBA))="0^0" ;Assume 0 if not found in list  .. F S C=$O(^IBM(361.1,A,15,B,1,C)) Q:'C S IB0=$G(^(C,0)) D  ... S D=0  ... F S D=$O(^IBM(361.1,A,15,B,1,C,1,D)) Q:'D S IB00=$S($G(SORT):$P($ G(^(D,0)),U,1,3),1:$G(^(D,0))) D  .... I $G(SORT),$P(IB0,U)="PR" D ;Check for deductible or co-ins  ..... I 'IBDED(IBA),$P(IB00,U)=1 S IBDED(IBA)=IB00,IB00="" Q  ..... I 'IBCOI(IBA),$P(IB00,U)=2 S IBCOI(IBA)=IB00,IB00="" Q  .... I $TR(IB00,U)'="" S IBB=$O(IBXDATA(IBI,"COB",IBS,IBA,$P(IB0,U),""),-1)+1,IBXDATA(IBI,"COB",IBS,IBA,$P(IB0,U),IBB)=IB00  .. Q:'$G(SORT)  .. S IBXDATA(IBI,"COB",IBS,IBA," PR",1)=IBDED(IBA)  .. S IBXDATA(IBI,"COB",IBS,IBA," PR",2)=IBCOI(IBA)  Q  ; | | | | | | | | | |
| Modified Logic (Changes are in bold) | | | | | | | | | |
| IBCEU6 ;ALB/ESG - EDI UTILITIES FOR EOB PROCESSING ;29-JUL-2003  ;;2.0;INTEGRATED BILLING;\*\*155,371,432\*\*;21-MAR-94;Build 192  ;;Per VHA Directive 2004-038, this routine should not be modified.  Q  ;  COBLINE(IBIFN,IBI,IBXDATA,SORT,IBXTRA) ; Extract all COB data for line item  ; from file 361.1 (EOB), subfile 15 into IBXDATA(IBI,"COB",n)  ;  ; IBIFN = bill entry #  ; IBI = VistA outbound line item #  ; IBXDATA = array returned with COB line item data/pass by reference  ; SORT = flag that determines whether the data should be sorted for  ; output for the 837 record ('PR' group always there and has  ; a reason code for deductible first and co-insurance second -  ; even if they are 0).  ; 1 = sort, 0 = no sort needed  ;  ; Returns IBXDATA(IBI,"COB",COB,n) with COB data for each line item  ; found in an accepted EOB for the bill and = the '0' node data of  ; file 361.115 (LINE LEVEL ADJUSTMENTS)  ; -- AND --  ; IBXDATA(IBI,"COB",COB,n,z,p)=  ; the data on the '0' node for each subordinate entry of file  ; 361.11511 (REASONS) (Only first 3 pieces for 837 output)  ; z = this is either piece 1 of the 0-node for subfile  ; 361.1151 (ADJUSTMENTS)  ; OR  ; for the 837 COB 'sorted' output, this will be ' PR'  ; for the forced/extracted entries for deductible  ; and co-insurance so they are always output first  ; The space needs to be stripped off on output  ; -- AND --  ; IBXTRA = array returned if passed by reference if line is found  ; associated with line IBI due to bundling/unbundling  ; IBXTRA("ALL",x,paid procedure)=COB SEQ ^ seq # corresponding  ; to subscript n in IBXDATA(,"COB",COB,n  ; (x = line #-original proc-service dt)  ;  ;IB\*2.0\*432/TAZ - Added loop to extract data from all associated EOBs.  ;  N IB,IBBILL,IBCURR  S IBCURR=$$COB^IBCEF(IBIFN)  S IBMRAF=$$MCRONBIL^IBEFUNC(IBIFN)  S IB=$P($G(^DGCR(399,IBIFN,"M1")),U,5,7)  ;  F B=1:1:3 S IBBILL=$P(IB,U,B) I IBBILL D COB1(IBBILL,.IBXDATA,IBMRAF,IBCURR)  Q  ;  COB1(IBIFN,IBXDATA,IBMRAF,IBCURR) ; Process the EOB  ;  N A,B,B1,C,D,IBDATA,IB0,IB00,IBA,IBB,IBDED,IBCOI,IBS,IBN,IBDT  ;  ; If multiple EOB's reference this line for the same COB sequence,  ; extract only the last one marked accepted containing this line item  .  ;  S A=0  F S A=$O(^IBM(361.1,"B",IBIFN,A)) Q:'A D  .**; ib\*2.0\*547: Make sure this code handles these scenarios:**  **. ;** **When transmitting a CLONed secondary or tertiary claim, the system shall continue to not send COB data for the current payer but continue to send the COB data for all prior payers.  Ie. transmitting a cloned secondary claim should include COB data from the primary claim and transmitting a cloned tertiary claim should include COB data from the primary and secondary claims. The transmit process relies on the data in piece 5,6 & 7 of the M1 node**  .I '$$EOBELIG^IBCEU1(A,IBMRAF,IBCURR) Q ; eob not eligible for secondary claim  . I '$D(^IBM(361.1,A,15,"AC",IBI)) Q ; this EOB does not reference VistA line# IBI  . S IBA=0  . S IBDATA=$G(^IBM(361.1,A,0))  . S IBS=$P(IBDATA,U,15) ; insurance sequence#  . S IBN=+$O(IBXDATA(IBI,"COB",IBS,0))  . I IBN D Q:IBN ; check for later EOB  .. I $G(IBDT(IBI,IBS)),IBDT(IBI,IBS)<$P(IBDATA,U,6) K IBDT(IBI,IBS),IBX  DATA(IBI,"COB",IBS) S IBN=0  . ;  . S IBDT(IBI,IBS)=$P(IBDATA,U,6)  . S B=0  . F S B=$O(^IBM(361.1,A,15,"AC",IBI,B)) Q:'B S IB0=$G(^IBM(361.1,A,15 ,B,0)),IB0=IB0\_U\_IBDT(IBI,IBS) D  .. Q:$TR(IB0,U)=""  .. S IBA=IBA+1,IBXDATA(IBI,"COB",IBS,IBA)=IBI\_U\_IB0  .. ;  .. ; capture the modifiers (361.1152)  .. I $D(^IBM(361.1,A,15,B,2)) M IBXDATA(IBI,"COBMOD")=^IBM(361.1,A,15,B,2)  .. I $P(IB0,U,15)'="" D ;Line involved in bundling/unbundling  ... N Z0 S Z0=IBI\_"-"\_$P(IB0,U,15)\_"-"\_$P(IB0,U,16)  ... S IBXTRA("ALL",Z0,$P(IB0,U,4))=IBS\_U\_IBA,$P(IBXDATA(IBI,"COB",IBS,IBA),U)=""  .. S C=0,(IBDED(IBA),IBCOI(IBA))="0^0" ;Assume 0 if not found in list  .. F S C=$O(^IBM(361.1,A,15,B,1,C)) Q:'C S IB0=$G(^(C,0)) D  ... S D=0  ... F S D=$O(^IBM(361.1,A,15,B,1,C,1,D)) Q:'D S IB00=$S($G(SORT):$P($ G(^(D,0)),U,1,3),1:$G(^(D,0))) D  .... I $G(SORT),$P(IB0,U)="PR" D ;Check for deductible or co-ins  ..... I 'IBDED(IBA),$P(IB00,U)=1 S IBDED(IBA)=IB00,IB00="" Q  ..... I 'IBCOI(IBA),$P(IB00,U)=2 S IBCOI(IBA)=IB00,IB00="" Q  .... I $TR(IB00,U)'="" S IBB=$O(IBXDATA(IBI,"COB",IBS,IBA,$P(IB0,U),""),-1)+1,IBXDATA(IBI,"COB",IBS,IBA,$P(IB0,U),IBB)=IB00  .. Q:'$G(SORT)  .. S IBXDATA(IBI,"COB",IBS,IBA," PR",1)=IBDED(IBA)  .. S IBXDATA(IBI,"COB",IBS,IBA," PR",2)=IBCOI(IBA)  Q  ; | | | | | | | | | |

##### System Feature: COB Management Worklist (CBW)

###### Functional Requirement: COB Management Worklist - Search

The IB system shall provide the ability for users to search for claims on the COB Management Worklist by the following payer sequences:

* Primary Payer, or
* Secondary/Tertiary Payer, or
* Both (BN 14.2)

**Design Element**

COB Management Worklist

Select BILLER: ALL//

Include All Divisions or Selected Divisions? All// Divisions

**Select: (P)rimary Claims,(S)econdary/Tertiary Claims or (B)oth: Both// ??**

**This field determines whether you want to search for just**

**primary claims, just secondary/tertiary claims or both.**

**Select one of the following:**

**P – Primary Claims**

**S – Secondary/Tertiary Claims**

**B – Both**

**Select: (P)rimary Claims,(S)econdary/Tertiary Claims or (B)oth// BOTH**

Sort By: BILLER// ??

Select one of the following:

B BILLER

D DAYS SINCE TRANSMISSION OF LATEST BILL

L DATE LAST EOB RECEIVED

I SECONDARY**/TERTIARY** INSURANCE COMPANY

M EOB STATUS

P PATIENT NAME

R PATIENT RESPONSIBILITY

S SERVICE DATE

**K PRIMARY INSURANCE COMPANY**

Do you want to include Denied EOBs for Duplicate Claim/Service? No// NO

1. In INIT^IBCECOB add code to search for Primary, Secondary/Tertiary or Both:

 S DIR("A")="Select: ",DIR("B")="BOTH"  
 S DIR(0)="SBA^P:(P)rimary;S:(S)econdary/Tertiary;B:(B)oth"

 S DIR("?")="Enter the code to indicate how the data should be searched." D ^DIR K DIR  
 I $D(DTOUT)!$D(DUOUT) S VALMQUIT=1 G INITQ  
 S IBSRCH=Y  
 ;

In BLD1^IBCECOB1 screen entries based on search criteria

###### Functional Requirement: COB Management Worklist – Sort

The IB system shall provide the ability for users to sort claims on the COB Management Worklist based on the following:

* Biller
* Days since transmission of latest bill
* Date last EOB received
* Secondary/Tertiary Insurance Company
* EOB Status
* Patient Name
* Patient Responsibility
* Service Date
* Primary Insurance Company (BN 14.2)

**Design Element**

1. Add Primary Insurance company to the following line in INIT^IBCECOB:

 S DIR(0)="SBA^B:BILLER;D:DAYS SINCE TRANSMISSION OF LATEST BILL;L:DATE LAST "\_$S($G(IBMRANOT):"EOB",1:"MRA")\_" RECEIVED;"  
 S DIR(0)=DIR(0)\_"I:SECONDARY INSURANCE COMPANY;M:"\_$S($G(IBMRANOT):"EOB",1:"MRA")\_" STATUS;P:PATIENT NAME;R:PATIENT RESPONSIBILITY;S:SERVICE DATE"

1. Logic will have to added to this line in BLD1^IBCECOB1:

 S Z0=$S(IBSRT="B":IBMUT,IBSRT="D":-IBDAY,IBSRT="I":$P(IBINS2,U,2)\_"~"\_$P(IBINS2,U),IBSRT="M":$$EXTERNAL^DILFD(361.1,.13,"",$P(IB3611,"^",13)),IBSRT="R":-IBPTRSP,IBSRT="P":IBPTNM,IBSRT="S":+IBSRVC,1:+IBDT)

###### Functional Requirement: COB Management Worklist – CARC/RARC

The IB system shall provide the ability for users to display the CARC and RARC descriptions from the new AR EDI CARC DATA and AR EDI RARC DATA files (345 and 346) from the following actions:

* Print EOB
* View EOB (BN 6.4)

**Design Element**

CLVLA^ IBCECSA6 – Claim Level Adjustments

 .. S IB=$$SETSTR^VALM1("REASON CODE: "\_RSN\_" "\_$P(IBREC,U,4),"",3,77)

Replace $P(IBREC3,"^",4) with Description (4) from file 345 or 346. An ICR will be needed.

MRALLA^IBCECSA5 – Line Level Adjustments

 ... S IBTX(1)="ADJ: "\_$P(IBREC2,"^")\_" "\_$P(IBREC3,"^")\_" "\_$P(IBREC3,"^",4) D TXT1(.IBTX,0,79) S IBT=0 F  S IBT=$O(IBTX(IBT)) Q:IBT<1 D SET(IBTX(IBT))

1. Replace $P(IBREC3,"^",4) with Description (4) from file 345 or 346.
2. An ICR will be needed.

##### System Feature: Request for Additional Information Worklist

###### Functional Requirement: Request for Additional Information (RFAI) (277RFAI) Worklist - Search

The IB system shall provide the ability for users to search for a list of ASC X12N Health Care Claim Request For Additional Information (RFAI) (277RFAI) transactions based on the following criteria:

* Authorizing Biller (BN 3.1.2)

**Design Element** - all of 6.2.2.2.13.\*

Select Billing Supervisor Menu <TEST ACCOUNT> Option: edi EDI Menu For Electronic Bills

MM EDI Return Message Management ...

TR EDI Transmission Status Reports ...

MRA MRA Management Menu ...

RCB View/Resubmit Claims - Live or Test

CBW COB Management Worklist

**RFI RFAI Management Worklist**

PEB Print EOB

EXT Extract Status Management

SEND Transmit EDI Bills - Manual

Select EDI Menu For Electronic Bills <TEST ACCOUNT> Option: RFI

New Menu Option for RFI -RFAI Management Worklist.

Option name : IBRFI 277 Worklist

Calls EN^IBRFIWL which invokes ListMan template - IBRFI 277 WL

1. Add this new option to the EDI Menu for Electronic Bills [IBCE 837 EDI MENU] – between 90 and 95.

OUTPUT FROM WHAT FILE: 19 OPTION (10324 entries)

Select OPTION NAME: EDI MENU FOR ELECTRONIC BILLS IBCE 837 EDI MENU EDI Men

u For Electronic Bills

ANOTHER ONE:

STANDARD CAPTIONED OUTPUT? Yes// (Yes)

Include COMPUTED fields: (N/Y/R/B): NO// - No record number (IEN), no Computed

Fields

NAME: IBCE 837 EDI MENU MENU TEXT: EDI Menu For Electronic Bills

TYPE: menu CREATOR: RYAN,DOLORES G

PACKAGE: INTEGRATED BILLING

DESCRIPTION: This menu contains the options needed to process and maintain

EDI 837 bill submission functions.

ITEM: IBCE 837 EDI REPORTS SYNONYM: MM

DISPLAY ORDER: 10

ITEM: IBCE 837 MANUAL TRANSMIT SYNONYM: SEND

ITEM: IBCE EXTRACT STATUS SYNONYM: EXT

ITEM: IBCE TXMT MGMNT REPORTS SYNONYM: TR

DISPLAY ORDER: 20

ITEM: IBCEM MRA MANAGEMENT MENU SYNONYM: MRA

DISPLAY ORDER: 30

ITEM: IBCE PREV TRANSMITTED CLAIMS SYNONYM: RCB

DISPLAY ORDER: 40

ITEM: IBCE COB MANAGEMENT SYNONYM: CBW

DISPLAY ORDER: 90

ITEM: IBCE PRINT EOB SYNONYM: PEB

DISPLAY ORDER: 95

TIMESTAMP: 62402,43499 TIMESTAMP OF PRIMARY MENU: 58500,34241

UPPERCASE MENU TEXT: EDI MENU FOR ELECTRONIC BILLS

**Select Authorizing Biller: ALL//IB,CLERK 2**

**Select Another Biller:IB,CLERK 55**

**Select Another Biller:**

**Select Primary Sort: LOINC CODE//?? 🡨 Default LOINC**

**This code determines the primary sort criteria**

**by which the list will be sorted.**

**Select one of the following:**

**B AUTHORIZING BILLER**

**O OLDEST MESSAGE FIRST**

**N NEW MESSAGE FIRST**

**I INSURANCE COMPANY NAME**

**P PATIENT NAME**

**L LOINC CODE**

**Select Primary Sort: LOINC CODE //**

**Select Secondary Sort: OLDEST MESSAGE FIRST//?? 🡨 Default OLDEST**

The above selection criteria are prompted for in the INIT tag of the initial/main ListMan screen/routine, INIT^IBRFIWL. This type of selection is prevalent in IB and an example can be found in INIT^IBCECSA.

In that tag, they also have an example of prompting for sort by fields which is usually handled by a DIR call – well documented in the FM Developers Guide. Elsewhere in this design we used MIX^DIC1 so that may be an option as well when using a non-lookup XREF for lookup.

If Oldest Message First is chosen as the Primary Sort, do not ask for a Secondary sort.

**RFAI Management Worklist Apr 28, 2015@14:25:12 Page: 1 of 16**

**Bill # Payer Name Patient Name SSN Svc Date Curr Bal**

**Authorizing Biller: IB,CLERK 1🡨 IF they chose Biller sort**

**1 K100XXX MEDICARE (WNR) IB,PATIENT 333 XXXX 06/29/09 $43851.78**

**Can we display the Code - LOINC Code definition here?**

**2 K100XXX MEDICARE (WNR) IB,PATIENT 22 XXXX 11/05/10 $1226.18**

**LOINC**

**3 K100XXX UNITEDHEALTHCARE IB,PATIENT 765 XXXX 11/05/10 $9.65**

**Error Code: 108 ACK/RETURNED - COVERAGE HAS BEEN CANCELED FOR THIS ENTITY.**

**4 K100XXX MEDICARE (WNR) IB,PATIENT 22 XXXX 11/05/10 $1226.18**

**LOINC**

**Authorizing Biller: IB,CLERK 177**

**+ \* Indicates RFAI review in progress**

**Select Message Exit**

**ReSort Messages** **🡨If you want to add this, it’s not in the RSD but makes sense**

**Select Action: Next Screen//Select Message**

**Select RFAI Message: (1-4):1**

Above is a multi-line display similar to the MRW, CBW, and CSA options in Billing. This new ListMan display should be patterned off those existing and commonly used worklists to maintain the same look and feel across IB.

Here is the CSA menu option to be used as an example:

NAME: **IBCE CLAIMS STATUS AWAITING**

MENU TEXT: Claims Status Awaiting Resolution

TYPE: run routine CREATOR: KOPP,TERRY

LOCK: IB SUPERVISOR PACKAGE: INTEGRATED BILLING

DESCRIPTION: Used by bill staff to review the most current status messages

received for a bill(s) and do follow-up on the bills. Users will be able to

select a bill from the list to view the details and the entire message text as

well as to mark the message as reviewed or under review and document user

comments.

**ROUTINE: EN^IBCECSA**

UPPERCASE MENU TEXT: CLAIMS STATUS AWAITING RESOLUT

To create the above list, the following is needed:

A new ListMan template needs to be defined. (IBRFI 277 WL) – See ListMan template - IBCEM CSA LIST - as an example.

List Manager Workbench May 19, 2015@23:02:59 Page: 1 of 1

Template: **IBCEM CSA LIST**

---------------------------------------------------------------------------------------

Demographics List Region

Template Name: IBCEM CSA LIST Top Margin: 4

Entity Name: Claims Status Bottom " : 20

Screen Title: Claims Status Awaiting List Right " : 80

Protocol Information Other Fields

Type of List: PROTOCOL OK to Transport?: OK

Protocol Menu: **IBCEM CLAIMS STATUS AWAITIN** Use Cursor Control: YES

Print Protocol: Allowable Number of Actions:

Hidden Menu: VALM HIDDEN ACTIONS Date Range Limit:

Automatic Defaults:

**MUMPS Code Related**

**Header: D HDR^IBCECSA**

**Entry: D INIT^IBCECSA**

**Exit: D EXIT^IBCECSA**

**Expand:**

**Help: D HELP^IBCECSA**

**Array: ^TMP("IBCECSA",$J)**

Caption Line Information

Name Column Width Display Text Video Scroll Lock

NUMBER 1 4 NO

BILL 6 8 Bill # NO

PNAME 15 18 Payer Name NO

PANAME 35 20 Patient Name NO

SSN 56 4 SSN NO

SERVICE 62 8 Svc Date NO

CURBAL 71 10 Curr Bal NO

A new ListMan routine mentioned earlier (IBRFIWL) - Use **IBCECSA** as an example

1 new protocol menu to hold the 3 new protocols – IBRFI INITIAL WL MENU – Add the menu to ListMan.

NAME: **IBCEM CLAIMS STATUS AWAITING** TYPE: menu

CREATOR: RYAN,DOLORES G

DESCRIPTION: This is the main menu that contains the actions that can be

performed to review the most current status messages received for a bill and

do follow-up on the bills. Users will be able to select a bill from the list

to view the details and the entire message text as well as to mark the message

as reviewed or under review and to document user comments.

COLUMN WIDTH: 26 MNEMONIC WIDTH: 4

**ITEM: IBCEM COB EXIT SEQUENCE: 100**

ITEM: IBCEM CSA REPORT SEQUENCE: 50

DISPLAY NAME: Print Report

ITEM: IBCEM CSA MSG DETAIL SEQUENCE: 5

**DISPLAY NAME: Select Message**

**ITEM: IBCEM CSA MULTI SELECT REVIEW SEQUENCE: 7**

**ITEM: IBCEM CSA RE-SORT MESSAGES SEQUENCE: 70**

ITEM: IBCEM CSA MSG MAN SEQUENCE: 85

EXIT ACTION: I $G(IBFASTXT) S VALMBCK="Q"

ENTRY ACTION: K IBFASTXT HEADER: D SHOW^VALM

MENU PROMPT: Select Action: TIMESTAMP: 60471,33874

3 new protocols (Select Message, ReSort Messages, Exit) in file 101

**Select Message** – allows user to select the message to be displayed and invoke a second ListMan template detailed later. There is a good example of Select Message in the CSA worklist.

NAME: **IBCEM CSA MSG DETAIL** ITEM TEXT: Claims Status Awaiting Detail

TYPE: action CREATOR: RYAN,DOLORES G

PACKAGE: INTEGRATED BILLING

DESCRIPTION: This action allows a user to view the details of a bill

selected from the summary screen. It will display the message text, user

comments that have been entered during review of the message, and all of the

fields from the summary page.

**ENTRY ACTION: D SMSG^IBCECSA4** TIMESTAMP: 60295,55881

**ReSort** - allows user to resort the list. Also an example from the CSA worklist.

        \* Indicates CSA review in progress

    Select Message            Print Report              Multiple Status Messages

    Auto review Message(s)    ReSort Messages           Exit

Select Action: Next Screen// res   ReSort Messages

  The CSA screen is currently sorted in the following manner:

         Primary Sort:  Error Code Text

       Secondary Sort:  n/a

        Tertiary Sort:  n/a

Would you like to change the sort criteria? Yes//

NAME: **IBCEM CSA RE-SORT MESSAGES** ITEM TEXT: ReSort Messages

TYPE: action CREATOR: RYAN,DOLORES G

PACKAGE: INTEGRATED BILLING

DESCRIPTION: This action allows the user to re-sort the CSA status messages

in the list without exiting the option. IB patch 320 added this.

ENTRY ACTION: **D RESORT^IBCECSA3** TIMESTAMP: 60471,33874

**Exit** - This one is everywhere including CSA.

NAME: **IBCEM COB EXIT** ITEM TEXT: Exit

TYPE: action CREATOR: RYAN,DOLORES G

PACKAGE: INTEGRATED BILLING

DESCRIPTION: This action is allowed a user to exit out of COB menu.

ENTRY ACTION: **D EXIT^IBCECOB2** TIMESTAMP: 60295,55881

**Note:** The whole transaction screen is at the end of this – these are only partials.

RFAI Message Apr 28, 2015@14:43:44 Page: 1 of 2

**Bill # Payer Name Patient Name SSN Svc Date Curr Bal**

**K100XXX IB INSURANCE CO IB,PATIENT 33 XXXX 06/29/09 $43851.78**

**Information Source**

**Payer Name: IB INSURANCE COMPANY**

**Payer Contact 1: FAX Number**

**Payer Contact #: XXX XXX-XXXX**

**Payer Contact 2: Telephone**

**Payer Contact #: XXX XXX-XXXX EXT: XXXXXXX**

**Payer Response Contact 1:**

**Payer Response Contact #: XXX XXX-XXXX**

**Payer Response Contact 2: Telephone**

**+ Enter ?? for more actions**

**EC Enter/Edit Comments TJ Third Party Joint Inq. 🡨 Include TPJI jump point**

**RS Review Status EX Exit**

**RE Remove Entry**

**Select Action: Next Screen//** R**EVIEW STATUS**

**Base this design on the way it works in COB/MRW**

**RFAI Message Review Status: REVIEW IN PROCESS// ?? 🡨 Default In Process**

**Enter a review status.**

**Choose from:**

**0 NOT BEING REVIEWED**

**1 REVIEW IN PROCESS**

**RFAI Message review Status: REVIEW IN PROCESS//**

RFAI Message Apr 28, 2015@14:43:44 Page: 1 of 2

**Bill # Payer Name Patient Name SSN Svc Date Curr Bal**

**K100XXX IB INSURANCE CO IB,PATIENT 33 XXXX 06/29/09 $43851.78**

**Information Source**

**Payer Name: IB INSURANCE COMPANY**

**Payer Contact 1: FAX Number**

**Payer Contact #: XXX XXX-XXXX**

**Payer Contact 2: Telephone**

**Payer Contact #: XXX XXX-XXXX EXT: XXXXXXX**

**Payer Response Contact 1:**

**Payer Response Contact #: XXX XXX-XXXX**

**Payer Response Contact 2: Telephone**

**+ Enter ?? for more actions**

**EC Enter/Edit Comments TJ Third Party Joint Inq. 🡨 Include TPJI jump point**

**RS Review Status EX Exit**

**RE Remove Entry**

**Select Action: Next Screen// EC Enter/Edit Comment**

**Claim Comment History Apr 28, 2015@15:02:42 Page: 1 of 1**

**RFAI Claim K101XXX**

**5605478 10/30/14 ERA Payer Contact Information FOLLOW-UP DT:**

**Payer Name: AETNA US HEALTHCARE**

**Contact Name: CONTACT IB**

**Phone Number: 5555555555**

**Email Address: IBCONTACT@EMAIL.COM**

**COB MANAGMENT CLAIM COMMENTS**

**----------------------------**

**10/30/14 Entered by SIMONS,MARY**

**This is a test.**

**Base this design on the way it works in CBW**

**Enter ?? for more actions**

**COMMENTS:**

**No existing text**

**Edit? NO//**

**==[ WRAP ]==[ INSERT ]==============< COMMENTS >=============[ <PF1>H=Help ]====**

**This is a test.**

**<=======T=======T=======T=======T=======T=======T=======T=======T=======T>======**

**RFAI Review Status: REVIEW IN PROCESS// 🡨 If they add a comment, default IN Process**

RFAI Message Apr 28, 2015@14:43:44 Page: 1 of 2

**Bill # Payer Name Patient Name SSN Svc Date Curr Bal**

**K100XXX IB INSURANCE CO IB,PATIENT 33 XXXX 06/29/09 $43851.78**

**Information Source**

**Payer Name: IB INSURANCE COMPANY**

Payer Contact 1: FAX Number 🡨 There can be up to 3 contact methods

Payer Contact #: XXX XXX-XXXX

Payer Contact 2: Telephone

Payer Contact #: XXX XXX-XXXX EXT: XXXXXXX

Payer Response Contact 1: 🡨 There can be up to 3 contact methods

Payer Response Contact #: XXX XXX-XXXX

Payer Response Contact 2: Telephone

+ Enter ?? for more actions

EC Enter/Edit Comments TJ Third Party Joint Inq.

RS Review Status EX Exit

RE Remove Entry

**Select Action: Next Screen// Remove Entry 🡨 Force them into screen to enter reason comment**

After the message is selected from the main screen, we get to go to another ListMan screen which will require another ListMan template. To continue the CSA theme, use IBCEM CSA MSG as an example since it to displays the detailed message after selection.

List Manager Workbench May 19, 2015@23:27:34 Page: 1 of 1

Template: **IBCEM CSA MSG**

--------------------------------------------------------------------------------

Demographics List Region

Template Name: IBCEM CSA MSG Top Margin: 6

Entity Name: Claims Status Bottom " : 18

Screen Title: Claims Status Awaiting Right " : 80

Protocol Information Other Fields

Type of List: PROTOCOL OK to Transport?: OK

Protocol Menu: **IBCEM CSA MSG MENU** Use Cursor Control: YES

Print Protocol: Allowable Number of Actions: 1

Hidden Menu: VALM HIDDEN ACTIONS Date Range Limit:

Automatic Defaults: YES

**MUMPS Code Related**

**Header: D HDR^IBCECSA2**

**Entry: D INIT^IBCECSA2**

**Exit: D EXIT^IBCECSA2**

**Expand:**

**Help: D HELP^IBCECSA2**

**Array: ^TMP("IBCECSC",$J)**

Caption Line Information

Name Column Width Display Text Video Scroll Lock

BILL 6 8 Bill # NO

PNAME 15 18 Payer Name NO

PANAME 35 20 Patient Name NO

SSN 56 4 SSN NO

SERVICE 62 8 Svc Date NO

CURBAL 71 10 Curr Bal NO

Enter RETURN to continue or '^' to exit:

A routine in needed to compile the template and have the expected tags for ListMan. Use IBCECSA2 as an example.

1 New protocol menu:

NAME: IBCEM CSA MSG MENU ITEM TEXT: Select Message Menu

TYPE: menu CREATOR: RYAN,DOLORES G

PACKAGE: INTEGRATED BILLING

DESCRIPTION: This menu contains actions to perform functions that allow for

the review and processing of return status messages.

COLUMN WIDTH: 26 MNEMONIC WIDTH: 4

ITEM: IBCEM CSA EDI HISTORY SEQUENCE: 15

DISPLAY NAME: EDI History Display

**ITEM: IBCEM CSA TPJI SEQUENCE: 45**

**DISPLAY NAME: Third Party Joint Inq.**

ITEM: IBCEM CSA PROCESS COB SEQUENCE: 28

DISPLAY NAME: Process COB

ITEM: IBCEM CSA CANCEL BILL SEQUENCE: 1

DISPLAY NAME: Cancel Bill

ITEM: IBCEM CSA RESUBMIT BILL SEQUENCE: 30

DISPLAY NAME: Resubmit by Print

ITEM: IBCEM CSA PRINT BILL SEQUENCE: 50

DISPLAY NAME: Print Bill

**ITEM: IBCE EXIT SEQUENCE: 100**

**DISPLAY NAME: Exit**

**ITEM: IBCEM CSA REVIEW STATUS SEQUENCE: 40**

**DISPLAY NAME: Review Status**

**ITEM: IBCEM CSA COMMENTS SEQUENCE: 25**

**DISPLAY NAME: Enter/Edit Comments**

ITEM: IBCEM CSA RETRANSMIT BILL SEQUENCE: 35

ITEM: IBCEM CSA CORRECT REJECTED/DENIED BILL

SEQUENCE: 10

EXIT ACTION: I $G(IBFASTXT) S VALMBCK="Q"

ENTRY ACTION: K IBFASTXT HEADER: D SHOW^VALM

MENU PROMPT: Select Action: TIMESTAMP: 62238,38284

5 new protocols for the new protocol menu:

**EC – Enter Edit Comments**

From CSA:

NAME: **IBCEM CSA COMMENTS** ITEM TEXT: CSA ENTER/EDIT COMMENTS

TYPE: action CREATOR: RYAN,DOLORES G

PACKAGE: INTEGRATED BILLING

DESCRIPTION: This action allows user to document user comments for the

specific message from the selection list.

ENTRY ACTION: **D COM^IBCECSA2** TIMESTAMP: 60295,55881

**TJ – Third Party Join Inquiry**

**Note:** May be able to just use this one from CSA as is.

NAME: **IBCEM CSA TPJI** TYPE: action

CREATOR: RYAN,DOLORES G PACKAGE: INTEGRATED BILLING

DESCRIPTION: There are set of actions and screens for Third Party AR/IB

Joint Inquiry Provide detailed information on any Third Party Claim.

**ENTRY ACTION: D TPJI^IBCECSA4**

**RS – Review Status**

While CSA has one of these, we are going to break up the monotony (and see who is paying attention) by using the one from CBW. CBW was a developed after CSA and this action was improved there.

NAME: **IBCEM VIEW COMMENTS** ITEM TEXT: View Comments

TYPE: action CREATOR: SHURMAN,JILLIAN A

PACKAGE: INTEGRATED BILLING IDENTIFIER: VC

**ENTRY ACTION: D EN^IBCECOB6** TIMESTAMP: 61177,21414

RE – Remove Entry

This was is from CBW.

NAME: **IBCEM REMOVE FROM WORKLIST** ITEM TEXT: Remove From Worklist

TYPE: action CREATOR: SCHARF,KARYN

PACKAGE: INTEGRATED BILLING **ENTRY ACTION: D WLRMV^IBCECOB1**

It will need to:

1. Automatically capture User Name and Date/Time for all comments and removals
2. If message is IN PROCESS – Do not allow removal

**EX - Exit**

Again, like CSA, this drops you out of both lists and back to the menu.

NAME: IBCE EXIT ITEM TEXT: Exit

TYPE: action CREATOR: RYAN,DOLORES G

PACKAGE: INTEGRATED BILLING

DESCRIPTION: Allows the user to exit the system without quitting through the

hierarchy of screens, or the user can exit to the previous screen.

SYNONYM: EX

IDENTIFIER: EX **ENTRY ACTION: D FASTEXIT^IBCEFG4**

TIMESTAMP: 61152,53381

This next section is the entire list display after the users choose which entry they want to work with from the worklist. It will not be displayed in its entirety, but users can use ListMan to scroll through the data. The code for this ListMan is described earlier in this section. This is just a visual of all the data that will be displayed.

RFAI Message Apr 28, 2015@14:43:44 Page: 1 of 2

**Bill # Payer Name Patient Name SSN Svc Date Curr Bal**

**K100XXX IB INSURANCE CO IB,PATIENT 33 XXXX 06/29/09 $43851.78**

**Information Source**

**Payer Name: IB INSURANCE COMPANY**

**Payer Contact 1: FAX Number 🡨 There can be up to 3 contact methods**

**Payer Contact #: XXX XXX-XXXX**

**Payer Contact 2: Telephone**

**Payer Contact #: XXX XXX-XXXX EXT: XXXXXXX**

**Payer Response Contact 1: 🡨 There can be up to 3 contact methods**

**Payer Response Contact #: XXX XXX-XXXX**

**Payer Response Contact 2: Telephone**

**Payer Response Contact #: XXX XXX-XXXX EXT: XXXXXXX**

**Payer Address: PO BOX XYZ New York, New York 10001 🡨Concatenate the whole address**

**Payer Claim Control Number: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX**

Claim Level Status Information

**Patient Control #: XXXXXXX 🡨 Claim Number**

**Date of Service: XX/XX/XX**

**Medical Records Number: XXXXXXXX**

**Member Identification Number: XXXXXXXXXX**

**Type of Service: XXX 🡨 Institutional Only Type of Bill**

**Health Care Claim Status Category: 🡨 These 3 can repeat**

**Additional Information Request Modifier: 🡨 Show LOINC Code Text not just code**

**Status Information Effective Date: XX/XX/XX**

**Response Due Date: XX/XX/XX**

**Service Line Information/ Service Line Status Information**

**Line Item Control Number: XXXXXX**

**Service Line Date:**

**Revenue Code:**

**Coding Method: HCPCS**

**Procedure Code:XXXXXXX**

**Procedure Modifier: 🡨 There can be up to 4**

**Procedure Modifier:**

**Line Item Charge Amount: XXXXXXXXXXXXXXXXXX**

**Health Care Claim Status Category: 🡨 These 3 can repeat**

**Additional Information Request Modifier: 🡨 Show LOINC Code Text not just code**

**Status Information Effective Date: XX/XX/XX**

**Response Due Date: XX/XX/XX**

###### Functional Requirement: Request for Additional Information (RFAI) (277RFAI) Worklist – Primary Sort

The IB system shall provide the ability for users to display a list of ASC X12N Health Care Claim Request For Additional Information (RFAI) (277RFAI) transactions based on the following criteria:

* Chronological order
* Reverse chronological order
* Insurance company name
* Patient name
* Authorizing Biller
* Logical Observation Identifiers Names and Codes (LOINC) (BN 3.1.2) - Default

**Design Element** Refer to 6.2.2.2.13.1

###### Functional Requirement: Request for Additional Information (RFAI) (277RFAI) Worklist – Secondary Sort

The IB system shall provide the ability for users to display a list of ASC X12N Health Care Claim Request For Additional Information (RFAI) (277RFAI) transactions based on the following secondary criteria:

* Chronological order
* Reverse chronological order - Default
* Insurance company name
* Patient name
* Authorizing Biller
* LOINC (BN 3.1.2)

**Design Element** Refer to 6.2.2.2.13.1

###### Functional Requirement: Request for Additional Information (RFAI) (277RFAI) Worklist – Actions

The IB system shall provide the ability for users to perform the following actions for an ASC X12N Health Care Claim Request For Additional Information (RFAI) (277RFAI) transaction:

* Mark as being worked by a user
* Add comments – automatically capture user name and date/time
* Remove entry – automatically capture user name and date/time (BN 3.1.2)

**Design Element** Refer to 6.2.2.2.13.1

###### Functional Requirement: Request for Additional Information (RFAI) (277RFAI) Worklist – Visual Indicator

The IB system shall place a visual indicator on an entry on the RFAI Worklist when a user marks the entry as be worked on by a user. (BN 3.1.2)

**Design Element** Refer to 6.2.2.2.13.1

###### Functional Requirement: Request for Additional Information (RFAI) (277RFAI) Worklist – Comment History

The IB system shall capture the following data when an entry is removed from the RFAI Worklist:

* User Name
* Date
* Time
* Reason Removed – Free Text (BN 3.1)

**Design Element** Refer to 6.2.2.2.13.1

##### System Feature: ASC X12N Health Care Claim (837) Transactions

###### Functional Requirement: Transmit Blank POA Value – Institutional Inpatient

The IB system shall provide the ability for users to transmit a diagnosis with a blank POA value in an inpatient, institutional ASC X12N Health Care Claim (837) transaction. (BN 6.3)

**Design Element**

Modify entry number 1879 in file 364.7:

Original:

NUMBER: 1579

FORM FIELD REFERENCE: IB 837 TRANSMISSION

SECURITY LEVEL: NATIONAL,NO EDIT

DATA ELEMENT: N-GET FROM PREVIOUS EXTRACT

PAD CHARACTER: NO PAD REQUIRED

FORMAT CODE: K IBXDATA N Z S Z=0 F S Z=$O(^TMP("DCX",$J,1,Z)) Q:'Z S IBXDATA

(Z)=$P(^TMP("DCX",$J,1,Z),U,3)

FORMAT CODE DESCRIPTION: POA indicator for this diagnosis. Defaults to "1".

Modified:

NUMBER: 1579

FORM FIELD REFERENCE: IB 837 TRANSMISSION

SECURITY LEVEL: NATIONAL,NO EDIT

DATA ELEMENT: N-GET FROM PREVIOUS EXTRACT

PAD CHARACTER: NO PAD REQUIRED

FORMAT CODE: K IBXDATA N Z**,Z1** S Z=0 F S Z=$O(^TMP("DCX",$J,1,Z)) Q:'Z S **Z1=$P(^TMP("DCX",$J,1,Z),U,3),IBXDATA(Z)=$S(Z1=1:””,1:$P(^TMP("DCX",$J,1,Z),U,3))**

FORMAT CODE DESCRIPTION: POA indicator for this diagnosis. Defaults to "".

###### Functional Requirement: Transmit All Rate Types – Responsible Party Equals Insurer - Institutional

The IB system shall provide the ability for users to transmit all claims with a Rate Type for which the insurer is responsible, in an institutional ASC X12N Health Care Claim (837) transaction. (BN 8.1.2)

**Design Element**

In the Post Install Routine, loop through all entries in the Rate Type File (399.3) and set the Electronic Transmit field (.1) to 1. This will allow all claims to transmit based on the rate type.

###### Functional Requirement: Transmit All Rate Types – Responsible Party Equals Insurer - Professional

The IB system shall provide the ability for users to transmit all claims with a Rate Type for which the insurer is responsible, in a professional ASC X12N Health Care Claim (837) transaction. (BN 8.1.1)

**Design Element** Refer to 6.2.2.2.14.2

###### Functional Requirement: Transmit up to 25 Procedures - Institutional

The IB system shall provide the ability for users to transmit up to 25 procedures codes in an institutional ASC X12N Health Care Claim (837) transaction. (BN 6.5)

**Design Element**

Current:

NUMBER: 37

FORM FIELD REFERENCE: IB 837 TRANSMISSION

SECURITY LEVEL: NATIONAL,NO EDIT DATA ELEMENT: N-UB-04 PROCEDURES

PAD CHARACTER: NO PAD REQUIRED

FORMAT CODE: K:$$FT^IBCEF(IBXIEN)=2!'$$INPAT^IBCEF(IBXIEN) IBXDATA N Z S Z=0 F

S Z=$O(IBXDATA(Z)) K:'Z IBXDATA Q:'Z I '$D(IBXDATA(Z,"M")) S IBXSAVE("PROC",Z

)=IBXDATA(Z) I Z'<6 K IBXDATA Q

FORMAT CODE DESCRIPTION: This is a group data element so more than 1

occurrence of a value is possible for the data element in the IBXDATA array.

If an institutional bill or if the bill is professional and the procedure

being extracted was not added as a result of being a modifier with a 5-digit

code starting with 0 ("M" node does not exist), save in an IBXSAVE array for

later use. No output.

Modified:

NUMBER: 37

FORM FIELD REFERENCE: IB 837 TRANSMISSION

SECURITY LEVEL: NATIONAL,NO EDIT DATA ELEMENT: N-UB-04 PROCEDURES

PAD CHARACTER: NO PAD REQUIRED

FORMAT CODE: K:$$FT^IBCEF(IBXIEN)=2!'$$INPAT^IBCEF(IBXIEN) IBXDATA N Z S Z=0 F

S Z=$O(IBXDATA(Z)) K:'Z IBXDATA Q:'Z I '$D(IBXDATA(Z,"M")) S IBXSAVE("PROC",Z

)=IBXDATA(Z) I Z'<**25** K IBXDATA Q

FORMAT CODE DESCRIPTION: This is a group data element so more than 1

occurrence of a value is possible for the data element in the IBXDATA array.

If an institutional bill or if the bill is professional and the procedure

being extracted was not added as a result of being a modifier with a 5-digit

code starting with 0 ("M" node does not exist), save in an IBXSAVE array for

later use. No output.

###### Functional Requirement: Transmit Up To 12 e-Code Diagnoses - Institutional

The IB system shall provide the ability for users to transmit up to 12 e-Code diagnosis codes in an institutional ASC X12N Health Care Claim (837) transaction. (BN 6.5)

**Design Element**

ID1^IBCEF2

Original:

ID1(LN,DX,CT) ;Special entrypoint for diagnoses to 'save' the fact  
 ; a dx code is an e-code.  
 ; LN is last entry # output, returned as the entry # (IBXLINE) to assign to this entry  
 ; DX = the actual Dx code array(RECORD ID). Pass by reference, DX returned null if  
 ; dx was not output  
 ; CT = the ct on the 'DC' entry. pass by reference, returned null if  
 ; the end of the valid dx codes has been reached  
 ; External Cause of Injury codes and qualifier changed with ICD-10: E-codes in ICD-9, V,X,W,Y-codes in ICD-10  
 N IBINS,VAL,CNT,DXIEN,DXQ,EDX,I,POA,ICDV  
 S IBINS=($$FT^IBCEF(IBXIEN)=3)  
 S VAL="DC"\_CT  
 S VAL=$E(VAL\_" ",1,4)  
 ;  
 S EDX=0,DX=$G(DX)  
 S ICDV=$$ICD9VER^IBACSV(+$G(DX(CT)))  
 I ICDV=1,$E(DX)="E" S EDX=1 ; TRUE if ECI ICD-9 Dx (e-code)  
 I ICDV=30,"VWXY"[$E(DX) S EDX=1 ; TRUE if ECI ICD-10 Dx  
 ;  
 S I=$S(EDX:3,1:2)  
 ;  
 S:'EDX DXQ=$S(+$G(^TMP("DCX",$J,2))>0:"BF",1:"BK") ; first non e-code DX is principal (qulifier "BK"), the rest have qualifier "BF"  
 ;  
 I IBINS D  
 .I CT>28 S CT="" Q     ; Max of 28 codes for institutional/UB  
 .S DXIEN=$P(DX(CT),U,2) Q:DXIEN=""  
 .S POA=$P($G(^IBA(362.3,DXIEN,0)),U,4) I POA="",$$INPAT^IBCEF(IBXIEN) S POA=1 ; POA indicator defaults to "1", if not present on inpatient claim  
 .S:EDX DXQ="BN" ; e-code DX qualifier  
 .Q  
 ;  
 I 'IBINS S:EDX DXQ="BF" S POA="" ; on CMS-1500 e-code DX qualifiers are "BF" and there's no POA  
 ;  
 I ICDV=30 S DXQ="A"\_DXQ ; adjust Qualifier for ICD-10 codes  
 ;  
 ;Changed 8 to 12 so we can transmit 12 codes. BAA \*488\*  
 I 'IBINS,CT>12 S ^TMP("IBXSAVE",$J,"DX",IBXIEN)=$G(^TMP("IBXSAVE",$J,"DX",IBXIEN))+1,^TMP("IBXSAVE",$J,"DX",IBXIEN,$P(DX(+^TMP("IBXSAVE",$J,"DX",IBXIEN)),U,2))=$G(^TMP("IBXSAVE",$J,"DX",IBXIEN)) S DX="" Q  
 ;  
 I CT'="",DX'="" D  
 .; populate ^TMP("DCX") scratch global  
 .S ^TMP("DCX",$J,1)=CT,CNT=$G(^TMP("DCX",$J,I))+1,^TMP("DCX",$J,I)=CNT  
 .S (^TMP("DCX",$J,I,CNT),^TMP("DCX",$J,1,CT))=DX\_U\_DXQ\_U\_POA  
 .S LN=LN+1 D ID(LN,VAL) S ^TMP("IBXSAVE",$J,"DX",IBXIEN,$P(DX(LN),U,2))=LN,^TMP("IBXSAVE",$J,"DX",IBXIEN)=CT,CT=CT+1  
 .Q  
 Q

Modified:

ID1(LN,DX,CT**,DCT,ECT**) ;Special **entry point** for diagnoses to 'save' the fact  
 ; a dx code is an e-code.  
 ; LN is last entry # output, returned as the entry # (IBXLINE) to assign to this entry  
 ; DX = the actual Dx code array(RECORD ID). Pass by reference, DX returned null if  
 ; dx was not output  
 ; CT = the ct on the 'DC' entry. pass by reference, returned null if  
 ; the end of the valid dx codes has been reached  
**; DCT= Count of regular DX codes. UB-04 can have 25 non External Cause codes.  
 ; ECT= Count of External Cause codes. UB-04 can have 12 External Cause codes.** ; External Cause of Injury codes and qualifier changed with ICD-10: E-codes in ICD-9, V,X,W,Y-codes in ICD-10  
 N IBINS,VAL,CNT,DXIEN,DXQ,EDX,I,POA,ICDV  
 S IBINS=($$FT^IBCEF(IBXIEN)=3)  
 S VAL="DC"\_CT  
 S VAL=$E(VAL\_" ",1,4)  
**S DCT=+$G(DCT),ECT=+$G(ECT) ;Make sure variables are initialized.** ;  
 S EDX=0,DX=$G(DX)  
 S ICDV=$$ICD9VER^IBACSV(+$G(DX(CT)))  
 I ICDV=1,$E(DX)="E" S EDX=1 ; TRUE if ECI ICD-9 Dx (e-code)  
 I ICDV=30,"VWXY"[$E(DX) S EDX=1 ; TRUE if ECI ICD-10 Dx  
 ;  
 S I=$S(EDX:3,1:2)  
 ;  
 S:'EDX DXQ=$S(+$G(^TMP("DCX",$J,2))>0:"BF",1:"BK") ; first non e-code DX is principal (**qualifier** "BK"), the rest have qualifier "BF"  
 ;  
 I IBINS D  **I DX="" G ID1X**  
 .**;**I CT>28 S CT="" Q ; Max of 28 codes for institutional/UB  
**.I EDX S ECT=ECT+1 I ECT>12 S DX="" Q  ;Only 12 E-codes allowed  
 .I 'EDX S DCT=DCT+1 I DCT>25 S DX="" Q  ;Only 25 DX codes allowed** .S DXIEN=$P(DX(CT),U,2) Q:DXIEN=""  
 .S POA=$P($G(^IBA(362.3,DXIEN,0)),U,4) I POA="",$$INPAT^IBCEF(IBXIEN) S POA=1 ; POA indicator defaults to "1", if not present on inpatient claim  
 .S:EDX DXQ="BN" ; e-code DX qualifier  
 .Q  
 ;  
 I 'IBINS S:EDX DXQ="BF" S POA="" ; on CMS-1500 e-code DX qualifiers are "BF" and there's no POA  
 ;  
 I ICDV=30 S DXQ="A"\_DXQ ; adjust Qualifier for ICD-10 codes  
 ;  
 ;Changed 8 to 12 so we can transmit 12 codes. BAA \*488\*  
 I 'IBINS,CT>12 S ^TMP("IBXSAVE",$J,"DX",IBXIEN)=$G(^TMP("IBXSAVE",$J,"DX",IBXIEN))+1,^TMP("IBXSAVE",$J,"DX",IBXIEN,$P(DX(+^TMP("IBXSAVE",$J,"DX",IBXIEN)),U,2))=$G(^TMP("IBXSAVE",$J,"DX",IBXIEN)) S DX="" Q  
 ;  
 I CT'="",DX'="" D  
 .; populate ^TMP("DCX") scratch global  
 .S ^TMP("DCX",$J,1)=CT,CNT=$G(^TMP("DCX",$J,I))+1,^TMP("DCX",$J,I)=CNT  
 .S (^TMP("DCX",$J,I,CNT),^TMP("DCX",$J,1,CT))=DX\_U\_DXQ\_U\_POA  
 .S LN=LN+1 D ID(LN,VAL) S ^TMP("IBXSAVE",$J,"DX",IBXIEN,$P(DX(LN),U,2))=LN,^TMP("IBXSAVE",$J,"DX",IBXIEN)=CT,CT=CT+1  
 .Q  
**ID1X ;** Q

Entry 27 in File 364.7

Original:

NUMBER: 27

FORM FIELD REFERENCE: IB 837 TRANSMISSION

SECURITY LEVEL: NATIONAL,NO EDIT DATA ELEMENT: N-DIAGNOSES

PAD CHARACTER: NO PAD REQUIRED

FORMAT CODE: N A,C,R,Z M A=IBXDATA S (Z,R)=0,C=1 K IBXDATA F S Z=$O(A(Z)) Q:'

Z S A=$TR($P($$ICD9^IBACSV(+A(Z),$$BDATE^IBACSV(IBXIEN)),U),".") I A'="" D ID1^

IBCEF2(.R,.A,.C) Q:C="" I A'="" S IBXDATA(R)=A

FORMAT CODE DESCRIPTION: This is a group data element so more than 1

occurrence of a value is possible for the data element in the IBXDATA array.

Each diagnosis code name is stripped of its decimal point and is output on its

own DCn entry where n is a record count that will allow it to be mapped into

one of the 12 available pieces of the 837 diagnosis code record correctly.

This is done to accommodate Austin's translator and one of its shortcomings.

Save off the extract sequence # of each diagnosis output in the global array

^TMP("IBXSAVE",$J,"DX") for later use. Z>4 ADDED TO PREVENT SENDING MORE THAN

4 DIAG CODES (BL)

Modified:

NUMBER: 27

FORM FIELD REFERENCE: IB 837 TRANSMISSION

SECURITY LEVEL: NATIONAL,NO EDIT DATA ELEMENT: N-DIAGNOSES

PAD CHARACTER: NO PAD REQUIRED

FORMAT CODE: N A,C,R,Z**,E,D** M A=IBXDATA S (Z,R)=0,C=1 K IBXDATA F S Z=$O(A(Z)) Q:'

Z S A=$TR($P($$ICD9^IBACSV(+A(Z),$$BDATE^IBACSV(IBXIEN)),U),".") I A'="" D ID1^

IBCEF2(.R,.A,.C**,.D,.E**) Q:C="" I A'="" S IBXDATA(R)=A

FORMAT CODE DESCRIPTION: This is a group data element so more than 1

occurrence of a value is possible for the data element in the IBXDATA array.

Each diagnosis code name is stripped of its decimal point and is output on its

own DCn entry where n is a record count that will allow it to be mapped into

one of the 12 available pieces of the 837 diagnosis code record correctly.

This is done to accommodate Austin's translator and one of its shortcomings.

Save off the extract sequence # of each diagnosis output in the global array

^TMP("IBXSAVE",$J,"DX") for later use. Z>4 ADDED TO PREVENT SENDING MORE THAN

4 DIAG CODES (BL)

###### Deleted 6/10/2015 Functional Requirement: Transmission Field Lengths - Institutional

The IB system shall provide the ability for the data elements in the ASC X12N Health Care Claim (837) transaction to accept data in the maximum length allowed in the 837 - I Health Care Claim: Institutional ASC X12 Standards for Electronic Data Exchange Technical Report Type 3 – May 2006 manual. (BN 5.0)

###### Deleted 6/10/2015 Functional Requirement: Transmission Field Lengths - Professional

The IB system shall provide the ability for the data elements in the ASC X12N Health Care Claim (837) transaction to accept data in the maximum length allowed in the 837 - P Health Care Claim: Professional ASC X12 Standards for Electronic Data Exchange Technical Report Type 3 – May 2006 manual. (BN 5.0)

###### Functional Requirement: Transmit Admission Date – Inpatient Institutional

The IB system shall provide the ability for users to transmit an Admission Date in an inpatient only institutional ASC X12N Health Care Claim (837) transaction. (BN 5.4)

**Design Element**

Modify entry 77 in File 364.7

Original:

NUMBER: 77

FORM FIELD REFERENCE: IB 837 TRANSMISSION

SECURITY LEVEL: NATIONAL,NO EDIT

DATA ELEMENT: N-GET FROM PREVIOUS EXTRACT

PAD CHARACTER: NO PAD REQUIRED

FORMAT C: S IBXDATA=$G(IBXSAVE("ADMDT")) S:$L(IBXDATA)=6 IBXDATA=$$DATE^IBCEU(

$E(IBXDATA,5,6)\_$E(IBXDATA,1,4)) D:$S(IBXDATA="":'$$INPAT^IBCEF(IBXIEN,1),1:0) F

^IBCEF("N-STATEMENT COVERS FROM DATE",,,IBXIEN) I IBXDATA S IBXDATA=$$DT^IBCEFG1

(IBXDATA,"","D8")

FORMAT CODE DESCRIPTION: If data exists from the previous extract of

IBXSAVE("ADMDT"), output it. If no data here and outpatient bill, use

statement from date. Format date in CCYYMMDD format.

Modified:

NUMBER: 77

FORM FIELD REFERENCE: IB 837 TRANSMISSION

SECURITY LEVEL: NATIONAL,NO EDIT

DATA ELEMENT: N-GET FROM PREVIOUS EXTRACT

PAD CHARACTER: NO PAD REQUIRED

**FORMAT C: S IBXDATA=$G(IBXSAVE("ADMDT")) S:$L(IBXDATA)=6 IBXDATA=$$DATE^IBCEU(**

**$E(IBXDATA,5,6)\_$E(IBXDATA,1,4)) I IBXDATA S IBXDATA=$$DT^IBCEFG1**

**(IBXDATA,"","D8")**

FORMAT CODE DESCRIPTION: If data exists from the previous extract of

IBXSAVE("ADMDT"), output it. **IB\*2.0\*547 Removed the code to extract the STATEMENT COVERS FROM DATE for outpatient claims.**

###### Functional Requirement: Transmit Admission Date – Inpatient Professional

The IB system shall provide the ability for users to transmit an Admission Date in an inpatient only professional ASC X12N Health Care Claim (837) transaction. (BN 5.4)

**Design Element** Refer to 6.2.2.2.14.8

###### Added 6/10/2015 Functional Requirement: Transmission Field Lengths – Institutional

The IB system shall provide the ability for the following data elements in the ASC X12N Health Care Claim (837) transaction to accept data in the maximum length allowed in the 837 - I Health Care Claim: Institutional ASC X12 Standards for Electronic Data Exchange Technical Report Type 3 – May 2006 manual:

* Subscriber Group or Policy Number (SBR03) – Maximum 50 Alphanumeric
* Subscriber Group Name (SBR04) – Maximum 60 Alphanumeric
* Subscriber Primary Identifier (NM109) – Maximum 80 Alphanumeric
* Subscriber Supplemental Identifier (REF02) – Maximum 50 Alphanumeric
* Subscriber Last Name (NM103) – Maximum 60 Alphanumeric
* Subscriber First Name (NM104) – Maximum 35 Alphanumeric
* Subscriber Address Line (N301) – Maximum 55 Alphanumeric
* Subscriber Address Line (N302) – Maximum 55 Alphanumeric

**Design Element**

The developer will first modify the lengths of some existing fields. Next the developer will create new fields to replace the fields being moved, and then the length of the original fields will be cleared out to null and the name changed to BLANK.

1. Modify existing lengths:

* Edit LENGTH field in file IB FORM SKELETON DEFINITION (364.6)

1. Move field to new record:

* Use current entry from IB DATA ELEMENT DEFINITION NAME (364.5)
* Create new field in IB FORM SKELETON DEFINITION (364.6) using data from old entry in IB FORM SKELETON DEFINITION (364.6)
* Create new IB FORM FIELD CONTENT FORM FIELD REFERENCE (364.7) to link 364.5 entry and 364.6 entry to the new record
* Modify current LENGTH field to null
* Modify existing SHORT DESCRIPTION field to BLANK

###### Added 6/10/2015 Functional Requirement: Transmission Field Lengths – Professional

The IB system shall provide the ability for the following data elements in the ASC X12N Health Care Claim (837) transaction to accept data in the maximum length allowed in the 837 - P Health Care Claim: Institutional ASC X12 Standards for Electronic Data Exchange Technical Report Type 3 – May 2006 manual:

* Subscriber Group or Policy Number (SBR03) – Maximum 50 Alphanumeric
* Subscriber Group Name (SBR04) – Maximum 60 Alphanumeric
* Subscriber Primary Identifier (NM109) – Maximum 80 Alphanumeric
* Subscriber Supplemental Identifier (REF02) – Maximum 50 Alphanumeric
* Subscriber Last Name (NM103) – Maximum 60 Alphanumeric
* Subscriber First Name (NM104) – Maximum 35 Alphanumeric
* Subscriber Address Line (N301) – Maximum 55 Alphanumeric
* Subscriber Address Line (N302) – Maximum 55 Alphanumeric

**Note:** The 837 map already allows for the maximum lengths for Subscriber Middle Name and Subscriber City so no changes are needed for those elements.

**Design Element** Refer to 6.2.2.14.10

##### System Feature: ASC X12N Health Care Claim Request For Additional Information (RFAI) (277RFAI) Transactions

###### Functional Requirement: Receive Health Care Claim RFAI (277RFAI)

The IB system shall provide the ability to receive an ASC X12N Health Care Claim Request For Additional Information (277RFAI) from the FSC which includes the data specified in the 277 Health Care Claim Request for Additional Information: ASC X12 Standard for Electronic Data Exchange Technical Report Type 3 – May 2006 manual. (BN 3.1)

**Design Element** - this covers all 6.2.2.2.15.\*.\* subsections below)

1. A new HL7 application parameter will be created.

NAME: IB RFAI EC ACTIVE/INACTIVE: ACTIVE

MAIL GROUP: IBRFI 277 MESSAGE COUNTRY CODE: USA

HL7 ENCODING CHARACTERS: ^~\& HL7 FIELD SEPARATOR: |

1. Two (2) new protocols will be created.

NAME: IBRFI 277 IN ITEM TEXT: IBRFI 277 Server

TYPE: event driver CREATOR:

DESCRIPTION: This is event driver protocol for incoming X12 277 RFAI messages.

TIMESTAMP: 63322,49786 SENDING APPLICATION: RFAI EC

TRANSACTION MESSAGE TYPE: EHC EVENT TYPE: E12

VERSION ID: 2.6 RESPONSE PROCESSING ROUTINE: D ^IBRFIHLI

SUBSCRIBERS: IBRFI 277 REQUEST

NAME: IBRFI 277 REQUEST ITEM TEXT: IBRFI 277 response message

TYPE: subscriber CREATOR:

DESCRIPTION: This is subscriber protocol for X217 277 Requests.

TIMESTAMP: 63322,49917 RECEIVING APPLICATION: HCSR VISTA

TRANSACTION MESSAGE TYPE: EHC EVENT TYPE: E12

VERSION ID: 2.6 RESPONSE MESSAGE TYPE: ACK

PROCESSING ROUTINE: D ^IBRFIHLI

1. A new routine will be created for processing incoming HL7 messages.

**Routines (Entry Points):**

| Routine Name | IBTRHLI | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Enhancement Category | New | | Modify | Delete | | | | No Change | | |
| RTM | 2.6.15.1 | | | | | | | | | |
| Related Options | N/A | | | | | | | | | |
| Related Routines | Routines “Called By” | | | | | Routines “Called” | | | | |
|  | N/A | | | | | N/A | | | | |
| Routines | Activities | | | | | | | | | |
| Data Dictionary (DD) References | N/A | | | | | | | | | |
| Related Protocols | N/A | | | | | | | | | |
| Related Integration Control Registrations (ICRs) | N/A | | | | | | | | | |
| Data Passing | Input | Output Reference | | | Both | | Global Reference | | Local | |
| Input Attribute Name and Definition | Name:  Definition: | | | | | | | | | |
| Output Attribute Name and Definition | Name:  Definition: | | | | | | | | | |
| Current Logic | | | | | | | | | | |
| N/A | | | | | | | | | | |
| Modified Logic (Changes are in bold) | | | | | | | | | | |
| Routine should process an incoming EHC\_E12 HL7 message and call new routine ^IBTRHLI in order to parse and file the message into file 368. General design is similar to routine ^IBCNEHLI (eIV messaging) or IBTRHLI (278 HCSR). | | | | | | | | | | |

###### Functional Requirement: Store Health Care Claim RFAI (277RFAI)

The IB system shall provide the ability to store an ASC X12N Health Care Claim Request For Additional Information (277RFAI) from the FSC for the length of time specified in the IB Site Parameters. (BN 3.1)

1. A new routine will be created for filing incoming HL7 messages.

**Routines (Entry Points):**

| Routine Name | IBRFIHL1 | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Enhancement Category | New | | Modify | Delete | | | No Change | | | |
| RTM | 2.6.15.1 | | | | | | | | | |
| Related Options | N/A | | | | | | | | | |
| Related Routines | Routines “Called By” | | | | Routines “Called” | | | | | |
|  | N/A | | | | N/A | | | | | |
| Routines | Activities | | | | | | | | | |
| Data Dictionary (DD) References | N/A | | | | | | | | | |
| Related Protocols | N/A | | | | | | | | | |
| Related Integration Control Registrations (ICRs) | N/A | | | | | | | | | |
| Data Passing | Input | Output Reference | | | | Both | | Global Reference | Local | |
| Input Attribute Name and Definition | Name:  Definition: | | | | | | | | | |
| Output Attribute Name and Definition | Name:  Definition: | | | | | | | | | |
| Current Logic | | | | | | | | | | |
| N/A | | | | | | | | | | |
| Modified Logic (Changes are in bold) | | | | | | | | | | |
| Routine should parse an incoming EHC\_E12 HL7 message and file the message into file 368. General design is similar to routine ^IBCNEHL1 (eIV messaging) or IBTRHLI1 (278 HCSR). | | | | | | | | | | |

Below is the design of a new FileMan file that should be created for storage of the 277 Request For Additional Information segments:

Since little to no validation is done prior to getting the records to VistA and this is a one way interface, all fields are stored as free text.

**Node;Piece Field Description Type Length**

0;1 .01 Transaction ID Free Text 20

1;1 1.01 Payer Name Free Text 60

1;2 1.02 Payer Identifier Free Text 80

1;3 1.03 Payer Contact Name Free Text 60

2;1 2.01 Payer Contact Communication Type 1 Free Text 2

2;2 2.02 Payer Contact Communication Type 2 Free Text 2

2;3 2.03 Payer Contact Communication Type 3 Free Text 2

3;1 3.01 Payer Contact Communication 1 Free Text 250

4;1 4.01 Payer Contact Communication 2 Free Text 250

5;1 5.01 Payer Contact Communication 3 Free Text 250

6;1 6.01 Information Receiver Name Free Text 120

6;2 6.02 Information Receiver ID Free Text 80

7;1 7.01 Service Provider Name Free Text 130

7;2 7.02 Service Provider Federal Taxpayer Code Free Text 2

8;1 8.01 Service Provider ID Free Text 80

9;1 9.01 Patient Name Free Text 130

10;1 10.01 Patient Primary Identifier Free Text 80

11;1 11.01 Patient Control Number Free Text 50

11;2 11.02 Payer Claim Control Number Free Text 50

11;3 11.03 Medical Record Number Free Text 50

11;4 11.04 Clearinghouse Trace Number Free Text 50

12;1 12.01 Response Due Date Free Text 35

12;2 12.02 Report Transmission Code Free Text 2

13;1 13.01 Health Care Claim Status 1 Free Text 30

13;2 13.02 Additional Information Request Modifier Free Text 30

13;3 13.03 Status Information Effective Date Free Text 8

14;1 14.01 Health Care Claim Status 2 Free Text 30

14;2 14.02 Additional Information Request Modifier 2 Free Text 30

14;3 14.03 Health Care Claim Status 3 Free Text 30

14;4 14.04 Additional Information Request Modifier 3 Free Text 30

14;5 14.05 Claim Status Period Free Text 35

15;1 15.01 Payer Response Contact Name Free Text 60

16;1 16.01 Payer Response Contact Communication Type 1 Free Text 2

16;2 16.02 Payer Response Contact Communication Type 2 Free Text 2

16;3 16.03 Payer Response Contact Communication Type 3 Free Text 2

17;1 17.01 Payer Response Contact Communication 1 Free Text 250

18;1 18.01 Payer Response Contact Communication 2 Free Text 250

19;1 19.01 Payer Response Contact Communication 3 Free Text 250

20;1 20.01 Payer Response Contact Address Line 1 Free Text 55

20;2 20.02 Payer Response Contact Address Line 2 Free Text 55

20;3 20.03 Payer Response Contact Address City Free Text 30

20;4 20.04 Payer Response Contact Address State Free Text 2

20;5 20.05 Payer Response Contact Postal or Zip Code Free Text 15

20;6 20.06 Payer Response Contact Country Free Text 3

21;1 21.01 Product/Service ID Qualifier Free Text 2

21;2 21.02 Service Identification Code Free Text 48

21;3 21.03 Procedure Modifier 1 Free Text 2

21;4 21.04 Procedure Modifier 2 Free Text 2

21;5 21.05 Procedure Modifier 3 Free Text 2

21;6 21.06 Procedure Modifier 4 Free Text 2

21;7 21.07 Line Item Charge Amount Free Text 18

21;8 21.08 Product Service ID Free Text 48

22;1 22.01 Health Care Claim Status Category 1 Free Text 30

22;2 22.02 Additional Information Request Modifier 1 Free Text 30

22;3 22.03 Code List Qualifier 1 Free Text 3

22;4 22.04 Service Line Date Free Text 8

23;1 23.01 Health Care Claim Status Category 2 Free Text 30

23;2 23.02 Additional Information Request Modifier 2 Free Text 30

23;3 23.03 Code List Qualifier 2 Free Text 3

24;1 24.01 Health Care Claim Status Category 3 Free Text 30

24;2 24.02 Additional Information Request Modifier 3 Free Text 30

24;3 24.03 Code List Qualifier 3 Free Text 3

24;4 24.04 Line Item Control Number Free Text 50

24;5 24.05 Service Line Date Free Text 35

## Network Detailed Design

No changes to network design required by these enhancements.

## Service Oriented Architecture / ESS Detailed Design

No changes to Service Oriented Architecture / ESS Detailed Design required by these enhancements.

### Service Description for <Consumed Service Name>

The Service Description section is does not apply to this VistA enhancement.

### Service Design for <Provided Service Name>

The Service Design section is does not apply to this VistA enhancement.

# External System Interface Design

The IB module already transmits and receives HL7 messages from FSC. This effort will add a new VistA inbound HL7 message for the ASC X12N Health Care Claim Request For Additional Information (RFAI) (277RFAI) transactions to the existing interfaces with FSC. Below is a high level view of the new ASC X12N Health Care Claim Request For Additional Information (277RFAI):



Figure 6: RFAI (277RFAI) Screen Description

## Interface Architecture

This enhancement will use the existing VistA HL7, VA MailMan and VA network architecture.

## Interface Detailed Design

There are two interfaces included in this development effort.

The first is the EDI X12 837 Claims Transmission, an existing proprietary interface that uses MailMan to communicate between VAMCs and FSC. The minor enhancements to this interface are described in the individual requirements and in the accompanying updated ICD.

<http://vaww.yourserver.domain/pm/hape/ipt_5010/EDI_Portfolio/Program%20Level%20Documentation/MCCF/FY%202015/Vendor%20Deliverables/Design/MCCF%20eBilling%20Compliance%20Phase%203/09-023%20eBilling%20ICD%20Incr02%20v7.00.docx>

The second interface is a new EDI X12 277 Request For Additional Information (RFAI) which will be using VistA’s HL7 application to communicate with FSC.

At this time it is anticipated that we will use the existing event, EHC^E12 – REQUEST ADDITIONAL INFORMATION (EVENT E12). A Payer or Transitional Patient Advocate (TPA) uses this message to request additional information in support of an Invoice or a (Pre) Authorization Request. It is found in Chapter 25, Claims and Reimbursement, of HL7 v2.6.

EHC^E12^EHC\_E12 Request Additional Information Status Chapter

MSH Message Header 2

[ { SFT } ] Software 2

[ { UAC } ] User Authentication Credential 2

RFI Request for Information

{ [ CTD } ] Contact Data

IVC Invoice Identifier.

PSS Product/Service Section

PSG Product/Service Group

[ PID ] Person Identification

[ { PSL } ] Product/Service Line Item

{ --- REQUEST begin

  [ CTD ] Contact Data

  OBR Observation Request

  [ NTE ] Notes and Comments

  [ { OBX } ]  Observation Results

} --- REQUEST end

Further information about this existing event can be found here:[HL7 Claims & Reimbursement Messaging Specifications](http://vaww.yourserver.domain/applications/HL7MR/HL7%20Public%20Document%20Library/Forms/AllItems.aspx?RootFolder=%2Fapplications%2FHL7MR%2FHL7%20Public%20Document%20Library%2Fhl7%202%2D6&FolderCTID=0x0120002F99B5DA0B76A34AA8FBCD8347EC25B9&View=%7bAC82CFE8-A4DA-454B-A23D-E162F28942A0%7d)

The following figure represents the context in which the new HL7 transaction will exist.



Figure 7: X12N 277 Response Application Context Diagram

The addition of this batched transaction will minimally affect the workload of the Integrated Billing (IB) clerks and the nurses who do Utilization Reviews. Currently requests for additional clinical data to support claims for health care services come from either claim rejection or denial messages or contact by the payers, and they average about 85 per month, per facility. Now these requests will be a separate, batched HL7 transaction, and they will be located on a separate worklist the IB staff will need to monitor and respond to. The manual process of responding to them will not change; just the location of where the request is displayed to the user is changing.

**Hl7 Messages Protocols**

|  |  |
| --- | --- |
| **Interface ID** | VistA X12 277 Request |
| **Organization** |  |
| **HL7 Version** | 2.6 |
| **Spec Version** |  |
| **Application Role** | Receiver |
| **Conformance Type** | Implementable |
| **Encodings** |  |
|  | ER7 |
| **Event Description** | EHC - Request Additional Information (Event E12) |
| **Message Type** | EHC |
| **Event Type** | E12 |
| **Order Control Code** |  |
| **Message Structure** | BHS,{(G1R)MSH,RFI,{[CTD]},IVC,[PID],{[PSL]},[PYE]}BTS |
| **Structure Type** |  |
| **Accept Ack** | NE |
| **Application Ack** | AL |
| **Ack Mode** | Deferred |
| **Static Profile ID** | {ConfSig(1) null(0) null(0) static-profile(1) null(0) null(0) null(0) (1) (1) Receiver(2)} |
| **Dynamic Profile ID** | {ConfSig(1) null(0) null(0) dynamic-profile(2) AccNE\_AppAL(2) defer\_mode\_ack(1)} |

**Segments**

|  |  |  |
| --- | --- | --- |
| **Optionality Codes:**   * R - required * RE - required or empty * C - conditional * CE - conditional or empty * O - optional * NS - not supported * U - unknown | **Abbreviations:**   * seq - sequence * DT - datatype * Len - length * Opt - optionality * Rep - repeatable * Min - quantity min * Max - quantity max * Tbl - table | **Color codes**:   * Fields * *Components* * ***Sub Components*** * *impl. note* * *NS Element* * *CM* Datatype |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Segment** | **Description** | **Opt** | **Rep** | **Min** | **Max** | **Reference** |
| BHS | Batch Header | R | False |  |  | 2.14.2 |

**Fields**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Seq** | **DT** | **Len** | **Opt** | **Rep** | **Min** | **Max** | **Tbl** | **Predicate** | **Fx Val** | **Ex Val** | **Reference** |
| Batch Field Separator | 1 | ST | 1 | R | False | 1 | 1 |  |  |  | ^ | 2.14.2.1 |
| Batch Encoding Characters | 2 | ST | 4 | R | False | 1 | 1 |  |  |  |  | 2.14.2.2 |
| Batch Sending Application | 3 | HD | 1027 | NS | False | 0 | 0 |  |  |  |  | 2.14.2.3 |
| Batch Sending Facility | 4 | HD | 1027 | NS | False | 0 | 0 |  |  |  |  | 2.14.2.4 |
| Batch Receiving Application | 5 | HD | 1027 | NS | False | 0 | 0 |  |  |  |  | 2.14.2.5 |
| Batch Receiving Facility | 6 | HD | 1027 | NS | False | 0 | 0 |  |  |  |  | 2.14.2.6 |
| Batch Creation Date/Time | 7 | DTM | 24 | NS | False | 0 | 0 |  |  |  |  | 2.14.2.7 |
| Batch Security | 8 | ST | 40 | NS | False | 0 | 0 |  |  |  |  | 2.14.2.8 |
| Batch Name/ID/Type | 9 | ST | 20 | NS | False | 0 | 0 |  |  |  |  | 2.14.2.9 |
| Batch Comment | 10 | ST | 80 | NS | False | 0 | 0 |  |  |  |  | 2.14.2.10 |
| Batch Control ID | 11 | ST | 20 | NS | False | 0 | 0 |  |  |  |  | 2.14.2.11 |
| Reference Batch Control ID | 12 | ST | 20 | NS | False | 0 | 0 |  |  |  |  | 2.14.2.12 |
| Batch Sending Network Address | 13 | HD | 1027 | NS | False | 0 | 0 |  |  |  |  | 2.14.2.13 |
| Batch Receiving Network Address | 14 | HD | 1027 | NS | False | 0 | 0 |  |  |  |  | 2.14.2.14 |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Segment** | **Description** | **Opt** | **Rep** | **Min** | **Max** | **Reference** |
| BTS | Batch Trailer | R | False |  |  | 2.14.3 |

**Fields**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Seq** | **DT** | **Len** | **Opt** | **Rep** | **Min** | **Max** | **Tbl** | **Predicate** | **Fx Val** | **Ex Val** | **Reference** |
| Batch Message Count | 1 | ST | 10 | NS | False | 0 | 0 |  |  |  |  | 2.14.3.1 |
| Batch Comment | 2 | ST | 80 | NS | False | 0 | 0 |  |  |  |  | 2.14.3.2 |
| Batch Totals | 3 | NM | 100 | NS | False | 0 | 0 |  |  |  |  | 2.14.3.3 |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Seg Group** | **Description** | **Opt** | **Rep** | **Min** | **Max** | **Reference** |
| G1R | G1R | R | True | 1 | \* |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Segment** | **Description** | **Opt** | **Rep** | **Min** | **Max** | **Reference** |
| MSH | Message Header | R | False |  |  | 2.14.9 |

**Fields**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Seq** | **DT** | **Len** | **Opt** | **Rep** | **Min** | **Max** | **Tbl** | **Predicate** | **Fx Val** | **Ex Val** | **Reference** |
| Field Separator | 1 | ST | 1 | R | False | 1 | 1 |  |  |  |  | 2.14.9.1 |
| Encoding Characters | 2 | ST | 4 | R | False | 1 | 1 |  |  |  |  | 2.14.9.2 |
| Sending Application | 3 | HD | 1027 | NS | False | 0 | 0 | 0361 |  |  |  | 2.14.9.3 |
| Sending Facility | 4 | HD | 1027 | NS | False | 0 | 0 | 0362 |  |  |  | 2.14.9.4 |
| Receiving Application | 5 | HD | 1027 | NS | False | 0 | 0 | 0361 |  |  |  | 2.14.9.5 |
| Receiving Facility | 6 | HD | 1027 | NS | False | 0 | 0 | 0362 |  |  |  | 2.14.9.6 |
| Date/Time of Message | 7 | DTM | 24 | R | False | 1 | 1 |  |  |  |  | 2.14.9.7 |
| Security | 8 | ST | 40 | NS | False | 0 | 0 |  |  |  |  | 2.14.9.8 |
| Message Type | 9 | MSG | 15 | R | False | 1 | 1 |  |  |  |  | 2.14.9.9 |
| *Message Code* | *1* | ID | 3 | R |  | 1 | 1 | 0076 |  |  |  |  |
| *Trigger Event* | *2* | ID | 3 | R |  | 1 | 1 | 0003 |  |  |  |  |
| *Message Structure* | *3* | ID | 7 | R |  | 1 | 1 | 0354 |  |  |  |  |
| Message Control ID | 10 | ST | 199 | R | False | 1 | 1 |  |  |  |  | 2.14.9.10 |
| Processing ID | 11 | PT | 3 | R | False | 1 | 1 |  |  |  |  | 2.14.9.11 |
| *Processing ID* | 1 | ID | 1 | R |  | 1 | 1 | 0103 |  |  |  |  |
| *Processing Mode* | 2 | ID | 0 | NS |  | 0 | 0 | 0207 |  |  |  |  |
| Version ID | 12 | VID | 1399 | R | False | 1 | 1 |  |  |  |  | 2.14.9.12 |
| *Version ID* | 1 | ID | 5 | R |  | 1 | 1 | 0104 |  |  |  |  |
| *Internationalization Code* | 2 | CWE | 0 | NS |  | 0 | 0 | 0399 |  |  |  |  |
| *International Version ID* | 3 | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Sequence Number | 13 | NM | 15 | NS | False | 0 | 0 |  |  |  |  | 2.14.9.13 |
| Continuation Pointer | 14 | ST | 180 | NS | False | 0 | 0 |  |  |  |  | 2.14.9.14 |
| Accept Acknowledgment Type | 15 | ID | 2 | NS | False | 0 | 0 | 0155 |  |  |  | 2.14.9.15 |
| Application Acknowledgment Type | 16 | ID | 2 | NS | False | 0 | 0 | 0155 |  |  |  | 2.14.9.16 |
| Country Code | 17 | ID | 3 | NS | False | 0 | 0 | 0399 |  |  |  | 2.14.9.17 |
| Character Set | 18 | ID | 16 | NS | False | 0 | 0 | 0211 |  |  |  | 2.14.9.18 |
| Principal Language Of Message | 19 | CWE | 705 | NS | False | 0 | 0 |  |  |  |  | 2.14.9.19 |
| Alternate Character Set Handling Scheme | 20 | ID | 20 | NS | False | 0 | 0 | 0356 |  |  |  | 2.14.9.20 |
| Message Profile Identifier | 21 | EI | 427 | NS | False | 0 | 0 |  |  |  |  | 2.14.9.21 |
| Sending Responsible Organization | 22 | XON | 2166 | NS | False | 0 | 0 |  |  |  |  | 2.14.9.22 |
| Receiving Responsible Organization | 23 | XON | 2166 | NS | False | 0 | 0 |  |  |  |  | 2.14.9.23 |
| Sending Network Address | 24 | HD | 1027 | NS | False | 0 | 0 |  |  |  |  | 2.14.9.24 |
| Receiving Network Address | 25 | HD | 1027 | NS | False | 0 | 0 |  |  |  |  | 2.14.9.25 |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Segment** | **Description** | **Opt** | **Rep** | **Min** | **Max** | **Reference** |
| RFI | Request for Information | R | False |  |  | 16.4.1 |

**Fields**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Seq** | **DT** | **Len** | **Opt** | **Rep** | **Min** | **Max** | **Tbl** | **Predicate** | **Fx Val** | **Ex Val** | **Reference** |
| Request Date | 1 | DTM | 24 | R | False | 1 | 1 |  |  |  | 01012015 | File: 368 Field: .02 |
| Implementation Note: | | | | | | | | | | |  |  |
| *BHT04 Transaction Set Creation Date &* | | | | | | | | | | |  |  |
| *BHT05 Transaction Set Creation Time* | | | | | | | | | | |  |  |
| Response Due Date | 2 | DTM | 35 | R | False | 1 | 1 |  |  |  |  | File: 368 Field: 12.01 |
| Implementation Note: | | | | | | | | | | |  |  |
| *DPT03 Date Time Period (Response Due* | | | | | | | | | | |  |  |
| *Date)* | | | | | | | | | | |  |  |
| Patient Consent | 3 | ID | 1 | NS | False | 0 | 0 | 0136 |  |  |  | 16.4.1.3 |
| Date Additional Information was submitted | 4 | DTM | 24 | NS | False | 0 | 0 |  |  |  |  | 16.4.1.4 |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Segment** | **Description** | **Opt** | **Rep** | **Min** | **Max** | **Reference** |
| CTD | Contact Data | RE | True |  |  | 11.6.4 |

**Fields**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Seq** | **DT** | **Len** | **Opt** | **Rep** | **Min** | **Max** | **Tbl** | **Predicate** | **Fx Val** | **Ex Val** | **Reference** |
| Contact Role | 1 | CWE | 705 | R | True | 1 | \* | 0131 |  |  |  | 11.6.4.1 |
| *Identifier* | 1 | ST | 2 | R |  | 1 | 1 |  |  |  | IC |  |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *PER01 Contact Function Code* | | | | | | | | | | |  |  |
| *Text* | 2 | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Coding System* | 3 | ID | 0 | NS |  | 0 | 0 | 0396 |  |  |  |  |
| *Alternate Identifier* | 4 | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Alternate Text* | 5 | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Alternate Coding System* | 6 | ID | 0 | NS |  | 0 | 0 | 0396 |  |  |  |  |
| *Coding System Version ID* | 7 | ST | 10 | C |  | 0 | 1 |  |  |  |  |  |
| *Alternate Coding System Version ID* | 8 | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Original Text* | 9 | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Contact Name | 2 | XPN | 1262 | RE | True | 0 | \* |  |  |  |  | 11.6.4.2 |
| *Family Name* | *1* | FN | 194 | RE |  | 0 | 1 |  |  |  |  |  |
| *�  Surname* | *1* | ST | 30 | R |  | 1 | 1 |  |  |  |  | File: 368 Field: 1.03 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *PER02 Name (Payer Contact Name)* | | | | | | | | | | |  |  |
| *�  Own Surname Prefix* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Own Surname* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Surname Prefix from Partner/Spouse* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Surname from Partner/Spouse* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Given Name* | *2* | ST | 1 | RE |  | 0 | 1 |  |  |  | John | File: 368 Field: 1.03 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *PER02 Name (Payer Contact Name)* | | | | | | | | | | |  |  |
| *Second and Further Given Names or Initials Thereof* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Suffix (e.g., JR or III)* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Prefix (e.g., DR)* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Degree (e.g., MD)* | *6* | IS | 0 | NS |  | 0 | 0 | 0360 |  |  |  |  |
| *Name Type Code* | *7* | ID | 0 | NS |  | 0 | 0 | 0200 |  |  |  |  |
| *Name Representation Code* | *8* | ID | 0 | NS |  | 0 | 0 | 0465 |  |  |  |  |
| *Name Context* | *9* | CWE | 0 | NS |  | 0 | 0 | 0448 |  |  |  |  |
| *Name Validity Range* | *10* | DR | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name Assembly Order* | *11* | ID | 0 | NS |  | 0 | 0 | 0444 |  |  |  |  |
| *Effective Date* | *12* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *13* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Professional Suffix* | *14* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Contact Address* | *3* | XAD | 2915 | RE | False | 0 | 1 |  |  |  |  | 11.6.4.3 |
| *Street Address* | *1* | SAD | 184 | RE |  | 0 | 1 |  |  |  |  |  |
| *�  Street or Mailing Address* | *1* | ST | 55 | RE |  | 0 | 1 |  |  |  | 100 Street A | File: 368 Field: 20.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *N301 Address Information (Response* | | | | | | | | | | |  |  |
| *Contact Address Line)* | | | | | | | | | | |  |  |
| *�  Street Name* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Dwelling Number* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Other Designation* | *2* | ST | 55 | RE |  | 0 | 1 |  |  |  | Apt A | File: 368 Field: 20.02 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *N302 Address Information (Response* | | | | | | | | | | |  |  |
| *Contact Additional Address Line)* | | | | | | | | | | |  |  |
| *City* | *3* | ST | 30 | RE |  | 0 | 1 |  |  |  |  | File: 368 Field: 20.03 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *N401 City Name (Response Contact City* | | | | | | | | | | |  |  |
| *Name)* | | | | | | | | | | |  |  |
| *State or Province* | *4* | ST | 2 | RE |  | 0 | 1 |  |  |  |  | File: 368 Field: 20.04 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *N402 State or Province Code (Response* | | | | | | | | | | |  |  |
| *Contact State Code)* | | | | | | | | | | |  |  |
| *Zip or Postal Code* | *5* | ST | 15 | RE |  | 0 | 1 |  |  |  |  | File: 368 Field: 20.05 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *N403 Postal Code (Response Contact* | | | | | | | | | | |  |  |
| *Postal Zone or Zip Code)* | | | | | | | | | | |  |  |
| *Country* | *6* | ID | 3 | RE |  | 0 | 1 | 0399 |  |  |  | File: 368 Field: 20.06 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *N404 Country Code* | | | | | | | | | | |  |  |
| Address Type | 7 | ID | 0 | NS |  | 0 | 0 | 0190 |  |  |  |  |
| *Other Geographic Designation* | *8* | ST | 3 | RE |  | 0 | 1 |  |  |  |  | File: 368 Field: 20.07 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *N407 Country Subdivision Code* | | | | | | | | | | |  |  |
| *County/Parish Code* | *9* | IS | 0 | NS |  | 0 | 0 | 0289 |  |  |  |  |
| *Census Tract* | *10* | IS | 0 | NS |  | 0 | 0 | 0288 |  |  |  |  |
| *Address Representation Code* | *11* | ID | 0 | NS |  | 0 | 0 | 0465 |  |  |  |  |
| *Address Validity Range* | *12* | DR | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Effective Date* | *13* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *14* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Reason* | *15* | CWE | 0 | NS |  | 0 | 0 | 0616 |  |  |  |  |
| *Temporary Indicator* | *16* | ID | 0 | NS |  | 0 | 0 | 0136 |  |  |  |  |
| *Bad Address Indicator* | *17* | ID | 0 | NS |  | 0 | 0 | 0136 |  |  |  |  |
| *Address Usage* | *18* | ID | 0 | NS |  | 0 | 0 | 0617 |  |  |  |  |
| *Addressee* | *19* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Comment* | *20* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Preference Order* | *21* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Protection Code* | *22* | CWE | 0 | NS |  | 0 | 0 | 0618 |  |  |  |  |
| *Address Identifier* | *23* | EI | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Contact Location | 4 | PL | 2830 | NS | False | 0 | 0 |  |  |  |  | 11.6.4.4 |
| Contact Communication Information | 5 | XTN | 2543 | RE | True | 0 | \* |  |  |  |  | 11.6.4.5 |
| *Telecommunication Use Code* | *1* | ID | 3 | RE |  | 0 | 1 | 0201 |  |  | NET | File: 368 Field: 2.01, 2.02, 2.03 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *PER03,PER05,PER07 Communication* | | | | | | | | | | |  |  |
| *Number Qualifier* | | | | | | | | | | |  |  |
| *Telecommunication Equipment Type* | *2* | ID | 8 | RE |  | 0 | 1 | 0202 |  |  | Internet | File: 368 Field: 2.01, 2.02, 2.03 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *PER03,PER05,PER07 Communication* | | | | | | | | | | |  |  |
| *Number Qualifier* | | | | | | | | | | |  |  |
| *Communication Address* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Country Code* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Area/City Code* | *5* | NM | 5 | RE |  | 0 | 1 |  |  |  |  | File: 368 Field: 3.01, 4.01, 5.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *PER04,PER06,PER08 Payer Contact* | | | | | | | | | | |  |  |
| *Communication Number (Payer Contact* | | | | | | | | | | |  |  |
| *Communication Number)* | | | | | | | | | | |  |  |
| *Local Number* | *6* | NM | 100 | RE |  | 0 | 1 |  |  |  | 8881112222 | File: 368 Field: 3.01, 4.01, 5.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *PER04,PER06,PER08 Payer Contact* | | | | | | | | | | |  |  |
| *Communication Number (Payer Contact* | | | | | | | | | | |  |  |
| *Communication Number)* | | | | | | | | | | |  |  |
| *Extension* | *7* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Any Text* | *8* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Extension Prefix* | *9* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Speed Dial Code* | *10* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Unformatted Telephone number* | *11* | ST | 199 | C |  | 0 | 1 |  |  |  |  |  |
| *Effective Start Date* | *12* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *13* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Reason* | *14* | CWE | 0 | NS |  | 0 | 0 | 0868 |  |  |  |  |
| *Protection Code* | *15* | CWE | 0 | NS |  | 0 | 0 | 0618 |  |  |  |  |
| *Shared Telecommunication Identifier* | *16* | EI | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Preference Order* | *17* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Preferred Method of Contact | 6 | CWE | 705 | RE | False | 0 | 1 | 0185 |  |  |  | 11.6.4.6 |
| *Identifier* | *1* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Text* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Coding System* | *3* | ID | 20 | RE |  | 0 | 1 | 0396 |  |  |  |  |
| *Alternate Identifier* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Alternate Text* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Alternate Coding System* | *6* | ID | 0 | NS |  | 0 | 0 | 0396 |  |  |  |  |
| *Coding System Version ID* | *7* | ST | 10 | C |  | 0 | 1 |  |  |  |  |  |
| *Alternate Coding System Version ID* | *8* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Original Text* | *9* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Contact Identifiers | 7 | PLN | 100 | RE | True | 0 | \* | 0338 |  |  |  | 11.6.4.7 |
| *ID Number* | *1* | ST | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *Type of ID Number* | *2* | IS | 8 | R |  | 1 | 1 | 0338 |  |  |  |  |
| *State/other Qualifying Information* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *4* | DT | 0 | NS |  | 0 | 0 |  |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Segment** | **Description** | **Opt** | **Rep** | **Min** | **Max** | **Reference** |
| CTD | Contact Data | RE | False |  |  | 11.6.4 |

**Fields**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Seq** | **DT** | **Len** | **Opt** | **Rep** | **Min** | **Max** | **Tbl** | **Predicate** | **Fx Val** | **Ex Val** | **Reference** |
| Contact Role | 1 | CWE | 705 | R | True | 1 | \* | 0131 |  |  |  | 11.6.4.1 |
| *Identifier* | *1* | ST | 2 | R |  | 1 | 1 |  |  |  | RE |  |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *PER01 Contact Function Code* | | | | | | | | | | |  |  |
| *Text* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Coding System* | *3* | ID | 0 | NS |  | 0 | 0 | 0396 |  |  |  |  |
| *Alternate Identifier* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Alternate Text* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Alternate Coding System* | *6* | ID | 0 | NS |  | 0 | 0 | 0396 |  |  |  |  |
| *Coding System Version ID* | *7* | ST | 10 | C |  | 0 | 1 |  |  |  |  |  |
| *Alternate Coding System Version ID* | *8* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Original Text* | *9* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Contact Name | 2 | XPN | 1262 | RE | True | 0 | \* |  |  |  |  | 11.6.4.2 |
| *Family Name* | *1* | FN | 194 | RE |  | 0 | 1 |  |  |  |  |  |
| *�  Surname* | *1* | ST | 30 | R |  | 1 | 1 |  |  |  |  | File: 368 Field: 15.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *PER02 Name (Payer Contact Name)* | | | | | | | | | | |  |  |
| *�  Own Surname Prefix* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Own Surname* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Surname Prefix from Partner/Spouse* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Surname from Partner/Spouse* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Given Name* | *2* | ST | 30 | RE |  | 0 | 1 |  |  |  | John | File: 368 Field: 15.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *PER02 Name (Payer contact Name)* | | | | | | | | | | |  |  |
| *Second and Further Given Names or Initials Thereof* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Suffix (e.g., JR or III)* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Prefix (e.g., DR)* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Degree (e.g., MD)* | *6* | IS | 0 | NS |  | 0 | 0 | 0360 |  |  |  |  |
| *Name Type Code* | *7* | ID | 0 | NS |  | 0 | 0 | 0200 |  |  |  |  |
| *Name Representation Code* | *8* | ID | 0 | NS |  | 0 | 0 | 0465 |  |  |  |  |
| *Name Context* | *9* | CWE | 0 | NS |  | 0 | 0 | 0448 |  |  |  |  |
| *Name Validity Range* | *10* | DR | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name Assembly Order* | *11* | ID | 0 | NS |  | 0 | 0 | 0444 |  |  |  |  |
| *Effective Date* | *12* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *13* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Professional Suffix* | *14* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Contact Address | 3 | XAD | 2915 | RE | False | 0 | 1 |  |  |  |  | 11.6.4.3 |
| *Street Address* | *1* | SAD | 184 | RE |  | 0 | 1 |  |  |  |  |  |
| *�  Street or Mailing Address* | *1* | ST | 55 | RE |  | 0 | 1 |  |  |  | 100 Street A | File: 368 Field 20.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *N301 Address Information (Response* | | | | | | | | | | |  |  |
| *Contact Address Line)* | | | | | | | | | | |  |  |
| *�  Street Name* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Dwelling Number* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Other Designation* | *2* | ST | 55 | RE |  | 0 | 1 |  |  |  | Apt A | File: 368 Field 20.02 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *N302 Address Information (Response* | | | | | | | | | | |  |  |
| *Contact Additional Address Line)* | | | | | | | | | | |  |  |
| *City* | *3* | ST | 30 | RE |  | 0 | 1 |  |  |  | Lubbock | File: 368 Field 20.03 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *N401 City Name (Response Contact City* | | | | | | | | | | |  |  |
| *Name)* | | | | | | | | | | |  |  |
| *State or Province* | *4* | ST | 2 | RE |  | 0 | 1 |  |  |  | TX | File: 368 Field 20.04 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *N402 State or Province Code (Response* | | | | | | | | | | |  |  |
| *Contact State Code)* | | | | | | | | | | |  |  |
| *Zip or Postal Code* | *5* | ST | 15 | RE |  | 0 | 1 |  |  |  | 99999 | File: 368 Field 20.05 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *N403 Postal Code (Response Contact* | | | | | | | | | | |  |  |
| *Postal Zone or Zip Code)* | | | | | | | | | | |  |  |
| *Country* | *6* | ID | 3 | RE |  | 0 | 1 | 0399 |  |  | USA | File: 368 Field 20.06 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *N404 Country Code* | | | | | | | | | | |  |  |
| *Address Type* | *7* | ID | 0 | NS |  | 0 | 0 | 0190 |  |  |  |  |
| *Other Geographic Designation* | *8* | ST | 3 | RE |  | 0 | 1 |  |  |  |  | File: 368 Field: 20.07 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *N407 Country Subdivision Code* | | | | | | | | | | |  |  |
| *County/Parish Code* | *9* | IS | 0 | NS |  | 0 | 0 | 0289 |  |  |  |  |
| *Census Tract* | *10* | IS | 0 | NS |  | 0 | 0 | 0288 |  |  |  |  |
| *Address Representation Code* | *11* | ID | 0 | NS |  | 0 | 0 | 0465 |  |  |  |  |
| *Address Validity Range* | *12* | DR | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Effective Date* | *13* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *14* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Reason* | *15* | CWE | 0 | NS |  | 0 | 0 | 0616 |  |  |  |  |
| *Temporary Indicator* | *16* | ID | 0 | NS |  | 0 | 0 | 0136 |  |  |  |  |
| *Bad Address Indicator* | *17* | ID | 0 | NS |  | 0 | 0 | 0136 |  |  |  |  |
| *Address Usage* | *18* | ID | 0 | NS |  | 0 | 0 | 0617 |  |  |  |  |
| *Addressee* | *19* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Comment* | *20* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Preference Order* | *21* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Protection Code* | *22* | CWE | 0 | NS |  | 0 | 0 | 0618 |  |  |  |  |
| *Address Identifier* | *23* | EI | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Contact Location | 4 | PL | 2830 | NS | False | 0 | 0 |  |  |  |  | 11.6.4.4 |
| Contact Communication Information | 5 | XTN | 2543 | RE | True | 0 | \* |  |  |  |  | 11.6.4.5 |
| *Telecommunication Use Code* | *1* | ID | 3 | RE |  | 0 | 1 | 0201 |  |  | NET | File: 368 Field: 16.01, 16.02, 16.03 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *PER03,PER05,PER07 Communication* | | | | | | | | | | |  |  |
| *Number Qualifier* | | | | | | | | | | |  |  |
| *Telecommunication Equipment Type* | *2* | ID | 8 | RE |  | 0 | 1 | 0202 |  |  | Internet | File: 368 Field: 16.01, 16.02, 16.03 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *PER03,PER05,PER07 Communication* | | | | | | | | | | |  |  |
| *Number Qualifier* | | | | | | | | | | |  |  |
| *Communication Address* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Country Code* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Area/City Code* | *5* | NM | 5 | RE |  | 0 | 1 |  |  |  |  | File: 368 Field: 17.01, 18.01, 19.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *PER04,PER06,PER08 Payer Contact* | | | | | | | | | | |  |  |
| *Communication Number (Payer Contact* | | | | | | | | | | |  |  |
| *Communication Number)* | | | | | | | | | | |  |  |
| *Local Number* | *6* | NM | 100 | RE |  | 0 | 1 |  |  |  | 8881112222 | File: 368 Field: 17.01, 18.01, 19.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *PER04,PER06,PER08 Payer Contact* | | | | | | | | | | |  |  |
| *Communication Number (Payer Contact* | | | | | | | | | | |  |  |
| *Communication Number)* | | | | | | | | | | |  |  |
| *Extension* | *7* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Any Text* | *8* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Extension Prefix* | *9* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Speed Dial Code* | *10* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Unformatted Telephone number* | *11* | ST | 199 | C |  | 0 | 1 |  |  |  |  |  |
| *Effective Start Date* | *12* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *13* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Reason* | *14* | CWE | 0 | NS |  | 0 | 0 | 0868 |  |  |  |  |
| *Protection Code* | *15* | CWE | 0 | NS |  | 0 | 0 | 0618 |  |  |  |  |
| *Shared Telecommunication Identifier* | *16* | EI | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Preference Order* | *17* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Preferred Method of Contact | 6 | CWE | 705 | RE | False | 0 | 1 | 0185 |  |  |  | 11.6.4.6 |
| *Identifier* | *1* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Text* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Coding System* | *3* | ID | 20 | RE |  | 0 | 1 | 0396 |  |  |  |  |
| *Alternate Identifier* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Alternate Text* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Alternate Coding System* | *6* | ID | 0 | NS |  | 0 | 0 | 0396 |  |  |  |  |
| *Coding System Version ID* | *7* | ST | 10 | C |  | 0 | 1 |  |  |  |  |  |
| *Alternate Coding System Version ID* | *8* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Original Text* | *9* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Contact Identifiers | 7 | PLN | 100 | RE | True | 0 | \* | 0338 |  |  |  | 11.6.4.7 |
| *ID Number* | *1* | ST | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *Type of ID Number* | *2* | IS | 8 | R |  | 1 | 1 | 0338 |  |  |  |  |
| *State/other Qualifying Information* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *4* | DT | 0 | NS |  | 0 | 0 |  |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Segment** | **Description** | **Opt** | **Rep** | **Min** | **Max** | **Reference** |
| IVC | Invoice Segment | R | False |  |  | 16.4.2 |

**Fields**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Seq** | **DT** | **Len** | **Opt** | **Rep** | **Min** | **Max** | **Tbl** | **Predicate** | **Fx Val** | **Ex Val** | **Reference** |
| Provider Invoice Number | 1 | EI | 424 | R | False | 1 | 1 |  |  |  |  | 16.4.2.1 |
| *Entity Identifier* | *1* | ST | 199 | R |  | 1 | 1 |  |  |  |  |  |
| *Namespace ID* | *2* | IS | 0 | NS |  | 0 | 0 | 0363 |  |  |  |  |
| *Universal ID* | *3* | ST | 199 | C |  | 0 | 1 |  |  |  |  |  |
| *Universal ID Type* | *4* | ID | 6 | C |  | 0 | 1 | 0301 |  |  |  |  |
| Payer Invoice Number | 2 | EI | 427 | R | False | 1 | 1 |  |  |  |  | 16.4.2.2 |
| *Entity Identifier* | *1* | ST | 50 | R |  | 1 | 1 |  |  |  |  | File: 368 Field: 11.02 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *TRN02 Reference Identification (Payer* | | | | | | | | | | |  |  |
| *Claim Control Number)* | | | | | | | | | | |  |  |
| *Namespace ID* | *2* | IS | 0 | NS |  | 0 | 0 | 0363 |  |  |  |  |
| *Universal ID* | *3* | ST | 199 | C |  | 0 | 1 |  |  |  |  |  |
| *Universal ID Type* | *4* | ID | 6 | C |  | 0 | 1 | 0301 |  |  |  |  |
| Contract/Agreement Number | 3 | EI | 427 | NS | False | 0 | 0 |  |  |  |  | 16.4.2.3 |
| Invoice Control | 4 | IS | 2 | R | False | 1 | 1 | 0553 |  |  |  | 16.4.2.4 |
| Invoice Reason | 5 | IS | 4 | R | False | 1 | 1 | 0554 |  |  |  | 16.4.2.5 |
| Invoice Type | 6 | IS | 2 | R | False | 1 | 1 | 0555 |  |  |  | 16.4.2.6 |
| Invoice Date/Time | 7 | DTM | 24 | R | False | 1 | 1 |  |  |  |  | File: 368 Field: 14.05 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *DTP03 Date Time Period (Claim Service* | | | | | | | | | | |  |  |
| *Period)* | | | | | | | | | | |  |  |
| Invoice Amount | 8 | CP | 765 | R | False | 1 | 1 |  |  |  |  | 16.4.2.8 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| Payment Terms | 9 | ST | 80 | NS | False | 0 | 0 |  |  |  |  | 16.4.2.9 |
| Provider Organization | 10 | XON | 5066 | R | False | 1 | 1 |  |  |  |  | 16.4.2.10 |
| *Organization Name* | *1* | ST | 60 | R |  | 1 | 1 |  |  |  | Provider Corp | File: 368 Field: 7.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *NM103 Provider Last or Organization* | | | | | | | | | | |  |  |
| *Name (Provider Last or Organization* | | | | | | | | | | |  |  |
| *Name), NM104 Name First, NM105 Name* | | | | | | | | | | |  |  |
| *Middle, NM107 Name Suffix* | | | | | | | | | | |  |  |
| *Organization Name Type Code* | *2* | IS | 1 | RE |  | 0 | 1 | 0204 |  |  |  |  |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *NM102 Entity Type Qualifier* | | | | | | | | | | |  |  |
| *ID Number* | *3* | NM | 3 | RE |  | 0 | 1 |  |  |  | 1P | File: 368 Field: 8.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *NM101 Entity Identifier Code* | | | | | | | | | | |  |  |
| *Identifier Check Digit* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Check Digit Scheme* | *5* | ID | 0 | NS |  | 0 | 0 | 0061 |  |  |  |  |
| *Assigning Authority* | *6* | HD | 0 | NS |  | 0 | 0 | 0363 |  |  |  |  |
| *Identifier Type Code* | *7* | ID | 0 | NS |  | 0 | 0 | 0203 |  |  |  |  |
| *Assigning Facility* | *8* | HD | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name Representation Code* | *9* | ID | 0 | NS |  | 0 | 0 | 0465 |  |  |  |  |
| *Organization Identifier* | *10* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Payer Organization | 11 | XON | 2146 | R | False | 1 | 1 |  |  |  |  |  |
| *Organization Name* | *1* | ST | 60 | R |  | 1 | 1 |  |  |  |  | File: 368 Field: 1.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *NM103 Name Last or Organization Name* | | | | | | | | | | |  |  |
| *(Payer Name)* | | | | | | | | | | |  |  |
| *Organization Name Type Code* | *2* | IS | 0 | NS |  | 0 | 0 | 0204 |  |  |  |  |
| *ID Number* | *3* | NM | 80 | R |  | 1 | 1 |  |  |  |  | File: 368 Field: 1.02 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *NM109 Identification Code (Payer* | | | | | | | | | | |  |  |
| *Identifier)* | | | | | | | | | | |  |  |
| *Identifier Check Digit* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Check Digit Scheme* | *5* | ID | 0 | NS |  | 0 | 0 | 0061 |  |  |  |  |
| *Assigning Authority* | *6* | HD | 0 | NS |  | 0 | 0 | 0363 |  |  |  |  |
| *Identifier Type Code* | *7* | ID | 2 | R |  | 1 | 1 | 0203 |  |  |  |  |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *NM108 Identification Code Qualifier* | | | | | | | | | | |  |  |
| *Assigning Facility* | *8* | HD | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name Representation Code* | *9* | ID | 0 | NS |  | 0 | 0 | 0465 |  |  |  |  |
| *Organization Identifier* | *10* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Attention | 12 | XCN | 4751 | RE | False | 0 | 1 |  |  |  |  | 16.4.2.12 |
| ID Number | 1 | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Family Name* | *2* | FN | 194 | RE |  | 0 | 1 |  |  |  |  |  |
| *�  Surname* | *1* | ST | 50 | R |  | 1 | 1 |  |  |  |  | File: 368 Field: 15.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *PER02 Payer Contact Name* | | | | | | | | | | |  |  |
| *�  Own Surname Prefix* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Own Surname* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Surname Prefix from Partner/Spouse* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Surname from Partner/Spouse* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Given Name* | *3* | ST | 30 | RE |  | 0 | 1 |  |  |  |  | File: 368 Field: 15.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *PER02 Payer Contact Name* | | | | | | | | | | |  |  |
| *Second and Further Given Names or Initials Thereof* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Suffix (e.g., JR or III)* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Prefix (e.g., DR)* | *6* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Degree (e.g., MD)* | *7* | IS | 0 | NS |  | 0 | 0 | 0360 |  |  |  |  |
| *Source Table* | *8* | IS | 4 | C |  | 0 | 1 | 0297 |  |  |  |  |
| *Assigning Authority* | *9* | HD | 0 | NS |  | 0 | 0 | 0363 |  |  |  |  |
| *Name Type Code* | *10* | ID | 0 | NS |  | 0 | 0 | 0200 |  |  |  |  |
| *Identifier Check Digit* | *11* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Check Digit Scheme* | *12* | ID | 3 | C |  | 0 | 1 | 0061 |  |  |  |  |
| *Identifier Type Code* | *13* | ID | 0 | NS |  | 0 | 0 | 0203 |  |  |  |  |
| *Assigning Facility* | *14* | HD | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name Representation Code* | *15* | ID | 0 | NS |  | 0 | 0 | 0465 |  |  |  |  |
| *Name Context* | *16* | CWE | 0 | NS |  | 0 | 0 | 0448 |  |  |  |  |
| *Name Validity Range* | *17* | DR | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name Assembly Order* | *18* | ID | 0 | NS |  | 0 | 0 | 0444 |  |  |  |  |
| *Effective Date* | *19* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *20* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Professional Suffix* | *21* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Jurisdiction* | *22* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Agency or Department* | *23* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Last Invoice Indicator | 13 | ID | 1 | NS | False | 0 | 0 | 0136 |  |  |  | 16.4.2.13 |
| Invoice Booking Period | 14 | DTM | 24 | NS | False | 0 | 0 |  |  |  |  | 16.4.2.14 |
| Origin | 15 | ST | 250 | NS | False | 0 | 0 |  |  |  |  | 16.4.2.15 |
| Invoice Fixed Amount | 16 | CP | 765 | RE | False | 0 | 1 |  |  |  |  | 16.4.2.16 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| Special Costs | 17 | CP | 765 | RE | False | 0 | 1 |  |  |  |  | 16.4.2.17 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| Amount for Doctors Treatment | 18 | CP | 765 | RE | False | 0 | 1 |  |  |  |  | 16.4.2.18 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| Responsible Physician | 19 | XCN | 4751 | RE | False | 0 | 1 |  |  |  |  | 16.4.2.19 |
| *ID Number* | *1* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Family Name* | *2* | FN | 194 | RE |  | 0 | 1 |  |  |  |  |  |
| *�  Surname* | *1* | ST | 50 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Own Surname Prefix* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Own Surname* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Surname Prefix from Partner/Spouse* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Surname from Partner/Spouse* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Given Name* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Second and Further Given Names or Initials Thereof* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Suffix (e.g., JR or III)* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Prefix (e.g., DR)* | *6* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Degree (e.g., MD)* | *7* | IS | 0 | NS |  | 0 | 0 | 0360 |  |  |  |  |
| *Source Table* | *8* | IS | 4 | C |  | 0 | 1 | 0297 |  |  |  |  |
| *Assigning Authority* | *9* | HD | 0 | NS |  | 0 | 0 | 0363 |  |  |  |  |
| *Name Type Code* | *10* | ID | 0 | NS |  | 0 | 0 | 0200 |  |  |  |  |
| *Identifier Check Digit* | *11* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Check Digit Scheme* | *12* | ID | 3 | C |  | 0 | 1 | 0061 |  |  |  |  |
| *Identifier Type Code* | *13* | ID | 0 | NS |  | 0 | 0 | 0203 |  |  |  |  |
| *Assigning Facility* | *14* | HD | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name Representation Code* | *15* | ID | 0 | NS |  | 0 | 0 | 0465 |  |  |  |  |
| *Name Context* | *16* | CWE | 0 | NS |  | 0 | 0 | 0448 |  |  |  |  |
| *Name Validity Range* | *17* | DR | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name Assembly Order* | *18* | ID | 0 | NS |  | 0 | 0 | 0444 |  |  |  |  |
| *Effective Date* | *19* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *20* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Professional Suffix* | *21* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Jurisdiction* | *22* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Agency or Department* | *23* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Cost Center | 20 | CX | 3512 | RE | False | 0 | 1 |  |  |  |  | 16.4.2.20 |
| *ID Number* | *1* | ST | 15 | R |  | 1 | 1 |  |  |  |  |  |
| *Identifier Check Digit* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Check Digit Scheme* | *3* | ID | 0 | NS |  | 0 | 0 | 0061 |  |  |  |  |
| *Assigning Authority* | *4* | HD | 0 | NS |  | 0 | 0 | 0363 |  |  |  |  |
| *Identifier Type Code* | *5* | ID | 0 | NS |  | 0 | 0 | 0203 |  |  |  |  |
| *Assigning Facility* | *6* | HD | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Effective Date* | *7* | DT | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *8* | DT | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Jurisdiction* | *9* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Agency or Department* | *10* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Invoice Prepaid Amount | 21 | CP | 765 | RE | False | 0 | 1 |  |  |  |  | 16.4.2.21 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| Total Invoice Amount without Prepaid Amount | 22 | CP | 765 | RE | False | 0 | 1 |  |  |  |  | 16.4.2.22 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| Total-Amount of VAT | 23 | CP | 765 | C | False | 0 | 1 |  |  |  |  | 16.4.2.23 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| VAT-Rates applied | 24 | NM | 1024 | NS | False | 0 | 0 |  |  |  |  | 16.4.2.24 |
| Benefit Group | 25 | IS | 4 | R | False | 1 | 1 | 0556 |  |  |  | 16.4.2.25 |
| Provider Tax ID | 26 | ST | 80 | RE | False | 0 | 1 |  |  |  |  | File: 368 Field: 8.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *NM108 Service Provider Federal* | | | | | | | | | | |  |  |
| *Taxapayer Code* | | | | | | | | | | |  |  |
| Payer Tax ID | 27 | ST | 20 | NS | False | 0 | 0 |  |  |  |  | 16.4.2.27 |
| Provider Tax status | 28 | IS | 2 | RE | False | 0 | 1 | 0572 |  |  |  | 16.4.2.28 |
| Payer Tax status | 29 | IS | 4 | NS | False | 0 | 0 | 0572 |  |  |  | 16.4.2.29 |
| Sales Tax ID | 30 | ST | 20 | NS | False | 0 | 0 |  |  |  |  | 16.4.2.30 |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Segment** | **Description** | **Opt** | **Rep** | **Min** | **Max** | **Reference** |
| PID | Patient Identification | RE | False |  |  | 3.4.2 |

**Fields**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Seq** | **DT** | **Len** | **Opt** | **Rep** | **Min** | **Max** | **Tbl** | **Predicate** | **Fx Val** | **Ex Val** | **Reference** |
| Set ID - PID | 1 | SI | 4 | NS | False | 0 | 0 |  |  |  |  | 3.4.2.1 |
| Patient ID | 2 | CX | 3516 | NS | False | 0 | 0 |  |  |  |  | 3.4.2.2 |
| Patient Identifier List | 3 | CX | 3512 | R | True | 1 | \* |  |  |  |  | 3.4.2.3 |
| *ID Number* | *1* | ST | 80 | R |  | 1 | 1 |  |  |  |  | File: 368 Field: 10.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *NM109 Identification Code (Primary* | | | | | | | | | | |  |  |
| *Identifier)* | | | | | | | | | | |  |  |
| *Identifier Check Digit* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Check Digit Scheme* | *3* | ID | 0 | NS |  | 0 | 0 | 0061 |  |  |  |  |
| *Assigning Authority* | *4* | HD | 0 | NS |  | 0 | 0 | 0363 |  |  |  |  |
| *Identifier Type Code* | *5* | ID | 2 | RE |  | 0 | 1 | 0203 |  |  |  |  |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *NM108 Identification Code Qualifier* | | | | | | | | | | |  |  |
| *Assigning Facility* | *6* | HD | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Effective Date* | *7* | DT | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *8* | DT | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Jurisdiction* | *9* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Agency or Department* | *10* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Patient Identifier List | 3 | CX | 3512 | R | False | 1 | 1 |  |  |  |  |  |
| *ID Number* | *1* | ST | 50 | RE |  | 0 | 1 |  |  |  |  | File: 368 Field: 11.03 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *REF02 Reference Identification (Medical* | | | | | | | | | | |  |  |
| *Record Identification Number)* | | | | | | | | | | |  |  |
| *Identifier Check Digit* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Check Digit Scheme* | *3* | ID | 0 | NS |  | 0 | 0 | 0061 |  |  |  |  |
| *Assigning Authority* | *4* | HD | 0 | NS |  | 0 | 0 | 0363 |  |  |  |  |
| *Identifier Type Code* | *5* | ID | 2 | RE |  | 0 | 1 | 0203 |  |  |  |  |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *REF01 Reference Identification Qualifier* | | | | | | | | | | |  |  |
| *Assigning Facility* | *6* | HD | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Effective Date* | *7* | DT | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *8* | DT | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Jurisdiction* | *9* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Agency or Department* | *10* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Patient Identifier List | 3 | CX | 3512 | R | False | 1 | 1 |  |  |  |  |  |
| *ID Number* | *1* | ST | 50 | R |  | 1 | 1 |  |  |  |  | File: 368 Field: 11.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *REF02 Reference Identification (Patient* | | | | | | | | | | |  |  |
| *Control Number)* | | | | | | | | | | |  |  |
| *Identifier Check Digit* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Check Digit Scheme* | *3* | ID | 0 | NS |  | 0 | 0 | 0061 |  |  |  |  |
| *Assigning Authority* | *4* | HD | 0 | NS |  | 0 | 0 | 0363 |  |  |  |  |
| *Identifier Type Code* | *5* | ID | 3 | RE |  | 0 | 1 | 0203 |  |  |  |  |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *REF01 Reference Identification Qualifier* | | | | | | | | | | |  |  |
| *Assigning Facility* | *6* | HD | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Effective Date* | *7* | DT | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *8* | DT | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Jurisdiction* | *9* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Agency or Department* | *10* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Alternate Patient ID - PID | 4 | CX | 3516 | NS | False | 0 | 0 |  |  |  |  | 3.4.2.4 |
| Patient Name | 5 | XPN | 1262 | R | True | 1 | \* | 0200 |  |  |  | 3.4.2.5 |
| *Family Name* | *1* | FN | 194 | RE |  | 0 | 1 |  |  |  |  |  |
| *�  Surname* | *1* | ST | 60 | R |  | 1 | 1 |  |  |  |  | File: 368 Field: 9.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *NM103 Name Last or Organization Name* | | | | | | | | | | |  |  |
| *(Patient Last Name)* | | | | | | | | | | |  |  |
| *�  Own Surname Prefix* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Own Surname* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Surname Prefix from Partner/Spouse* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Surname from Partner/Spouse* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Given Name* | *2* | ST | 35 | RE |  | 0 | 1 |  |  |  | John | File: 368 Field: 9.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *NM104 Name First (Patient First Name)* | | | | | | | | | | |  |  |
| *Second and Further Given Names or Initials Thereof* | *3* | ST | 1 | RE |  | 0 | 1 |  |  |  |  | File: 368 Field: 9.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *NM105 Name Middle (Patient Middle Name* | | | | | | | | | | |  |  |
| *or Initial)* | | | | | | | | | | |  |  |
| *Suffix (e.g., JR or III)* | *4* | ST | 1 | RE |  | 0 | 1 |  |  |  |  | File: 368 Field: 9.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *NM107 Name Suffix (Patient Name Suffix)* | | | | | | | | | | |  |  |
| *Prefix (e.g., DR)* | *5* | ST | 10 | RE |  | 0 | 1 |  |  |  | Mr | File: 368 Field: 9.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *NM106 Name Prefix* | | | | | | | | | | |  |  |
| *Degree (e.g., MD)* | *6* | IS | 0 | NS |  | 0 | 0 | 0360 |  |  |  |  |
| *Name Type Code* | *7* | ID | 0 | NS |  | 0 | 0 | 0200 |  |  |  |  |
| *Name Representation Code* | *8* | ID | 0 | NS |  | 0 | 0 | 0465 |  |  |  |  |
| *Name Context* | *9* | CWE | 0 | NS |  | 0 | 0 | 0448 |  |  |  |  |
| *Name Validity Range* | *10* | DR | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name Assembly Order* | *11* | ID | 0 | NS |  | 0 | 0 | 0444 |  |  |  |  |
| *Effective Date* | *12* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *13* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Professional Suffix* | *14* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Mother's Maiden Name | 6 | XPN | 1262 | RE | True | 0 | \* |  |  |  |  | 3.4.2.6 |
| *Family Name* | *1* | FN | 194 | RE |  | 0 | 1 |  |  |  |  |  |
| *�  Surname* | *1* | ST | 50 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Own Surname Prefix* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Own Surname* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Surname Prefix from Partner/Spouse* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Surname from Partner/Spouse* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Given Name* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Second and Further Given Names or Initials Thereof* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Suffix (e.g., JR or III)* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Prefix (e.g., DR)* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Degree (e.g., MD)* | *6* | IS | 0 | NS |  | 0 | 0 | 0360 |  |  |  |  |
| *Name Type Code* | *7* | ID | 0 | NS |  | 0 | 0 | 0200 |  |  |  |  |
| *Name Representation Code* | *8* | ID | 0 | NS |  | 0 | 0 | 0465 |  |  |  |  |
| *Name Context* | *9* | CWE | 0 | NS |  | 0 | 0 | 0448 |  |  |  |  |
| *Name Validity Range* | *10* | DR | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name Assembly Order* | *11* | ID | 0 | NS |  | 0 | 0 | 0444 |  |  |  |  |
| *Effective Date* | *12* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *13* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Professional Suffix* | *14* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Date/Time of Birth | 7 | DTM | 24 | NS | False | 0 | 0 |  |  |  |  | 3.4.2.7 |
| Administrative Sex | 8 | IS | 1 | NS | False | 0 | 0 | 0001 |  |  |  | 3.4.2.8 |
| Patient Alias | 9 | XPN | 1262 | NS | False | 0 | 0 |  |  |  |  | 3.4.2.9 |
| Race | 10 | CWE | 705 | NS | False | 0 | 0 | 0005 |  |  |  | 3.4.2.10 |
| Patient Address | 11 | XAD | 2866 | NS | False | 0 | 0 |  |  |  |  | 3.4.2.11 |
| County Code | 12 | IS | 1 | NS | False | 0 | 0 | 0289 |  |  |  | 3.4.2.12 |
| Phone Number - Home | 13 | XTN | 2543 | NS | False | 0 | 0 |  |  |  |  | 3.4.2.13 |
| Phone Number - Business | 14 | XTN | 2543 | NS | False | 0 | 0 |  |  |  |  | 3.4.2.14 |
| Primary Language | 15 | CWE | 705 | NS | False | 0 | 0 | 0296 |  |  |  | 3.4.2.15 |
| Marital Status | 16 | CWE | 705 | NS | False | 0 | 0 | 0002 |  |  |  | 3.4.2.16 |
| Religion | 17 | CWE | 705 | NS | False | 0 | 0 | 0006 |  |  |  | 3.4.2.17 |
| Patient Account Number | 18 | CX | 3512 | RE | False | 0 | 1 |  |  |  |  | 3.4.2.18 |
| *ID Number* | *1* | ST | 15 | R |  | 1 | 1 |  |  |  |  |  |
| *Identifier Check Digit* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Check Digit Scheme* | *3* | ID | 0 | NS |  | 0 | 0 | 0061 |  |  |  |  |
| *Assigning Authority* | *4* | HD | 0 | NS |  | 0 | 0 | 0363 |  |  |  |  |
| *Identifier Type Code* | *5* | ID | 0 | NS |  | 0 | 0 | 0203 |  |  |  |  |
| *Assigning Facility* | *6* | HD | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Effective Date* | *7* | DT | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *8* | DT | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Jurisdiction* | *9* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Agency or Department* | *10* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| SSN Number - Patient | 19 | ST | 1 | NS | False | 0 | 0 |  |  |  |  | 3.4.2.19 |
| Driver's License Number - Patient | 20 | DLN | 50 | NS | False | 0 | 0 |  |  |  |  | 3.4.2.20 |
| Mother's Identifier | 21 | CX | 3512 | RE | True | 0 | \* |  |  |  |  | 3.4.2.21 |
| *ID Number* | *1* | ST | 15 | R |  | 1 | 1 |  |  |  |  |  |
| *Identifier Check Digit* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Check Digit Scheme* | *3* | ID | 0 | NS |  | 0 | 0 | 0061 |  |  |  |  |
| *Assigning Authority* | *4* | HD | 0 | NS |  | 0 | 0 | 0363 |  |  |  |  |
| *Identifier Type Code* | *5* | ID | 0 | NS |  | 0 | 0 | 0203 |  |  |  |  |
| *Assigning Facility* | *6* | HD | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Effective Date* | *7* | DT | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *8* | DT | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Jurisdiction* | *9* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Agency or Department* | *10* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Ethnic Group | 22 | CWE | 705 | NS | False | 0 | 0 | 0189 |  |  |  | 3.4.2.22 |
| Birth Place | 23 | ST | 250 | NS | False | 0 | 0 |  |  |  |  | 3.4.2.23 |
| Multiple Birth Indicator | 24 | ID | 1 | NS | False | 0 | 0 | 0136 |  |  |  | 3.4.2.24 |
| Birth Order | 25 | NM | 2 | NS | False | 0 | 0 |  |  |  |  | 3.4.2.25 |
| Citizenship | 26 | CWE | 705 | NS | False | 0 | 0 | 0171 |  |  |  | 3.4.2.26 |
| Veterans Military Status | 27 | CWE | 705 | NS | False | 0 | 0 | 0172 |  |  |  | 3.4.2.27 |
| Nationality | 28 | CWE | 705 | NS | False | 0 | 0 | 0212 |  |  |  | 3.4.2.28 |
| Patient Death Date and Time | 29 | DTM | 24 | NS | False | 0 | 0 |  |  |  |  | 3.4.2.29 |
| Patient Death Indicator | 30 | ID | 1 | NS | False | 0 | 0 | 0136 |  |  |  | 3.4.2.30 |
| Identity Unknown Indicator | 31 | ID | 1 | NS | False | 0 | 0 | 0136 |  |  |  | 3.4.2.31 |
| Identity Reliability Code | 32 | IS | 20 | NS | False | 0 | 0 | 0445 |  |  |  | 3.4.2.32 |
| Last Update Date/Time | 33 | DTM | 24 | NS | False | 0 | 0 |  |  |  |  | 3.4.2.33 |
| Last Update Facility | 34 | HD | 1027 | NS | False | 0 | 0 |  |  |  |  | 3.4.2.34 |
| Species Code | 35 | CWE | 705 | C | False | 0 | 1 | 0446 |  |  |  | 3.4.2.35 |
| *Identifier* | *1* | ST | 20 | RE |  | 0 | 1 |  |  |  |  |  |
| *Text* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Coding System* | *3* | ID | 0 | NS |  | 0 | 0 | 0396 |  |  |  |  |
| *Alternate Identifier* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Alternate Text* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Alternate Coding System* | *6* | ID | 0 | NS |  | 0 | 0 | 0396 |  |  |  |  |
| *Coding System Version ID* | *7* | ST | 10 | C |  | 0 | 1 |  |  |  |  |  |
| *Alternate Coding System Version ID* | *8* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Original Text* | *9* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Breed Code | 36 | CWE | 705 | C | False | 0 | 1 | 0447 |  |  |  | 3.4.2.36 |
| *Identifier* | *1* | ST | 20 | RE |  | 0 | 1 |  |  |  |  |  |
| *Text* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Coding System* | *3* | ID | 0 | NS |  | 0 | 0 | 0396 |  |  |  |  |
| *Alternate Identifier* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Alternate Text* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Alternate Coding System* | *6* | ID | 0 | NS |  | 0 | 0 | 0396 |  |  |  |  |
| *Coding System Version ID* | *7* | ST | 10 | C |  | 0 | 1 |  |  |  |  |  |
| *Alternate Coding System Version ID* | *8* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Original Text* | *9* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Strain | 37 | ST | 80 | NS | False | 0 | 0 |  |  |  |  | 3.4.2.37 |
| Production Class Code | 38 | CWE | 705 | NS | False | 0 | 0 | 0429 |  |  |  | 3.4.2.38 |
| Tribal Citizenship | 39 | CWE | 705 | NS | False | 0 | 0 | 0171 |  |  |  | 3.4.2.39 |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Segment** | **Description** | **Opt** | **Rep** | **Min** | **Max** | **Reference** |
| PSL | Product/Service Line Item | RE | True |  |  | 16.4.6 |

**Fields**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Seq** | **DT** | **Len** | **Opt** | **Rep** | **Min** | **Max** | **Tbl** | **Predicate** | **Fx Val** | **Ex Val** | **Reference** |
| Provider Product/Service Line Item Number | 1 | EI | 424 | R | False | 1 | 1 |  |  |  |  | 16.4.6.1 |
| *Entity Identifier* | *1* | ST | 199 | RE |  | 0 | 1 |  |  |  |  | File 368 Field 24.04 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *REF02 Reference Identification (Line Item* | | | | | | | | | | |  |  |
| *Control Number)* | | | | | | | | | | |  |  |
| *Namespace ID* | *2* | IS | 0 | NS |  | 0 | 0 | 0363 |  |  |  |  |
| *Universal ID* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Universal ID Type* | *4* | ID | 6 | C |  | 0 | 1 | 0301 |  |  |  |  |
| Payer Product/Service Line Item Number | 2 | EI | 427 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.2 |
| Product/Service Line Item Sequence Number | 3 | SI | 4 | R | False | 1 | 1 |  |  |  |  | 16.4.6.3 |
| Provider Tracking ID | 4 | EI | 427 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.4 |
| Payer Tracking ID | 5 | EI | 427 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.5 |
| Product/Service Line Item Status | 6 | CWE | 697 | R | False | 1 | 1 | 0559 |  |  |  | 16.4.6.6 |
| *Identifier* | *1* | ST | 1 | RE |  | 0 | 1 |  |  |  |  | File: 368 Field: 9.01, 14.01, 14.03 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *STC01,STC10,STC11 Health Care Claim* | | | | | | | | | | |  |  |
| *Status* | | | | | | | | | | |  |  |
| *Text* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Coding System* | *3* | ID | 0 | NS |  | 0 | 0 | 0396 |  |  |  |  |
| *Alternate Identifier* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Alternate Text* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Alternate Coding System* | *6* | ID | 0 | NS |  | 0 | 0 | 0396 |  |  |  |  |
| *Coding System Version ID* | *7* | ST | 10 | C |  | 0 | 1 |  |  |  |  |  |
| *Alternate Coding System Version ID* | *8* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Original Text* | *9* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Product/Service Code | 7 | CWE | 697 | R | False | 1 | 1 | 0879 |  |  |  | 16.4.6.7 |
| *Identifier* | *1* | ST | 30 | R |  | 1 | 1 |  |  |  |  | File 368 Field 22.01, 23.01, 24.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *STC01-1,STC10-1,STC11-1 Industry* | | | | | | | | | | |  |  |
| *Code (Health Care Claim Status Category* | | | | | | | | | | |  |  |
| *Code)* | | | | | | | | | | |  |  |
| *Text* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Coding System* | *3* | ID | 0 | NS |  | 0 | 0 | 0396 |  |  |  |  |
| *Alternate Identifier* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Alternate Text* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Alternate Coding System* | *6* | ID | 0 | NS |  | 0 | 0 | 0396 |  |  |  |  |
| Coding System Version ID | 7 | ST | 10 | C |  | 0 | 1 |  |  |  |  |  |
| Alternate Coding System Version ID | 8 | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Original Text | 9 | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Product/Service Code Modifier | 8 | CWE | 715 | RE | False | 0 | 1 | 0880 |  |  |  | 16.4.6.8 |
| *Identifier* | *1* | ST | 30 | RE |  | 0 | 1 |  |  |  |  | File: 368 Field: 14.02, 14.04 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *STC01-2,STC10-2,STC11-2 Industry* | | | | | | | | | | |  |  |
| *Code (Additional Information Request* | | | | | | | | | | |  |  |
| *Modifier)* | | | | | | | | | | |  |  |
| *Text* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Coding System* | *3* | ID | 0 | NS |  | 0 | 0 | 0396 |  |  |  |  |
| *Alternate Identifier* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Alternate Text* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Alternate Coding System* | *6* | ID | 0 | NS |  | 0 | 0 | 0396 |  |  |  |  |
| *Coding System Version ID* | *7* | ST | 10 | C |  | 0 | 1 |  |  |  |  |  |
| *Alternate Coding System Version ID* | *8* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Original Text* | *9* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Product/Service Code Description | 9 | ST | 80 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.9 |
| Product/Service Effective Date | 10 | DTM | 8 | RE | False | 0 | 1 |  |  |  |  | File: 368 Field: 13.03 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *STC02 Date (Status Information Effective* | | | | | | | | | | |  |  |
| *Date)* | | | | | | | | | | |  |  |
| Product/Service Expiration Date | 11 | DTM | 24 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.11 |
| Product/Service Quantity | 12 | CQ | 721 | C | False | 0 | 1 | 0560 |  |  |  | 16.4.6.12 |
| *Quantity* | *1* | NM | 16 | RE |  | 0 | 1 |  |  |  |  |  |
| *Units* | *2* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Product/Service Unit Cost | 13 | CP | 765 | C | False | 0 | 1 |  |  |  |  | 16.4.6.13 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| Number of Items per Unit | 14 | NM | 10 | C | False | 0 | 1 |  |  |  |  | 16.4.6.14 |
| Product/Service Gross Amount | 15 | CP | 765 | C | False | 0 | 1 |  |  |  |  | 16.4.6.15 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| Product/Service Billed Amount | 16 | CP | 765 | C | False | 0 | 1 |  |  |  |  | 16.4.6.16 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  | File: 368 Field: 21.07 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *SVC-02 Monetary Amount (Line item* | | | | | | | | | | |  |  |
| *Charge Amount)* | | | | | | | | | | |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| Product/Service Clarification Code Type | 17 | IS | 10 | NS | False | 0 | 0 | 0561 |  |  |  | 16.4.6.17 |
| Product/Service Clarification Code Value | 18 | ST | 40 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.18 |
| Health Document Reference Identifier | 19 | EI | 427 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.19 |
| Processing Consideration Code | 20 | IS | 10 | NS | False | 0 | 0 | 0562 |  |  |  | 16.4.6.20 |
| Restricted Disclosure Indicator | 21 | ID | 2 | R | False | 1 | 1 | 0532 |  |  |  | 16.4.6.21 |
| Related Product/Service Code Indicator | 22 | CWE | 705 | NS | False | 0 | 0 | 0879 |  |  |  | 16.4.6.22 |
| Product/Service Amount for Physician | 23 | CP | 765 | RE | False | 0 | 1 |  |  |  |  | 16.4.6.23 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| Product/Service Cost Factor | 24 | NM | 5 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.24 |
| Cost Center | 25 | CX | 3512 | RE | False | 0 | 1 |  |  |  |  | 16.4.6.25 |
| *ID Number* | *1* | ST | 15 | R |  | 1 | 1 |  |  |  |  |  |
| *Identifier Check Digit* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Check Digit Scheme* | *3* | ID | 0 | NS |  | 0 | 0 | 0061 |  |  |  |  |
| *Assigning Authority* | *4* | HD | 0 | NS |  | 0 | 0 | 0363 |  |  |  |  |
| *Identifier Type Code* | *5* | ID | 0 | NS |  | 0 | 0 | 0203 |  |  |  |  |
| *Assigning Facility* | *6* | HD | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Effective Date* | *7* | DT | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *8* | DT | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Jurisdiction* | *9* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Agency or Department* | *10* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Billing Period | 26 | DR | 49 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.26 |
| Days without Billing | 27 | NM | 5 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.27 |
| Session-No | 28 | NM | 4 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.28 |
| Executing Physician ID | 29 | XCN | 4751 | RE | False | 0 | 1 |  |  |  |  | 16.4.6.29 |
| *ID Number* | *1* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Family Name* | *2* | FN | 194 | RE |  | 0 | 1 |  |  |  |  |  |
| *�  Surname* | *1* | ST | 50 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Own Surname Prefix* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Own Surname* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Surname Prefix from Partner/Spouse* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Surname from Partner/Spouse* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Given Name* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Second and Further Given Names or Initials Thereof* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Suffix (e.g., JR or III)* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Prefix (e.g., DR)* | *6* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Degree (e.g., MD)* | *7* | IS | 0 | NS |  | 0 | 0 | 0360 |  |  |  |  |
| *Source Table* | *8* | IS | 4 | C |  | 0 | 1 | 0297 |  |  |  |  |
| *Assigning Authority* | *9* | HD | 0 | NS |  | 0 | 0 | 0363 |  |  |  |  |
| *Name Type Code* | *10* | ID | 0 | NS |  | 0 | 0 | 0200 |  |  |  |  |
| *Identifier Check Digit* | *11* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Check Digit Scheme* | *12* | ID | 3 | C |  | 0 | 1 | 0061 |  |  |  |  |
| *Identifier Type Code* | *13* | ID | 0 | NS |  | 0 | 0 | 0203 |  |  |  |  |
| *Assigning Facility* | *14* | HD | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name Representation Code* | *15* | ID | 0 | NS |  | 0 | 0 | 0465 |  |  |  |  |
| *Name Context* | *16* | CWE | 0 | NS |  | 0 | 0 | 0448 |  |  |  |  |
| *Name Validity Range* | *17* | DR | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name Assembly Order* | *18* | ID | 0 | NS |  | 0 | 0 | 0444 |  |  |  |  |
| *Effective Date* | *19* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *20* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Professional Suffix* | *21* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Jurisdiction* | *22* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Agency or Department* | *23* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Responsible Physician ID | 30 | XCN | 4751 | RE | False | 0 | 1 |  |  |  |  | 16.4.6.30 |
| *ID Number* | *1* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Family Name* | *2* | FN | 194 | RE |  | 0 | 1 |  |  |  |  |  |
| *�  Surname* | *1* | ST | 50 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Own Surname Prefix* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Own Surname* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Surname Prefix from Partner/Spouse* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Surname from Partner/Spouse* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Given Name* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Second and Further Given Names or Initials Thereof* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Suffix (e.g., JR or III)* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Prefix (e.g., DR)* | *6* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Degree (e.g., MD)* | *7* | IS | 0 | NS |  | 0 | 0 | 0360 |  |  |  |  |
| *Source Table* | *8* | IS | 4 | C |  | 0 | 1 | 0297 |  |  |  |  |
| *Assigning Authority* | *9* | HD | 0 | NS |  | 0 | 0 | 0363 |  |  |  |  |
| *Name Type Code* | *10* | ID | 0 | NS |  | 0 | 0 | 0200 |  |  |  |  |
| *Identifier Check Digit* | *11* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Check Digit Scheme* | *12* | ID | 3 | C |  | 0 | 1 | 0061 |  |  |  |  |
| *Identifier Type Code* | *13* | ID | 0 | NS |  | 0 | 0 | 0203 |  |  |  |  |
| *Assigning Facility* | *14* | HD | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name Representation Code* | *15* | ID | 0 | NS |  | 0 | 0 | 0465 |  |  |  |  |
| *Name Context* | *16* | CWE | 0 | NS |  | 0 | 0 | 0448 |  |  |  |  |
| *Name Validity Range* | *17* | DR | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name Assembly Order* | *18* | ID | 0 | NS |  | 0 | 0 | 0444 |  |  |  |  |
| *Effective Date* | *19* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *20* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Professional Suffix* | *21* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Jurisdiction* | *22* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Agency or Department* | *23* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Role Executing Physician | 31 | CWE | 705 | NS | False | 0 | 0 | 0881 |  |  |  | 16.4.6.31 |
| Medical Role Executing Physician | 32 | CWE | 705 | NS | False | 0 | 0 | 0882 |  |  |  | 16.4.6.32 |
| Side of body | 33 | CWE | 705 | NS | False | 0 | 0 | 0894 |  |  |  | 16.4.6.33 |
| Number of TP's PP | 34 | NM | 6 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.34 |
| TP-Value PP | 35 | CP | 765 | RE | False | 0 | 1 |  |  |  |  | 16.4.6.35 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| Internal Scaling Factor PP | 36 | NM | 4 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.36 |
| External Scaling Factor PP | 37 | NM | 4 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.37 |
| Amount PP | 38 | CP | 765 | RE | False | 0 | 1 |  |  |  |  | 16.4.6.38 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| Number of TP's Technical Part | 39 | NM | 6 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.39 |
| TP-Value Technical Part | 40 | CP | 765 | RE | False | 0 | 1 |  |  |  |  | 16.4.6.40 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| Internal Scaling Factor Technical Part | 41 | NM | 4 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.41 |
| External Scaling Factor Technical Part | 42 | NM | 4 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.42 |
| Amount Technical Part | 43 | CP | 765 | RE | False | 0 | 1 |  |  |  |  | 16.4.6.43 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| Total Amount Professional Part + Technical Part | 44 | CP | 765 | RE | False | 0 | 1 |  |  |  |  | 16.4.6.44 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| VAT-Rate | 45 | NM | 3 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.45 |
| Main-Service | 46 | ID | 20 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.46 |
| Validation | 47 | ID | 1 | NS | False | 0 | 0 | 0136 |  |  |  | 16.4.6.47 |
| Comment | 48 | ST | 255 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.48 |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Segment** | **Description** | **Opt** | **Rep** | **Min** | **Max** | **Reference** |
| PSL | Product/Service Line Item | RE | False |  |  | 16.4.6 |

**Fields**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Seq** | **DT** | **Len** | **Opt** | **Rep** | **Min** | **Max** | **Tbl** | **Predicate** | **Fx Val** | **Ex Val** | **Reference** |
| Provider Product/Service Line Item Number | 1 | EI | 424 | R | False | 1 | 1 |  |  |  |  | 16.4.6.1 |
| *Entity Identifier* | *1* | ST | 199 | R |  | 1 | 1 |  |  |  |  |  |
| *Namespace ID* | *2* | IS | 0 | NS |  | 0 | 0 | 0363 |  |  |  |  |
| *Universal ID* | *3* | ST | 199 | C |  | 0 | 1 |  |  |  |  |  |
| *Universal ID Type* | *4* | ID | 6 | C |  | 0 | 1 | 0301 |  |  |  |  |
| Payer Product/Service Line Item Number | 2 | EI | 427 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.2 |
| Product/Service Line Item Sequence Number | 3 | SI | 4 | R | False | 1 | 1 |  |  |  |  | 16.4.6.3 |
| Provider Tracking ID | 4 | EI | 427 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.4 |
| Payer Tracking ID | 5 | EI | 427 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.5 |
| Product/Service Line Item Status | 6 | CWE | 697 | R | False | 1 | 1 | 0559 |  |  |  | 16.4.6.6 |
| *Identifier* | *1* | ST | 1 | RE |  | 0 | 1 |  |  |  |  | File: 368 Field: 13.01, 14.01, 14.03 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *STC01,STC10,STC11 Health Care Claim* | | | | | | | | | | |  |  |
| *Status* | | | | | | | | | | |  |  |
| *Text* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Coding System* | *3* | ID | 0 | NS |  | 0 | 0 | 0396 |  |  |  |  |
| *Alternate Identifier* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Alternate Text* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Alternate Coding System* | *6* | ID | 0 | NS |  | 0 | 0 | 0396 |  |  |  |  |
| *Coding System Version ID* | *7* | ST | 10 | C |  | 0 | 1 |  |  |  |  |  |
| *Alternate Coding System Version ID* | *8* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Original Text* | *9* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Product/Service Code | 7 | CWE | 697 | R | False | 1 | 1 | 0879 |  |  |  | 16.4.6.7 |
| *Identifier* | *1* | ST | 2 | RE |  | 0 | 1 |  |  |  |  | File: 368 Field 21.02, 21.08 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *SVC01-1,SVC-04 Composite Medical* | | | | | | | | | | |  |  |
| *Procedure* | | | | | | | | | | |  |  |
| *Text* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Coding System* | *3* | ID | 0 | NS |  | 0 | 0 | 0396 |  |  |  |  |
| *Alternate Identifier* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Alternate Text* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Alternate Coding System* | *6* | ID | 0 | NS |  | 0 | 0 | 0396 |  |  |  |  |
| *Coding System Version ID* | *7* | ST | 10 | C |  | 0 | 1 |  |  |  |  |  |
| *Alternate Coding System Version ID* | *8* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Original Text* | *9* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Product/Service Code Modifier | 8 | CWE | 715 | RE | False | 0 | 1 | 0880 |  |  |  | 16.4.6.8 |
| *Identifier* | *1* | ST | 2 | RE |  | 0 | 1 |  |  |  |  | File 368 Field 21.03, 21.04, 21.05, 21.06 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *SVC01-3,SVC01-4,SVC01-5,SVC01-6* | | | | | | | | | | |  |  |
| *Product/Service ID Qualifier (Product or* | | | | | | | | | | |  |  |
| *Service ID Qualifier)* | | | | | | | | | | |  |  |
| *Text* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Coding System* | *3* | ID | 0 | NS |  | 0 | 0 | 0396 |  |  |  |  |
| *Alternate Identifier* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Alternate Text* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name of Alternate Coding System* | *6* | ID | 0 | NS |  | 0 | 0 | 0396 |  |  |  |  |
| *Coding System Version ID* | *7* | ST | 10 | C |  | 0 | 1 |  |  |  |  |  |
| *Alternate Coding System Version ID* | *8* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Original Text* | *9* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Product/Service Code Description | 9 | ST | 80 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.9 |
| Product/Service Effective Date | 10 | DTM | 8 | RE | False | 0 | 1 |  |  |  |  | File 368 Field 24.05 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *DTP03 Date Time Period (Service Line* | | | | | | | | | | |  |  |
| *Date)* | | | | | | | | | | |  |  |
| Product/Service Expiration Date | 11 | DTM | 24 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.11 |
| Product/Service Quantity | 12 | CQ | 721 | C | False | 0 | 1 | 0560 |  |  |  | 16.4.6.12 |
| *Quantity* | *1* | NM | 16 | RE |  | 0 | 1 |  |  |  |  |  |
| *Units* | *2* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Product/Service Unit Cost | 13 | CP | 765 | C | False | 0 | 1 |  |  |  |  | 16.4.6.13 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| Number of Items per Unit | 14 | NM | 10 | C | False | 0 | 1 |  |  |  |  | 16.4.6.14 |
| Product/Service Gross Amount | 15 | CP | 765 | C | False | 0 | 1 |  |  |  |  | 16.4.6.15 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| Product/Service Billed Amount | 16 | CP | 765 | C | False | 0 | 1 |  |  |  |  | 16.4.6.16 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 18 | R |  | 1 | 1 |  |  |  |  | File 368 Field 21.07 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *SVC-02 Monetary Amount (Line Item* | | | | | | | | | | |  |  |
| *Charge Amount)* | | | | | | | | | | |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| Product/Service Clarification Code Type | 17 | IS | 10 | NS | False | 0 | 0 | 0561 |  |  |  | 16.4.6.17 |
| Product/Service Clarification Code Value | 18 | ST | 40 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.18 |
| Health Document Reference Identifier | 19 | EI | 427 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.19 |
| Processing Consideration Code | 20 | IS | 10 | NS | False | 0 | 0 | 0562 |  |  |  | 16.4.6.20 |
| Restricted Disclosure Indicator | 21 | ID | 2 | R | False | 1 | 1 | 0532 |  |  |  | 16.4.6.21 |
| Related Product/Service Code Indicator | 22 | CWE | 705 | NS | False | 0 | 0 | 0879 |  |  |  | 16.4.6.22 |
| Product/Service Amount for Physician | 23 | CP | 765 | RE | False | 0 | 1 |  |  |  |  | 16.4.6.23 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| Product/Service Cost Factor | 24 | NM | 5 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.24 |
| Cost Center | 25 | CX | 3512 | RE | False | 0 | 1 |  |  |  |  | 16.4.6.25 |
| *ID Number* | *1* | ST | 15 | R |  | 1 | 1 |  |  |  |  |  |
| *Identifier Check Digit* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Check Digit Scheme* | *3* | ID | 0 | NS |  | 0 | 0 | 0061 |  |  |  |  |
| *Assigning Authority* | *4* | HD | 0 | NS |  | 0 | 0 | 0363 |  |  |  |  |
| *Identifier Type Code* | *5* | ID | 0 | NS |  | 0 | 0 | 0203 |  |  |  |  |
| *Assigning Facility* | *6* | HD | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Effective Date* | *7* | DT | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *8* | DT | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Jurisdiction* | *9* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Agency or Department* | *10* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Billing Period | 26 | DR | 49 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.26 |
| Days without Billing | 27 | NM | 5 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.27 |
| Session-No | 28 | NM | 4 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.28 |
| Executing Physician ID | 29 | XCN | 4751 | RE | False | 0 | 1 |  |  |  |  | 16.4.6.29 |
| *ID Number* | *1* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Family Name* | *2* | FN | 194 | RE |  | 0 | 1 |  |  |  |  |  |
| *�  Surname* | *1* | ST | 50 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Own Surname Prefix* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Own Surname* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Surname Prefix from Partner/Spouse* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Surname from Partner/Spouse* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Given Name* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Second and Further Given Names or Initials Thereof* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Suffix (e.g., JR or III)* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Prefix (e.g., DR)* | *6* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Degree (e.g., MD)* | *7* | IS | 0 | NS |  | 0 | 0 | 0360 |  |  |  |  |
| *Source Table* | *8* | IS | 4 | C |  | 0 | 1 | 0297 |  |  |  |  |
| *Assigning Authority* | *9* | HD | 0 | NS |  | 0 | 0 | 0363 |  |  |  |  |
| *Name Type Code* | *10* | ID | 0 | NS |  | 0 | 0 | 0200 |  |  |  |  |
| *Identifier Check Digit* | *11* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Check Digit Scheme* | *12* | ID | 3 | C |  | 0 | 1 | 0061 |  |  |  |  |
| *Identifier Type Code* | *13* | ID | 0 | NS |  | 0 | 0 | 0203 |  |  |  |  |
| *Assigning Facility* | *14* | HD | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name Representation Code* | *15* | ID | 0 | NS |  | 0 | 0 | 0465 |  |  |  |  |
| *Name Context* | *16* | CWE | 0 | NS |  | 0 | 0 | 0448 |  |  |  |  |
| *Name Validity Range* | *17* | DR | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name Assembly Order* | *18* | ID | 0 | NS |  | 0 | 0 | 0444 |  |  |  |  |
| *Effective Date* | *19* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *20* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Professional Suffix* | *21* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Jurisdiction* | *22* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Agency or Department* | *23* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Responsible Physician ID | 30 | XCN | 4751 | RE | False | 0 | 1 |  |  |  |  | 16.4.6.30 |
| *ID Number* | *1* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Family Name* | *2* | FN | 194 | RE |  | 0 | 1 |  |  |  |  |  |
| *�  Surname* | *1* | ST | 50 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Own Surname Prefix* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Own Surname* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Surname Prefix from Partner/Spouse* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Surname from Partner/Spouse* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Given Name* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Second and Further Given Names or Initials Thereof* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Suffix (e.g., JR or III)* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Prefix (e.g., DR)* | *6* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Degree (e.g., MD)* | *7* | IS | 0 | NS |  | 0 | 0 | 0360 |  |  |  |  |
| *Source Table* | *8* | IS | 4 | C |  | 0 | 1 | 0297 |  |  |  |  |
| *Assigning Authority* | *9* | HD | 0 | NS |  | 0 | 0 | 0363 |  |  |  |  |
| *Name Type Code* | *10* | ID | 0 | NS |  | 0 | 0 | 0200 |  |  |  |  |
| *Identifier Check Digit* | *11* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Check Digit Scheme* | *12* | ID | 3 | C |  | 0 | 1 | 0061 |  |  |  |  |
| *Identifier Type Code* | *13* | ID | 0 | NS |  | 0 | 0 | 0203 |  |  |  |  |
| *Assigning Facility* | *14* | HD | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name Representation Code* | *15* | ID | 0 | NS |  | 0 | 0 | 0465 |  |  |  |  |
| *Name Context* | *16* | CWE | 0 | NS |  | 0 | 0 | 0448 |  |  |  |  |
| *Name Validity Range* | *17* | DR | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name Assembly Order* | *18* | ID | 0 | NS |  | 0 | 0 | 0444 |  |  |  |  |
| *Effective Date* | *19* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *20* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Professional Suffix* | *21* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Jurisdiction* | *22* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Assigning Agency or Department* | *23* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Role Executing Physician | 31 | CWE | 705 | NS | False | 0 | 0 | 0881 |  |  |  | 16.4.6.31 |
| Medical Role Executing Physician | 32 | CWE | 705 | NS | False | 0 | 0 | 0882 |  |  |  | 16.4.6.32 |
| Side of body | 33 | CWE | 705 | NS | False | 0 | 0 | 0894 |  |  |  | 16.4.6.33 |
| Number of TP's PP | 34 | NM | 6 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.34 |
| TP-Value PP | 35 | CP | 765 | RE | False | 0 | 1 |  |  |  |  | 16.4.6.35 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| Internal Scaling Factor PP | 36 | NM | 4 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.36 |
| External Scaling Factor PP | 37 | NM | 4 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.37 |
| Amount PP | 38 | CP | 765 | RE | False | 0 | 1 |  |  |  |  | 16.4.6.38 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| Number of TP's Technical Part | 39 | NM | 6 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.39 |
| TP-Value Technical Part | 40 | CP | 765 | RE | False | 0 | 1 |  |  |  |  | 16.4.6.40 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| Internal Scaling Factor Technical Part | 41 | NM | 4 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.41 |
| External Scaling Factor Technical Part | 42 | NM | 4 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.42 |
| Amount Technical Part | 43 | CP | 765 | RE | False | 0 | 1 |  |  |  |  | 16.4.6.43 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| Total Amount Professional Part + Technical Part | 44 | CP | 765 | RE | False | 0 | 1 |  |  |  |  | 16.4.6.44 |
| *Price* | *1* | MO | 20 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Quantity* | *1* | NM | 16 | R |  | 1 | 1 |  |  |  |  |  |
| *�  Denomination* | *2* | ID | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Price Type* | *2* | ID | 0 | NS |  | 0 | 0 | 0205 |  |  |  |  |
| *From Value* | *3* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *To Value* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Units* | *5* | CWE | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Range Type* | *6* | ID | 0 | NS |  | 0 | 0 | 0298 |  |  |  |  |
| VAT-Rate | 45 | NM | 3 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.45 |
| Main-Service | 46 | ID | 20 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.46 |
| Validation | 47 | ID | 1 | NS | False | 0 | 0 | 0136 |  |  |  | 16.4.6.47 |
| Comment | 48 | ST | 255 | NS | False | 0 | 0 |  |  |  |  | 16.4.6.48 |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Segment** | **Description** | **Opt** | **Rep** | **Min** | **Max** | **Reference** |
| PYE | Payee Information | RE | False |  |  | 16.4.3 |

**Fields**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Seq** | **DT** | **Len** | **Opt** | **Rep** | **Min** | **Max** | **Tbl** | **Predicate** | **Fx Val** | **Ex Val** | **Reference** |
| Set ID - PYE | 1 | SI | 4 | R | False | 1 | 1 |  |  |  |  | 16.4.3.1 |
| Payee Type | 2 | IS | 6 | R | False | 1 | 1 | 0557 |  |  |  | 16.4.3.2 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *NM101 Entity Identifier Code* | | | | | | | | | | |  |  |
| Payee Relationship to Invoice (Patient) | 3 | IS | 80 | RE | False | 0 | 1 | 0558 |  |  |  |  |
| Payee Identification List | 4 | XON | 2146 | RE | True | 0 | \* |  |  |  |  | 16.4.3.4 |
| *Organization Name* | *1* | ST | 50 | RE |  | 0 | 1 |  |  |  |  | File: 368 Field: 6.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *NM103 Information Receiver Last or* | | | | | | | | | | |  |  |
| *Organization Name* | | | | | | | | | | |  |  |
| *Organization Name Type Code* | *2* | IS | 0 | NS |  | 0 | 0 | 0204 |  |  |  |  |
| *ID Number* | *3* | NM | 80 | RE |  | 0 | 1 |  |  |  |  | File: 368 Field: 6.02 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *NM109 Information Receiver Identification* | | | | | | | | | | |  |  |
| *Number* | | | | | | | | | | |  |  |
| *Identifier Check Digit* | *4* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Check Digit Scheme* | *5* | ID | 0 | NS |  | 0 | 0 | 0061 |  |  |  |  |
| *Assigning Authority* | *6* | HD | 0 | NS |  | 0 | 0 | 0363 |  |  |  |  |
| *Identifier Type Code* | *7* | ID | 5 | RE |  | 0 | 1 | 0203 |  |  |  |  |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *NM108 Identification Code Qualifier* | | | | | | | | | | |  |  |
| *Assigning Facility* | *8* | HD | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name Representation Code* | *9* | ID | 0 | NS |  | 0 | 0 | 0465 |  |  |  |  |
| *Organization Identifier* | *10* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Payee Person Name | 5 | XPN | 1262 | C | True | 0 | \* |  |  |  |  | 16.4.3.5 |
| *Family Name* | *1* | FN | 194 | RE |  | 0 | 1 |  |  |  |  |  |
| *�  Surname* | *1* | ST | 60 | R |  | 1 | 1 |  |  |  | Jones | File: 368 Field: 6.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *NM103 Information Receiver Last or* | | | | | | | | | | |  |  |
| *Organization Name* | | | | | | | | | | |  |  |
| *�  Own Surname Prefix* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Own Surname* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Surname Prefix from Partner/Spouse* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Surname from Partner/Spouse* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Given Name | 2 | ST | 35 | RE |  | 0 | 1 |  |  |  | John | File: 368 Field: 6.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| NM104 Name First (Information Receiver | | | | | | | | | | |  |  |
| First Name) | | | | | | | | | | |  |  |
| *Second and Further Given Names or Initials Thereof* | *3* | *ST* | *25* | *RE* |  | *0* | *1* |  |  |  | Jim | File: 368 Field: 6.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *NM105 Name Middle (Information* | | | | | | | | | | |  |  |
| *Receiver Middle Name)* | | | | | | | | | | |  |  |
| *Suffix (e.g., JR or III)* | 4 | ST | 10 | RE |  | 0 | 1 |  |  |  | JR | File: 368 Field: 6.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| NM107 Name Suffix | | | | | | | | | | |  |  |
| *Prefix (e.g., DR)* | 5 | ST | 10 | RE |  | 0 | 1 |  |  |  | Mr | File: 368 Field: 6.01 |
| *Implementation Note:* | | | | | | | | | | |  |  |
| *NM106 Name Prefix* | | | | | | | | | | |  |  |
| *Degree (e.g., MD)* | *6* | IS | 0 | NS |  | 0 | 0 | 0360 |  |  |  |  |
| *Name Type Code* | *7* | ID | 0 | NS |  | 0 | 0 | 0200 |  |  |  |  |
| *Name Representation Code* | *8* | ID | 0 | NS |  | 0 | 0 | 0465 |  |  |  |  |
| *Name Context* | *9* | CWE | 0 | NS |  | 0 | 0 | 0448 |  |  |  |  |
| *Name Validity Range* | *10* | DR | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Name Assembly Order* | *11* | ID | 0 | NS |  | 0 | 0 | 0444 |  |  |  |  |
| *Effective Date* | *12* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *13* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Professional Suffix* | *14* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Payee Address | 6 | XAD | 2866 | C | True | 0 | \* |  |  |  |  | 16.4.3.6 |
| *Street Address* | *1* | SAD | 184 | RE |  | 0 | 1 |  |  |  |  |  |
| *�  Street or Mailing Address* | *1* | ST | 120 | RE |  | 0 | 1 |  |  |  |  |  |
| *�  Street Name* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *�  Dwelling Number* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Other Designation* | *2* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *City* | *3* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *State or Province* | *4* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Zip or Postal Code* | *5* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Country* | *6* | ID | 0 | NS |  | 0 | 0 | 0399 |  |  |  |  |
| *Address Type* | *7* | ID | 0 | NS |  | 0 | 0 | 0190 |  |  |  |  |
| *Other Geographic Designation* | *8* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *County/Parish Code* | *9* | IS | 0 | NS |  | 0 | 0 | 0289 |  |  |  |  |
| *Census Tract* | *10* | IS | 0 | NS |  | 0 | 0 | 0288 |  |  |  |  |
| *Address Representation Code* | *11* | ID | 0 | NS |  | 0 | 0 | 0465 |  |  |  |  |
| *Address Validity Range* | *12* | DR | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Effective Date* | *13* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Date* | *14* | DTM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Expiration Reason* | *15* | CWE | 0 | NS |  | 0 | 0 | 0616 |  |  |  |  |
| *Temporary Indicator* | *16* | ID | 0 | NS |  | 0 | 0 | 0136 |  |  |  |  |
| *Bad Address Indicator* | *17* | ID | 0 | NS |  | 0 | 0 | 0136 |  |  |  |  |
| *Address Usage* | *18* | ID | 0 | NS |  | 0 | 0 | 0617 |  |  |  |  |
| *Addressee* | *19* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Comment* | *20* | ST | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Preference Order* | *21* | NM | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| *Protection Code* | *22* | CWE | 0 | NS |  | 0 | 0 | 0618 |  |  |  |  |
| *Address Identifier* | *23* | EI | 0 | NS |  | 0 | 0 |  |  |  |  |  |
| Payment Method | 7 | IS | 80 | NS | False | 0 | 0 | 0570 |  |  |  | 16.4.3.7 |

**Tables**

**ID: 0003 Name: Event type** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |
| 1 | A01 | ADT/ACK - Admit/visit notification | User | Optional |  | 2.17.2 |
| 2 | A02 | ADT/ACK - Transfer a patient | User | Optional |  | 2.17.2 |
| 3 | A03 | ADT/ACK - Discharge/end visit | User | Optional |  | 2.17.2 |
| 4 | A04 | ADT/ACK - Register a patient | User | Optional |  | 2.17.2 |
| 5 | A05 | ADT/ACK - Pre-admit a patient | User | Optional |  | 2.17.2 |
| 6 | A06 | ADT/ACK - Change an outpatient to an inpatient | User | Optional |  | 2.17.2 |
| 7 | A07 | ADT/ACK - Change an inpatient to an outpatient | User | Optional |  | 2.17.2 |
| 8 | A08 | ADT/ACK - Update patient information | User | Optional |  | 2.17.2 |
| 9 | A09 | ADT/ACK - Patient departing - tracking | User | Optional |  | 2.17.2 |
| 10 | A10 | ADT/ACK - Patient arriving - tracking | User | Optional |  | 2.17.2 |
| 11 | A11 | ADT/ACK - Cancel admit/visit notification | User | Optional |  | 2.17.2 |
| 12 | A12 | ADT/ACK - Cancel transfer | User | Optional |  | 2.17.2 |
| 13 | A13 | ADT/ACK - Cancel discharge/end visit | User | Optional |  | 2.17.2 |
| 14 | A14 | ADT/ACK - Pending admit | User | Optional |  | 2.17.2 |
| 15 | A15 | ADT/ACK - Pending transfer | User | Optional |  | 2.17.2 |
| 16 | A16 | ADT/ACK - Pending discharge | User | Optional |  | 2.17.2 |
| 17 | A17 | ADT/ACK - Swap patients | User | Optional |  | 2.17.2 |
| 18 | A18 | ADT/ACK - Merge patient information (for backward compatibility only) | User | Optional |  | 2.17.2 |
| 19 | A19 | QRY/ADR - Patient query | User | Optional |  | 2.17.2 |
| 20 | A20 | ADT/ACK - Bed status update | User | Optional |  | 2.17.2 |
| 21 | A21 | ADT/ACK - Patient goes on a \_??leave of absence\_?\_ | User | Optional |  | 2.17.2 |
| 22 | A22 | ADT/ACK - Patient returns from a \_??leave of absence\_?\_ | User | Optional |  | 2.17.2 |
| 23 | A23 | ADT/ACK - Delete a patient record | User | Optional |  | 2.17.2 |
| 24 | A24 | ADT/ACK - Link patient information | User | Optional |  | 2.17.2 |
| 25 | A25 | ADT/ACK - Cancel pending discharge | User | Optional |  | 2.17.2 |
| 26 | A26 | ADT/ACK - Cancel pending transfer | User | Optional |  | 2.17.2 |
| 27 | A27 | ADT/ACK - Cancel pending admit | User | Optional |  | 2.17.2 |
| 28 | A28 | ADT/ACK - Add person information | User | Optional |  | 2.17.2 |
| 29 | A29 | ADT/ACK - Delete person information | User | Optional |  | 2.17.2 |
| 30 | A30 | ADT/ACK - Merge person information (for backward compatibility only) | User | Optional |  | 2.17.2 |
| 31 | A31 | ADT/ACK - Update person information | User | Optional |  | 2.17.2 |
| 32 | A32 | ADT/ACK - Cancel patient arriving - tracking | User | Optional |  | 2.17.2 |
| 33 | A33 | ADT/ACK - Cancel patient departing - tracking | User | Optional |  | 2.17.2 |
| 34 | A34 | ADT/ACK - Merge patient information - patient ID only (for backward compatibility only) | User | Optional |  | 2.17.2 |
| 35 | A35 | ADT/ACK - Merge patient information - account number only (for backward compatibility only) | User | Optional |  | 2.17.2 |
| 36 | A36 | ADT/ACK - Merge patient information - patient ID and account number (for backward compatibility only) | User | Optional |  | 2.17.2 |
| 37 | A37 | ADT/ACK - Unlink patient information | User | Optional |  | 2.17.2 |
| 38 | A38 | ADT/ACK - Cancel pre-admit | User | Optional |  | 2.17.2 |
| 39 | A39 | ADT/ACK - Merge person - patient ID (for backward compatibility only) | User | Optional |  | 2.17.2 |
| 40 | A40 | ADT/ACK - Merge patient - patient identifier list | User | Optional |  | 2.17.2 |
| 41 | A41 | ADT/ACK - Merge account - patient account number | User | Optional |  | 2.17.2 |
| 42 | A42 | ADT/ACK - Merge visit - visit number | User | Optional |  | 2.17.2 |
| 43 | A43 | ADT/ACK - Move patient information - patient identifier list | User | Optional |  | 2.17.2 |
| 44 | A44 | ADT/ACK - Move account information - patient account number | User | Optional |  | 2.17.2 |
| 45 | A45 | ADT/ACK - Move visit information - visit number | User | Optional |  | 2.17.2 |
| 46 | A46 | ADT/ACK - Change patient ID (for backward compatibility only) | User | Optional |  | 2.17.2 |
| 47 | A47 | ADT/ACK - Change patient identifier list | User | Optional |  | 2.17.2 |
| 48 | A48 | ADT/ACK - Change alternate patient ID (for backward compatibility only) | User | Optional |  | 2.17.2 |
| 49 | A49 | ADT/ACK - Change patient account number | User | Optional |  | 2.17.2 |
| 50 | A50 | ADT/ACK - Change visit number | User | Optional |  | 2.17.2 |
| 51 | A51 | ADT/ACK - Change alternate visit ID | User | Optional |  | 2.17.2 |
| 52 | A52 | ADT/ACK - Cancel leave of absence for a patient | User | Optional |  | 2.17.2 |
| 53 | A53 | ADT/ACK - Cancel patient returns from a leave of absence | User | Optional |  | 2.17.2 |
| 54 | A54 | ADT/ACK - Change attending doctor | User | Optional |  | 2.17.2 |
| 55 | A55 | ADT/ACK - Cancel change attending doctor | User | Optional |  | 2.17.2 |
| 56 | A60 | ADT/ACK - Update allergy information | User | Optional |  | 2.17.2 |
| 57 | A61 | ADT/ACK - Change consulting doctor | User | Optional |  | 2.17.2 |
| 58 | A62 | ADT/ACK - Cancel change consulting doctor | User | Optional |  | 2.17.2 |
| 59 | B01 | PMU/ACK - Add personnel record | User | Optional |  | 2.17.2 |
| 60 | B02 | PMU/ACK - Update personnel record | User | Optional |  | 2.17.2 |
| 61 | B03 | PMU/ACK - Delete personnel re cord | User | Optional |  | 2.17.2 |
| 62 | B04 | PMU/ACK - Active practicing person | User | Optional |  | 2.17.2 |
| 63 | B05 | PMU/ACK - Deactivate practicing person | User | Optional |  | 2.17.2 |
| 64 | B06 | PMU/ACK - Terminate practicing person | User | Optional |  | 2.17.2 |
| 65 | B07 | PMU/ACK - Grant Certificate/Permission | User | Optional |  | 2.17.2 |
| 66 | B08 | PMU/ACK - Revoke Certificate/Permission | User | Optional |  | 2.17.2 |
| 67 | C01 | CRM - Register a patient on a clinical trial | User | Optional |  | 2.17.2 |
| 68 | C02 | CRM - Cancel a patient registration on clinical trial (for clerical mistakes only) | User | Optional |  | 2.17.2 |
| 69 | C03 | CRM - Correct/update registration information | User | Optional |  | 2.17.2 |
| 70 | C04 | CRM - Patient has gone off a clinical trial | User | Optional |  | 2.17.2 |
| 71 | C05 | CRM - Patient enters phase of clinical trial | User | Optional |  | 2.17.2 |
| 72 | C06 | CRM - Cancel patient entering a phase (clerical mistake) | User | Optional |  | 2.17.2 |
| 73 | C07 | CRM - Correct/update phase information | User | Optional |  | 2.17.2 |
| 74 | C08 | CRM - Patient has gone off phase of clinical trial | User | Optional |  | 2.17.2 |
| 75 | C09 | CSU - Automated time intervals for reporting, like monthly | User | Optional |  | 2.17.2 |
| 76 | C10 | CSU - Patient completes the clinical trial | User | Optional |  | 2.17.2 |
| 77 | C11 | CSU - Patient completes a phase of the clinical trial | User | Optional |  | 2.17.2 |
| 78 | C12 | CSU - Update/correction of patient order/result information | User | Optional |  | 2.17.2 |
| 79 | CNQ | Cancel Query | User | Optional |  | 2.17.2 |
| 80 | I01 | RQI/RPI - Request for insurance information | User | Optional |  | 2.17.2 |
| 81 | I02 | RQI/RPL - Request/receipt of patient selection display list | User | Optional |  | 2.17.2 |
| 82 | I03 | RQI/RPR - Request/receipt of patient selection list | User | Optional |  | 2.17.2 |
| 83 | I04 | RQD/RPI - Request for patient demographic data | User | Optional |  | 2.17.2 |
| 84 | I05 | RQC/RCI - Request for patient clinical information | User | Optional |  | 2.17.2 |
| 85 | I06 | RQC/RCL - Request/receipt of clinical data listing | User | Optional |  | 2.17.2 |
| 86 | I07 | PIN/ACK - Unsolicited insurance information | User | Optional |  | 2.17.2 |
| 87 | I08 | RQA/RPA - Request for treatment authorization information | User | Optional |  | 2.17.2 |
| 88 | I09 | RQA/RPA - Request for modification to an authorization | User | Optional |  | 2.17.2 |
| 89 | I10 | RQA/RPA - Request for resubmission of an authorization | User | Optional |  | 2.17.2 |
| 90 | I11 | RQA/RPA - Request for cancellation of an authorization | User | Optional |  | 2.17.2 |
| 91 | I12 | REF/RRI - Patient referral | User | Optional |  | 2.17.2 |
| 92 | I13 | REF/RRI - Modify patient referral | User | Optional |  | 2.17.2 |
| 93 | I14 | REF/RRI - Cancel patient referral | User | Optional |  | 2.17.2 |
| 94 | I15 | REF/RRI - Request patient referral status | User | Optional |  | 2.17.2 |
| 95 | J01 | QCN/ACK - Cancel query/acknowledge message | User | Optional |  | 2.17.2 |
| 96 | J02 | QSX/ACK - Cancel subscription/acknowledge message | User | Optional |  | 2.17.2 |
| 97 | K11 | RSP - Segment pattern response in response to QBP^Q11 | User | Optional |  | 2.17.2 |
| 98 | K13 | RTB - Tabular response in response to QBP^Q13 | User | Optional |  | 2.17.2 |
| 99 | K15 | RDY - Display response in response to QBP^Q15 | User | Optional |  | 2.17.2 |
| 100 | K21 | RSP - Get person demographics response | User | Optional |  | 2.17.2 |
| 101 | K22 | RSP - Find candidates response | User | Optional |  | 2.17.2 |
| 102 | K23 | RSP - Get corresponding identifiers response | User | Optional |  | 2.17.2 |
| 103 | K24 | RSP - Allocate identifiers response | User | Optional |  | 2.17.2 |
| 104 | K25 | RSP - Personnel Information by Segment Response | User | Optional |  | 2.17.2 |
| 105 | K31 | RSP - Dispense History | User | Optional |  | 2.17.2 |
| 106 | M01 | MFN/MFK - Master file not otherwise specified (for backward compatibility only) | User | Optional |  | 2.17.2 |
| 107 | M02 | MFN/MFK - Master file - staff practitioner | User | Optional |  | 2.17.2 |
| 108 | M03 | MFN/MFK - Master file - test/observation (for backward compatibility only) | User | Optional |  | 2.17.2 |
| 109 | M04 | MFN/MFK - Master files charge description | User | Optional |  | 2.17.2 |
| 110 | M05 | MFN/MFK - Patient location master file | User | Optional |  | 2.17.2 |
| 111 | M06 | MFN/MFK - Clinical study with phases and schedules master file | User | Optional |  | 2.17.2 |
| 112 | M07 | MFN/MFK - Clinical study without phases but with schedules master file | User | Optional |  | 2.17.2 |
| 113 | M08 | MFN/MFK - Test/observation (numeric) master file | User | Optional |  | 2.17.2 |
| 114 | M09 | MFN/MFK - Test/observation (categorical) master file | User | Optional |  | 2.17.2 |
| 115 | M10 | MFN/MFK - Test /observation batteries master file | User | Optional |  | 2.17.2 |
| 116 | M11 | MFN/MFK - Test/calculated observations master file | User | Optional |  | 2.17.2 |
| 117 | M12 | MFN/MFK - Master file notification message | User | Optional |  | 2.17.2 |
| 118 | M13 | MFN/MFK - Master file notification - general | User | Optional |  | 2.17.2 |
| 119 | M14 | MFN/MFK - Master file notification - site defined | User | Optional |  | 2.17.2 |
| 120 | M15 | MFN/MFK - Inventory item master file notification | User | Optional |  | 2.17.2 |
| 121 | N01 | NMQ/NMR - Application management query message | User | Optional |  | 2.17.2 |
| 122 | N02 | NMD/ACK - Application management data message (unsolicited) | User | Optional |  | 2.17.2 |
| 123 | O01 | ORM - Order message (also RDE, RDS, RGV, RAS) | User | Optional |  | 2.17.2 |
| 124 | O02 | ORR - Order response (also RRE, RRD, RRG, RRA) | User | Optional |  | 2.17.2 |
| 125 | O03 | OMD - Diet order | User | Optional |  | 2.17.2 |
| 126 | O04 | ORD - Diet order acknowledgment | User | Optional |  | 2.17.2 |
| 127 | O05 | OMS - Stock requisition order | User | Optional |  | 2.17.2 |
| 128 | O06 | ORS - Stock requisition acknowledgment | User | Optional |  | 2.17.2 |
| 129 | O07 | OMN - Non-stock requisition order | User | Optional |  | 2.17.2 |
| 130 | O08 | ORN - Non-stock requisition acknowledgment | User | Optional |  | 2.17.2 |
| 131 | O09 | OMP - Pharmacy/treatment order | User | Optional |  | 2.17.2 |
| 132 | O10 | ORP - Pharmacy/treatment order acknowledgment | User | Optional |  | 2.17.2 |
| 133 | O11 | RDE - Pharmacy/treatment encoded order | User | Optional |  | 2.17.2 |
| 134 | O12 | RRE - Pharmacy/treatment encoded order acknowledgment | User | Optional |  | 2.17.2 |
| 135 | O13 | RDS - Pharmacy/treatment dispense | User | Optional |  | 2.17.2 |
| 136 | O14 | RRD - Pharmacy/treatment dispense acknowledgment | User | Optional |  | 2.17.2 |
| 137 | O15 | RGV - Pharmacy/treatment give | User | Optional |  | 2.17.2 |
| 138 | O16 | RRG - Pharmacy/treatment give acknowledgment | User | Optional |  | 2.17.2 |
| 139 | O17 | RAS - Pharmacy/treatment administration | User | Optional |  | 2.17.2 |
| 140 | O18 | RRA - Pharmacy/treatment administration acknowledgment | User | Optional |  | 2.17.2 |
| 141 | O19 | OMG - General clinical order | User | Optional |  | 2.17.2 |
| 142 | O20 | ORG/ORL - General clinical order response | User | Optional |  | 2.17.2 |
| 143 | O21 | OML - Laboratory order | User | Optional |  | 2.17.2 |
| 144 | O22 | ORL - General laboratory order response message to any OML | User | Optional |  | 2.17.2 |
| 145 | O23 | OMI - Imaging order | User | Optional |  | 2.17.2 |
| 146 | O24 | ORI - Imaging order response message to any OMI | User | Optional |  | 2.17.2 |
| 147 | O25 | RDE - Pharmacy/treatment refill authorization request | User | Optional |  | 2.17.2 |
| 148 | O26 | RRE - Pharmacy/Treatment Refill Authorization Acknowledgement | User | Optional |  | 2.17.2 |
| 149 | O27 | OMB - Blood product order | User | Optional |  | 2.17.2 |
| 150 | O28 | ORB - Blood product order acknowledgment | User | Optional |  | 2.17.2 |
| 151 | O29 | BPS - Blood product dispense status | User | Optional |  | 2.17.2 |
| 152 | O30 | BRP - Blood product dispense status acknowledgment | User | Optional |  | 2.17.2 |
| 153 | O31 | BTS - Blood product transfusion/disposition | User | Optional |  | 2.17.2 |
| 154 | O32 | BRT - Blood product transfusion/disposition acknowledgment | User | Optional |  | 2.17.2 |
| 155 | O33 | OML - Laboratory order for multiple orders related to a single specimen | User | Optional |  | 2.17.2 |
| 156 | O34 | ORL - Laboratory order response message to a multiple order related to single specimen OML | User | Optional |  | 2.17.2 |
| 157 | O35 | OML - Laboratory order for multiple orders related to a single container of a specimen | User | Optional |  | 2.17.2 |
| 158 | O36 | ORL - Laboratory order response message to a single container of a specimen OML | User | Optional |  | 2.17.2 |
| 159 | P01 | BAR/ACK - Add patient accounts | User | Optional |  | 2.17.2 |
| 160 | P02 | BAR/ACK - Purge patient accounts | User | Optional |  | 2.17.2 |
| 161 | P03 | DFT/ACK - Post detail financial transaction | User | Optional |  | 2.17.2 |
| 162 | P04 | QRY/DSP - Generate bill and A/R statements | User | Optional |  | 2.17.2 |
| 163 | P05 | BAR/ACK - Update account | User | Optional |  | 2.17.2 |
| 164 | P06 | BAR/ACK - End account | User | Optional |  | 2.17.2 |
| 165 | P07 | PEX - Unsolicited initial individual product experience report | User | Optional |  | 2.17.2 |
| 166 | P08 | PEX - Unsolicited update individual product experience report | User | Optional |  | 2.17.2 |
| 167 | P09 | SUR - Summary product experience report | User | Optional |  | 2.17.2 |
| 168 | P10 | BAR/ACK -Transmit Ambulatory Payment Classification(APC) | User | Optional |  | 2.17.2 |
| 169 | P11 | DFT/ACK - Post Detail Financial Transactions - New | User | Optional |  | 2.17.2 |
| 170 | P12 | BAR/ACK - Update Diagnosis/Procedure | User | Optional |  | 2.17.2 |
| 171 | PC1 | PPR - PC/ problem add | User | Optional |  | 2.17.2 |
| 172 | PC2 | PPR - PC/ problem update | User | Optional |  | 2.17.2 |
| 173 | PC3 | PPR - PC/ problem delete | User | Optional |  | 2.17.2 |
| 174 | PC4 | QRY - PC/ problem query | User | Optional |  | 2.17.2 |
| 175 | PC5 | PRR - PC/ problem response | User | Optional |  | 2.17.2 |
| 176 | PC6 | PGL - PC/ goal add | User | Optional |  | 2.17.2 |
| 177 | PC7 | PGL - PC/ goal update | User | Optional |  | 2.17.2 |
| 178 | PC8 | PGL - PC/ goal delete | User | Optional |  | 2.17.2 |
| 179 | PC9 | QRY - PC/ goal query | User | Optional |  | 2.17.2 |
| 180 | PCA | PPV - PC/ goal response | User | Optional |  | 2.17.2 |
| 181 | PCB | PPP - PC/ pathway (problem-oriented) add | User | Optional |  | 2.17.2 |
| 182 | PCC | PPP - PC/ pathway (problem-oriented) update | User | Optional |  | 2.17.2 |
| 183 | PCD | PPP - PC/ pathway (problem-oriented) delete | User | Optional |  | 2.17.2 |
| 184 | PCE | QRY - PC/ pathway (problem-oriented) query | User | Optional |  | 2.17.2 |
| 185 | PCF | PTR - PC/ pathway (problem-oriented) query response | User | Optional |  | 2.17.2 |
| 186 | PCG | PPG - PC/ pathway (goal-oriented) add | User | Optional |  | 2.17.2 |
| 187 | PCH | PPG - PC/ pathway (goal-oriented) update | User | Optional |  | 2.17.2 |
| 188 | PCJ | PPG - PC/ pathway (goal-oriented) delete | User | Optional |  | 2.17.2 |
| 189 | PCK | QRY - PC/ pathway (goal-oriented) query | User | Optional |  | 2.17.2 |
| 190 | PCL | PPT - PC/ pathway (goal-oriented) query response | User | Optional |  | 2.17.2 |
| 191 | Q01 | QRY/DSR - Query sent for immediate response | User | Optional |  | 2.17.2 |
| 192 | Q02 | QRY/QCK - Query sent for deferred response | User | Optional |  | 2.17.2 |
| 193 | Q03 | DSR/ACK - Deferred response to a query | User | Optional |  | 2.17.2 |
| 194 | Q04 | EQQ - Embedded query language query | User | Optional |  | 2.17.2 |
| 195 | Q05 | UDM/ACK - Unsolicited display update message | User | Optional |  | 2.17.2 |
| 196 | Q06 | OSQ/OSR - Query for order status | User | Optional |  | 2.17.2 |
| 197 | Q07 | VQQ - Virtual table query | User | Optional |  | 2.17.2 |
| 198 | Q08 | SPQ - Stored procedure request | User | Optional |  | 2.17.2 |
| 199 | Q09 | RQQ - event replay query | User | Optional |  | 2.17.2 |
| 200 | Q11 | QBP - Query by parameter requesting an RSP segment pattern response | User | Optional |  | 2.17.2 |
| 201 | Q13 | QBP - Query by parameter requesting an RTB - tabular response | User | Optional |  | 2.17.2 |
| 202 | Q15 | QBP - Query by parameter requesting an RDY display response | User | Optional |  | 2.17.2 |
| 203 | Q16 | QSB - Create subscription | User | Optional |  | 2.17.2 |
| 204 | Q17 | QVR - Query for previous events | User | Optional |  | 2.17.2 |
| 205 | Q21 | QBP - Get person demographics | User | Optional |  | 2.17.2 |
| 206 | Q22 | QBP - Find candidates | User | Optional |  | 2.17.2 |
| 207 | Q23 | QBP - Get corresponding identifiers | User | Optional |  | 2.17.2 |
| 208 | Q24 | QBP - Allocate identifiers | User | Optional |  | 2.17.2 |
| 209 | Q25 | QBP - Personnel Information by Segment Query | User | Optional |  | 2.17.2 |
| 210 | Q26 | ROR - Pharmacy/treatment order response | User | Optional |  | 2.17.2 |
| 211 | Q27 | RAR - Pharmacy/treatment administration information | User | Optional |  | 2.17.2 |
| 212 | Q28 | RDR - Pharmacy/treatment dispense information | User | Optional |  | 2.17.2 |
| 213 | Q29 | RER - Pharmacy/treatment encoded order information | User | Optional |  | 2.17.2 |
| 214 | Q30 | RGR - Pharmacy/treatment dose information | User | Optional |  | 2.17.2 |
| 215 | Q31 | DBP - Dispense History | User | Optional |  | 2.17.2 |
| 216 | R01 | ORU/ACK - Unsolicited transmission of an observation message | User | Optional |  | 2.17.2 |
| 217 | R02 | QRY - Query for results of observation | User | Optional |  | 2.17.2 |
| 218 | R03 | QRY/DSR Display-oriented results, query/unsol. update (for backward compatibility only) (Replaced by Q05) | User | Optional |  | 2.17.2 |
| 219 | R04 | ORF - Response to query; transmission of requested observation | User | Optional |  | 2.17.2 |
| 220 | R07 | EDR - Enhanced Display Response | User | Optional |  | 2.17.2 |
| 221 | R08 | TBR - Tabular Data Response | User | Optional |  | 2.17.2 |
| 222 | R09 | ERP - Event Replay Response | User | Optional |  | 2.17.2 |
| 223 | R21 | OUL - Unsolicited laboratory observation | User | Optional |  | 2.17.2 |
| 224 | R22 | OUL - Unsolicited Specimen Oriented Observation Message | User | Optional |  | 2.17.2 |
| 225 | R23 | OUL - Unsolicited Specimen Container Oriented Observation Message | User | Optional |  | 2.17.2 |
| 226 | R24 | OUL - Unsolicited Order Oriented Observation Message | User | Optional |  | 2.17.2 |
| 227 | R30 | ORU - Unsolicited Point-Of-Care Observation Message Without Existing Order - Place An Order | User | Optional |  | 2.17.2 |
| 228 | R31 | ORU - Unsolicited New Point-Of-Care Observation Message - Search For An Order | User | Optional |  | 2.17.2 |
| 229 | R32 | ORU - Unsolicited Pre-Ordered Point-Of-Care Observation | User | Optional |  | 2.17.2 |
| 230 | ROR | ROR - Pharmacy prescription order query response | User | Optional |  | 2.17.2 |
| 231 | S01 | SRM/SRR - Request new appointment booking | User | Optional |  | 2.17.2 |
| 232 | S02 | SRM/SRR - Request appointment rescheduling | User | Optional |  | 2.17.2 |
| 233 | S03 | SRM/SRR - Request appointment modification | User | Optional |  | 2.17.2 |
| 234 | S04 | SRM/SRR - Request appointment cancellation | User | Optional |  | 2.17.2 |
| 235 | S05 | SRM/SRR - Request appointment discontinuation | User | Optional |  | 2.17.2 |
| 236 | S06 | SRM/SRR - Request appointment deletion | User | Optional |  | 2.17.2 |
| 237 | S07 | SRM/SRR - Request addition of service/resource on appointment | User | Optional |  | 2.17.2 |
| 238 | S08 | SRM/SRR - Request modification of service/resource on appointment | User | Optional |  | 2.17.2 |
| 239 | S09 | SRM/SRR - Request cancellation of service/resource on appointment | User | Optional |  | 2.17.2 |
| 240 | S10 | SRM/SRR - Request discontinuation of service/resource on appointment | User | Optional |  | 2.17.2 |
| 241 | S11 | SRM/SRR - Request deletion of service/resource on appointment | User | Optional |  | 2.17.2 |
| 242 | S12 | SIU/ACK - Notification of new appointment booking | User | Optional |  | 2.17.2 |
| 243 | S13 | SIU/ACK - Notification of appointment rescheduling | User | Optional |  | 2.17.2 |
| 244 | S14 | SIU/ACK - Notification of appointment modification | User | Optional |  | 2.17.2 |
| 245 | S15 | SIU/ACK - Notification of appointment cancellation | User | Optional |  | 2.17.2 |
| 246 | S16 | SIU/ACK - Notification of appointment discontinuation | User | Optional |  | 2.17.2 |
| 247 | S17 | SIU/ACK - Notification of appointment deletion | User | Optional |  | 2.17.2 |
| 248 | S18 | SIU/ACK - Notification of addition of service/resource on appointment | User | Optional |  | 2.17.2 |
| 249 | S19 | SIU/ACK - Notification of modification of service/resource on appointment | User | Optional |  | 2.17.2 |
| 250 | S20 | SIU/ACK - Notification of cancellation of service/resource on appointment | User | Optional |  | 2.17.2 |
| 251 | S21 | SIU/ACK - Notification of discontinuation of service/resource on appointment | User | Optional |  | 2.17.2 |
| 252 | S22 | SIU/ACK - Notification of deletion of service/resource on appointment | User | Optional |  | 2.17.2 |
| 253 | S23 | SIU/ACK - Notification of blocked schedule time slot(s) | User | Optional |  | 2.17.2 |
| 254 | S24 | SIU/ACK - Notification of opened (\_??unblocked\_?\_) schedule time slot(s) | User | Optional |  | 2.17.2 |
| 255 | S25 | SQM/SQR - Schedule query message and response | User | Optional |  | 2.17.2 |
| 256 | S26 | SIU/ACK Notification that patient did not show up for schedule appointment | User | Optional |  | 2.17.2 |
| 257 | T01 | MDM/ACK - Original document notification | User | Optional |  | 2.17.2 |
| 258 | T02 | MDM/ACK - Original document notification and content | User | Optional |  | 2.17.2 |
| 259 | T03 | MDM/ACK - Document status change notification | User | Optional |  | 2.17.2 |
| 260 | T04 | MDM/ACK - Document status change notification and content | User | Optional |  | 2.17.2 |
| 261 | T05 | MDM/ACK - Document addendum notification | User | Optional |  | 2.17.2 |
| 262 | T06 | MDM/ACK - Document addendum notification and content | User | Optional |  | 2.17.2 |
| 263 | T07 | MDM/ACK - Document edit notification | User | Optional |  | 2.17.2 |
| 264 | T08 | MDM/ACK - Document edit notification and content | User | Optional |  | 2.17.2 |
| 265 | T09 | MDM/ACK - Document replacement notification | User | Optional |  | 2.17.2 |
| 266 | T10 | MDM/ACK - Document replacement notification and content | User | Optional |  | 2.17.2 |
| 267 | T11 | MDM/ACK - Document cancel notification | User | Optional |  | 2.17.2 |
| 268 | T12 | QRY/DOC - Document query | User | Optional |  | 2.17.2 |
| 269 | U01 | ESU/ACK - Automated equipment status update | User | Optional |  | 2.17.2 |
| 270 | U02 | ESR/ACK - Automated equipment status request | User | Optional |  | 2.17.2 |
| 271 | U03 | SSU/ACK - Specimen status update | User | Optional |  | 2.17.2 |
| 272 | U04 | SSR/ACK - specimen status request | User | Optional |  | 2.17.2 |
| 273 | U05 | INU/ACK - Automated equipment inventory update | User | Optional |  | 2.17.2 |
| 274 | U06 | INR/ACK - Automated equipment inventory request | User | Optional |  | 2.17.2 |
| 275 | U07 | EAC/ACK - Automated equipment command | User | Optional |  | 2.17.2 |
| 276 | U08 | EAR/ACK - Automated equipment response | User | Optional |  | 2.17.2 |
| 277 | U09 | EAN/ACK - Automated equipment notification | User | Optional |  | 2.17.2 |
| 278 | U10 | TCU/ACK - Automated equipment test code settings update | User | Optional |  | 2.17.2 |
| 279 | U11 | TCR/ACK - Automated equipment test code settings request | User | Optional |  | 2.17.2 |
| 280 | U12 | LSU/ACK - Automated equipment log/service update | User | Optional |  | 2.17.2 |
| 281 | U13 | LSR/ACK - Automated equipment log/service request | User | Optional |  | 2.17.2 |
| 282 | V01 | VXQ - Query for vaccination record | User | Optional |  | 2.17.2 |
| 283 | V02 | VXX - Response to vaccination query returning multiple PID matches | User | Optional |  | 2.17.2 |
| 284 | V03 | VXR - Vaccination record response | User | Optional |  | 2.17.2 |
| 285 | V04 | VXU - Unsolicited vaccination record update | User | Optional |  | 2.17.2 |
| 286 | Varies | MFQ/MFR - Master files query (use event same as asking for e.g., M05 - location) | User | Optional |  | 2.17.2 |
| 287 | W01 | ORU - Waveform result, unsolicited transmission of requested information | User | Optional |  | 2.17.2 |
| 288 | W02 | QRF - Waveform result, response to query | User | Optional |  | 2.17.2 |

**ID: 0061 Name: Check digit scheme** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |
| 1 | ISO | ISO 7064: 1983 | User | Optional |  | 2.A.1.14.3 |
| 2 | M10 | Mod 10 algorithm | User | Optional |  | 2.A.1.14.3 |
| 3 | M11 | Mod 11 algorithm | User | Optional |  | 2.A.1.14.3 |
| 4 | NPI | Check digit algorithm in the US National Provider Identifier | User | Optional |  | 2.A.1.14.3 |

**ID: 0076 Name: Message type** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |
| 1 | ACK | General acknowledgment message | User | Optional |  | 2.17.1 |
| 2 | ADR | ADT response | User | Optional |  | 2.17.1 |
| 3 | ADT | ADT message | User | Optional |  | 2.17.1 |
| 4 | BAR | Add/change billing account | User | Optional |  | 2.17.1 |
| 5 | BPS | Blood product dispense status message | User | Optional |  | 2.17.1 |
| 6 | BRP | Blood product dispense status acknowledgement message | User | Optional |  | 2.17.1 |
| 7 | BRT | Blood product transfusion/disposition acknowledgement message | User | Optional |  | 2.17.1 |
| 8 | BTS | Blood product transfusion/disposition message | User | Optional |  | 2.17.1 |
| 9 | CRM | Clinical study registration message | User | Optional |  | 2.17.1 |
| 10 | CSU | Unsolicited study data message | User | Optional |  | 2.17.1 |
| 11 | DFT | Detail financial transactions | User | Optional |  | 2.17.1 |
| 12 | DOC | Document response | User | Optional |  | 2.17.1 |
| 13 | DSR | Display response | User | Optional |  | 2.17.1 |
| 14 | EAC | Automated equipment command message | User | Optional |  | 2.17.1 |
| 15 | EAN | Automated equipment notification message | User | Optional |  | 2.17.1 |
| 16 | EAR | Automated equipment response message | User | Optional |  | 2.17.1 |
| 17 | EDR | Enhanced display response | User | Optional |  | 2.17.1 |
| 18 | EQQ | Embedded query language query | User | Optional |  | 2.17.1 |
| 19 | ERP | Event replay response | User | Optional |  | 2.17.1 |
| 20 | ESR | Automated equipment status update acknowledgment message | User | Optional |  | 2.17.1 |
| 21 | ESU | Automated equipment status update message | User | Optional |  | 2.17.1 |
| 22 | INR | Automated equipment inventory request message | User | Optional |  | 2.17.1 |
| 23 | INU | Automated equipment inventory update message | User | Optional |  | 2.17.1 |
| 24 | LSR | Automated equipment log/service request message | User | Optional |  | 2.17.1 |
| 25 | LSU | Automated equipment log/service update message | User | Optional |  | 2.17.1 |
| 26 | MCF | Delayed Acknowledgment (Retained for backward compatibility only) | User | Optional |  | 2.17.1 |
| 27 | MDM | Medical document management | User | Optional |  | 2.17.1 |
| 28 | MFD | Master files delayed application acknowledgment | User | Optional |  | 2.17.1 |
| 29 | MFK | Master files application acknowledgment | User | Optional |  | 2.17.1 |
| 30 | MFN | Master files notification | User | Optional |  | 2.17.1 |
| 31 | MFQ | Master files query | User | Optional |  | 2.17.1 |
| 32 | MFR | Master files response | User | Optional |  | 2.17.1 |
| 33 | NMD | Application management data message | User | Optional |  | 2.17.1 |
| 34 | NMQ | Application management query message | User | Optional |  | 2.17.1 |
| 35 | NMR | Application management response message | User | Optional |  | 2.17.1 |
| 36 | OMB | Blood product order message | User | Optional |  | 2.17.1 |
| 37 | OMD | Dietary order | User | Optional |  | 2.17.1 |
| 38 | OMG | General clinical order message | User | Optional |  | 2.17.1 |
| 39 | OMI | Imaging order | User | Optional |  | 2.17.1 |
| 40 | OML | Laboratory order message | User | Optional |  | 2.17.1 |
| 41 | OMN | Non-stock requisition order message | User | Optional |  | 2.17.1 |
| 42 | OMP | Pharmacy/treatment order message | User | Optional |  | 2.17.1 |
| 43 | OMS | Stock requisition order message | User | Optional |  | 2.17.1 |
| 44 | ORB | Blood product order acknowledgement message | User | Optional |  | 2.17.1 |
| 45 | ORD | Dietary order acknowledgment message | User | Optional |  | 2.17.1 |
| 46 | ORF | Query for results of observation | User | Optional |  | 2.17.1 |
| 47 | ORG | General clinical order acknowledgment message | User | Optional |  | 2.17.1 |
| 48 | ORI | Imaging order acknowledgement message | User | Optional |  | 2.17.1 |
| 49 | ORL | Laboratory acknowledgment message (unsolicited) | User | Optional |  | 2.17.1 |
| 50 | ORM | Pharmacy/treatment order message | User | Optional |  | 2.17.1 |
| 51 | ORN | Non-stock requisition - General order acknowledgment message | User | Optional |  | 2.17.1 |
| 52 | ORP | Pharmacy/treatment order acknowledgment message | User | Optional |  | 2.17.1 |
| 53 | ORR | General order response message response to any ORM | User | Optional |  | 2.17.1 |
| 54 | ORS | Stock requisition - Order acknowledgment message | User | Optional |  | 2.17.1 |
| 55 | ORU | Unsolicited transmission of an observation message | User | Optional |  | 2.17.1 |
| 56 | OSQ | Query response for order status | User | Optional |  | 2.17.1 |
| 57 | OSR | Query response for order status | User | Optional |  | 2.17.1 |
| 58 | OUL | Unsolicited laboratory observation message | User | Optional |  | 2.17.1 |
| 59 | PEX | Product experience message | User | Optional |  | 2.17.1 |
| 60 | PGL | Patient goal message | User | Optional |  | 2.17.1 |
| 61 | PIN | Patient insurance information | User | Optional |  | 2.17.1 |
| 62 | PMU | Add personnel record | User | Optional |  | 2.17.1 |
| 63 | PPG | Patient pathway message (goal-oriented) | User | Optional |  | 2.17.1 |
| 64 | PPP | Patient pathway message (problem-oriented) | User | Optional |  | 2.17.1 |
| 65 | PPR | Patient problem message | User | Optional |  | 2.17.1 |
| 66 | PPT | Patient pathway goal-oriented response | User | Optional |  | 2.17.1 |
| 67 | PPV | Patient goal response | User | Optional |  | 2.17.1 |
| 68 | PRR | Patient problem response | User | Optional |  | 2.17.1 |
| 69 | PTR | Patient pathway problem-oriented response | User | Optional |  | 2.17.1 |
| 70 | QBP | Query by parameter | User | Optional |  | 2.17.1 |
| 71 | QCK | Deferred query | User | Optional |  | 2.17.1 |
| 72 | QCN | Cancel query | User | Optional |  | 2.17.1 |
| 73 | QRY | Query, original mode | User | Optional |  | 2.17.1 |
| 74 | QSB | Create subscription | User | Optional |  | 2.17.1 |
| 75 | QSX | Cancel subscription/acknowledge message | User | Optional |  | 2.17.1 |
| 76 | QVR | Query for previous events | User | Optional |  | 2.17.1 |
| 77 | RAR | Pharmacy/treatment administration information | User | Optional |  | 2.17.1 |
| 78 | RAS | Pharmacy/treatment administration message | User | Optional |  | 2.17.1 |
| 79 | RCI | Return clinical information | User | Optional |  | 2.17.1 |
| 80 | RCL | Return clinical list | User | Optional |  | 2.17.1 |
| 81 | RDE | Pharmacy/treatment encoded order message | User | Optional |  | 2.17.1 |
| 82 | RDR | Pharmacy/treatment dispense information | User | Optional |  | 2.17.1 |
| 83 | RDS | Pharmacy/treatment dispense message | User | Optional |  | 2.17.1 |
| 84 | RDY | Display based response | User | Optional |  | 2.17.1 |
| 85 | REF | Patient referral | User | Optional |  | 2.17.1 |
| 86 | RER | Pharmacy/treatment encoded order information | User | Optional |  | 2.17.1 |
| 87 | RGR | Pharmacy/treatment dose information | User | Optional |  | 2.17.1 |
| 88 | RGV | Pharmacy/treatment give message | User | Optional |  | 2.17.1 |
| 89 | ROR | Pharmacy/treatment order response | User | Optional |  | 2.17.1 |
| 90 | RPA | Return patient authorization | User | Optional |  | 2.17.1 |
| 91 | RPI | Return patient information | User | Optional |  | 2.17.1 |
| 92 | RPL | Return patient display list | User | Optional |  | 2.17.1 |
| 93 | RPR | Return patient list | User | Optional |  | 2.17.1 |
| 94 | RQA | Request patient authorization | User | Optional |  | 2.17.1 |
| 95 | RQC | Request clinical information | User | Optional |  | 2.17.1 |
| 96 | RQI | Request patient information | User | Optional |  | 2.17.1 |
| 97 | RQP | Request patient demographics | User | Optional |  | 2.17.1 |
| 98 | RQQ | Event replay query | User | Optional |  | 2.17.1 |
| 99 | RRA | Pharmacy/treatment administration acknowledgment message | User | Optional |  | 2.17.1 |
| 100 | RRD | Pharmacy/treatment dispense acknowledgment message | User | Optional |  | 2.17.1 |
| 101 | RRE | Pharmacy/treatment encoded order acknowledgment message | User | Optional |  | 2.17.1 |
| 102 | RRG | Pharmacy/treatment give acknowledgment message | User | Optional |  | 2.17.1 |
| 103 | RRI | Return referral information | User | Optional |  | 2.17.1 |
| 104 | RSP | Segment pattern response | User | Optional |  | 2.17.1 |
| 105 | RTB | Tabular response | User | Optional |  | 2.17.1 |
| 106 | SIU | Schedule information unsolicited | User | Optional |  | 2.17.1 |
| 107 | SPQ | Stored procedure request | User | Optional |  | 2.17.1 |
| 108 | SQM | Schedule query message | User | Optional |  | 2.17.1 |
| 109 | SQR | Schedule query response | User | Optional |  | 2.17.1 |
| 110 | SRM | Schedule request message | User | Optional |  | 2.17.1 |
| 111 | SRR | Scheduled request response | User | Optional |  | 2.17.1 |
| 112 | SSR | Specimen status request message | User | Optional |  | 2.17.1 |
| 113 | SSU | Specimen status update message | User | Optional |  | 2.17.1 |
| 114 | SUR | Summary product experience report | User | Optional |  | 2.17.1 |
| 115 | TBR | Tabular data response | User | Optional |  | 2.17.1 |
| 116 | TCR | Automated equipment test code settings request message | User | Optional |  | 2.17.1 |
| 117 | TCU | Automated equipment test code settings update message | User | Optional |  | 2.17.1 |
| 118 | UDM | Unsolicited display update message | User | Optional |  | 2.17.1 |
| 119 | VQQ | Virtual table query | User | Optional |  | 2.17.1 |
| 120 | VXQ | Query for vaccination record | User | Optional |  | 2.17.1 |
| 121 | VXR | Vaccination record response | User | Optional |  | 2.17.1 |
| 122 | VXU | Unsolicited vaccination record update | User | Optional |  | 2.17.1 |
| 123 | VXX | Response for vaccination query with multiple PID matches | User | Optional |  | 2.17.1 |

**ID: 0103 Name: Processing ID** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

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| --- | --- | --- | --- | --- | --- | --- |
| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |
| 1 | D | Debugging | User | Optional |  | 2.A.1.57.1 |
| 2 | P | Production | User | Optional |  | 2.A.1.57.1 |
| 3 | T | Training | User | Optional |  | 2.A.1.57.1 |

**ID: 0104 Name: Version ID** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

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| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |
| 1 | 2.0 | Release 2.0 | User | Optional |  | 2.15.9.12 |
| 2 | 2.0D | Demo 2.0 | User | Optional |  | 2.15.9.12 |
| 3 | 2.1 | Release 2. 1 | User | Optional |  | 2.15.9.12 |
| 4 | 2.2 | Release 2.2 | User | Optional |  | 2.15.9.12 |
| 5 | 2.3 | Release 2.3 | User | Optional |  | 2.15.9.12 |
| 6 | 2.3.1 | Release 2.3.1 | User | Optional |  | 2.15.9.12 |
| 7 | 2.4 | Release 2.4 | User | Optional |  | 2.15.9.12 |
| 8 | 2.5 | Release 2.5 | User | Optional |  | 2.15.9.12 |
| 9 | 2.5.1 | Release 2.5.1 | User | Optional |  | 2.15.9.12 |

**ID: 0131 Name: Contact Role** Type: USER Coding Sys: HL7 Defined Codes - HL7nnn

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| --- | --- | --- | --- | --- | --- | --- |
| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |
| 1 | C | Emergency Contact | User | Optional |  | 3.4.5.7 |
| 2 | E | Employer | User | Optional |  | 3.4.5.7 |
| 3 | F | Federal Agency | User | Optional |  | 3.4.5.7 |
| 4 | I | Insurance Company | User | Optional |  | 3.4.5.7 |
| 5 | N | Next-of-Kin | User | Optional |  | 3.4.5.7 |
| 6 | O | Other | User | Optional |  | 3.4.5.7 |
| 7 | S | State Agency | User | Optional |  | 3.4.5.7 |
| 8 | U | Unknown | User | Optional |  | 3.4.5.7 |

**ID: 0185 Name: Preferred method of contact** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

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| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |
| 1 | B | Beeper Number | User | Optional |  | 15.4.8.16 |
| 2 | C | Cellular Phone Number | User | Optional |  | 15.4.8.16 |
| 3 | E | E-Mail Address (for backward compatibility) | User | Optional |  | 15.4.8.16 |
| 4 | F | FAX Number | User | Optional |  | 15.4.8.16 |
| 5 | H | Home Phone Number | User | Optional |  | 15.4.8.16 |
| 6 | O | Office Phone Number | User | Optional |  | 15.4.8.16 |

**ID: 0200 Name: Name type** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

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| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |
| 1 | A | Alias Name | User | Optional |  | 3.4.2.5 |
| 2 | B | Name at Birth | User | Optional |  | 3.4.2.5 |
| 3 | C | Adopted Name | User | Optional |  | 3.4.2.5 |
| 4 | D | Display Name | User | Optional |  | 3.4.2.5 |
| 5 | I | Licensing Name | User | Optional |  | 3.4.2.5 |
| 6 | L | Legal Name | User | Optional |  | 3.4.2.5 |
| 7 | M | Maiden Name | User | Optional |  | 3.4.2.5 |
| 8 | N | name /"Call me" Name/Street Name | User | Optional |  | 3.4.2.5 |
| 9 | P | Name of Partner/Spouse (retained for backward compatibility only) | User | Optional |  | 3.4.2.5 |
| 10 | R | Registered Name (animals only) | User | Optional |  | 3.4.2.5 |
| 11 | S | Coded Pseudo-Name to ensure anonymity | User | Optional |  | 3.4.2.5 |
| 12 | T | Indigenous/Tribal/Community Name | User | Optional |  | 3.4.2.5 |
| 13 | U | Unspecified | User | Optional |  | 3.4.2.5 |

**ID: 0201 Name: Telecommunication use code** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

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| --- | --- | --- | --- | --- | --- | --- |
| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |
| 1 | ASN | Answering Service Number | User | Optional |  | 2.A.1.89.2 |
| 2 | BPN | Beeper Number | User | Optional |  | 2.A.1.89.2 |
| 3 | EMR | Emergency Number | User | Optional |  | 2.A.1.89.2 |
| 4 | NET | Network (email) Address | User | Optional |  | 2.A.1.89.2 |
| 5 | ORN | Other Residence Number | User | Optional |  | 2.A.1.89.2 |
| 6 | PRN | Primary Residence Number | User | Optional |  | 2.A.1.89.2 |
| 7 | VHN | Vacation Home Number | User | Optional |  | 2.A.1.89.2 |
| 8 | WPN | Work Number | User | Optional |  | 2.A.1.89.2 |

**ID: 0202 Name: Telecommunication equipment type** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

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| --- | --- | --- | --- | --- | --- | --- |
| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |
| 1 | BP | Beeper | User | Optional |  | 2.A.1.89.3 |
| 2 | CP | Cellular Phone | User | Optional |  | 2.A.1.89.3 |
| 3 | FX | Fax | User | Optional |  | 2.A.1.89.3 |
| 4 | Internet | Internet Address: Use Only If Telecommunication Use Code Is NET | User | Optional |  | 2.A.1.89.3 |
| 5 | MD | Modem | User | Optional |  | 2.A.1.89.3 |
| 6 | PH | Telephone | User | Optional |  | 2.A.1.89.3 |
| 7 | TDD | Telecommunications Device for the Deaf | User | Optional |  | 2.A.1.89.3 |
| 8 | TTY | Teletypewriter | User | Optional |  | 2.A.1.89.3 |
| 9 | X.400 | X.400 email address: Use Only If Telecommunication Use Code Is NET | User | Optional |  | 2.A.1.89.3 |

**ID: 0203 Name: Identifier type** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

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| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |
| 1 | AM | American Express | User | Optional |  | 2.A.1.14.5 |
| 2 | AN | Account number | User | Optional |  | 2.A.1.14.5 |
| 3 | ANC | Account number Creditor | User | Optional |  | 2.A.1.14.5 |
| 4 | AND | Account number debitor | User | Optional |  | 2.A.1.14.5 |
| 5 | ANON | Anonymous identifier | User | Optional |  | 2.A.1.14.5 |
| 6 | ANT | Temporary Account Number | User | Optional |  | 2.A.1.14.5 |
| 7 | APRN | Advanced Practice Registered Nurse number | User | Optional |  | 2.A.1.14.5 |
| 8 | BA | Bank Account Number | User | Optional |  | 2.A.1.14.5 |
| 9 | BC | Bank Card Number | User | Optional |  | 2.A.1.14.5 |
| 10 | BR | Birth registry number | User | Optional |  | 2.A.1.14.5 |
| 11 | BRN | Breed Registry Number | User | Optional |  | 2.A.1.14.5 |
| 12 | CC | Cost Center number | User | Optional |  | 2.A.1.14.5 |
| 13 | CY | County number | User | Optional |  | 2.A.1.14.5 |
| 14 | DDS | Dentist license number | User | Optional |  | 2.A.1.14.5 |
| 15 | DEA | Drug Enforcement Administration registration number | User | Optional |  | 2.A.1.14.5 |
| 16 | DFN | Drug Furnishing or prescriptive authority Number | User | Optional |  | 2.A.1.14.5 |
| 17 | DI | Diner's Club card | User | Optional |  | 2.A.1.14.5 |
| 18 | DL | Driver's license number | User | Optional |  | 2.A.1.14.5 |
| 19 | DN | Doctor number | User | Optional |  | 2.A.1.14.5 |
| 20 | DO | Osteopathic License number | User | Optional |  | 2.A.1.14.5 |
| 21 | DPM | Podiatrist license number | User | Optional |  | 2.A.1.14.5 |
| 22 | DR | Donor Registration Number | User | Optional |  | 2.A.1.14.5 |
| 23 | DS | Discover Card | User | Optional |  | 2.A.1.14.5 |
| 24 | EI | Employee number | User | Optional |  | 2.A.1.14.5 |
| 25 | EN | Employer number | User | Optional |  | 2.A.1.14.5 |
| 26 | FI | Facility ID | User | Optional |  | 2.A.1.14.5 |
| 27 | GI | Guarantor internal identifier | User | Optional |  | 2.A.1.14.5 |
| 28 | GL | General ledger number | User | Optional |  | 2.A.1.14.5 |
| 29 | GN | Guarantor external identifier | User | Optional |  | 2.A.1.14.5 |
| 30 | HC | Health Card Number | User | Optional |  | 2.A.1.14.5 |
| 31 | IND | Indigenous/Aboriginal | User | Optional |  | 2.A.1.14.5 |
| 32 | JHN | Jurisdictional health number (Canada) | User | Optional |  | 2.A.1.14.5 |
| 33 | LI | Labor and industries number | User | Optional |  | 2.A.1.14.5 |
| 34 | LN | License number | User | Optional |  | 2.A.1.14.5 |
| 35 | LR | Local Registry ID | User | Optional |  | 2.A.1.14.5 |
| 36 | MA | Patient Medicaid number | User | Optional |  | 2.A.1.14.5 |
| 37 | MB | Member Number | User | Optional |  | 2.A.1.14.5 |
| 38 | MC | Patient's Medicare number | User | Optional |  | 2.A.1.14.5 |
| 39 | MCD | Practitioner Medicaid number | User | Optional |  | 2.A.1.14.5 |
| 40 | MCN | Microchip Number | User | Optional |  | 2.A.1.14.5 |
| 41 | MCR | Practitioner Medicare number | User | Optional |  | 2.A.1.14.5 |
| 42 | MD | Medical License number | User | Optional |  | 2.A.1.14.5 |
| 43 | MI | Military ID number | User | Optional |  | 2.A.1.14.5 |
| 44 | MR | Medical record number | User | Optional |  | 2.A.1.14.5 |
| 45 | MRT | Temporary Medical Record Number | User | Optional |  | 2.A.1.14.5 |
| 46 | MS | MasterCard | User | Optional |  | 2.A.1.14.5 |
| 47 | NE | National employer identifier | User | Optional |  | 2.A.1.14.5 |
| 48 | NH | National Health Plan Identifier | User | Optional |  | 2.A.1.14.5 |
| 49 | NI | National unique individual identifier | User | Optional |  | 2.A.1.14.5 |
| 50 | NII | National Insurance Organization Identifier | User | Optional |  | 2.A.1.14.5 |
| 51 | NIIP | National Insurance Payor Identifier (Payor) | User | Optional |  | 2.A.1.14.5 |
| 52 | NNxxx | National Person Identifier where the xxx is the ISO table 3166 3-character (alphabetic) country code | User | Optional |  | 2.A.1.14.5 |
| 53 | NP | Nurse practitioner number | User | Optional |  | 2.A.1.14.5 |
| 54 | NPI | National provider identifier | User | Optional |  | 2.A.1.14.5 |
| 55 | OD | Optometrist license number | User | Optional |  | 2.A.1.14.5 |
| 56 | PA | Physician Assistant number | User | Optional |  | 2.A.1.14.5 |
| 57 | PCN | Penitentiary/correctional institution Number | User | Optional |  | 2.A.1.14.5 |
| 58 | PE | Living Subject Enterprise Number | User | Optional |  | 2.A.1.14.5 |
| 59 | PEN | Pension Number | User | Optional |  | 2.A.1.14.5 |
| 60 | PI | Patient internal identifier | User | Optional |  | 2.A.1.14.5 |
| 61 | PN | Person number | User | Optional |  | 2.A.1.14.5 |
| 62 | PNT | Temporary Living Subject Number | User | Optional |  | 2.A.1.14.5 |
| 63 | PPN | Passport number | User | Optional |  | 2.A.1.14.5 |
| 64 | PRC | Permanent Resident Card Number | User | Optional |  | 2.A.1.14.5 |
| 65 | PRN | Provider number | User | Optional |  | 2.A.1.14.5 |
| 66 | PT | Patient external identifier | User | Optional |  | 2.A.1.14.5 |
| 67 | QA | QA number | User | Optional |  | 2.A.1.14.5 |
| 68 | RI | Resource identifier | User | Optional |  | 2.A.1.14.5 |
| 69 | RN | Registered Nurse Number | User | Optional |  | 2.A.1.14.5 |
| 70 | RPH | Pharmacist license number | User | Optional |  | 2.A.1.14.5 |
| 71 | RR | Railroad Retirement number | User | Optional |  | 2.A.1.14.5 |
| 72 | RRI | Regional registry ID | User | Optional |  | 2.A.1.14.5 |
| 73 | SL | State license | User | Optional |  | 2.A.1.14.5 |
| 74 | SN | Subscriber Number | User | Optional |  | 2.A.1.14.5 |
| 75 | SR | State registry ID | User | Optional |  | 2.A.1.14.5 |
| 76 | SS | Social Security number | User | Optional |  | 2.A.1.14.5 |
| 77 | TAX | Tax ID number | User | Optional |  | 2.A.1.14.5 |
| 78 | TN | Treaty Number/ (Canada) | User | Optional |  | 2.A.1.14.5 |
| 79 | U | Unspecified identifier | User | Optional |  | 2.A.1.14.5 |
| 80 | UPIN | Medicare/CMS (formerly HCFA)'s Universal Physician Identification numbers | User | Optional |  | 2.A.1.14.5 |
| 81 | VN | Visit number | User | Optional |  | 2.A.1.14.5 |
| 82 | VS | VISA | User | Optional |  | 2.A.1.14.5 |
| 83 | WC | WIC identifier | User | Optional |  | 2.A.1.14.5 |
| 84 | WCN | Workers' Comp Number | User | Optional |  | 2.A.1.14.5 |
| 85 | XX | Organization identifier | User | Optional |  | 2.A.1.14.5 |

**ID: 0204 Name: Organizational name type** Type: USER Coding Sys: HL7 Defined Codes - HL7nnn

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| --- | --- | --- | --- | --- | --- | --- |
| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |
| 1 | A | Alias name | User | Optional |  | 2.A.1.87.2 |
| 2 | D | Display name | User | Optional |  | 2.A.1.87.2 |
| 3 | L | Legal name | User | Optional |  | 2.A.1.87.2 |
| 4 | SL | Stock exchange listing name | User | Optional |  | 2.A.1.87.2 |

**ID: 0297 Name: CN ID source** Type: USER Coding Sys: HL7 Defined Codes - HL7nnn

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| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |
| 1 | ... | No suggested values defined | User | Optional |  | 2.A.1.55.8 |

**ID: 0301 Name: Universal ID type** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

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| --- | --- | --- | --- | --- | --- | --- |
| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |
| 1 | DNS | An Internet dotted name. Either in ASCII or as integers | User | Optional |  | 2.A.1.33.3 |
| 2 | GUID | Same as UUID. | User | Optional |  | 2.A.1.33.3 |
| 3 | HCD | The CEN Healthcare Coding Scheme Designator. (Identifiers used in DICOM follow this assignment scheme.) | User | Optional |  | 2.A.1.33.3 |
| 4 | HL7 | Reserved for future HL7 registration schemes | User | Optional |  | 2.A.1.33.3 |
| 5 | ISO | An International Standards Organization Object Identifier | User | Optional |  | 2.A.1.33.3 |
| 6 | L,M,N | These are reserved for locally defined coding schemes. | User | Optional |  | 2.A.1.33.3 |
| 7 | Random | Usually a base64 encoded string of random bits.<p>The uniqueness depends on the length of the bits. Mail systems often generate ASCII string \_??unique names," from a combination of random bits and system names. Obviously, such identifiers will not be cons | User | Optional |  | 2.A.1.33.3 |
| 8 | URI | Uniform Resource Identifier | User | Optional |  | 2.A.1.33.3 |
| 9 | UUID | The DCE Universal Unique Identifier | User | Optional |  | 2.A.1.33.3 |
| 10 | x400 | An X.400 MHS format identifier | User | Optional |  | 2.A.1.33.3 |
| 11 | x500 | An X.500 directory name | User | Optional |  | 2.A.1.33.3 |

**ID: 0338 Name: Practitioner ID number type** Type: USER Coding Sys: HL7 Defined Codes - HL7nnn

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| --- | --- | --- | --- | --- | --- | --- |
| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |
| 1 | CY | County number | User | Optional |  | 2.A.1.54.2 |
| 2 | DEA | Drug Enforcement Agency no. | User | Optional |  | 2.A.1.54.2 |
| 3 | GL | General ledger number | User | Optional |  | 2.A.1.54.2 |
| 4 | L&I | Labor and industries number | User | Optional |  | 2.A.1.54.2 |
| 5 | LI | Labor and industries number | User | Optional |  | 2.A.1.54.2 |
| 6 | MCD | Medicaid number | User | Optional |  | 2.A.1.54.2 |
| 7 | MCR | Medicare number | User | Optional |  | 2.A.1.54.2 |
| 8 | QA | QA number | User | Optional |  | 2.A.1.54.2 |
| 9 | SL | State license number | User | Optional |  | 2.A.1.54.2 |
| 10 | TAX | Tax ID number | User | Optional |  | 2.A.1.54.2 |
| 11 | TRL | Training license number | User | Optional |  | 2.A.1.54.2 |
| 12 | UPIN | Unique physician ID no. | User | Optional |  | 2.A.1.54.2 |

**ID: 0354 Name: Message structure** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

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| --- | --- | --- | --- | --- | --- | --- |
| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |
| 1 | ACK | Varies | User | Optional |  | 2.17.3 |
| 2 | ADR\_A19 | A19 | User | Optional |  | 2.17.3 |
| 3 | ADT\_A01 | A01, A04, A08, A13 | User | Optional |  | 2.17.3 |
| 4 | ADT\_A02 | A02 | User | Optional |  | 2.17.3 |
| 5 | ADT\_A03 | A03 | User | Optional |  | 2.17.3 |
| 6 | ADT\_A05 | A05, A14, A28, A31 | User | Optional |  | 2.17.3 |
| 7 | ADT\_A06 | A06, A07 | User | Optional |  | 2.17.3 |
| 8 | ADT\_A09 | A09, A10, A11 | User | Optional |  | 2.17.3 |
| 9 | ADT\_A12 | A12 | User | Optional |  | 2.17.3 |
| 10 | ADT\_A15 | A15 | User | Optional |  | 2.17.3 |
| 11 | ADT\_A16 | A16 | User | Optional |  | 2.17.3 |
| 12 | ADT\_A17 | A17 | User | Optional |  | 2.17.3 |
| 13 | ADT\_A18 | A18 | User | Optional |  | 2.17.3 |
| 14 | ADT\_A20 | A20 | User | Optional |  | 2.17.3 |
| 15 | ADT\_A21 | A21, A22, A23, A25, A26, A27, A29, A32, A33 | User | Optional |  | 2.17.3 |
| 16 | ADT\_A24 | A24 | User | Optional |  | 2.17.3 |
| 17 | ADT\_A30 | A30, A34, A35, A36, A46, A47, A48, A49 | User | Optional |  | 2.17.3 |
| 18 | ADT\_A37 | A37 | User | Optional |  | 2.17.3 |
| 19 | ADT\_A38 | A38 | User | Optional |  | 2.17.3 |
| 20 | ADT\_A39 | A39, A40, A41, A42 | User | Optional |  | 2.17.3 |
| 21 | ADT\_A43 | A43, A44 | User | Optional |  | 2.17.3 |
| 22 | ADT\_A45 | A45 | User | Optional |  | 2.17.3 |
| 23 | ADT\_A50 | A50, A51 | User | Optional |  | 2.17.3 |
| 24 | ADT\_A52 | A52, A53, A55 | User | Optional |  | 2.17.3 |
| 25 | ADT\_A54 | A54 | User | Optional |  | 2.17.3 |
| 26 | ADT\_A60 | A60 | User | Optional |  | 2.17.3 |
| 27 | ADT\_A61 | A61, A62 | User | Optional |  | 2.17.3 |
| 28 | BAR\_P01 | P01 | User | Optional |  | 2.17.3 |
| 29 | BAR\_P02 | P02 | User | Optional |  | 2.17.3 |
| 30 | BAR\_P05 | P05 | User | Optional |  | 2.17.3 |
| 31 | BAR\_P06 | P06 | User | Optional |  | 2.17.3 |
| 32 | BAR\_P10 | P10 | User | Optional |  | 2.17.3 |
| 33 | BAR\_P12 | P12 | User | Optional |  | 2.17.3 |
| 34 | BPS\_O29 | O29 | User | Optional |  | 2.17.3 |
| 35 | BRP\_O30 | O30 | User | Optional |  | 2.17.3 |
| 36 | BRT\_O32 | O32 | User | Optional |  | 2.17.3 |
| 37 | BTS\_O31 | O31 | User | Optional |  | 2.17.3 |
| 38 | CRM\_C01 | C01, C02, C03, C04, C05, C06, C07, C08 | User | Optional |  | 2.17.3 |
| 39 | CSU\_C09 | C09, C10, C11, C12 | User | Optional |  | 2.17.3 |
| 40 | DFT\_P03 | P03 | User | Optional |  | 2.17.3 |
| 41 | DFT\_P11 | P11 | User | Optional |  | 2.17.3 |
| 42 | DOC\_T12 | T12 | User | Optional |  | 2.17.3 |
| 43 | DSR\_P04 | P04 | User | Optional |  | 2.17.3 |
| 44 | DSR\_Q01 | Q01 | User | Optional |  | 2.17.3 |
| 45 | DSR\_Q03 | Q03 | User | Optional |  | 2.17.3 |
| 46 | EAC\_U07 | U07 | User | Optional |  | 2.17.3 |
| 47 | EAN\_U09 | U09 | User | Optional |  | 2.17.3 |
| 48 | EAR\_U08 | U08 | User | Optional |  | 2.17.3 |
| 49 | EDR\_R07 | R07 | User | Optional |  | 2.17.3 |
| 50 | EQQ\_Q04 | Q04 | User | Optional |  | 2.17.3 |
| 51 | ERP\_R09 | R09 | User | Optional |  | 2.17.3 |
| 52 | ESR\_U02 | U02 | User | Optional |  | 2.17.3 |
| 53 | ESU\_U01 | U01 | User | Optional |  | 2.17.3 |
| 54 | INR\_U06 | U06 | User | Optional |  | 2.17.3 |
| 55 | INU\_U05 | U05 | User | Optional |  | 2.17.3 |
| 56 | LSU\_U12 | U12, U13 | User | Optional |  | 2.17.3 |
| 57 | MDM\_T01 | T01, T03, T05, T07, T09, T11 | User | Optional |  | 2.17.3 |
| 58 | MDM\_T02 | T02, T04, T06, T08, T10 | User | Optional |  | 2.17.3 |
| 59 | MFD\_MFA | MFA | User | Optional |  | 2.17.3 |
| 60 | MFK\_M01 | M01, M02, M03, M04, M05, M06, M07, M08, M09, M10, M11 | User | Optional |  | 2.17.3 |
| 61 | MFN\_M01 | M01 | User | Optional |  | 2.17.3 |
| 62 | MFN\_M02 | M02 | User | Optional |  | 2.17.3 |
| 63 | MFN\_M03 | M03 | User | Optional |  | 2.17.3 |
| 64 | MFN\_M04 | M04 | User | Optional |  | 2.17.3 |
| 65 | MFN\_M05 | M05 | User | Optional |  | 2.17.3 |
| 66 | MFN\_M06 | M06 | User | Optional |  | 2.17.3 |
| 67 | MFN\_M07 | M07 | User | Optional |  | 2.17.3 |
| 68 | MFN\_M08 | M08 | User | Optional |  | 2.17.3 |
| 69 | MFN\_M09 | M09 | User | Optional |  | 2.17.3 |
| 70 | MFN\_M10 | M10 | User | Optional |  | 2.17.3 |
| 71 | MFN\_M11 | M11 | User | Optional |  | 2.17.3 |
| 72 | MFN\_M12 | M12 | User | Optional |  | 2.17.3 |
| 73 | MFN\_M13 | M13 | User | Optional |  | 2.17.3 |
| 74 | MFN\_M15 | M15 | User | Optional |  | 2.17.3 |
| 75 | MFQ\_M01 | M01, M02, M03, M04, M05, M06 | User | Optional |  | 2.17.3 |
| 76 | MFR\_M01 | M01, M02, M03 | User | Optional |  | 2.17.3 |
| 77 | MFR\_M04 | M04 | User | Optional |  | 2.17.3 |
| 78 | MFR\_M05 | Mo5 | User | Optional |  | 2.17.3 |
| 79 | MFR\_M06 | M06 | User | Optional |  | 2.17.3 |
| 80 | MFR\_M07 | M07 | User | Optional |  | 2.17.3 |
| 81 | NMD\_N02 | N02 | User | Optional |  | 2.17.3 |
| 82 | NMQ\_N01 | N01 | User | Optional |  | 2.17.3 |
| 83 | NMR\_N01 | N01 | User | Optional |  | 2.17.3 |
| 84 | OMB\_O27 | O27 | User | Optional |  | 2.17.3 |
| 85 | OMD\_O03 | O03 | User | Optional |  | 2.17.3 |
| 86 | OMG\_O19 | O19 | User | Optional |  | 2.17.3 |
| 87 | OMI\_O23 | O23 | User | Optional |  | 2.17.3 |
| 88 | OML\_O21 | O21 | User | Optional |  | 2.17.3 |
| 89 | OML\_O33 | O33 | User | Optional |  | 2.17.3 |
| 90 | OML\_O35 | O35 | User | Optional |  | 2.17.3 |
| 91 | OMN\_O07 | 007 | User | Optional |  | 2.17.3 |
| 92 | OMP\_O09 | O09 | User | Optional |  | 2.17.3 |
| 93 | OMS\_O05 | O05 | User | Optional |  | 2.17.3 |
| 94 | ORB\_O28 | O28 | User | Optional |  | 2.17.3 |
| 95 | ORD\_O04 | O04 | User | Optional |  | 2.17.3 |
| 96 | ORF\_R04 | R04 | User | Optional |  | 2.17.3 |
| 97 | ORG\_O20 | O20 | User | Optional |  | 2.17.3 |
| 98 | ORI\_O24 | O24 | User | Optional |  | 2.17.3 |
| 99 | ORL\_O22 | 022 | User | Optional |  | 2.17.3 |
| 100 | ORL\_O34 | O34 | User | Optional |  | 2.17.3 |
| 101 | ORL\_O36 | O36 | User | Optional |  | 2.17.3 |
| 102 | ORM\_O01 | O01 | User | Optional |  | 2.17.3 |
| 103 | ORN\_O08 | O08 | User | Optional |  | 2.17.3 |
| 104 | ORP\_O10 | O10 | User | Optional |  | 2.17.3 |
| 105 | ORR\_O02 | O02 | User | Optional |  | 2.17.3 |
| 106 | ORS\_O06 | O06 | User | Optional |  | 2.17.3 |
| 107 | ORU\_R01 | R01 | User | Optional |  | 2.17.3 |
| 108 | ORU\_R30 | R30, R31, R32 | User | Optional |  | 2.17.3 |
| 109 | ORU\_W01 | W01 | User | Optional |  | 2.17.3 |
| 110 | OSQ\_Q06 | Q06 | User | Optional |  | 2.17.3 |
| 111 | OSR\_Q06 | Q06 | User | Optional |  | 2.17.3 |
| 112 | OUL\_R21 | R21 | User | Optional |  | 2.17.3 |
| 113 | OUL\_R22 | R22 | User | Optional |  | 2.17.3 |
| 114 | OUL\_R23 | R23 | User | Optional |  | 2.17.3 |
| 115 | OUL\_R24 | R24 | User | Optional |  | 2.17.3 |
| 116 | PEX\_P07 | P07, P08 | User | Optional |  | 2.17.3 |
| 117 | PGL\_PC6 | PC6, PC7, PC8 | User | Optional |  | 2.17.3 |
| 118 | PMU\_B01 | B01, B02 | User | Optional |  | 2.17.3 |
| 119 | PMU\_B03 | B03 | User | Optional |  | 2.17.3 |
| 120 | PMU\_B04 | B04, B05, B06 | User | Optional |  | 2.17.3 |
| 121 | PMU\_B07 | B07 | User | Optional |  | 2.17.3 |
| 122 | PMU\_B08 | B08 | User | Optional |  | 2.17.3 |
| 123 | PPG\_PCG | PCC, PCG, PCH, PCJ | User | Optional |  | 2.17.3 |
| 124 | PPP\_PCB | PCB, PCD | User | Optional |  | 2.17.3 |
| 125 | PPR\_PC1 | PC1, PC2, PC3 | User | Optional |  | 2.17.3 |
| 126 | PPT\_PCL | PCL | User | Optional |  | 2.17.3 |
| 127 | PPV\_PCA | PCA | User | Optional |  | 2.17.3 |
| 128 | PRR\_PC5 | PC5 | User | Optional |  | 2.17.3 |
| 129 | PTR\_PCF | PCF | User | Optional |  | 2.17.3 |
| 130 | QBP\_Q11 | Q11 | User | Optional |  | 2.17.3 |
| 131 | QBP\_Q13 | Q13 | User | Optional |  | 2.17.3 |
| 132 | QBP\_Q15 | Q15 | User | Optional |  | 2.17.3 |
| 133 | QBP\_Q21 | Q21, Q22, Q23,Q24, Q25 | User | Optional |  | 2.17.3 |
| 134 | QCK\_Q02 | Q02 | User | Optional |  | 2.17.3 |
| 135 | QCN\_J01 | J01, J02 | User | Optional |  | 2.17.3 |
| 136 | QRF\_W02 | W02 | User | Optional |  | 2.17.3 |
| 137 | QRY\_A19 | A19 | User | Optional |  | 2.17.3 |
| 138 | QRY\_P04 | P04 | User | Optional |  | 2.17.3 |
| 139 | QRY\_PC4 | PC4, PC9, PCE, PCK | User | Optional |  | 2.17.3 |
| 140 | QRY\_Q01 | Q01, Q26, Q27, Q28, Q29, Q30 | User | Optional |  | 2.17.3 |
| 141 | QRY\_Q02 | Q02 | User | Optional |  | 2.17.3 |
| 142 | QRY\_R02 | R02 | User | Optional |  | 2.17.3 |
| 143 | QRY\_T12 | T12 | User | Optional |  | 2.17.3 |
| 144 | QSB\_Q16 | Q16 | User | Optional |  | 2.17.3 |
| 145 | QVR\_Q17 | Q17 | User | Optional |  | 2.17.3 |
| 146 | RAR\_RAR | RAR | User | Optional |  | 2.17.3 |
| 147 | RAS\_O17 | O17 | User | Optional |  | 2.17.3 |
| 148 | RCI\_I05 | I05 | User | Optional |  | 2.17.3 |
| 149 | RCL\_I06 | I06 | User | Optional |  | 2.17.3 |
| 150 | RDE\_O11 | O11, O25 | User | Optional |  | 2.17.3 |
| 151 | RDR\_RDR | RDR | User | Optional |  | 2.17.3 |
| 152 | RDS\_O13 | O13 | User | Optional |  | 2.17.3 |
| 153 | RDY\_K15 | K15 | User | Optional |  | 2.17.3 |
| 154 | REF\_I12 | I12, I13, I14, I15 | User | Optional |  | 2.17.3 |
| 155 | RER\_RER | RER | User | Optional |  | 2.17.3 |
| 156 | RGR\_RGR | RGR | User | Optional |  | 2.17.3 |
| 157 | RGV\_O15 | O15 | User | Optional |  | 2.17.3 |
| 158 | ROR\_ROR | ROR | User | Optional |  | 2.17.3 |
| 159 | RPA\_I08 | I08, I09. I10, I11 | User | Optional |  | 2.17.3 |
| 160 | RPI\_I01 | I01 | User | Optional |  | 2.17.3 |
| 161 | RPI\_I04 | I04 | User | Optional |  | 2.17.3 |
| 162 | RPL\_I02 | I02 | User | Optional |  | 2.17.3 |
| 163 | RPR\_I03 | I03 | User | Optional |  | 2.17.3 |
| 164 | RQA\_I08 | I08, I09, I10, I11 | User | Optional |  | 2.17.3 |
| 165 | RQC\_I05 | I05, I06 | User | Optional |  | 2.17.3 |
| 166 | RQI\_I01 | I01, I02, I03, I07 | User | Optional |  | 2.17.3 |
| 167 | RQP\_I04 | I04 | User | Optional |  | 2.17.3 |
| 168 | RQQ\_Q09 | Q09 | User | Optional |  | 2.17.3 |
| 169 | RRA\_O18 | O18 | User | Optional |  | 2.17.3 |
| 170 | RRD\_O14 | O14 | User | Optional |  | 2.17.3 |
| 171 | RRE\_O12 | O12, O26 | User | Optional |  | 2.17.3 |
| 172 | RRG\_O16 | O16 | User | Optional |  | 2.17.3 |
| 173 | RRI\_I12 | I12, I13, I14, I15 | User | Optional |  | 2.17.3 |
| 174 | RSP\_K11 | K11 | User | Optional |  | 2.17.3 |
| 175 | RSP\_K21 | K21 | User | Optional |  | 2.17.3 |
| 176 | RSP\_K22 | K22 | User | Optional |  | 2.17.3 |
| 177 | RSP\_K23 | K23, K24 | User | Optional |  | 2.17.3 |
| 178 | RSP\_K25 | K25 | User | Optional |  | 2.17.3 |
| 179 | RSP\_K31 | K31 | User | Optional |  | 2.17.3 |
| 180 | RSP\_Q11 | Q11 | User | Optional |  | 2.17.3 |
| 181 | RTB\_K13 | K13 | User | Optional |  | 2.17.3 |
| 182 | SIU\_S12 | S12, S13, S14, S15, S16, S17, S18, S19, S20, S21, S22, S23, S24, S26 | User | Optional |  | 2.17.3 |
| 183 | SPQ\_Q08 | Q08 | User | Optional |  | 2.17.3 |
| 184 | SQM\_S25 | S25 | User | Optional |  | 2.17.3 |
| 185 | SQR\_S25 | S25 | User | Optional |  | 2.17.3 |
| 186 | SRM\_S01 | S01, S02, S03, S04, S05, S06, S07, S08, S09, S10, S11 | User | Optional |  | 2.17.3 |
| 187 | SRR\_S01 | S01, S02, S03, S04, S05, S06, S07, S08, S09, S10, S11 | User | Optional |  | 2.17.3 |
| 188 | SSR\_U04 | U04 | User | Optional |  | 2.17.3 |
| 189 | SSU\_U03 | U03 | User | Optional |  | 2.17.3 |
| 190 | SUR\_P09 | P09 | User | Optional |  | 2.17.3 |
| 191 | TBR\_R08 | R08 | User | Optional |  | 2.17.3 |
| 192 | TBR\_R09 | R09 | User | Optional |  | 2.17.3 |
| 193 | TCU\_U10 | U10, U11 | User | Optional |  | 2.17.3 |
| 194 | UDM\_Q05 | Q05 | User | Optional |  | 2.17.3 |
| 195 | VQQ\_Q07 | Q07 | User | Optional |  | 2.17.3 |
| 196 | VXQ\_V01 | V01 | User | Optional |  | 2.17.3 |
| 197 | VXR\_V03 | V03 | User | Optional |  | 2.17.3 |
| 198 | VXU\_V04 | V04 | User | Optional |  | 2.17.3 |
| 199 | VXX\_V02 | V02 | User | Optional |  | 2.17.3 |

**ID: 0396 Name: Coding system** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

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| --- | --- | --- | --- | --- | --- | --- |
| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |
| 1 | 99zzz or L | Local general code (where z is an alphanumeric character) | User | Optional |  | 2.17.4 |
| 2 | ACR | American College of Radiology finding codes | User | Optional |  | 2.17.4 |
| 3 | ANS+ | HL7 set of units of measure | User | Optional |  | 2.17.4 |
| 4 | ART | WHO Adverse Reaction Terms | User | Optional |  | 2.17.4 |
| 5 | AS4 | ASTM E1238/ E1467 Universal | User | Optional |  | 2.17.4 |
| 6 | AS4E | AS4 Neurophysiology Codes | User | Optional |  | 2.17.4 |
| 7 | ATC | American Type Culture Collection | User | Optional |  | 2.17.4 |
| 8 | C4 | CPT-4 | User | Optional |  | 2.17.4 |
| 9 | C5 | CPT-5 | User | Optional |  | 2.17.4 |
| 10 | CAS | Chemical abstract codes | User | Optional |  | 2.17.4 |
| 11 | CD2 | CDT-2 Codes | User | Optional |  | 2.17.4 |
| 12 | CDCA | CDC Analyte Codes | User | Optional |  | 2.17.4 |
| 13 | CDCM | CDC Methods/Instruments Codes | User | Optional |  | 2.17.4 |
| 14 | CDS | CDC Surveillance | User | Optional |  | 2.17.4 |
| 15 | CE | CEN ECG diagnostic codes | User | Optional |  | 2.17.4 |
| 16 | CLP | CLIP | User | Optional |  | 2.17.4 |
| 17 | CPTM | CPT Modifier Code | User | Optional |  | 2.17.4 |
| 18 | CST | COSTART | User | Optional |  | 2.17.4 |
| 19 | CVX | CDC Vaccine Codes | User | Optional |  | 2.17.4 |
| 20 | DCM | DICOM Controlled Terminology | User | Optional |  | 2.17.4 |
| 21 | E | EUCLIDES | User | Optional |  | 2.17.4 |
| 22 | E5 | Euclides quantity codes | User | Optional |  | 2.17.4 |
| 23 | E6 | Euclides Lab method codes | User | Optional |  | 2.17.4 |
| 24 | E7 | Euclides Lab equipment codes | User | Optional |  | 2.17.4 |
| 25 | ENZC | Enzyme Codes | User | Optional |  | 2.17.4 |
| 26 | FDDC | First DataBank Drug Codes | User | Optional |  | 2.17.4 |
| 27 | FDDX | First DataBank Diagnostic Codes | User | Optional |  | 2.17.4 |
| 28 | FDK | FDA K10 | User | Optional |  | 2.17.4 |
| 29 | HB | HIBCC | User | Optional |  | 2.17.4 |
| 30 | HCPCS | CMS (formerly HCFA) Common Procedure Coding System | User | Optional |  | 2.17.4 |
| 31 | HCPT | Health Care Provider Taxonomy | User | Optional |  | 2.17.4 |
| 32 | HHC | Home Health Care | User | Optional |  | 2.17.4 |
| 33 | HI | Health Outcomes | User | Optional |  | 2.17.4 |
| 34 | HL7nnnn | HL7 Defined Codes where nnnn is the HL7 table number | User | Optional |  | 2.17.4 |
| 35 | HOT | Japanese Nationwide Medicine Code | User | Optional |  | 2.17.4 |
| 36 | HPC | CMS (formerly HCFA )Procedure Codes (HCPCS) | User | Optional |  | 2.17.4 |
| 37 | I10 | ICD-10 | User | Optional |  | 2.17.4 |
| 38 | I10P | ICD-10 Procedure Codes | User | Optional |  | 2.17.4 |
| 39 | I9 | ICD9 | User | Optional |  | 2.17.4 |
| 40 | I9C | ICD-9CM | User | Optional |  | 2.17.4 |
| 41 | IBT | ISBT | User | Optional |  | 2.17.4 |
| 42 | IBTnnnn | ISBT 128 codes where nnnn specifies a specific table within ISBT 128. | User | Optional |  | 2.17.4 |
| 43 | IC2 | ICHPPC-2 | User | Optional |  | 2.17.4 |
| 44 | ICD10AM | ICD-10 Australian modification | User | Optional |  | 2.17.4 |
| 45 | ICD10CA | ICD-10 Canada | User | Optional |  | 2.17.4 |
| 46 | ICDO | International Classification of Diseases for Oncology | User | Optional |  | 2.17.4 |
| 47 | ICS | ICCS | User | Optional |  | 2.17.4 |
| 48 | ICSD | International Classification of Sleep Disorders | User | Optional |  | 2.17.4 |
| 49 | ISO+ | ISO 2955.83 (units of measure) with HL7 extensions | User | Optional |  | 2.17.4 |
| 50 | ISOnnnn | ISO Defined Codes where nnnn is the ISO table number | User | Optional |  | 2.17.4 |
| 51 | IUPC | IUPAC/IFCC Component Codes | User | Optional |  | 2.17.4 |
| 52 | IUPP | IUPAC/IFCC Property Codes | User | Optional |  | 2.17.4 |
| 53 | JC10 | JLAC/JSLM, nationwide laboratory code | User | Optional |  | 2.17.4 |
| 54 | JC8 | Japanese Chemistry | User | Optional |  | 2.17.4 |
| 55 | JJ1017 | Japanese Image Examination Cache | User | Optional |  | 2.17.4 |
| 56 | LB | Local billing code | User | Optional |  | 2.17.4 |
| 57 | LN | Logical Observation Identifier Names and Codes (LOINC\_\_) | User | Optional |  | 2.17.4 |
| 58 | MCD | Medicaid | User | Optional |  | 2.17.4 |
| 59 | MCR | Medicare | User | Optional |  | 2.17.4 |
| 60 | MDDX | Medispan Diagnostic Codes | User | Optional |  | 2.17.4 |
| 61 | MEDC | Medical Economics Drug Codes | User | Optional |  | 2.17.4 |
| 62 | MEDR | Medical Dictionary for Drug Regulatory Affairs (MEDDRA) | User | Optional |  | 2.17.4 |
| 63 | MEDX | Medical Economics Diagnostic Codes | User | Optional |  | 2.17.4 |
| 64 | MGPI | Medispan GPI | User | Optional |  | 2.17.4 |
| 65 | MVX | CDC Vaccine Manufacturer Codes | User | Optional |  | 2.17.4 |
| 66 | NDA | NANDA | User | Optional |  | 2.17.4 |
| 67 | NDC | National drug codes | User | Optional |  | 2.17.4 |
| 68 | NIC | Nursing Interventions Classification | User | Optional |  | 2.17.4 |
| 69 | NPI | National Provider Identifier | User | Optional |  | 2.17.4 |
| 70 | NUBC | National Uniform Billing Committee Code | User | Optional |  | 2.17.4 |
| 71 | OHA | Omaha System | User | Optional |  | 2.17.4 |
| 72 | POS | POS Codes | User | Optional |  | 2.17.4 |
| 73 | RC | Read Classification | User | Optional |  | 2.17.4 |
| 74 | SDM | SNOMED- DICOM Microglossary | User | Optional |  | 2.17.4 |
| 75 | SNM | Systemized Nomenclature of Medicine (SNOMED) | User | Optional |  | 2.17.4 |
| 76 | SNM3 | SNOMED International | User | Optional |  | 2.17.4 |
| 77 | SNT | SNOMED topology codes (anatomic sites) | User | Optional |  | 2.17.4 |
| 78 | UC | UCDS | User | Optional |  | 2.17.4 |
| 79 | UMD | MDNS | User | Optional |  | 2.17.4 |
| 80 | UML | Unified Medical Language | User | Optional |  | 2.17.4 |
| 81 | UPC | Universal Product Code | User | Optional |  | 2.17.4 |
| 82 | UPIN | UPIN | User | Optional |  | 2.17.4 |
| 83 | USPS | United States Postal Service | User | Optional |  | 2.17.4 |
| 84 | W1 | WHO record # drug codes (6 digit) | User | Optional |  | 2.17.4 |
| 85 | W2 | WHO record # drug codes (8 digit) | User | Optional |  | 2.17.4 |
| 86 | W4 | WHO record # code with ASTM extension | User | Optional |  | 2.17.4 |
| 87 | WC | WHO ATC | User | Optional |  | 2.17.4 |

**ID: 0399 Name: Country code** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

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| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |
| 1 | ... | use 3-character (alphabetic) form of ISO 3166 | User | Optional |  | 2.15.9.17 |

**ID: 0446 Name: Species Code** Type: USER Coding Sys: HL7 Defined Codes - HL7nnn

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| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |
| 1 | ... | no suggested values | User | Optional |  | 3.4.2.35 |

**ID: 0447 Name: Breed Code** Type: USER Coding Sys: HL7 Defined Codes - HL7nnn

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| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |
| 1 | ... | no suggested values | User | Optional |  | 3.4.2.36 |

**ID: 0532 Name: Expanded yes/no indicator** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

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| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |
| 1 | ASKU | asked but unknown | User | Optional |  | 2.17.6 |
| 2 | N | No | User | Optional |  | 2.17.6 |
| 3 | NA | not applicable | User | Optional |  | 2.17.6 |
| 4 | NASK | not asked | User | Optional |  | 2.17.6 |
| 5 | NAV | temporarily unavailable | User | Optional |  | 2.17.6 |
| 6 | NI | No Information | User | Optional |  | 2.17.6 |
| 7 | NP | not present | User | Optional |  | 2.17.6 |
| 8 | UNK | unknown | User | Optional |  | 2.17.6 |
| 9 | Y | Yes | User | Optional |  | 2.17.6 |

**ID: Name:** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

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| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |

**ID: Name:** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

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| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |

**ID: Name:** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

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| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |

**ID: Name:** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

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| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |

**ID: Name:** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

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| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |

**ID: Name:** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

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| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |

**ID: Name:** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

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| --- | --- | --- | --- | --- | --- | --- |
| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |

**ID: Name:** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |

**ID: Name:** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |

**ID: Name:** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |

**ID: Name:** Type: HL7 Coding Sys: HL7 Defined Codes - HL7nnn

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Order** | **Code** | **Description** | **Source** | **Usage** | **Display Name** | **Instructions** |

# Human-Machine Interface

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

This VistA enhancement does not change the human-machine interface.

## Interface Design Rules

The intent is to maintain the look and feel of the current Integrated Billing User Interface.

## Inputs

### Functional Requirement: Present on Admission (POA) Code - Institutional

The IB system shall provide the ability for users to associate one of the following POA codes to a diagnosis on an inpatient, institutional claim:

* Y – Yes
* N – No
* U – No Information in the Record
* W – Clinically Undetermined (BN 6.3)

SELECT DIAGNOSIS FROM THE PTF RECORD TO INCLUDE ON THE BILL: X1-X2

YOU HAVE SELECTED X1,X2, TO BE ADDED TO THE BILL

IS THIS CORRECT? YES// ..

----------------- Existing Diagnoses for Bill -----------------

466.0 ACUTE BRONCHITIS (3)

253.5 DIABETES INSIPIDUS (6)

Edit POA indicators? NO// YES

466.0: ??

Enter the value that correctly indicates if this condition was present

at the time the patient was admitted.

Choose from:

Y Yes

N No

U No Information

W Clinically Undetermined

**1 Blank/Exempt from POA Reporting – Remove this selection**

1. Remove selection 1
2. Stop placing 1 in the outbound 837 – Allow data element to be BLANK

### Functional Requirement: Designate Claims Administrative Contractor – Professional

The IB system shall provide the ability for a user to change the default EDI - Prof Payer Primary ID to an additional professional primary payer ID when creating a professional claim. (BN 8.2)

IB,PATIENT 1 BILL#: K101XXX - Inpat/UB04 SCREEN <10>

================================================================================

BILLING - SPECIFIC INFORMATION

[1] Bill Remarks

- FL-80 : UNSPECIFIED [NOT REQUIRED]

ICN/DCN(s) : UNSPECIFIED [NOT REQUIRED]

Auth/Referral : UNSPECIFIED [NOT REQUIRED]

Admitting Dx : 466.0 - ACUTE BRONCHITIS

PPS (DRG) : 0202 - BRONCHITIS & ASTHMA W CC/MCC

<2> Pt Reason f/Visit : UNSPECIFIED [NOT USED]

[3] Providers :

- ATTENDING : UNSPECIFIED

[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]

[5] Billing Provider : CHEYENNE VAMC

Taxonomy Code : 282N00000X

[6] Alt Prim Payer IDs: UNSPECIFIED

[7] Force MRA Sec Prt?: NO FORCED PRINT

[8] Provider ID Maint : (Edit Provider ID information)

<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT: 6

**Primary Payer - Alt Inst Prim Payer ID Type: ??**

**This is the Alternate Inst Primary Payer ID Type which is used**

**to identify an Alternate Inst Primary Payer ID for this payer.**

**If this value is unspecified, the EDI-Inst Primar**

**Choose from:**

**1 DME**

**2 Hospice 🡨 Just an example**

**Alt Inst Prim Payer ID Type: 1 DME**

**Alt Inst Prim Payer ID: 7766554432// ??🡨 Pull the ID from the Insurance Co file and let them enter a onetime ID if they want.**

**This is the Alternate Inst Prim Payer ID which is**

**used to route claims to an alternate administration**

**contractor for certain claims.**

**Secondary Payer – Alt Inst Prim Payer ID Type:**

**Tertiary Payer – Alt Inst Prim Payer ID Type:**

1. If the Alt Inst Primary Payer ID is UNSPECIFIED, then send the regular EDI ID
2. Default PI as the Qualifier in the 837
3. This goes in CI5, Pieces 2, 3 in place of regular Emdeon ID

IB,PATIENT 12 BILL#: K101XXX - Outpat/1500 SCREEN <10>

================================================================================

BILLING - SPECIFIC INFORMATION

[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]

Unable To Work To : UNSPECIFIED [NOT REQUIRED]

[2] ICN/DCN(s) : UNSPECIFIED [NOT REQUIRED]

Auth/Referral : UNSPECIFIED [NOT REQUIRED]

[3] Providers :

- RENDERING : UNSPECIFIED

[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]

Lab CLIA # : UNSPECIFIED [NOT REQUIRED]

Mammography Cert # : UNSPECIFIED [NOT REQUIRED]

[5] Chiropractic Data : UNSPECIFIED [NOT REQUIRED]

[6] CMS-1500 Box 19 : UNSPECIFIED [NOT REQUIRED]

[7] Billing Provider : CHEYENNE VAMC

Taxonomy Code : 282N00000X

**[8] Alt Prim Payer ID : UNSPECIFIED**

**[9]** Force MRA Sec Prt? : NO FORCED PRINT

**[10]** Provider ID Maint : (Edit Provider ID information)

<RET> to CONTINUE, 1-9 to EDIT, '^N' for screen N, or '^' to QUIT:8

**Alt Prof Prim Payer ID Type: ??**

**This is the Alternate Prof Primary Payer ID Type which is used**

**to identify an Alternate Prof Primary Payer ID for this payer.**

**Choose from:**

**1 DME**

**2 Hospice**

**Alt Prof Prim Payer ID Type: 1 DME**

**Alt Prof Prim Payer ID: 7766554432// 🡨 Pull the ID from the Insurance Co file and let them enter a one time ID if they want.**

1. If the Alt Inst Primary Payer ID is UNSPECIFIED, then send the regular EDI ID
2. Default PI as the Qualifier in the 837
3. This goes in CI5, Piece 2
4. Default what is the Ins Co file but let them override it but don’t save the override

### Functional Requirement: Additional EDI – Professional Primary Payer IDs

The IB system shall provide the ability to define 0 – n additional professional primary payer IDs for an insurance company with the following data:

* Additional ID Type, and
* Additional ID (BN 8.2)

Insurance Company Editor Apr 27, 2015@09:42:49 Page: 1 of 10

Insurance Company Information for: MEDICARE (WNR)

Type of Company: MEDICARE Currently Active

Billing Parameters

Signature Required?: NO Type Of Coverage: MEDICARE

Reimburse?: WILL NOT REIMBURSE Billing Phone: 972-766-5252

Mult. Bedsections: YES Verification Phone: 888-226-5511

One Opt. Visit: NO Precert Comp. Name:

Diff. Rev. Codes: Precert Phone: 800-655-1636

Amb. Sur. Rev. Code:

Rx Refill Rev. Code:

Filing Time Frame: WITHIN 1 YR FROM DOS

EDI Parameters

Transmit?: YES-LIVE Insurance Type: MEDICARE

+ Enter ?? for more actions >>>

BP Billing/EDI Param IO Inquiry Office EA Edit All

MM Main Mailing Address AC Associate Companies AI (In)Activate Company

IC Inpt Claims Office ID Prov IDs/ID Param CC Change Insurance Co.

OC Opt Claims Office PA Payer DC Delete Company

PC Prescr Claims Of RE Remarks VP View Plans

AO Appeals Office SY Synonyms EX Exit

Select Action: Next Screen// BP Billing/EDI Param

SIGNATURE REQUIRED ON BILL?: NO//

REIMBURSE?: WILL NOT REIMBURSE//

ALLOW MULTIPLE BEDSECTIONS: YES//

DIFFERENT REVENUE CODES TO USE:

ONE OPT. VISIT ON BILL ONLY: NO//

AMBULATORY SURG. REV. CODE:

PRESCRIPTION REFILL REV. CODE:

STANDARD FILING TIME FRAME:

FILING TIME FRAME: WITHIN 1 YR FROM DOS Replace

TYPE OF COVERAGE: MEDICARE//

BILLING PHONE NUMBER: 972-766-5252//

VERIFICATION PHONE NUMBER: 888-226-5511//

Are Precerts Processed by Another Insurance Co.?: NO

//

PRECERTIFICATION PHONE NUMBER: 800-655-1636//

EDI - Transmit?: YES-LIVE//

EDI - Inst Payer Primary ID: 12M30//

**EDI – Alt Inst Payer Primary ID Type: ??**

**This ID Type designates the type of claims which are**

**processed by a different Administration Contractor**

**than normal claims. It determines which Alternate**

**Institutional Payer Primary ID will be transmitted.**

**Choose from: 🡨 These choices will come from the IB Site Parameters**

**1 DME**

**EDI – Alt Inst Payer Primary ID Type: DME**

**EDI – Alt Inst Payer** **Primary ID: XYZABC** **🡨 Do not allow PRNT values**

**EDI – Alt Inst Payer Primary ID Type: DME**

EDI - 1ST Inst Payer Sec. ID Qualifier: PAYER ID #//

EDI - 1ST Inst Payer Sec. ID: 670899//

EDI - 2ND Inst Payer Sec. ID Qualifier:

EDI - Prof Payer Primary ID: SMWYO//

**EDI – Alt Prof Payer Primary ID Type: 🡨 Same as above except Prof**

EDI - 1ST Prof Payer Sec. ID Qualifier: PAYER ID #//

EDI - 1ST Prof Payer Sec. ID: VA442//

EDI - 2ND Prof Payer Sec. ID Qualifier:

EDI - Insurance Type: MEDICARE//

1. The new fields are multiples
2. Automatically transmit the Qualifier = PI in CI5, Piece 2
3. The Type will not transmit – it’s just used for selection in billing
4. Use the same logic as the existing Primary Payer ID fields to prevent PRNT values

### Functional Requirement: Display ASC X12N Health Care Claim Request For Additional Information (RFAI) (277RFAI) Transactions – Default

The IB system shall set the ASC X12N Health Care Claim Request For Additional Information (RFAI) (277RFAI) transaction display period to twenty days when the software is installed. (BN 3.1.1)

Claims Tracking Parameters Apr 27, 2015@13:50:19 Page: 1 of 2

Only authorized persons may edit this data.

Tracking Parameters Random Sample Parameters

Track Inpatient: INSURED AND UR ONLY Medicine Sample: 5

Track Outpatient: INSURED ONLY Medicine Admissions: 5

Track Rx: INSURED ONLY Surgery Sample: 5

Track Prosthetics: INSURED ONLY Surgery Admissions: 5

Reports Can Add CT: YES Psych Sample: 1

Psych Admissions: 5

General Parameters **Request For Additional Info**

Initialization Date: 01/01/94 **Save 277 RFAI:**

Use Admission Sheet: YES **Remove 277 RFAI from WL: 20 Days**

Header Line 1: CHEYENNE VAMC

Header Line 2: 2360 E. PERSHING BLVD

Header Line 3: CHEYENNE, WY

+ Enter ?? for more actions **\* Note HS is from Patch 517**

TP Tracking **HS HCSR** EX Exit

RS Random Sample **RI RFAI**

GP General EA Edit All

Select Action: Next Screen//RI

**Years to store 277 RFAI Transactions: 🡨 Default Forever**

**This is the number of years for which 277 RFAI transactions**

**will be saved in VistA.**

**Years to store 277 RFAI Transactions:**

**Days to wait to purge entry on RFAI Worklist Response: 20 Days// 🡨 Default 20**

**This is the number of days a 277 RFAI transaction will**

**remain on the RFAI Worklist unless specifically removed**

**by a user.**

**Days to wait to purge entry on RFAI Worklist Response: 20 Days//**

### Functional Requirement: Additional Primary Payer ID Types - Default Values

The IB system shall create the Additional Primary Payer ID Type for Medicare (WNR) claims equal to Durable Medical Equipment (DME) when the software is installed. (BN 3.1)

IB Site Parameters Apr 27, 2015@13:12:45 Page: 4 of 5

Only authorized persons may edit this data.

+

EDI 837 Live Transmit Queue : MCT

EDI 837 Test Transmit Queue : MCT

Auto-Txmt Bill Frequency : Every Day

Hours To Auto-Transmit : 1130;1500;1700

Max # Bills Per Batch : 10

Only Allow 1 Ins Co/Claim Batch?: NO

Last Auto-Txmt Run Date : 04/27/15

Days To Wait To Purge Msgs : 15

Allow MRA Processing? : YES

Enable Automatic MRA Processing?: YES

Enable Auto Reg EOB Processing? : YES

**[17] Alt Primary Payer ID Type:**

**[18]** Are we using ClaimsManager? : NO

Is ClaimsManager working OK? : NO

+ Enter ?? for more actions

EP Edit Set EX Exit

Select Action: Next Screen// **EP=16**

**Alternate Primary Payer ID Types Apr 27, 2015@13:17:44 Page: 1 of 1**

**Medicare (Electronic Payer Type = MX Medicare A or B)**

**1. DME 🡨 Default**

**Commercial (All others)**

**1. DME**

**AM Add Medicare Type AC Add Commercial Type Ex Exit**

**EM Edit Medicare Type EC Edit Commercial Type**

**DM Delete Medicare Type DC Delete Commercial Type**

**Select Item(s): Quit//**

1. Do NOT let them delete an ID Type that is in use – Warn them – You cannot delete an ID Type that is being used. You must delete the ID from the Insurance Company file first.

### Functional Requirement: Revenue Codes – Default Values

The IB system shall add the following revenue codes to the list of codes to be excluded from the printed claims report when the software is installed:

* 270 through 279
* 290 through 299 (BN 9.1)

IB Site Parameters Apr 27, 2015@10:34:51 Page: 2 of 5

Only authorized persons may edit this data.

+

[5] Medical Center : CHEYENNE VAMC Default Division : CHEYENNE VAMR

MAS Service : BUSINESS OFFICE Billing Supervisor : WAITHE,MOSES

[6] Initiator Authorize: YES Xfer Proc to Sched : YES

Ask HINQ in MCCR : YES Use Non-PTF Codes : YES

Multiple Form Types: YES Use OP CPT screen : YES

[7] UB-04 Print IDs : YES UB-04 Address Col :

CMS-1500 Print IDs : YES CMS-1500 Addr Col : 40

CMS-1500 Auto Prter: UB-04 Auto Prter :

EOB Auto Prter : MRA Auto Prter :

**[8] Printed Claims Rev Code Excl: 🡨 Not sure what we can display here**

**[9]** Default RX DX Cd : V68.1 (ICD-9) Default ASC Rev Cd : 490

Default RX CPT Cd : J8499 Default RX Rev Cd : 250

**[10]** Bill Signer Name : <No longer used> Federal Tax # : 83-0168494

Bill Signer Title : <No longer used>

+ Enter ?? for more actions

EP Edit Set EX Exit

Select Action: Next Screen//**EP=8**

**Excluded Revenue Codes Apr 27, 2015@10:41:46 Page: 1 of 1**

**1. 270 🡨 These are the default exclusions 270-279 and 290-299**

**2. 271**

**3. 272**

**4. 273**

**5. 274**

**6. 275**

**7. 276**

**8. 277**

**9. 278**

**10. 279**

**11. 290**

**12. 291**

**13. 292**

**+**

**AC Add Revenue Code DC Delete Revenue Code**

**EC Edit Revenue Code EX Exit**

**Select Item(s): Next Screen// AC Add Revenue Code**

**Revenue Code: ??**

**Enter a Revenue Code that will be used to exclude a**

**claim from the Locally Printed Claims Report.**

**Choose from:**

**100 ALL INCL R&B/ANC ALL-INCLUSIVE ROOM AND BOARD PLUS ANCILLARY**

**101 ALL INCL R&B ALL-INCLUSIVE ROOM AND BOARD**

**110 ROOM-BOARD/PVT GENERAL CLASSIFICATION**

**111 MED-SUR-GY/PVT MEDICAL/SURGICAL/GYN**

**112 OB/PVT OB**

**113 PEDS/PVT PEDIATRIC**

**114 PSYCH/PVT PSYCHIATRIC**

**115 HOSPICE/PVT HOSPICE**

**116 DETOX/PVT DETOXIFICATION**

**117 ONCOLOGY/PVT ONCOLOGY**

**118 REHAB/PVT REHABILITATION**

**119 OTHER/PVT OTHER**

**120 ROOM-BOARD/SEMI GENERAL CLASSIFICATION**

### Functional Requirement: RFAI Worklist Comments - TPJI

The IB system shall provide the ability for users to view the comments added in the RFAI Worklist by claim in the Comment History of TPJI. (BN 3.1.2)

Comment History Apr 27, 2015@14:37:02 Page: 1 of 1

K600XXX IB,PATIENT 33 IXXXX DOB: XX/XX/XX Subsc ID: SUBSC ID XXXXXXX

AR Status: BILL INCOMPLETE Orig Amt: 0.00 Balance Due: 0.00

MRA REQUEST CLAIM COMMENTS

--------------------------

04/27/15 Entered by IB,CLERK 1

This is a test MRA comment.

**RFAI CLAIM COMMENTS**

**-------------------**

**05/07/15 Entered by IB,CLERK 2**

**This is another test RFAI comment>**

|% EEOB | Enter ?? for more actions|

BC Bill Charges AR Account Profile VI Insurance Company

DX Bill Diagnosis AD Add Comment VP Policy

PR Bill Procedures IR Insurance Reviews AB Annual Benefits

CI Go to Claim Screen HS Health Summary EL Patient Eligibility

AL Go to Active List EX Exit

Select Action: Quit//

1. Create a new category to display comments entered via the new RFAI Worklist

### Functional Requirement: Request for Additional Information (RFAI) (277RFAI) Worklist – Comment History

The IB system shall capture the following data when an entry is removed from the RFAI Worklist:

* User Name
* Date
* Time
* Reason Removed – Free Text (BN 3.1)

Select Billing Supervisor Menu <TEST ACCOUNT> Option: edi EDI Menu For Electron

ic Bills

MM EDI Return Message Management ...

TR EDI Transmission Status Reports ...

MRA MRA Management Menu ...

RCB View/Resubmit Claims - Live or Test

CBW COB Management Worklist

**RFI RFAI Management Worklist**

PEB Print EOB

EXT Extract Status Management

SEND Transmit EDI Bills - Manual

Select EDI Menu For Electronic Bills <TEST ACCOUNT> Option: RFI

**Select Authorizing Biller: ALL//IB,CLERK 2**

**Select Another Biller:IB,CLERK 55**

**Select Another Biller:**

**Select Primary Sort: LOINC CODE//?? 🡨 Default LOINC**

**This code determines the primary sort criteria**

**by which the list will be sorted.**

**Select one of the following:**

**B AUTHORIZING BILLER**

**O OLDEST MESSAGE FIRST**

**I INSURANCE COMPANY NAME**

**P PATIENT NAME**

**L LOINC CODE**

**Select Primary Sort: OLDEST MESSAGE FIRST//**

**Select Secondary Sort: OLDEST MESSAGE FIRST//?? 🡨 Default OLDEST**

RFAI Management Worklist Apr 28, 2015@14:25:12 Page: 1 of 16

Bill # Payer Name Patient Name NNN Svc Date Curr Bal

Authorizing Biller: IB,CLERK 1  IF they chose Biller sort

1 K100XXX MEDICARE (WNR) IB,PATIENT 333 XXXX 06/29/09 $43851.78

Can we display the LOINC Code definition here?

2 K100XXX MEDICARE (WNR) IB,PATIENT 22 XXXX 11/05/10 $1226.18

LOINC

3 K100XXX UNITEDHEALTHCARE IB,PATIENT 765 XXXX 11/05/10 $9.65

Error Code: 108 ACK/RETURNED - COVERAGE HAS BEEN CANCELED FOR THIS ENTITY.

4 K100XXX MEDICARE (WNR) IB,PATIENT 22 XXXX 11/05/10 $1226.18

LOINC

Authorizing Biller: IB,CLERK 177

+ **\* Indicates RFAI review in progress**

**Select Message Exit**

**ReSort Messages**

**Select Action: Next Screen//Select Message**

**Select RFAI Message: (1-4):1**

**Note:** The whole transaction screen is at the end of this – these are only partials

**RFAI Message Apr 28, 2015@14:43:44 Page: 1 of 2**

**Bill # Payer Name Patient Name NNN Svc Date Curr Bal**

**K100XXX IB INSURANCE CO IB,PATIENT 33 XXXX 06/29/09 $43851.78**

**Information Source**

**Payer Name: IB INSURANCE COMPANY**

**Payer Contact 1: FAX Number**

**Payer Contact #: XXX XXX-XXXX**

**Payer Contact 2: Telephone**

**Payer Contact #: XXX XXX-XXXX EXT: XXXXXXX**

**Payer Response Contact 1:**

**Payer Response Contact #: XXX XXX-XXXX**

**Payer Response Contact 2: Telephone**

**+ Enter ?? for more actions**

**EC Enter/Edit Comments TJ Third Party Joint Inq. 🡨 Include TPJI jump point**

**RS Review Status EX Exit**

**RE Remove Entry**

**Select Action: Next Screen// REVIEW STATUS**

**Base this design on the way it works in RCB**

**RFAI Message Review Status: REVIEW IN PROCESS// ?? 🡨 Default In Process**

**Enter a review status.**

**Choose from:**

**0 NOT BEING REVIEWED**

**1 REVIEW IN PROCESS**

**RFAI Message review Status: REVIEW IN PROCESS//**

**RFAI Message Apr 28, 2015@14:43:44 Page: 1 of 2**

**Bill # Payer Name Patient Name NNN Svc Date Curr Bal**

**K100XXX IB INSURANCE CO IB,PATIENT 33 XXXX 06/29/09 $43851.78**

**Information Source**

**Payer Name: IB INSURANCE COMPANY**

**Payer Contact 1: FAX Number**

**Payer Contact #: XXX XXX-XXXX**

**Payer Contact 2: Telephone**

**Payer Contact #: XXX XXX-XXXX EXT: XXXXXXX**

**Payer Response Contact 1:**

**Payer Response Contact #: XXX XXX-XXXX**

**Payer Response Contact 2: Telephone**

**+ Enter ?? for more actions**

**EC Enter/Edit Comments TJ Third Party Joint Inq. 🡨 Include TPJI jump point**

**RS Review Status EX Exit**

**RE Remove Entry**

**Select Action: Next Screen// EC Enter/Edit Comment**

**Claim Comment History Apr 28, 2015@15:02:42 Page: 1 of 1**

**RFAI Claim K101XXX**

**5605478 10/30/14 ERA Payer Contact Information FOLLOW-UP DT:**

**Payer Name: AETNA US HEALTHCARE**

**Contact Name: CONTACT IB**

**Phone Number: 5555555555**

**Email Address: IBCONTACT@EMAIL.COM**

**COB MANAGMENT CLAIM COMMENTS**

**----------------------------**

**10/30/14 Entered by SIMONS,MARY**

**This is a test.**

**Base this design on the way it works in RCB**

**Enter ?? for more actions**

**COMMENTS:**

**No existing text**

**Edit? NO//**

**==[ WRAP ]==[ INSERT ]==============< COMMENTS >=============[ <PF1>H=Help ]====**

**This is a test.**

**<=======T=======T=======T=======T=======T=======T=======T=======T=======T>======**

**RFAI Review Status: REVIEW IN PROCESS// 🡨 If they add a comment, default IN Process**

**RFAI Message Apr 28, 2015@14:43:44 Page: 1 of 2**

**Bill # Payer Name Patient Name NNN Svc Date Curr Bal**

**K100XXX IB INSURANCE CO IB,PATIENT 33 XXXX 06/29/09 $43851.78**

**Information Source**

**Payer Name: IB INSURANCE COMPANY**

**Payer Contact 1: FAX Number 🡨 There can be up to 3 contact methods**

**Payer Contact #: XXX XXX-XXXX**

**Payer Contact 2: Telephone**

**Payer Contact #: XXX XXX-XXXX EXT: XXXXXXX**

**Payer Response Contact 1: 🡨 There can be up to 3 contact methods**

**Payer Response Contact #: XXX XXX-XXXX**

**Payer Response Contact 2: Telephone**

**+ Enter ?? for more actions**

**EC Enter/Edit Comments TJ Third Party Joint Inq.**

**RS Review Status EX Exit**

**RE Remove Entry**

**Select Action: Next Screen// Remove Entry 🡨 Force them into screen to enter reason comment**

1. Automatically capture User Name and Date/Time for all comments and removals

**RFAI Message Apr 28, 2015@14:43:44 Page: 1 of 2**

**Bill # Payer Name Patient Name SSN Svc Date Curr Bal**

**K100XXX IB INSURANCE CO IB,PATIENT 33 XXXX 06/29/09 $43851.78**

**Information Source**

**Payer Name: IB INSURANCE COMPANY**

**Payer Contact 1: FAX Number 🡨 There can be up to 3 contact methods**

**Payer Contact #: XXX XXX-XXXX**

**Payer Contact 2: Telephone**

**Payer Contact #: XXX XXX-XXXX EXT: XXXXXXX**

**Payer Response Contact 1: 🡨 There can be up to 3 contact methods**

**Payer Response Contact #: XXX XXX-XXXX**

**Payer Response Contact 2: Telephone**

**Payer Response Contact #: XXX XXX-XXXX EXT: XXXXXXX**

**Payer Address: PO BOX XYZ New York, New York 10001 🡨Concatenate the whole address**

**Payer Claim Control Number: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX**

**Claim Level Status Information**

**Patient Control #: XXXXXXX 🡨 Claim Number**

**Date of Service: XX/XX/XX**

**Medical Records Number: XXXXXXXXX**

**Member Identification Number:**

**Type of Service: XXX 🡨 Institutional Only Type of Bill**

**Health Care Claim Status Category: 🡨 These 3 can repeat**

**Additional Information Request Modifier: 🡨 Show LOINC Code Text not just code**

**Status Information Effective Date: XX/XX/XX**

**Response Due Date: XX/XX/XX**

**Service Line Information/ Service Line Status Information**

**Line Item Control Number: XXXXXX**

**Service Line Date:**

**Revenue Code:**

**Coding Method: HCPCS**

**Procedure Code:XXXXXXX**

**Procedure Modifier: 🡨 There can be up to 4**

**Procedure Modifier:**

**Line Item Charge Amount: XXXXXXXXXXXXXXXXXX**

**Health Care Claim Status Category: 🡨 These 3 can repeat**

**Additional Information Request Modifier: 🡨 Show LOINC Code Text not just code**

**Status Information Effective Date: XX/XX/XX**

**Response Due Date: XX/XX/XX**

## Outputs

### Functional Requirement: View/Resubmit Claims - Live or Test (RCB) – Printed Claim Test Queue

The IB system shall provide the ability for users to transmit previously printed claims to the test queue only from the View/Resubmit Claims - Live or Test option by Electronic Data Interchange (EDI) option. (BN n/a)

Select EDI Menu For Electronic Bills <TEST ACCOUNT> Option: RCB View/Resubmit C

laims - Live or Test

\*\*\* Please Note \*\*\* 2 '^' are needed to abort this option (^^)

1 '^' brings you back to the previous prompt (^)

**Run report for (P)rinted or (T)ransmitted claims: Transmitted// Printed 🡨If they run for transmitted, it behaves as it does today**

Select By: (C)laim or see a (L)ist to pick from?: List// 🡨 Claims can now only be printed claims

PAYER SELECTION:

Run for (A)ll Payers or (S)elected Payers?: Selected Payers//

Include all payers with the same electronic Payer ID? Yes// YES

**Select Insurance Company: ??**

**Enter the name of the Insurance Company or the**

**EDI – Inst Primary Payer ID or the EDI – Prof**

**Primary Payer ID. 🡨 They want to be able to use the Payer ID in addition to Name**

**to look up insurance company**

Choose from:

5STAR LIFE INSURANCE PO BOX 141159 CINCINNATI,OH

8TH DIST ELECTRICAL BENEFIT PO BOX 30101 SALT LAKE CITY,UT

AARP MEDICARERX PLAN PO BOX 6083 CYPRESS,CA

ABA PO BOX 10787 BURBANK,CA 95426/95426

ABERDEEN HEALTH CARE SERVICE PO BOX 4000 ABERDEEN,SD

ACORDIA PO BOX 2451 CHARLESTON,WV 87815/87815

ACORDIA NATIONAL PO BOX 3262 CHARLESTON,WV 87815/87815

ADMINISTRATION SERVICES PO BOX 5434 SPOKANE,WA

ADVANCE PCS PO BOX 686002 SAN ANTONIO,TX

ADVANCE PCS PO BOX 5099 MIDDLE TOWN,NY

ADVANCE PRESCRIPTION MGMT. 909 E COLLINS BLVD S RICHARDSON,TX

ADVANCED PCS PO BOX 961066 FT. WORTH,TX

ADVANTRA FREEDOM PO BOX 7154 LONDON,KY

ADVENTIST RISK MANAGEMENT PO BOX 4759 SILVER SPRING,MD

'^' TO STOP:^

Select Insurance Company: AETNAPO BOX 14094 LEXINGTON,KY 60054/60054

Select Another Insurance Company:

BILL FORM TYPE SELECTION:

Run for (U)B-04, (C)MS-1500 or (B)oth: Both//

LAST BATCH TRANSMIT DATE RANGE SELECTION:

Start with Date Last Transmitted: t-200 (OCT 10, 2014)

Go to Date Last Transmitted:(10/10/14-1/8/15): 1/8/15// t-190 (OCT 20, 2014)

ADDITIONAL SELECTION CRITERIA:

1 - MRA Secondary Only

2 - Primary Claims Only

3 - Secondary Claims Only

4 - Claims Sent to Print at Clearinghouse Only 🡨 Remove this option

Select Additional Limiting Criteria (optional):

Would you like to include cancelled claims? No// NO

**~~Would you like to include claims Forced to Print at the Clearinghouse? No~~//🡨 Remove this option**

**Sort By: Current Payer// ?? 🡨 Remove this and just sort by payer since the other choice isn’t valid**

**Enter a code from the list.**

**Select one of the following:**

**~~1 Batch By Last Transmitted Date (Claims within a Batch)~~**

**2 Current Payer (Insurance Company)**

**Do you want a (R)eport or a (S)creen List format?: Screen List//**

**PREVIOUSLY ~~TRANSMITTED~~ CLAIMS Apr 28, 2015@10:13:48 Page: 1 of 1**

**~~\*\* A claim may appear multiple times if transmitted more than once. \*\*~~**

**~~\*\* T = Test Claim \*\* R = Batch Rejected~~**

**Claims Selected: 0 (marked with \*)**

# Claim # Form Type Seq Status A/R Other Payer(s) Patient Na

AETNA

1 K100XXX UB04 INPT P PTNT/TXT BI UNITEDHEALTHCARE IB,PATIENT S

**There are 2 columns off screen - Last Transmit Batch Number – Last Transmit should be Last Printed and Batch Number needs to go away**

Enter ?? for more actions >>>

Claim(s) Select/De select View Claims Selected

**~~Batch Select/De select~~** Print Report

Resubmit Claims Exit

Action: Quit//Resubmit Claims **🡨Remove Batch Select and Resubmit should only allow TEST**

**You are about to resubmit 1 claims as TEST claims.**

**Are you sure you want to continue?: No// YES**

**Resubmission in process ...**

**Do you want to queue this transmission? YES//**

### Functional Requirement – Printed Claims Report – Inclusions – TRICARE/CHAMPVA

The IB system shall include locally printed claims from the Printed Claims report based on the following criteria when the report search criteria is equal to TRICARE/CHAMPVA:

* Claim does not contains one or more revenue codes equal to 270 – 279 and/or 290 – 299
* Destination payer is not equal to US Labor Department and
* Rate Type is one of the following and:
* CHAMPVA REIMB. INS. Who's Responsible: INSURER
* CHAMPVA Who's Responsible: INSURER
* TRICARE REIMB. INS. Who's Responsible: INSURER
* TRICARE Who's Responsible: INSURER
* Type of Plan is one of the following:
* TRICARE CHAMPUS
* TRICARE SUPPLEMENTAL MAJOR MEDICAL
* CHAMPVA MAJOR MEDICAL (BN 9.1)

Select Billing Supervisor Menu <TEST ACCOUNT> Option: tpb Third Party Billing M

enu

ADPR Print Bill Addendum Sheet

AUTH Authorize Bill Generation

BILL Enter/Edit Billing Information

CANC Cancel Bill

CLA Multiple CLAIMSMANAGER Claim Send

CLON Copy and Cancel

CRD Correct Rejected/Denied Bill

DLST Delete Auto Biller Results

GEN Print Bill

INQU Patient Billing Inquiry

LIST Print Auto Biller Results

PRNT Print Authorized Bills

RETN Return Bill Menu ...

VCB View Cancelled Bill

VIEW View Bills Pending Transmission

VIST Outpatient Visit Date Inquiry

**PCR Printed Claims Report**

Select Third Party Billing Menu <TEST ACCOUNT> Option: **PCR Printed Claims Report**

**Run Report for (C)PAC or (T)RICARE/CHAMPVA: CPAC// 🡨 Default CPAC**

**Run Report for (A)ll or (S)elected Divisions: All// S elected 🡨 Default ALL**

**Division: CHEYENNE VAMC**

**Division:**

**Earliest Printed Date: T-7// 🡨 Default - 7**

**Latest Printed Date: T// 🡨 Default Today**

**Sort Report By: Authorizing Biller//?? 🡨 Default Biller**

**This determines the criteria by which the claims will**

**be displayed.**

**Choose from:**

**I Insurance Company**

**B Authorizing Biller**

**R Rate Type**

**F Form Type**

**P Type of Plan**

**This is a 132 column report.**

**Device: HOME//0;132**

**Printed Claim Report XX/XX/XXXX – XX/XX/XXXX Page 1XXXXX of XXXXXX**

**Run for: CPAC, Divisions: CHEYENNE VAMC**

**Sorted by: Biller**

**IB,CLERK 33 🡨Include Station Number before claim**

**Claim # Type RateType PlanType Division Biller RevCode**

**InsuranceCo**

**-----------------------------------------------------------------------------------------------------------------------------------**

**442-K100XXX I/I REIMBRSIBLE INS. PPO CHEYENNE VAMC IB,XXXXXXXXXXXXXXXX 270,324,299**

**ABERDEEN HEALTH CARE SERV PO BOX 4000 ABERDEEN,SD**

**442-K101XXX O/I XXXXXXX XXXXXX XXXXX HMO CHEYENNE VAMC IB,XXXXXXXXXXXXXXXX 270,277,299**

**ADVENTIST RISK MANAGEMENT PO BOX 4759 SILVER SPRING,MD**

**442-K101XXX O/P REIMBRSIBLE INS. Major Medical CHEYENNE VAMC IB,XXXXXXXXXXXXXXXX 277,324,271,272**

**BLUE CROSS/BS AL (PHARMAC PO BOX 2294 BIRMINGHAM,AL**

### Functional Requirement: Re-generate Unbilled Amount Report – Sort

The IB system shall provide the ability for users to sort the Re-generate Unbilled Amount Detailed Report by the following:

* Division
* Patient name (alphabetical) (BN 14.1)

Re-Generate Unbilled Amounts Report

Do you want to store Unbilled Amounts figures? NO//

**Search by Division?: NO//??**

**This opt allows you to search for all unbilled amounts**

**or to search for unbilled amounts in only one or more**

**divisions.**

**Choose from:**

**N NO**

**Y YES**

Include All Divisions or Selected Divisions? All// Divisions **🡨 Only display if they choose Yes above**

Start with DATE: 08/23/1966// (AUG 23, 1966)

Go to DATE: 04/28/2015// (APR 28, 2015)

Choose report type(s) to print:

1 - INPATIENT UNBILLED

2 - OUTPATIENT UNBILLED

3 - PRESCRIPTION UNBILLED

4 - ALL OF THE ABOVE

Select: (1-4): 4//

You have selected

4 - ALL OF THE ABOVE

Are you sure? NO// y YES

Print detail report with the Unbilled Amounts summary? NO//

Do you want to include MRA claims?: NO//

**Sort by: Patient Name// ??**

**This determines whether the unbilled amounts are displayed**

**in alphabetical order of patient name or in alphabetical**

**order of patient name within a division.**

**Choose from:**

**N Patient Name**

**D Division**

This report takes a while to run, so you should queue it to run

after normal business hours.

You will need a 132 column printer for this report!

DEVICE: HOME//

1. Make sure the summary (email) prints the Totals before the individual division’s figures.

### Functional Requirement: COB Management Worklist – Sort

The IB system shall provide the ability for users to sort claims on the COB Management Worklist based on the following:

* Biller
* Days since transmission of latest bill
* Date last EOB received
* Secondary/Tertiary Insurance Company
* EOB Status
* Patient Name
* Patient Responsibility
* Service Date
* Primary Insurance Company (BN 14.2)

COB Management Worklist

Select BILLER: ALL//

Include All Divisions or Selected Divisions? All// Divisions

**Select: (P)rimary Claims,(S)econdary/Tertiary Claims or (B)oth: Both// ??**

**This field determines whether you want to search for just**

**primary claims, just secondary/tertiary claims or both.**

**Select one of the following**

**P – Primary Claims**

**S – Secondary/Tertiary Claims**

**B – Both**

**Select: (P)rimary Claims,(S)econdary/Tertiary Claims or (B)oth// BOTH**

Sort By: BILLER// ??

Select one of the following:

B BILLER

D DAYS SINCE TRANSMISSION OF LATEST BILL

L DATE LAST EOB RECEIVED

I SECONDARY**/TERTIARY** INSURANCE COMPANY

M EOB STATUS

P PATIENT NAME

R PATIENT RESPONSIBILITY

S SERVICE DATE

**K PRIMARY INSURANCE COMPANY**

Do you want to include Denied EOBs for Duplicate Claim/Service? No// NO

## Navigation Hierarchy

All navigation changes for this modification are described in Section 6.2.2.

# Security and Privacy

## Security

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

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

The HL7 interface to FSC is an existing interface to which a new transaction will be added.

## Privacy

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

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

The HL7 interface to FSC is an existing interface to which a new transaction will be added.

Attachment A – Approval Signatures

This section is used to document the approval of the System Design Document. The review should be conducted face to face where signatures can be obtained ‘live’ during the review. If unable to conduct a face-to-face meeting then it should be held via LiveMeeting and concurrence captured during the meeting. The Scribe should add /es/name by each position cited. Example provided below.

The Chair of the governing Integrated Project Team (IPT), Business Sponsor, IT Program Manager, and Project Manager are required to sign.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed: Date:

< Integrated Project Team (IPT) Chair >

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed: Date:

< Business Sponsor >

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed: Date:

< IT Program Manager >

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed: Date:

< Project Manager >

1. Additional Information
   1. RTM

The RTM, when approved, will be placed here:[MCCF eBilling Phase 3 TSPR](http://your_srver.domain.ext/warboard/anotebk.asp?proj=1724&Type=Active)

* 1. Packaging and Installation

Software packaging and installation will be done using the VistA Kernel Installation and Distribution System (KIDS) application.

* 1. Design Metrics

This section is not applicable to this SDD.

* 1. Acronym List and Glossary

| Acronyms | |
| --- | --- |
| Term | Definition |
| AERB | Architecture and Engineering Review Board |
| ADT | Admission/Discharge/Transfer |
| AITC | Austin Information Technology Center located in Austin, Texas; responsible for maintaining the hardware that supports the Lockbox system, including FSC servers, the Mailman routing system, and EPHRA database |
| ANSI | American National Standards Institute |
| AR | Accounts Receivable |
| ASC | American Standard Code |
| CARC | Claim Adjustment Reason Code |
| COB | Coordination of Benefits |
| CBO | Chief Business Office |
| CBW | COB Management Worklist |
| CLON | Copy and Cancel |
| CPAC | Consolidated Patient Account Center |
| CPT/HCPSCS | Current Procedural Terminology/Healthcare Common Procedure Coding System |
| CSA | Claim Status Awaiting Resolution |
| DME | Durable Medical Equipment |
| DMI | Data Management Interface |
| EDI | Electronic Data Interchange |
| EGHP | Employer Group Health Plans |
| EIN | Employer’s Identification Number |
| eIV | Electronic Insurance Verification |
| ERD | Entity Relationship Diagram |
| EOB/EEOB | Explanation of Benefits/Electronic Explanation of Benefits |
| FSC | Financial Services Center – Austin, Texas |
| GUI | Graphical User Interface |
| HCCH | Health Care Clearing House |
| HIPAA | Health Insurance Portability and Accountability Act of 1996 |
| HL7 | Health Level Seven |
| HPID | Health Plan Identifier |
| IB | Integrated Billing software version 2.0 |
| ICD | Interface Control Document |
| ICN | Individual Control Number |
| ISO | International Organization for Standardization |
| MCCF | Medical Care Collection Fund |
| MRA | Medicare-equivalent Remittance Advice |
| MRW | MRA Management Work List |
| M (MUMPS) | Massachusetts General Hospital Utility Multi-Programming System |
| Non-MRA | Translates to non-Medicare |
| NPI | National Provider Identifier |
| NUBC | National Uniform Billing Committee |
| NUCC | National Uniform Claim Committee |
| OED | Office of Enterprise Development |
| OEID | Other Entity Identifier |
| OI&T | Office of Information and Technology |
| PD | Product Development |
| PMAS | Program Management Accountability System |
| PMO | Product Management Office |
| POA | Present on Admission Indicator |
| PS | Product Support |
| RARC | Remittance Advice Remark Code |
| RCB | View/Resubmit Claims |
| RFAI | Request for additional information |
| RSD | Requirements Specification Document |
| RX | Prescription (Outpatient Medication) |
| SAC | Standards and Conventions |
| SDD | System Design Document |
| SQA | Software Quality Assurance |
| TBD | To Be Determined |
| TPA | Transitional Patient Advocate |
| TPJI | Third Party Joint Inquiry |
| TSPR | Technical Services Project Repository |
| VAMC | Veterans Administration Medical Center |
| VistA | Veterans Health Information Systems and Technology Architecture |
| VPE | View/Print EDI Bill Extract Data |
| WNR | Will Not Reimburse |

| Definitions | |
| --- | --- |
| Term | Definition |
| 277 (RFAI) | Transaction set for Health Care Claims Request for Additional Information – an unsolicited request that is sent by the payer to the provider. |
| 837 | Transaction set for Health Care Claim, used to send a claim to a trading partner. |
| 835 | Transaction set for Health Care Claim Payment Advice (or remittance advice). This is returned from the insurer to the billing facility. Generally this is referred to as an Explanation of Benefits (EOB or MRA). |
| CMS-1500 | Preprinted forms to which professional third-party claims can be printed. |
| Emdeon | The clearinghouse which handles both VA claims printing and the transmission of claims to electronic payers. |
| EOB | This is the return file (835) from non-Medicare payers that provides data pertaining to the claim adjudication and the amounts paid by the payer. |
| MRA Request Claim | This is the initial claim request to Medicare that is submitted for the purpose of obtaining MRA notice only. |
| MRA | This is the return file (835) from Medicare that provides data on allowable amounts. MRA reports are normally required for creation of secondary claims. |
| MRA Secondary Claim | This secondary claim is a result of the primary claim being an MRA Request claim. |
| Non-MRA Secondary Claim | This secondary claim is a result of the primary claim being to any insurer other than Medicare WNR. |
| Payer | An insurance company, fiscal intermediary, government agency, other agency, or individual responsible for the payment of health care claims. |
| Translator | A software package owned and residing at the Austin Services Center that allows reformatting data in internal VA formats to EDI formats and Vice Versa. This includes the ability to simultaneously handle multiple versions of EDI. The FSC translator also provides for non ASC X12 formats. |
| UB04 | Preprinted forms to which institutional third-party claims can be printed. |
| User | The person or persons who operate or interact directly with VistA. |

| References | | | |
| --- | --- | --- | --- |
| Name | Location | Date | |
| ASC X12N/005010X221 Health Care Claim Payment/Advice (835) – Technical Report Type 3 | <http://www.wpc-edi.com/> | May 2006 | |
| ASC X12N/005010X222 Health Care Claim - Professional (837) – Technical Report Type 3 | <http://www.wpc-edi.com/> | May 2006 | |
| ASC X12N/005010X223 Health Care Claim - Institutional (837) – Technical Report Type 3 | <http://www.wpc-edi.com/> | May 2006 | |
| ASC X12N/005010X213 Health Care Claim Request for Additional Information (277RFAI) – Technical Report Type 3 | <http://www.wpc-edi.com/> | | May 2006 |
| Draft Phase IV CAQH CORE 450 Health Care Claim (837) Infrastructure Rule version 4.0.0 | <http://www.caqh.org/CORESTRAW/DraftPAInfraRule_RWGReview.pdf> | |  |
| VA Software Document Library (VDL- IB) | <http://www.domain/vdl/application.asp?appid=45> | |  |
| Technical Services Project Repository (TSPR) | <http://your_srver.domain.ext/warboard/anotebk.asp?proj=1724&Type=Active> | |  |
| Health Level Seven (HL7) version 2.6 | [http://vaww.yourserver.domain/applications/HL7MR/HL7%20Public%20Document%20Library/Forms/AllItems.aspx?RootFolder=%2Fapplications%2FHL7MR%2FHL7%20Public%20Document%20Library%2Fhl7%202%2D6&FolderCTID=0x0120002F99B5DA0B76A34AA8FBCD8347EC25B9&View={AC82CFE8-A4DA-454B-A23D-E162F28942A0}](http://vaww.yourserver.domain/applications/HL7MR/HL7%20Public%20Document%20Library/Forms/AllItems.aspx?RootFolder=%2Fapplications%2FHL7MR%2FHL7%20Public%20Document%20Library%2Fhl7%202%2D6&FolderCTID=0x0120002F99B5DA0B76A34AA8FBCD8347EC25B9&View=%7bAC82CFE8-A4DA-454B-A23D-E162F28942A0%7d) | |  |
| Patch IB\*2\*516 ICD (5010) | <http://your_srver.domain.ext/warboard/anotebk.asp?proj=1646&Type=Active> | | June 2010 |
| National Uniform Claim Committee – 1500 Claim Form Reference Manual Version 9.0 | <http://www.nucc.org/index.php?option=com_content&view=featured&Itemid=101> | July 2013 | |

* 1. Required Technical Documents

There are no required technical documents for this VistA enhancement.

* 1. Attach Documents

This is a placeholder for the future AERB Design Compliance Decision Certificate.