Medical Care Collection Fund (MCCF) eBilling Compliance Phase 3

Version: 3.0

Test Cases IB\*2\*547



Department of Veterans Affairs

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Table of Contents

[1 Test Scripts 5](#_Toc435705633)

[1.1 Service Lines Issues (Prof) –TS1 5](#_Toc435705634)

[1.2 Service Lines Issues (Inst) –TS2 8](#_Toc435705635)

[1.3 Last Name Only (Prof) –TS3 11](#_Toc435705636)

[1.4 Last Name Only (Inst) –TS4 13](#_Toc435705637)

[1.5 Present on Admission (Inst/Inpt) –TS5 15](#_Toc435705638)

[1.6 Site Parameters - Alt Primary Payer ID Types –TS6 17](#_Toc435705639)

[1.7 Additional EDI – Primary Payer ID (MX) –TS7 18](#_Toc435705640)

[1.8 Additional EDI – Primary Payer ID (n/MX) –TS8 19](#_Toc435705641)

[1.9 Claims Administrative Contract ID (Inst) –TS9 20](#_Toc435705642)

[1.10 Claims Administrative Contract ID (Prof) –TS10 23](#_Toc435705643)

[1.11 CMS 1500 Amount Paid (Secondary) –TS11 25](#_Toc435705644)

[1.12 CMS 1500 Amount Paid (Tertiary) –TS12 26](#_Toc435705645)

[1.13 Admission Date/Time –TS13 27](#_Toc435705646)

[1.14 Admission Date/Time –TS14 (Regression Test) 28](#_Toc435705647)

[1.15 Site Parameters – 277 RFAI –TS15 29](#_Toc435705648)

[1.16 Site Parameters – Add Printed Claims Rev Cd –TS16 31](#_Toc435705649)

[1.17 Site Parameters – Delete Printed Claims Rev Cd –TS17 33](#_Toc435705650)

[1.18 CSA – Display Source Name –TS18 34](#_Toc435705651)

[1.19 TPJI – Display source Name – TS19 35](#_Toc435705652)

[1.20 TPJI – RFAI Comments – TS20 (Production Only) 36](#_Toc435705653)

[1.21 TPJI – EEOB (Electronic Explanation of Benefits) Detail CARC/RARC (Claim Adjustment Reason Codes/ Remittance Advice Remark Codes) – TS21 (Production Only) 37](#_Toc435705654)

[1.22 Print Explanation of Benefits (EOB )With CARC/RARC Descriptions – TS22 38](#_Toc435705655)

[1.23 View/Resubmit Claims - Live or Test (RCB) – TS23 39](#_Toc435705656)

[1.24 View/Resubmit Claims - Live or Test (RCB) – TS24 40](#_Toc435705657)

[1.25 Medicare Remittance Advice (MRA ) Duplicate Checking – Line Level CARCs (Development Only) – TS25 41](#_Toc435705658)

[1.26 MRA Duplicate Checking – Claim Level CARCs (Development Only) – TS26 42](#_Toc435705659)

[1.27 CARC/RARC - View MRA EOB (Stand-alone option) – TS27 43](#_Toc435705660)

[1.28 CAR/RARC – View MRA – TS28 44](#_Toc435705661)

[1.29 Create Printed Claims Report – TS29 45](#_Toc435705662)

[1.30 Create Printed Claims Report - Inclusions CPAC – TS30 48](#_Toc435705663)

[1.31 Create Printed Claims Report - Inclusions TRICARE/CHAMPVA – TS31 50](#_Toc435705664)

[1.32 Re-generate Unbilled Amount Report – TS32 52](#_Toc435705665)

[1.33 Re-generate Unbilled Amount Report – TS33 53](#_Toc435705666)

[1.34 Re-generate Unbilled Amount Report – TS34 54](#_Toc435705667)

[1.35 COB Data in CLON’d Claims (Secondary Medicare) – Outpatient – TS35 55](#_Toc435705668)

[1.36 COB Data in CLON’d Claims (Secondary Medicare) – Inpatient – TS36 56](#_Toc435705669)

[1.37 COB Data in CLON’d Claims (Primary Medicare) - Inpatient– TS37 57](#_Toc435705670)

[1.38 COB Data in CLON’d Claims (Primary Medicare) - Outpatient– TS38 58](#_Toc435705671)

[1.39 COB Data in CLON’d Claims (Secondary) – TS39 59](#_Toc435705672)

[1.40 COB Data in CLON’d Claims (Primary) – TS40 60](#_Toc435705673)

[1.41 COB Management Worklist (CBW) – TS41 61](#_Toc435705674)

[1.42 RFAI Management Worklist – Create – TS42 (Development Only) 63](#_Toc435705675)

[1.43 RFAI Management Worklist – Initial Actions (Development Only) – TS43 66](#_Toc435705676)

[1.44 RFAI Message Screen – Message Actions (Development Only) – TS44 67](#_Toc435705677)

[1.45 RFAI Message Screen – More Message Actions (Development Only) – TS45 69](#_Toc435705678)

[1.46 Transmit All Rate Types – Institutional – TS46 70](#_Toc435705679)

[1.47 Transmit All Rate Types – Professional – TS47 71](#_Toc435705680)

[1.48 Transmit 25 Procedures/12 External Cause of Injury Diagnoses (DX) – TS48 72](#_Toc435705681)

[1.49 Transmit Maximum Field Lengths – Professional (Development Only) – TS49 74](#_Toc435705682)

[1.50 Transmit Maximum Field Lengths – Institutional (Development Only) – TS50 76](#_Toc435705683)

[1.51 Accredited Standards Committee (ASC ) X12N Health Care Claim Request For Additional Information (RFAI) (277) Transactions (Development Only) – TS51 78](#_Toc435705684)

[1.52 Display Insurance Company Addresses –TS52 79](#_Toc435705685)

[1.53 Display of Complete and Correct Insurance Address –TS53 81](#_Toc435705686)

[1.54 EDI – UMO (Utilization Management Organization) Identifier – TS53 83](#_Toc435705687)

# Test Scripts

## Service Lines Issues (Prof) –TS1

### Requirements

2.6.1.1 Functional Requirement: Service Line Issues – No Print Order

### Menu Path

IB >SUP >BILL >Enter patient’s name/Claim #

### Objective

1. Ensure the system combines Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS ) procedures that have the exact same data elements and no print order; assign them the same revenue code with the combined number of units and monetary amounts

### Prerequisites

1. A patient with an outpatient appointment with multiple units of a single procedure

### Scenario

A biller is completing an outpatient professional claim with multiple units of a single procedure done in the same location

### Test Steps

1. Access the option BILL - Enter/Edit Billing
2. At the Enter BILL NUMBER or PATIENT NAME prompt, enter a **patient name** or a **bill number**
3. At the Enter BILLING LOCATION OF CARE prompt, enter **1** for Hospital
4. At the BILLING EVENT INFORMATION EVENT SOURCE prompt, enter **outpatient**
5. At the BILLING TIMEFRAME: prompt, enter **admit thru discharge**
6. At the BILLING IS THIS A SENSITIVE RECORD?: NO// prompt, press **Enter** to accept default of NO
7. At the BILLING RATE TYPE: prompt, enter **8** for REIMBURSABLE INS.
8. At the BILLING OUTPATIENT EVENT DATE: prompt, enter **T** for today or the date of the encounter you want
9. Enter any needed information on Screens 1-3 for a CMS-1500 claim and proceed to Screen 5
10. Access Section 2:

* At the Select International Classification of Diseases (ICD) DIAGNOSIS: prompt, enter 466.0 (or J15.3 for ICD10) or the DX from the encounter you are using

1. Access Section 3:

* At the Select OP VISITS DATE(S): prompt, enter **T** for today or the date of the encounter you want
* At the TYPE OF ADMISSION: ELECTIVE// prompt, press **Enter** to accept the default

1. Access Section 4:

* At the PROCEDURE CODING METHOD: Healthcare COMMON PROCEDURE CODING SYSTEM (HCPCS )// prompt, press **Enter** to accept default of HCPCS
* At the Select PROCEDURE DATE (6/1/15-6/1/15): prompt, enter **T** for today or the date of the encounter you want
* At the Select PROCEDURE: prompt, enter **71010**
* At the Select CPT MODIFIER SEQUENCE: prompt, enter **1**
* At the CPT MODIFIER: prompt, enter **26** for PROFESSIONAL COMPONENT
* At the Select CPT MODIFIER SEQUENCE: prompt, press **Enter**
* At the Rendering Provider: prompt, press **Enter**
* At the Referring Provider: prompt, press **Enter**
* At the Supervising Provider: prompt, press **Enter**
* At the ASSOCIATED CLINIC: prompt, enter **RADIOLOGY DIV 442 OOS ID 105** or the location for the claim you are using
* At the DIVISION: prompt, enter the **Division** you are billing for
* At the PLACE OF SERVICE: prompt, enter **22** for OUTPATIENT HOSPITAL
* At the TYPE OF SERVICE: prompt, enter **4** for DIAGNOSTIC X-RAY
* At the EMERGENCY PROCEDURE?: NO// prompt, press **Enter** to accept NO
* At the PRINT ORDER: prompt, press **Enter** – LEAVE THIS PROMPT BLANK
* At the National Drug Code ( NDC) NUMBER: prompt, press **Enter**
* At the Associated Diagnosis (1): prompt, enter **1** to link procedure to 466.0 or the DX you entered
* At the Associated Diagnosis (2): prompt, press **Enter**
* At the Purchased Cost: prompt, press **Enter**
* At the Service Line Comment Qualifier: prompt, press **Enter**
* At the Service Line Comment: prompt, press **Enter**
* At the Enter Attachment Control Number? NO// prompt, press **Enter**
* At the EPSDT (Early Periodic Screening, Diagnosis, and Treatment) Flag: prompt, press **Enter**
* At the Attending not Hospice Employee: prompt, press **Enter**
* At the Select PROCEDURE: prompt, enter “71010” Make sure the 2nd and 3rd procedures are exactly the same as the first with no Print order
* At the Select CPT MODIFIER SEQUENCE: prompt, enter **1**
* At the CPT MODIFIER: prompt, enter **26** for PROFESSIONAL COMPONENT
* At the Select CPT MODIFIER SEQUENCE: prompt, press **Enter**
* At the Rendering Provider: prompt, press **Enter**
* At the Referring Provider: prompt, press **Enter**
* At the Supervising Provider: prompt, press **Enter**
* At the ASSOCIATED CLINIC: prompt, enter **RADIOLOGY DIV 442 OOS ID 105** or the location for the claim you are using
* At the DIVISION: Enter the **Division** you are billing for //
* At the PLACE OF SERVICE: prompt, enter **22** for OUTPATIENT HOSPITAL
* At the TYPE OF SERVICE: prompt, enter **4** for DIAGNOSTIC X-RAY
* At the EMERGENCY PROCEDURE?: NO// prompt, press **Enter** to accept NO
* At the PRINT ORDER: prompt, press **Enter** – LEAVE THIS PROMPT BLANK
* At the NDC NUMBER: prompt, press **Enter**
* At the Associated Diagnosis (1): prompt, enter **1** to link procedure to 466.0 or the DX you entered
* At the Associated Diagnosis (2): prompt, press **Enter**
* At the Purchased Cost: prompt, press **Enter**
* At the Service Line Comment Qualifier: prompt, press **Enter**
* At the Service Line Comment: prompt, press **Enter**
* At the Enter Attachment Control Number? NO// prompt, press **Enter**
* At the EPSDT Flag: prompt, press **Enter**
* At the Attending not Hospice Employee: prompt, press **Enter**
* At the Select PROCEDURE: prompt, enter “71010” Make sure the 2nd and 3rd procedures are exactly the same as the first with no Print order
* At the Select CPT MODIFIER SEQUENCE: prompt, enter **1**
* At the CPT MODIFIER: prompt, enter **26** for PROFESSIONAL COMPONENT
* At the Select CPT MODIFIER SEQUENCE: prompt, press **Enter**
* At the Rendering Provider: prompt, press **Enter**
* At the Referring Provider: prompt, press **Enter**
* At the Supervising Provider: prompt, press **Enter**
* At the ASSOCIATED CLINIC: prompt, enter **RADIOLOGY DIV 442 OOS ID 105** or the location for the claim you are using
* At the DIVISION: Enter the **Division** you are billing for //
* At the PLACE OF SERVICE: prompt, enter **22** for OUTPATIENT HOSPITAL
* At the TYPE OF SERVICE: prompt, enter **4** for DIAGNOSTIC X-RAY
* At the EMERGENCY PROCEDURE?: NO// prompt, press **Enter** to accept NO
* At the PRINT ORDER: prompt, press **Enter** – LEAVE THIS PROMPT BLANK
* At the NDC NUMBER: prompt, press **Enter**
* At the Associated Diagnosis (1): prompt, enter **1** to link procedure to 466.0 or the DX you entered
* At the Associated Diagnosis (2): prompt, press **Enter**
* At the Purchased Cost: prompt, press **Enter**
* At the Service Line Comment Qualifier: prompt, press **Enter**
* At the Service Line Comment: prompt, press **Enter**
* At the Enter Attachment Control Number? NO// prompt, press **Enter**
* At the EPSDT Flag: prompt, press **Enter**
* At the Attending not Hospice Employee: prompt, press **Enter**

1. Access Screen 7:

* Verify the Charge Type = Professional

1. Verify that Section 5 contains the following:

* One Revenue Code with the procedure 71010 and the sum total of the charges X3

### Expected Outcomes

1. The software rolls up the 3 procedures with exactly the same data elements under one revenue code with a monetary total for 3 procedures

## Service Lines Issues (Inst) –TS2

### Requirements

2.6.1.1 Functional Requirement: Service Line Issues – No Print Order

### Menu Path

IB >SUP >BILL >Enter patient’s name/Claim #

### Objective

1. Ensure the system combines CPT/HCPCS procedures that have the exact same data elements and no print order and assigns them the same revenue code with the combined number of units and monetary amounts

### Prerequisites

1. A patient with an outpatient appointment with multiple units of a single procedure

### Scenario

A biller is completing an outpatient institutional claim with multiple units of a single procedure done in the same location

### Test Steps

1. Access the option BILL - Enter/Edit Billing Information
2. At the Enter BILL NUMBER or PATIENT NAME prompt, enter a **patient name** or a **bill number**
3. At the Enter BILLING LOCATION OF CARE prompt, enter **1** for Hospital
4. At the BILLING EVENT INFORMATION EVENT SOURCE prompt, enter **outpatient**
5. At the BILLING TIMEFRAME: prompt, enter **admit thru discharge**
6. At the BILLING IS THIS A SENSITIVE RECORD?: NO// prompt, press **Enter** to accept default of NO
7. At the BILLING RATE TYPE: prompt, enter **8** for REIMBURSABLE INS.
8. At the BILLING OUTPATIENT EVENT DATE: prompt, enter **T** for today or the date of the encounter you want
9. Enter any needed information on Screens 1-3 for a UB04 claim and proceed to Screen 5
10. Access Section 2:

* At the Select ICD DIAGNOSIS: prompt, enter **466.0** (or **J15.3** for ICD10) or the DX from the encounter you are using

1. Access Section 3:

* At the Select OP VISITS DATE(S): prompt, enter **T** for today or the date of the encounter you want
* At the TYPE OF ADMISSION: ELECTIVE// prompt, press **Enter** to accept the default

1. Access Section 4:

* At the PROCEDURE CODING METHOD: HCPCS (HCFA COMMON PROCEDURE CODING SYSTEM)// prompt. press **Enter** to accept default of HCPCS
* At the Select PROCEDURE DATE (6/1/15-6/1/15): prompt, enter **T** for today or the date of the encounter you want
* At the Select PROCEDURE: prompt, enter **71010**
* At the Select CPT MODIFIER SEQUENCE: prompt, press **Enter**
* At the Rendering Provider: prompt, press **Enter**
* At the Referring Provider: prompt, press **Enter**
* At the Operating Physician: prompt, press **Enter**
* At the Other Operating Physician: prompt, press **Enter**
* At the ASSOCIATED CLINIC: prompt, enter **RADIOLOGY DIV 442 OOS ID 105** or the location for the claim you are using
* At the DIVISION: Enter the **Division** you are billing for //
* At the PRINT ORDER: prompt, press **Enter** – LEAVE THIS PROMPT BLANK
* At the NDC NUMBER: prompt, press **Enter**
* At the Enter Attachment Control Number? NO// prompt, press **Enter**
* At the Select PROCEDURE: prompt, enter “71010” Make sure the 2nd and 3rd procedures are exactly the same as the first with no Print order
* At the PROCEDURE CODING METHOD: HCPCS (HCFA COMMON PROCEDURE CODING SYSTEM
* At the Select PROCEDURE DATE (6/1/15-6/1/15): prompt, enter **T** for today or the date of the encounter you want
* At the Select PROCEDURE: prompt, enter **71010**
* At the Select CPT MODIFIER SEQUENCE: prompt, press **Enter**
* At the Rendering Provider: prompt, press **Enter**
* At the Referring Provider: prompt, press **Enter**
* At the Operating Physician: prompt, press **Enter**
* At the Other Operating Physician: prompt, press **Enter**
* At the ASSOCIATED CLINIC: prompt, enter **RADIOLOGY DIV 442 OOS ID 105** or the location for the claim you are using
* At the DIVISION: Enter the **Division** you are billing for //
* At the PRINT ORDER: prompt, press **Enter** – LEAVE THIS PROMPT BLANK
* At the NDC NUMBER: prompt, press **Enter**
* At the Enter Attachment Control Number? NO// prompt, press **Enter**
* At the Select PROCEDURE: prompt, enter “71010” Make sure the 2nd and 3rd procedures are exactly the same as the first with no Print order
* At the PROCEDURE CODING METHOD: HCPCS (HCFA COMMON PROCEDURE CODING SYSTEM
* At the Select PROCEDURE DATE (6/1/15-6/1/15): prompt, enter **T** for today or the date of the encounter you want
* At the Select PROCEDURE: prompt, enter **71010**
* At the Select CPT MODIFIER SEQUENCE: prompt, press **Enter**
* At the Rendering Provider: prompt, press **Enter**
* At the Referring Provider: prompt, press **Enter**
* At the Operating Physician: prompt, press **Enter**
* At the Other Operating Physician: prompt, press **Enter**
* At the ASSOCIATED CLINIC: prompt, enter **RADIOLOGY DIV 442 OOS ID 105** or the location for the claim you are using
* At the DIVISION: CHEYENNE Enter the **Division** you are billing for //
* At the PRINT ORDER: prompt, press **Enter** – LEAVE THIS PROMPT BLANK
* At the NDC NUMBER: prompt, press **Enter**
* At the Enter Attachment Control Number? NO// prompt, press **Enter**

1. Access Screen 7:

* Verify the Charge Type = Institutional

1. Verify that Section 5 contains the following:

* One Revenue Code with the procedure 71010 and the sum total of the charges X3

### Expected Outcomes

1. The software rolls up the 3 procedures with exactly the same data elements under one revenue code with a monetary total for 3 procedures

## Last Name Only (Prof) –TS3

### Requirements

2.6.1.2 Functional Requirement: Last Name Only

2.6.1.8 Functional Requirement: Last Name Only – Subscriber

### Menu Path

IB >SUP >BILL >Enter patient’s name/Claim #

### Objective

1. Ensure the system no longer displays a fatal error when a patient has only one name and the payer is Medicare Part B
2. Ensure the system no longer displays a fatal error when the subscriber has only one name

### Prerequisites

1. A patient who is registered with only one name
2. A patient with Medicare Part B with SELF (18) as the relationship to insured
3. A patient with secondary, commercial insurance

### Scenario

A biller is completing an outpatient professional claim to Medicare Will Not Reimburse (WNR) for services to a patient with only one name in the Patient file

### Test Steps

1. Access the option BILL - Enter/Edit Billing Information
2. At the Enter BILL NUMBER or PATIENT NAME prompt, enter a **patient name or a bill number**
3. At the Enter BILLING LOCATION OF CARE prompt, enter **1** for Hospital
4. At the BILLING EVENT INFORMATION EVENT SOURCE prompt, enter **outpatient**
5. At the BILLING TIMEFRAME: prompt, enter **admit thru discharge**
6. At the BILLING IS THIS A SENSITIVE RECORD?: NO// prompt, press **Enter** to accept default of NO
7. At the BILLING RATE TYPE: prompt, enter **8** for REIMBURSABLE INS.
8. At the BILLING OUTPATIENT EVENT DATE: prompt, enter **T** for today or the date of the encounter you want
9. Enter any needed information on Screens 1-3 for a CMS 1500 claim and proceed to Screen 3
10. Access Section 1:

* Add Medicare Part B as the primary payer
* Add commercial insurance as the secondary payer

1. Add any information needed to complete the claim
2. Authorize the claim
3. Transmit the claim immediately using SEND option or wait for regularly scheduled claims transmission
4. Access the VPE option after the claim has been transmitted

### Expected Outcomes

1. Users can authorize a claim with a patient who is also the subscriber even when the patient has only one name
2. The following fatal errors are no longer triggered:

Errors\*\*:

Primary insurance subscriber's name is missing or invalid

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

1. VPE: CI2, Piece 3 = Subscriber Last Name contains the subscriber’s single name
2. VPE: PT1, Piece 4 = Pt Last Name contains the patient’s single name

## Last Name Only (Inst) –TS4

### Requirements

2.6.1.2 Functional Requirement: Last Name Only

2.6.1.8 Functional Requirement: Last Name Only – Subscriber

### Menu Path

IB >SUP >BILL >Enter patient’s name/Claim #

### Objective

1. Ensure the system no longer displays a fatal error when a subscriber has only one name

### Prerequisites

1. A patient who is registered with only one name
2. A patient with Medicare Part B with SELF (18) as the relationship to insured
3. A patient with secondary, commercial insurance

### Scenario

A biller is completing an outpatient institutional claim to Medicare (WNR) for services to a patient with only one name in the Patient file

### Test Steps

1. Access the option BILL - Enter/Edit Billing Information
2. At the Enter BILL NUMBER or PATIENT NAME prompt, enter a **patient name** or a **bill number**
3. At the Enter BILLING LOCATION OF CARE prompt, enter **1** for Hospital
4. At the BILLING EVENT INFORMATION EVENT SOURCE prompt, enter **outpatient**
5. At the BILLING TIMEFRAME: prompt, enter **admit thru discharge**
6. At the BILLING IS THIS A SENSITIVE RECORD?: NO// prompt, press **Enter** to accept default of NO
7. At the BILLING RATE TYPE: prompt, enter **8** for REIMBURSABLE INS.
8. At the BILLING OUTPATIENT EVENT DATE: prompt, enter **T** for today or the date of the encounter you want
9. Enter any needed information on Screens 1-3 for a CMS 1500 claim and proceed to Screen 3
10. Access Section 1:

* Add Medicare Part B as the primary payer
* Add commercial insurance as the secondary payer

1. Add any information needed to complete the claim
2. Authorize the claim
3. Transmit the claim immediately using SEND option or wait for regularly scheduled claims transmission
4. Access the VPE option after the claim has been transmitted

### Expected Outcomes

1. Users can authorize a claim with a patient who is also the subscriber even when the patient has only one name
2. The following fatal errors are no longer triggered:

Errors\*\*:

Primary insurance subscriber's name is missing or invalid

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

1. VPE: CI2, Piece 3 = Subscriber Last Name contains the subscriber’s single name
2. VPE: PT1, Piece 4 = Pt Last Name contains the patient’s single name

## Present on Admission (Inst/Inpt) –TS5

### Requirements

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

2.6.14.1 Functional Requirement: Transmit Blank POA Value – Institutional Inpatient

### Menu Path

IB >SUP >BILL >Enter patient’s name/Claim #

### Objective

1. Ensure the system only displays the following choices for POA when adding diagnoses to a claim:
   * Y-Yes
   * N-No
   * U-No Information in the Record
   * W-Clinically Undetermined (BN6.3)
2. Ensure the system no longer adds 1 as the POA for a diagnoses in the 837 when there is no POA – system allows blank

### Prerequisites

1. A patient who has an inpatient episode that requires a claim for inpatient, institutional services

### Scenario

A biller is completing an inpatient institutional claim and needs to double-check the POA indicators

### Test Steps

1. Access the option BILL - Enter/Edit Billing Information
2. At the Enter BILL NUMBER or PATIENT NAME prompt, enter a **patient name** or a **bill number**
3. At the Enter BILLING LOCATION OF CARE prompt, enter **1** for Hospital
4. At the BILLING EVENT INFORMATION EVENT SOURCE prompt, enter **inpatient**
5. At the BILLING TIMEFRAME: prompt, enter **admit thru discharge**
6. At the BILLING IS THIS A SENSITIVE RECORD?: NO// prompt, press **Enter** to accept default of NO
7. At the BILLING RATE TYPE: prompt, enter **8** for REIMBURSABLE INS.
8. At the elect INPATIENT EVENT (ADMISSION) DATE: prompt, select the **admission** you want
9. Enter any needed information on Screens 1-3 for a UB04 claim and proceed to Screen 4
10. Access Section 3:

* At the SELECT DIAGNOSIS FROM THE PTF RECORD TO INCLUDE ON THE BILL: prompt, enter the **diagnoses** (at least 2) you want to add
* At the YOU HAVE SELECTED n-n TO BE ADDED TO THE BILL IS THIS CORRECT? YES// prompt. press **Enter**
* At the Edit POA indicators? NO// prompt, enter **??**
* At the Edit POA indicators? NO// prompt, enter **YES**
* At the Order: 3// prompt, press return to accept the default
* At the next Diagnosis Number: prompt, press **Enter** to leave POA blank
* At the Prospective Payment System Code (DRG): n // prompt, press **Enter** to accept the default
* At the Select ICD DIAGNOSIS: prompt, press **Enter** to leave blank

1. Add any information needed to complete the claim
2. Authorize the claim
3. Transmit the claim immediately using SEND option or wait for regularly scheduled claims transmission
4. Access the VPE option after the claim has been transmitted

### Expected Outcomes

1. Users can select one of the following values for POA:

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. VPE: DC1-DC12, Piece 4 = Y
2. VPE: DC1-DC12, Piece 4 = blank

***Note:*** It is possible if you are testing after the ICD-10 patch which adds POAs to the PTF record, that none of the diagnoses POAs will be blank. In that case, remove one of the POAs for testing purposes.

## Site Parameters - Alt Primary Payer ID Types –TS6

### Requirements

2.6.4.5 Functional Requirement: Additional Primary Payer ID Types

2.6.4.6 Functional Requirement: Additional Primary Payer ID Types – Default Values

### Menu Path

IB🡪SUP🡪SYST🡪SITE

### Objective

1. Ensure users can define one or more Additional Primary Payer ID Types by electronic plan type
2. Ensure the system creates an Additional Primary Payer ID Type equal to Durable Medical Equipment (DME) for the electronic plan type equal to MX – Medicare A or B when the software is installed

### Prerequisites

n/a

### Scenario

A billing supervisor or Database Administrator needs to define additional primary payer ID types in the site parameters which will be used to define primary IDs for Administrative Contractor for specialized claims to an insurance company

### Test Steps

1. Access the option MCCR Site Parameter Display/Edit
2. At the Select Action: Quit// prompt, enter **IB Site Parameter**
3. At the Select Action: Next Screen// prompt, press **Enter** until you see Section 17
4. At the Select Action: Next Screen// prompt, enter **EP=17** for Alt Primary Payer ID Type
5. At the Select Item(s): Quit// prompt, enter **AC** for Add Commercial Type
6. At the Alt Primary Payer ID Type: prompt, enter **??** to view the HELP text
7. At the Alt Primary Payer ID Type: prompt, enter **Hospice**
8. At the Select Item(s): Quit// prompt, enter **EC** for Edit Commercial Type
9. At the Alt Primary Payer ID Type: Hospice// prompt, press **Enter an @ to remove**
10. At the replace Hospice with Hospice
11. At the Select Item(s): Quit// prompt, enter **EC** for Edit Commercial Type
12. At the Alt Primary Payer ID Type: Hospice// prompt, press **Enter**
13. At the Select Item(s): Quit// prompt, enter **AC** for Add Commercial Type
14. At the Alt Primary Payer ID Type: prompt, re-enter **Hospice**

### Expected Outcomes

1. Upon entering the IB Site Parameters, users note that DME is already defined for Medicare
2. User is able to add an Alternate Primary Payer ID Type – 2-30 characters of free text
3. User is able to edit an Alternate Primary Payer ID Type
4. User is able to delete an Alternate Primary Payer ID Type

## Additional EDI – Primary Payer ID (MX) –TS7

### Requirements

2.6.3.1 Functional Requirement: Additional EDI – Institutional Primary Payer IDs

2.6.3.2 Functional Requirement: Additional EDI – Professional Primary Payer IDs

### Menu Path

IB🡪PI🡪EI🡪Enter Insurance Company Name

### Objective

1. Ensure users can define one or more Additional EDI Institutional Primary Payer IDs per insurance company
2. Ensure users can define one or more Additional EDI Professional Primary Payer IDs per insurance company

### Prerequisites

1. An existing Medicare insurance company that has a contracted entity that processes specialized claims (i.e., DME claims)

### Scenario

An insurance clerk or Database Administrator needs to define specific primary payer IDs that will be used to route claims to an Administrative Contractor for an insurance company instead of the payer

### Test Steps

1. Access the option Insurance Company Entry/Edit
2. At the Select INSURANCE COMPANY NAME: prompt, enter **Medicare (WNR)** as the insurance company name
3. At the Select Action: Next Screen// prompt, enter **BP** for Billing/EDI Param
4. Press **Enter** until you get to the new EDI-Alt Inst Payer Primary ID Type: prompt, enter **??** to review HELP and list of available types
5. At the EDI-Alt Inst Payer Primary ID Type: prompt, select **DME**
6. At the EDI-Alt Inst Payer Primary ID: prompt, enter a **Payer ID Number**
7. Press **Enter** until you get to the new EDI-Alt Prof Payer Primary ID Type: prompt, enter **??** to review HELP and list of available types
8. At the EDI-Alt Inst Payer Primary ID Type: prompt, select **DME**
9. At the EDI-Alt Prof Payer Primary ID: prompt, enter a **Payer ID Number**

### Expected Outcomes

1. User is able to define an EDI-Alt Inst Payer Primary ID Type and ID number
2. User is able to define an EDI-Alt Prof Payer Primary ID Type and ID number

## Additional EDI – Primary Payer ID (n/MX) –TS8

### Requirements

2.6.3.1 Functional Requirement: Additional EDI – Institutional Primary Payer IDs

2.6.3.2 Functional Requirement: Additional EDI – Professional Primary Payer IDs

### Menu Path

IB🡪PI🡪EI🡪Enter Insurance Company Name

### Objective

1. Ensure users can define one or more Additional EDI Institutional Primary Payer IDs per insurance company
2. Ensure users can define one or more Additional EDI Professional Primary Payer IDs per insurance company

### Prerequisites

1. An existing commercial insurance company that has a contracted entity that processes specialized claims (i.e., Hospice claims)

### Scenario

An insurance clerk needs to define specific primary payer IDs that will be used to route claims to an Administrative Contractor for an insurance company instead of the payer

### Test Steps

1. Access the option Insurance Company Entry/Edit
2. At the Select INSURANCE COMPANY NAME: prompt, enter a **commercial company** as the insurance company name
3. At the Select Action: Next Screen// prompt, enter **BP** for Billing/EDI Param
4. Press **Enter** until you get to the new EDI-Alt Inst Payer Primary ID Type: prompt, enter **??** to review HELP and list of available types
5. At the EDI-Alt Inst Payer Primary ID Type: prompt, select **Hospice**
6. At the EDI-Alt Inst Payer Primary ID: prompt, enter a **Payer ID Number**
7. Press **Enter** until you get to the new EDI-Alt Prof Payer Primary ID Type: prompt, enter **??** to review HELP and list of available types
8. At the EDI-Alt Inst Payer Primary ID Type: prompt, select **Hospice**
9. At the EDI-Alt Prof Payer Primary ID: prompt, enter a **Payer ID Number**

### Expected Outcomes

1. User is able to define an EDI-Alt Inst Payer Primary ID Type and ID number
2. User is able to define an EDI-Alt Prof Payer Primary ID Type and ID number

## Claims Administrative Contract ID (Inst) –TS9

### Requirements

2.6.1.4 Functional Requirement: Default Primary Payer ID – Institutional

2.6.1.6 Functional Requirement: Designate Claims Administrative Contractor - Institutional

### Menu Path

IB >SUP >BILL >Enter patient’s name/Claim #

### Objective

1. Ensure the system uses the EDI- Inst Payer Primary ID as designated in the Insurance Company file as the Payer Primary ID (CI5, Piece 3) unless users add an EDI – Alt Inst Payer Primary ID (Claims Administrative Contractor ID) to a claim
2. Ensure the EDI – Alt Inst Payer Primary ID does not print in FL 51

### Prerequisites

1. A patient who has an outpatient episode that requires a claim for institutional services
2. A patient with insurance from an insurance company with a defined EDI - Alt Inst Payer Primary ID and secondary/tertiary insurance with an insurance company that does not have a EDI - Alt Inst Payer Primary ID

### Scenario

A biller is completing an outpatient institutional claim which needs to be processed by a specific Administrative Contractor

### Test Steps

1. Access the option BILL - Enter/Edit Billing Information
2. At the Enter BILL NUMBER or PATIENT NAME prompt, enter a **patient name** or a **bill number**
3. At the Enter BILLING LOCATION OF CARE prompt, enter **1** for Hospital
4. At the BILLING EVENT INFORMATION EVENT SOURCE prompt, enter **outpatient**
5. At the BILLING TIMEFRAME: prompt, enter **admit thru discharge**
6. At the BILLING IS THIS A SENSITIVE RECORD?: NO// prompt, press **Enter** to accept default of NO
7. At the BILLING RATE TYPE: prompt, enter **8** for REIMBURSABLE INS.
8. At the BILLING OUTPATIENT EVENT DATE: prompt, enter **T** for today or the date of the encounter you want
9. Enter any needed information on for a UB04 claim and proceed to Screen 10
10. Access Section 6:

* At the Primary Payer – Alt Inst Primary Payer ID Type: prompt, select **DME**
* At the Alt Inst Prim Payer ID: nnnnnnnnn// prompt, press **Enter** to accept the default
* At the Secondary Payer – Alt Inst Primary Payer ID Type: prompt, press **Enter**
* At the Tertiary Payer – Alt Inst Primary Payer ID Type: prompt, press **Enter**

1. Add any information needed to complete the claim
2. Authorize the claim
3. Transmit the claim immediately using SEND option or wait for regularly scheduled claims transmission
4. Access the VPE option after the claim has been transmitted
5. Reprint the claim after the claim has been transmitted

### Expected Outcomes

1. Users have the ability to override the EDI-Inst Payer Primary ID for a claim by selecting an Alt Inst Primary Payer ID Type and Alt Inst Prim Payer ID on Screen 10
2. VPE: CI5, Piece 2 = PI
3. VPE: CI5, Piece 3 = Alt Inst Prim Payer ID
4. FL 51, Lines 1-3 are blank

Example:

IB,PATIENT 17 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 [NOT REQUIRED]

[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 Payer Primary ID will be sent.

Choose from:

1 DME

2 Hospice

Alt Inst Prim Payer ID Type: 1 DME

Alt Inst Prim Payer ID: 7766554432/??

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:

## Claims Administrative Contract ID (Prof) –TS10

### Requirements

2.6.1.5 Functional Requirement: Default Primary Payer ID – Professional

2.6.1.7 Functional Requirement: Designate Claims Administrative Contractor - Professional

### Menu Path

IB >SUP >BILL >Enter patient’s name/Claim #

### Objective

1. Ensure the system uses the EDI-Prof Payer Primary ID as designated in the Insurance Company file as the Payer Primary ID (CI5, Piece 3) unless users add an EDI – Alt Prof Payer Primary ID (Claims Administrative Contractor ID) to a claim
2. Ensure the secondary claim has the EDI – Alt Prof Payer Primary ID as the Payer Primary ID when the secondary claim is created (CI5, Piece 3)

### Prerequisites

1. A patient who has an outpatient episode that requires a claim for professional services
2. A patient with secondary insurance from an insurance company with a defined EDI - Alt Prof Payer Primary ID and primary insurance with an insurance company that does not have a EDI - Alt Inst Payer Primary ID

### Scenario

A biller is completing an outpatient institutional claim which needs to be processed by a specific Administrative Contractor

### Test Steps

1. Access the option BILL - Enter/Edit Billing Information
2. At the Enter BILL NUMBER or PATIENT NAME prompt, enter a **patient name** or a **bill number**
3. At the Enter BILLING LOCATION OF CARE prompt, enter **1** for Hospital
4. At the BILLING EVENT INFORMATION EVENT SOURCE prompt, enter **outpatient**
5. At the BILLING TIMEFRAME: prompt, enter **admit thru discharge**
6. At the BILLING IS THIS A SENSITIVE RECORD?: NO// prompt, press **Enter** to accept default of NO
7. At the BILLING RATE TYPE: prompt, enter **8** for REIMBURSABLE INS.
8. At the BILLING OUTPATIENT EVENT DATE: prompt, enter **T** for today or the date of the encounter you want
9. Enter any needed information on for a UB04 claim and proceed to Screen 10
10. Access Section 8:

* At the Primary Payer – Alt Inst Primary Payer ID Type: prompt, press **Enter**
* At the Secondary Payer – Alt Inst Primary Payer ID Type: prompt, select **DME**
* At the Alt Inst Prim Payer ID: nnnnnnnnn// prompt, press **Enter** to accept the default

1. Add any information needed to complete the claim
2. Authorize the claim
3. Transmit the claim immediately using SEND option or wait for regularly scheduled claims transmission
4. Access the VPE option after the claim has been transmitted
5. Wait for secondary claim to be created
6. Access the VPE option after the claim has been transmitted

### Expected Outcomes

1. Users have the ability to override the EDI-Inst Payer Primary ID for a claim by selecting an Alt Inst Primary Payer ID Type and Alt Inst Prim Payer ID on Screen 10
2. Primary Claim - VPE: CI5, Piece 2 = PI
3. Primary Claim - VPE: CI5, Piece 3 = EDI – Prof Payer Primary ID
4. Secondary Claim - VPE: CI5, Piece 2 = PI
5. Secondary Claim - VPE: CI5, Piece 3 = EDI – Alt Prof Payer Primary ID

## CMS 1500 Amount Paid (Secondary) –TS11

### Requirements

2.6.2.1 Functional Requirement: Amount Paid – CMS 1500 - Secondary

### Menu Path

IB🡪TPB🡪GEN

### Objective

1. Ensure the Amount Paid by the primary payer is printed in Box 29 of the CMS 1500 when the claim is printed

### Prerequisites

1. A secondary CMS 1500 claim which has payment [or hypothetical payment if primary is Medicare (WNR)] associated with the primary claim

### Scenario

A biller needs to reprint a secondary claim

### Test Steps

1. Identify a secondary claim that has a payment from the primary payer and note the amount paid by the primary
2. Access the option GEN – Print Bill
3. At the Enter BILL NUMBER or PATIENT NAME prompt, enter the **bill number**
4. At the WANT TO PRINT IT ANYWAY? Y// prompt, press **Enter** to accept default
5. At the WANT TO REVIEW SCREENS? NO// prompt, press **Enter** to accept default
6. At the WANT TO PRINT BILL AT THIS TIME? No// prompt, enter **YES**
7. At theOutput Device: XXXXXXXX// prompt, either press **Enter** to accept default or enter the **name of the printer** you want

### Expected Outcomes

1. The dollar amount paid by the primary payer prints in Box 29 of the CMA 1500 form

## CMS 1500 Amount Paid (Tertiary) –TS12

### Requirements

2.6.2.2 Functional Requirement: Amount Paid – CMS 1500 - Tertiary

### Menu Path

IB🡪TPB🡪GEN

### Objective

1. Ensure the Amount Paid by the primary and secondary payers is printed in Box 29 of the CMS 1500 when the claim is printed

### Prerequisites

1. A tertiary CMS 1500 claim which has payment [or hypothetical payment if primary is Medicare (WNR)] associated with the primary and secondary claims

### Scenario

A biller needs to reprint a tertiary claim

### Test Steps

1. Identify a tertiary claim that has a payment from the primary and secondary payers and note the amount paid by the them
2. Access the option GEN – Print Bill
3. At the Enter BILL NUMBER or PATIENT NAME prompt, enter the **bill number**
4. At the WANT TO PRINT IT ANYWAY? Y// prompt, press **Enter** to accept default
5. At the WANT TO REVIEW SCREENS? NO// prompt, press **Enter** to accept default
6. At the WANT TO PRINT BILL AT THIS TIME? No// prompt, enter **YES**
7. At theOutput Device: XXXXXXXX// prompt, either press **Enter** to accept default or enter the **name of the printer** you want

### Expected Outcomes

1. The sum of the dollar amounts paid by the primary and secondary payers prints in Box 29 of the CMA 1500 form

## Admission Date/Time –TS13

### Requirements

2.6.2.3 Functional Requirement: Admission Date/Time – UB04 – Inpatient Only

### Menu Path

IB🡪TPB🡪GEN

### Objective

1. Ensure no Admission Date or Time prints in FL12 and 13 for an outpatient institutional claim

### Prerequisites

1. A previously completed outpatient, institutional claim

### Scenario

A biller needs to reprint a claim

### Test Steps

1. Identify an outpatient institutional (UB04) claim
2. Access the option GEN – Print Bill
3. At the Enter BILL NUMBER or PATIENT NAME prompt, enter the **bill number**
4. At the WANT TO PRINT IT ANYWAY? Y// prompt, press **Enter** to accept default
5. At the WANT TO REVIEW SCREENS? NO// prompt, press **Enter** to accept default
6. At the WANT TO PRINT BILL AT THIS TIME? No// prompt, enter **YES**
7. At the (2)nd Notice, (3)rd Notice, (C)opy or (O)riginal: C// prompt, press Enter to accept the default
8. At theOutput Device: XXXXXXXX// prompt, either press **Enter** to accept default or enter the **name of the printer** you want

### Expected Outcomes

1. FL 12 = No Admission Date prints
2. FL 13 = No Admission Hour prints

## Admission Date/Time –TS14 (Regression Test)

### Requirements

2.6.2.3 Functional Requirement: Admission Date/Time – UB04 – Inpatient Only

### Menu Path

IB🡪TPB🡪GEN

### Objective

1. Ensure the Admission Date and Time print in FL12 and 13 for an inpatient institutional claim

### Prerequisites

1. A previously completed inpatient institutional claim

### Scenario

A biller needs to reprint a claim

### Test Steps

1. Identify an inpatient institutional (UB04) claim
2. Access the option GEN – Print Bill
3. At the Enter BILL NUMBER or PATIENT NAME prompt, enter the **bill number**
4. At the WANT TO PRINT IT ANYWAY? Y// prompt, press **Enter** to accept default
5. At the WANT TO REVIEW SCREENS? NO// prompt, press **Enter** to accept default
6. At the WANT TO PRINT BILL AT THIS TIME? No// prompt, enter **YES**
7. At theOutput Device: XXXXXXXX// prompt, either press **Enter** to accept default or enter the **name of the printer** you want

### Expected Outcomes

1. FL 12 = Admission Date prints
2. FL 13 = Admission Hour prints

## Site Parameters – 277 RFAI –TS15

### Requirements

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

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

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

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

### Menu Path

IB🡪SUP🡪SYST🡪SITE

### Objective

1. Ensure users can define the length of time that 277 RFAI transactions will be stored
2. Ensure that the length of time that 277 RFAI transactions will be stored is set to forever when the software is installed
3. Ensure users can define the length of time that 277 RFAI transactions will be displayed on the worklist before being automatically removed
4. Ensure that the length of time that 277 RFAI transactions will be displayed on the worklist is set to 20 days when the software is installed

### Prerequisites

n/a

### Scenario

A billing supervisor needs to setup parameters related to the storage and display of 277 RFAI messages

### Test Steps

1. Access the option MCCR Site Parameter Display/Edit
2. At the Select Action: Quit// prompt, enter **CT** for Claims Tracking
3. At the Select Action: Quit// prompt, press **RI** for RFAI
4. At the Years to Store 277 RFAI Messages: prompt, enter **??** to see HELP
5. At the Years to Store 277 RFAI Messages: prompt, enter **7**
6. At the Days to remove entry on RFAI Worklist: 20// prompt, enter **??** to see HELP
7. At the Days to remove entry on RFAI Worklist: 20// prompt, enter **5**

### Expected Outcomes

1. The default value for Save 277 RFAI is blank (meaning they will be saved indefinitely)
2. The default value for Remove 277 RFAI From WL is 20 days
3. User is able to change the default value for Save 277 RFAI to 7 years
4. User is able to change the default value for Remove 277 RFAI From WL

Example:

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

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:7

Days to wait to purge entry on RFAI Worklist Response: 20// ?? 🡨 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//5

## Site Parameters – Add Printed Claims Rev Cd –TS16

### Requirements

2.6.4.7 Functional Requirement: Printed Claims Report – Revenue Code Exclusions

2.6.4.8 Functional Requirement: Revenue Codes – Default Values

### Menu Path

IB🡪SUP🡪SYST🡪SITE

### Objective

1. Ensure users can define Revenue Codes that will be used to exclude claims from the Printed Claims report
2. Ensure the following values are populated by the system when the software is installed:

* 270 – 279
* 290 – 299

### Prerequisites

n/a

### Scenario

A billing supervisor needs to add revenue codes to the site parameters for exclusion from the Printed Claims report

### Test Steps

1. Access the option MCCR Site Parameter Display/Edit
2. At the Select Action: Quit// prompt, enter **IB** for IB Site Parameters
3. At the Select Action: Next Screen// prompt, press **ENTER** for Next Screen until Section 8 appears
4. At the Select Action: Next Screen// prompt, enter **EP=8** to edit Printed Claims Rev Code Excl
5. At the Select Item(s): prompt, enter **AC** for Add Revenue Code
6. At the Select Item(s): prompt, enter **AC** for Add Revenue Code
7. At the Revenue Code prompt, enter **??** to see HELP
8. At the Revenue Code prompt, enter **118** for REHAB/PVT DETOXIFICATION

### Expected Outcomes

1. The following default values for Excluded Revenue Codes are displayed when users first access Section 8:

* 270
* 271
* 272
* 273
* 274
* 275
* 276
* 277
* 278
* 279
* 290
* 291
* 292
* 294
* 299

1. The following HELP Text appears

Enter a Revenue Code that will be used to exclude a claim from the Locally Printed Claims report.

1. Users are able to add a new Revenue Code to the list of excluded revenue codes

## Site Parameters – Delete Printed Claims Rev Cd –TS17

### Requirements

2.6.4.7 Functional Requirement: Printed Claims Report – Revenue Code Exclusions

### Menu Path

IB🡪SUP🡪SYST🡪SITE

### Objective

1. Ensure users can maintain Revenue Codes that will be used to exclude claims from the Printed Claims report

### Prerequisites

n/a

### Scenario

A billing supervisor needs to delete revenue codes from the site parameters so claims with that code will no longer be excluded from the Printed Claims report

### Test Steps

1. Access the option MCCR Site Parameter Display/Edit
2. At the Select Action: Quit// prompt, enter **IB** for IB Site Parameters
3. At the Select Action: Next Screen// prompt, press **ENTER** for Next Screen until Section 8 appears
4. At the Select Action: Next Screen// prompt, enter **EP=8** to edit Printed Claims Rev Code Excl
5. At the Select Item(s): prompt, enter **DC** for Delete Revenue Code
6. At the Select Revenue Code: prompt, enter the **number** of the Revenue Code you want to delete

### Expected Outcomes

1. Users are able to delete an existing Revenue Code from the list of excluded revenue codes

## CSA – Display Source Name –TS18

### Requirements

2.6.5.1 Functional Requirement: Health Care Clearing House (HCCH) – Claim Status Message Source

### Menu Path

IB🡪SUP🡪EDI🡪MM🡪CSA

### Objective

1. Ensure users can view the name of the HCCH that sent an EDI message to VistA

### Prerequisites

1. Claims that are on the CSA because they have Rejection or Informational EDI messages associated with them which were received from the HCCH

### Scenario

A biller needs to determine the source of an EDI message on the CSA so they can contact the correct HCCH for further information

### Test Steps

1. Access the option Claims Status Awaiting Resolution
2. At the MINIMUM # OF DAYS MSGS WAITING TO BE RESOLVED: 0// prompt, press **ENTER** to accept the default
3. At the AUTHORIZING BILLER: ALL// prompt, press **ENTER** to accept the default
4. At the DIVISION: ALL// prompt, press **ENTER** to accept the default
5. At the Primary Sort: (A/B/C/S/D/E/N/M/P/R/L): Error Code Text// prompt, press **ENTER** to accept the default
6. At the Secondary Sort: (A/B/C/S/D/N/M/P/R/L): prompt, press **ENTER** to accept the default
7. At the (R)ejects only OR (B)oth informational and rejects?: REJECTS ONLY// prompt, press **ENTER** to accept the default
8. At the Select Action: Next Screen// prompt, enter **S** for Select Messages
9. At the Select Claims Status: (1-n): prompt, enter the **Number** of the claim you want to review
10. At the Select Action: Next Screen// prompt, on the Detail screen, press **ENTER** until the Source field is displayed

### Expected Outcomes

1. The Source field will display the actual name of the HCCH that sent the EDI message

Example:

Source: Sent by non-payer (EMDEON)

## TPJI – Display source Name – TS19

### Requirements

2.6.6.1 Functional Requirement: TPJI – Claim Status Message Source

### Menu Path

IB🡪SUP🡪TPJI

### Objective

1. Ensure users can view the name of the HCCH that sent the EDI message to VistA

### Prerequisites

1. Existing claims (Active or Inactive) that have Rejection or Informational EDI messages associated with them

### Scenario

A biller needs to determine the source of an EDI message on the TPJI so they can contact the correct HCCH for further information

### Test Steps

1. Access the option Third Party Joint Inquiry
2. At the Enter BILL NUMBER or PATIENT NAME: prompt, enter **Patient Name** (or enter the claim number if you know it) - \*\*\* Note if there are no Active Bills, enter **IL** for Inactive Bills
3. At the Select Action: Quit// prompt, enter **CI** for Claims Information
4. At the Select Inactive Bill(s): (1-n): prompt, enter **Number** of the claim on the list
5. From the Claims Information screen at the Select Action: Next Screen// prompt, enter **ED** for EDI Status
6. At the Select Action: Next Screen// prompt, press **ENTER** until the EDI Bill Status Messages displays the Source field for the message

### Expected Outcomes

1. The Source field displays the actual name of the HCCH that sent the EDI message

Example:

Source: Sent by non-payer (EMDEON)

## TPJI – RFAI Comments – TS20 (Production Only)

### Requirements

2.6.6.2 Functional Requirement: RFAI Worklist Comments - TPJI

### Menu Path

IB🡪SUP🡪TPJI

### Objective

1. Ensure users can view the comments entered from within the RFAI Worklist from the comment history in TPJI

### Prerequisites

1. 277 RFAI messages on the RFAI Worklist

### Scenario

A billing supervisor wants to research what action was taken for a 277 RFAI message that it is no longer available on the RFAI Worklist so he/she accesses the TPJI and looks at the comments for that associated claim

### Test Steps

1. Access the option Third Party Joint Inquiry
2. At the Enter BILL NUMBER or PATIENT NAME: prompt, enter **Patient Name** (or enter the claim number if you know it) - \*\*\* Note if there are no Active Bills, enter **IL** for Inactive Bills
3. At the Select Action: Quit// prompt, enter **CI** for Claims Information
4. At the Select Inactive Bill(s): (1-n): prompt, enter **Number** of the claim on the list
5. From the Claims Information screen at the Select Action: Next Screen// prompt, enter **CM** for Comment History

### Expected Outcomes

1. There is a new comment section in the Comment History that displays comments entered via the RFAI Worklist

Example:

Comment History Apr 27, 2015@14:37:02 Page: 1 of 1

K600XXX IB,PATIENT E IXXXX DOB: XX/XX/XX Subsc ID: SUBSC ID XXXXXXXX

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//

## TPJI – EEOB (Electronic **Explanation of Benefits**) Detail CARC/RARC (Claim Adjustment Reason Codes/ Remittance Advice Remark Codes) – TS21 (Production Only)

### Requirements

2.6.6.3 Functional Requirement: EEOB Detail – CARC/RARC Descriptions

### Menu Path

IB🡪SUP🡪TPJI

### Objective

1. Ensure system displays the entire CARC description text when users view the EEOB details for a claim with an EEOB
2. Ensure system displays the entire RARC description text when users view the EEOB details for a claim with an EEOB

### Prerequisites

1. Claims for which an EEOB has been received and which contain CARCs and RARCs

### Scenario

Either an IB clerk or an AR clerk needs to see the CARCs and RARCs for a claim to determine why the claim was not paid in full

### Test Steps

1. Access the option Third Party Joint Inquiry
2. At the Enter BILL NUMBER or PATIENT NAME: prompt, enter **Patient Name** (or enter the claim number if you know it) - \*\*\* Note if there are no Active Bills, enter **IL** for Inactive Bills
3. At the Select Action: Quit// prompt, enter **CI** for Claims Information
4. At the Select Action: Next Screen// prompt, enter **BC** for Bill Charges
5. At the DO YOU WANT ALL EEOB DETAILS?: NO// prompt, enter **Y** for Yes
6. At the Select Action: Next Screen// prompt, press **Enter** until the CARC/RARCs are displayed

### Expected Outcomes

1. The CARCs are displayed with the full description for the adjustment code
2. The RARCs are displayed with the full description for the adjustment code

***Note:*** The full code descriptions can be found in codes sets ASC X12 External Code Source 139 (CARC) and ASC X12 External Code Source 411 (RARC) <http://www.wpc-edi.com/reference/>

## Print Explanation of Benefits (EOB )With CARC/RARC Descriptions – TS22

### Requirements

2.6.7.1 Functional Requirement: Print EOB with CARC/RARC Descriptions

### Menu Path

IB🡪SUP🡪EDI🡪PEB

### Objective

1. Ensure a printed EOB displays the full CARC/RARC descriptions

### Prerequisites

1. Several commercial claims for which an EOB has been received which contain CARCs and RARCs

### Scenario

A billing clerk or AR clerk is trying to determine why a claim was not paid in full so he/she uses the Print EOB option to review the CARCs and RARCs

### Test Steps

1. Access the Print EOB option
2. At the Select EXPLANATION OF BENEFITS BILL prompt, enter a **claim number**
3. At the EOB Device: HOME// prompt, enter a **printer name**

### Expected Outcomes

1. The printed EOB displays the complete CARC/RARC descriptions

## View/Resubmit Claims - Live or Test (RCB) – TS23

### Requirements

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

### Menu Path

IB🡪SUP🡪EDI🡪RCB

### Objective

1. Ensure users can look up claims in the View/Resubmit Claims – Live or Test option by EDI Payer ID

### Prerequisites

1. Several previously transmitted claims to the multiple payers

### Scenario

A user wishes to look up claims transmitted to the payers with a specific Payer ID during a specified time frame

### Test Steps

1. Access the View/Resubmit Claims - Live or Test option
2. At the Run report for (P)rinted or (Transmitted) Claims: Transmitted// prompt, enter **P**
3. At the select By: (C)laim, (B)atch or see a (L)ist to pick from?: List// prompt, press **Enter** to accept the default
4. At the Select a Claim: prompt, enter in a claim number
5. At the Run for (A)ll Payers or (S)elected Payers?: Selected Payers// prompt, press **Enter** to accept the default
6. At the Include all payers with the same electronic Payer ID? Yes// prompt, press **Enter** to accept the default
7. At the Select Insurance Company: prompt, enter in the insurance company’s **EDI number**
8. At the Select Another Insurance Company: prompt, press **Enter** to skip
9. At the Run for (U)B-04, (C)MS-1500 or (B)oth: Both//prompt, press **Enter** to accept the default
10. At the Start with Date Last Transmitted: prompt, enter **date**
11. At the Go to Date Last Transmitted: prompt, enter **date**
12. At the ADDITIONAL SELECTION CRITERIA: prompt, press **Enter** to skip
13. At the Would you like to include cancelled claims? No////prompt, press **Enter** to accept the default
14. At the Do you want a (R)eport or a (S)creen List format?:prompt, enter **S**

### Expected Outcomes

1. Users are able to look up previously transmitted claims using the insurance company’s EDI Payer ID

## View/Resubmit Claims - Live or Test (RCB) – TS24

### Requirements

2.6.8.2 Functional Requirement: View/Resubmit Claims - Live or Test (RCB) Printed

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

### Menu Path

IB🡪SUP🡪EDI🡪RCB

### Objective

1. Ensure users can create a list of locally printed claims in the View/Resubmit Claims – Live or Test option and resubmit one or more claims to the Test queue for transmission to Financial Services Center (FSC )

### Prerequisites

1. Several previously printed claims

### Scenario

A billing supervisor wishes to see a list of locally printed claims which can be submitted to the test queue at FSC for payer testing

### Test Steps

1. Access the View/Resubmit Claims – Live or Test option
2. At the Run report for (P)rinted or (Transmitted) Claims: Transmitted// prompt, enter **P** for printed claims
3. At the select By: (C)laim, (B)atch or see a (L)ist to pick from?: List// prompt, press **Enter** to accept the default
4. At the Run for (A)ll Payers or (S)elected Payers?: Selected Payers// prompt, enter **A** for all payers
5. At the Run for (U)B-04, (C)MS-1500 or (B)oth: Both// prompt, press **Enter** to accept the default
6. At the Start with Date Last Transmitted: prompt, enter **date range**
7. At the Go to Date Last Transmitted: prompt, enter **date range**
8. At the ADDITIONAL SELECTION CRITERIA: prompt, press **Enter** to skip
9. At the Would you like to include cancelled claims? No//// prompt, press **Enter** to accept the default
10. At the Do you want a (R)eport or a (S)creen List format?: prompt, enter **S** for a list of claims
11. On the Previously Printed Claims screen at the Action: Next Screen// prompt, enter **Claim(s) Select/Deselect** to select claims
12. At the Select CLAIM(s): (1-n): prompt, enter **1-2** to select claims
13. At the Action: Next Screen// prompt, enter **Resubmit Claims**
14. At the Are you sure you want to continue?:No// prompt, enter **Y for yes**
15. At the Do you want to queue this transmission? Yes// press **Enter** to accept the default
16. At the Requested Start Time: NOW// prompt, press **Enter** to accept the time of now

### Expected Outcomes

1. Users are able to look up locally printed claims using RCB
2. Users are able to resubmit previously printed claims to the Test queue only

## Medicare Remittance Advice (MRA ) Duplicate Checking – Line Level CARCs (Development Only) – TS25

### Requirements

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

### Menu Path

IB🡪SUP🡪EDI🡪MRA🡪MRW

### Objective

1. Ensure the system determines when MRA is a duplicate from Medicare payer utilizing the line level Claim Adjustment Reason Codes (CARC) in addition to the current Check Sum comparison

### Prerequisites

1. A multi-line MRA claim that has an MRA in VistA

### Scenario

n/a

### Test Steps

1. Create a duplicate MRA with the following:

* The exact same information as the original MRA (this means the check sums must be equal)
* A different claim level CARC that does not change the check sums of the original MRA

### Expected Outcomes

1. The system accepts and files the MRA even though the check sums are equal

## MRA Duplicate Checking – Claim Level CARCs (Development Only) – TS26

### Requirements

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

### Menu Path

IB🡪SUP🡪🡪EDI🡪MRA🡪MRW

### Objective

1. Ensure the system determines when a MRA is a duplicate from Medicare payer utilizing the claim level Claim Adjustment Reason Codes (CARC) in addition to the current Check Sum comparison

### Prerequisites

1. A multi-line MRA claim that has an MRA in VistA

### Scenario

n/a

### Test Steps

1. Create a duplicate MRA with the following:

* The exact same information as the original MRA (this means the check sums must be equal)
* A different CARC for one of the line items that does not change the check sums of the original MRA

### Expected Outcomes

1. The system accepts and files the MRA even though the check sums are equal

## CARC/RARC - View MRA EOB (Stand-alone option) – TS27

### Requirements

2.6.9.3 Functional Requirement: EEOB View – CARC/RARC

### Menu Path

IB🡪SUP🡪EDI🡪MRA🡪EOB

### Objective

1. Ensure users are able to view the CARC and RARC full descriptions in the EOB option

### Prerequisites

1. Several Medicare (WNR) claims with MRAs with both claim and line level CARCs and RARCs

### Scenario

A biller is trying to determine why certain MRA claims are not getting paid in full so he/she accesses the View MRA EOB option to review the claim and line level adjustments made by the payer

### Test Steps

1. Access the View MRA EOB option
2. At the Select EXPLANATION OF BENEFITS BILL:// prompt, enter a **Bill Number**
3. At the Select Action: Next Screen// prompt, press **Enter** to accept the default and print to the screen or enter the name of a printer

### Expected Outcomes

1. Users are able to view the complete CARC and RARC descriptions

***Note:*** Repeat with different claims to make sure different CARC/s and RARCs are displayed with their full descriptions

## CAR/RARC – View MRA – TS28

### Requirements

2.6.9.3 Functional Requirement: EEOB View – CARC/RARC

### Menu Path

IB🡪SUP🡪EDI🡪MRA🡪MRW

### Objective

1. Ensure users are able to view the complete CARC and RARC descriptions in the MRW option using the View EOB action

### Prerequisites

1. Several Medicare (WNR) claims with MRAs containing CARCs and RARCs which failed automatic secondary processing and are on the MRW complete descriptions

### Scenario

A biller is trying to determine why some Medicare claims on the MRW were not pay in full and needs to review the CARCs and RARCs

### Test Steps

1. Access the MRA Management Worklist option
2. At the Select BILLER: ALL// prompt, press **Enter** to accept the default of **All**
3. At the Within Division Sort By: BILLER// prompt, press **Enter** to accept the default
4. At the Do you want to include Denied MRAs for Duplicate Claim/Service? No// press **Enter** to accept the default
5. At the Select Action: Next Screen// prompt, enter **VE** to view the EOB
6. At the Select MRA/EOB: Enter the correct number associated with the MRA to be used
7. Return through the prompts until you are back to the Select Action: Next Screen// prompt
8. At the Select Action: Next Screen// prompt, enter **SU** to view the summary MRA information
9. At the Select MRA/EOB: Enter the correct number associated with the MRA to be used
10. At the DEVICE: HOME// prompt, press **Enter** to display on screen

### Expected Outcomes

1. Users are able to see the complete CARC and RARC full descriptions from within the following MRW Actions:

* VE-View an EOB
* SU-Summary MRA Info

## Create Printed Claims Report – TS29

### Requirements

2.6.10.1 Functional Requirement: Printed Claims Report – Create  
2.6.10.2 Functional Requirement: Printed Claims Report – Search  
2.6.10.3 Functional Requirement: Printed Claims Report – Sort

### Menu Path

IB🡪SUP🡪TPB🡪PCR

### Objective

1. Ensure users are able to create a report of claims that have been locally printed based on the following:

* Search
* User-specified date range, and
* All or selected divisions, and
* CPAC or CHAMPVA/TRICARE claims
* Sort
* Insurance Company
* Authorizing Biller
* Rate Type
* Form Type
* Type of Plan

### Prerequisites

1. Claims that have been locally printed and do *not* contain excluded data
2. Claims that have been locally printed and do contain excluded data
3. Established site parameters that define what type of claims are included in the report

### Scenario

A billing supervisor is trying to ensure that all claims that can be transmitted electronically are being transmitted and not locally printed. He/she creates this report in an effort to identify problems associated with the goal of all claims being transmitted.

### Test Steps

1. Access the Printed Claims Report option
2. At Run Report for (C)PAC or (T)TRICARE/CHAMPVA: CPAC// prompt, press **Enter** to accept the default
3. At the Run Report for (A)ll or (S)elected Divisions: All// prompt, press **Enter** to accept the default
4. At the Earliest Printed Date: T-7// prompt, press **Enter** to accept the default
5. At the Latest Printed Date: T// prompt, press **Enter** to accept the default
6. At the Sort Report by: Authorizing Biller// press **Enter** to accept the default
7. At the Device: HOME// prompt, enter the **name of a 132 column printer**
8. Repeat test steps using the search and sort parameters in the Note below

### Expected Outcomes

1. A report of locally printed claims is created based on the user’s criteria
2. A report of locally printed claims is created based on the criteria in the MCCR Site Parameter Display/Edit
3. The report contains the following data fields:

* Timeframe
* Station Number and Claim Number
* Division
* Destination Payer
* Form Type
* TOP
* Rate Type
* Revenue Codes
* Authorizing Biller
* Summary Information (% of total claims/total number printed)

Example:

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

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 PO BOX 2294 BIRMINGHAM,AL***Note:*** Repeat test above to include each possible combination of criteria:

***Note:*** Repeat this test for each combination of criteria

Search criteria:

* A user specified date range and
* Selected Divisions and
* TRICARE /CHAMPVA

Sort criteria:

* Insurance Company
* Rate Type
* Form Type
* Type of Plan

## Create Printed Claims Report - Inclusions CPAC – TS30

### Requirements

2.6.10.4 Functional Requirement: Printed Claims Report

### Menu Path

IB🡪SUP🡪TPB🡪PCR

### Objective

1. Ensure users are able to create a report of claims that have been locally printed based on the following inclusions:

* Search criteria is equal to CPAC
* Claim does not contain 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 and is one of the specified types in the spreadsheet noted below
* Type of Plan is one of the specified Types in the spreadsheet noted below

### Prerequisites

1. Claims that have been locally printed and do *not* contain excluded data
2. Claims that have been locally printed and do contain included data

### Scenario

A billing supervisor is trying to ensure that all claims that can be transmitted electronically are being transmitted and not locally printed. He/she creates this report in an effort to identify problems associated with the goal of all claims being transmitted.

### Test Steps

1. Access the Printed Claims Report option
2. At Run Report for (C)PAC or (T)TRICARE/CHAMPVA: CPAC// prompt, press **Enter** to accept the default
3. At the Run Report for (A)ll or (S)elected Divisions: All// prompt, press **Enter** to accept the default
4. At the Earliest Printed Date: T-7// prompt, press **Enter** to accept the default
5. At the Latest Printed Date: T// prompt, press **Enter** to accept the default
6. At the Sort Report by: Authorizing Biller// press **Enter** to accept the default
7. At the Device: HOME// prompt, enter the **name of a 132 column printer**
8. Repeat test steps using claims that contain combinations of Rate Types and Type Of Plan outlined in the Note below

### Expected Outcomes

1. A report of locally printed claims is created based the search criteria of CPAC
2. A report of locally printed reports is created based on the Destination Payer, Rate Type and Type of Plan criteria
3. The report contains the following data fields:

* Timeframe
* Station Number and Claim Number
* Division
* Destination Payer
* Form Type
* TOP
* Rate Type
* Revenue Codes
* Authorizing Biller
* Summary Information (% of total claims/total number printed)



## Create Printed Claims Report - Inclusions TRICARE/CHAMPVA – TS31

### Requirements

2.6.10.5 Functional Requirement: Printed Claims Report

### Menu Path

IB🡪SUP🡪TPB🡪PCR

### Objective

1. Ensure users are able to create a report of claims that have been locally printed based on the following inclusions:

* Search criteria is equal to TRICARE/CHAMPVA
* Claim does not contain 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 and Type of Plan are one of the each specified types in the note below

### Prerequisites

1. Claims that have been locally printed and do *not* contain excluded data
2. Claims that have been locally printed and do contain included data

### Scenario

A billing supervisor is trying to ensure that all claims that can be transmitted electronically are being transmitted and not locally printed. He/she creates this report in an effort to identify problems associated with the goal of all claims being transmitted.

### Test Steps

1. Access the Printed Claims Report option
2. At Run Report for (C)PAC or (T)TRICARE/CHAMPVA: CPAC// prompt, press **Enter** to accept the default
3. At the Run Report for (A)ll or (S)elected Divisions: All// prompt, press **Enter** to accept the default
4. At the Earliest Printed Date: T-7// prompt, press **Enter** to accept the default
5. At the Latest Printed Date: T// prompt, press **Enter** to accept the default
6. At the Sort Report by: Authorizing Biller// press **Enter** to accept the default
7. At the Device: HOME// prompt, enter the **name of a 132 column printer**
8. Repeat test steps using claims that contain combinations of Rate Types and Type Of Plan outlined in the Note below

### Expected Outcomes

1. A report of locally printed claims is created based the search criteria of TRICARE/CHAMPVA
2. A report of locally printed reports based on the Destination Payer, Rate Type and Type of Plan criteria
3. The report contains the following data fields:

* Timeframe
* Station Number and Claim Number
* Division
* Destination Payer
* Form Type
* TOP
* Rate Type
* Revenue Codes
* Authorizing Biller
* Summary Information (% of total claims/total number printed)

***Note:*** Repeat test above to include each possible combination of criteria:

Rate Type meets one of the following criteria 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 meets one of the following criteria:

* Insurance Company
* Rate Type
* Form Type
* Type of Plan

## Re-generate Unbilled Amount Report – TS32

### Requirements

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

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

### Menu Path

1. IB🡪SUP🡪REPT🡪UBIL🡪Re-Generate Unbilled Amounts Report

### Objective

1. Ensure users can create the Unbilled Amounts Report for all divisions that is not sorted by division
2. Ensure the Unbilled Amounts report is sorted by alphabetical order of patient name when it is not created by Division

### Prerequisites

1. Claims that have not be completed and submitted to a payer for payment

### Scenario

A user needs to review how many claims for potentially reimbursable services have not been submitted in a specified amount of time

### Test Steps

1. Access the Re-Generate Average Bill Amounts option
2. At the Do you want to store Unbilled Amounts figures? NO// prompt, press **Enter** to accept the default
3. At the Search by Division?: NO// prompt, enter **No**
4. At the Start with DATE: 08/23/1966 // prompt, enter **T-30**
5. At the Go to DATE: Today// prompt, press **Enter** to accept the default
6. At the Choose report type(s) to print – Select: (1-4) 4// prompt, press **Enter** to accept the default
7. At the Are you sure? NO// prompt, enter **YES**
8. At the Print detail report with the Unbilled Amounts summary? NO// prompt, enter **YES**
9. At the Do you want to include MRA claims?: NO// prompt, **Enter** to accept the default
10. At the DEVICE: HOME// prompt, enter the **name of a 132 column printe**r

### Expected Outcomes

1. The report contains the data for all the site’s divisions
2. The report displays the data by patient name in alphabetical order

***Note:*** Test extracting report to Excel if your site normally does that and report any issues to development

## Re-generate Unbilled Amount Report – TS33

### Requirements

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

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

### Menu Path

IB🡪SUP🡪REPT🡪UBIL🡪Re-Generate Unbilled Amounts Report

### Objective

1. Ensure users can create the Unbilled Amounts Report for all divisions and display the claims by division
2. Ensure the totals for claims with unbilled amounts prints before division data in the mailman message that contains the Detailed Report

### Prerequisites

1. Claims that have not be completed and submitted to a payer for payment

### Scenario

A billing supervisor needs to review how many claims for potentially reimbursable services have not been submitted in a specified amount of time

### Test Steps

1. Access the Re-Generate Average Bill Amounts option
2. At the Do you want to store Unbilled Amounts figures? NO// prompt, press **Enter** to accept the default
3. At the Search by Division?: NO// prompt, enter **YES**
4. At the Include All Divisions or Selected Divisions? All// prompt, press **Enter** to accept the default
5. At the Start with DATE: 08/23/1966 // prompt, enter **T-30**
6. At the Go to DATE: Today// prompt, press **Enter** to accept the default
7. At the Choose report type(s) to print – Select: (1-4) 4// prompt, press **Enter** to accept the default
8. At the Are you sure? NO// prompt, enter **YES**
9. At the Print detail report with the Unbilled Amounts summary? NO// prompt, enter **YES**
10. At the Do you want to include MRA claims?: NO// prompt, enter **YES**
11. At the Sort by: Patient Name:// prompt, press **Enter** to accept the default answer
12. At the DEVICE: HOME// prompt, enter the **name of a 132 column printe**r

### Expected Outcomes

1. The report contains the data for all the site’s divisions
2. The report displays the data by patient name in alphabetical order

## Re-generate Unbilled Amount Report – TS34

### Requirements

2.6.10.8 Functional Requirement: Re-generate Unbilled Amount Report – Order

### Menu Path

IB🡪SUP🡪REPT🡪UBIL🡪Re-Generate Unbilled Amounts Report

### Objective

1. Ensure the summary totals are displayed on the report before the individual division data in the mailman message generated from the Unbilled Amounts Report option

### Prerequisites

1. Claims that have not be completed and submitted to a payer for payment

### Scenario

A billing supervisor needs to review the Unbilled Amount Report with the summary totals displayed first

### Test Steps

1. Access the Re-Generate Average Bill Amounts option
2. At the Do you want to store Unbilled Amounts figures? NO// prompt, press **Enter** to accept the default
3. At the Search by Division?: NO// prompt, enter **YES**
4. At the Include All Divisions or Selected Divisions? All// prompt, press **Enter** to accept the default
5. At the Start with DATE: 08/23/1966 // prompt, enter **T-30**
6. At the Go to DATE: Today// prompt, press **Enter** to accept the default
7. At the Choose report type(s) to print – Select: (1-4) 4// prompt, press **Enter** to accept the default
8. At the Are you sure? NO// prompt, enter **YES**
9. At the Print detail report with the Unbilled Amounts summary? NO// prompt, enter **YES**
10. At the Do you want to include MRA claims?: NO// prompt, enter **YES**
11. At the Sort by: Patient Name:// prompt, enter D to sort by Division
12. At the DEVICE: HOME// prompt, enter the **name of a 132 column printe**r

### Expected Outcomes

1. The summary totals are displayed on the report before the individual division data in the mailman message generated from the Unbilled Amounts Report option
2. The Outpatient claims will display the CPT, Institutional Rate and Professional Rate columns.

## COB Data in CLON’d Claims (Secondary Medicare) – Outpatient – TS35

### Requirements

2.6.11.1 Functional Requirement: Copy and Cancel - COB Data

### Menu Path

IB🡪SUP🡪TPB🡪CLON

### Objective

1. Ensure that the COB data is copied from the primary payer when a secondary Medicare claim is copied and cancelled (CLON to create a new secondary claim

### Prerequisites

1. A primary Medicare claim with an MRA in VistA

### Scenario

A secondary Medicare outpatient claim is rejected by the secondary payer because the patient no longer has that insurance. A biller needs to CLON the claim and change the secondary payer to the patient’s new secondary insurer

### Test Steps

1. Access the Copy and Cancel Option
2. Enter BILL NUMBER NUMBER or Patient NAME: prompt, enter **patient name or bill number**
3. At the ARE YOU SURE YOU WANT TO CANCEL THIS BILL? No// prompt, enter **YES**
4. At the CANCEL BILL?: NO// prompt, enter **YES**
5. At the REASON CANCELLED prompt: enter a **free text reason**
6. At the Reason Not Billable: prompt, enter the necessary Reason Not Billable (**RNB) code**
7. At the IS THE ABOVE INFORMATION CORRECT AS SHOWN? Yes// prompt, press **Enter** to accept the default of Yes
8. At the screens displaying the new bill verify the information is correct and proceed to Screen 3
9. Access Section 1 and change the secondary payer to the new secondary insurer
10. Add any information needed to complete the claim
11. Authorize the claim
12. Transmit the claim immediately using SEND option or wait for regularly scheduled claims transmission
13. Access the VPE option after the claim has been transmitted

### Expected Outcomes

1. The VPE will contain the following:

* COB1, Piece 7 = ICN from the MRA
* MOA1 = Payment Amounts and any Remark Codes from the MRA
* CCAS = Claim Level Adjustments from the MRA
* LCOB, Piece 4 = Service Line Paid Amount from the MRA
* LCOB, Piece 17 = Remaining Liability
* LCAS = Line Level Adjustments from the MRA

## COB Data in CLON’d Claims (Secondary Medicare) – Inpatient – TS36

### Requirements

2.6.11.1 Functional Requirement: Copy and Cancel - COB Data

### Menu Path

IB🡪SUP🡪TPB🡪CLON

### Objective

Ensure that the COB data is copied from the primary payer when a secondary Medicare claim is copied and cancelled (CLON) to create a new secondary claim

### Prerequisites

1. A primary inpatient Medicare claim with an MRA in VistA

### Scenario

A secondary Medicare inpatient claim is rejected by the secondary payer because the patient no longer has that insurance. A biller needs to CLON the claim and change the secondary payer to the patient’s new secondary insurer

### Test Steps

1. Access the Copy and Cancel option
2. Enter BILL NUMBER or Patient NAME: prompt, enter **patient name or bill number**
3. At the ARE YOU SURE YOU WANT TO CANCEL THIS BILL? No// prompt, enter **YES**
4. At the CANCEL BILL?: NO// prompt, enter **YES**
5. At the REASON CANCELLED prompt: enter a **free text reason**
6. At the Reason Not Billable prompt: enter the necessary **RNB code**
7. At the IS THE ABOVE INFORMATION CORRECT AS SHOWN? Yes// prompt, press **Enter** to accept the default of Yes
8. At the screens displaying the new bill verify the information is correct and proceed to Screen 3
9. Access Section 1 and change the secondary payer to the **new secondary insurer**
10. Add any information needed to complete the claim
11. Authorize the claim
12. Transmit the claim immediately using SEND option or wait for regularly scheduled claims transmission
13. Access the VPE option after the claim has been transmitted

### Expected Outcomes

1. The VPE will contain the following:

* COB1, Piece 7 = ICN from the MRA
* MIA1 = Payment Amounts
* MIA2 = Payment Amounts and any Remark Codes from the MRA
* CCAS = Claim Level Adjustments from the MRA
* LCOB, Piece 4 = Service Line Paid Amount from the MRA
* LCOB, Piece 17 = Remaining Liability
* LCAS = Line Level Adjustments from the MRA

## COB Data in CLON’d Claims (Primary Medicare) - Inpatient– TS37

### Requirements

2.6.11.1 Functional Requirement: Copy and Cancel - COB Data

### Menu Path

IB🡪SUP🡪TPB🡪CLON

### Objective

1. Ensure that the COB data is not copied from the primary payer when a primary Medicare claim is copied and cancelled (CLON) to create a new primary claim

### Prerequisites

1. A primary inpatient Medicare claim with a Denied MRA in VistA

### Scenario

A primary Medicare inpatient claim is denied by the primary payer. A biller needs to CLON the claim and change the Bill Type to an adjustment claim, enter corrected data and resubmit.

### Test Steps

1. Access the Copy and Cancel option
2. Enter BILL NUMBER or Patient NAME: prompt, enter **patient name or bill number**
3. At the ARE YOU SURE YOU WANT TO CANCEL THIS BILL? No// prompt, enter **YES**
4. At the CANCEL BILL?: NO// prompt, enter **YES**
5. At the REASON CANCELLED prompt: enter a **free text reason**
6. At the Reason Not Billable prompt: enter the necessary **RNB code**
7. At the IS THE ABOVE INFORMATION CORRECT AS SHOWN? Yes// prompt, press **Enter** to accept the default of Yes
8. At the screens displaying the new bill verify the information is correct and proceed to Screen 6
9. Access Section 1 and change the Bill Type to an adjustment claim
10. Proceed to Screen 10
11. Access Section 1 and enter the ICN from the MRA
12. Add any information needed to complete the claim
13. Authorize the claim
14. Transmit the claim immediately using SEND option or wait for regularly scheduled claims transmission
15. Access the VPE option after the claim has been transmitted

### Expected Outcomes

1. The VPE will contain the following:

* COB1, Piece 7 = ICN from the MRA
* No other COB data is copied to the new claim

## COB Data in CLON’d Claims (Primary Medicare) - Outpatient– TS38

### Requirements

2.6.11.1 Functional Requirement: Copy and Cancel - COB Data

### Menu Path

IB🡪SUP🡪TPB🡪CLON

### Objective

1. Ensure that the COB data is not copied from the primary payer when a primary Medicare claim is copied and cancelled (CLON) to create a new primary claim

### Prerequisites

1. A primary outpatient Medicare claim with a DENIED MRA in VistA

### Scenario

A primary Medicare outpatient claim is denied by the primary payer. A biller needs to CLON the claim and change the Bill Type to an adjustment claim, add correct data and resubmit.

### Test Steps

1. Access the Copy and Cancel option
2. Enter BILL NUMBER or Patient NAME: prompt, enter **patient name or bill number**
3. At the ARE YOU SURE YOU WANT TO CANCEL THIS BILL? No// prompt, enter **YES**
4. At the CANCEL BILL?: NO// prompt, enter **YES**
5. At the REASON CANCELLED prompt: enter a **free text reason**
6. At the Reason Not Billable prompt: enter the necessary **RNB code**
7. At the IS THE ABOVE INFORMATION CORRECT AS SHOWN? Yes// prompt, press **Enter** to accept the default of Yes
8. At the screens displaying the new bill verify the information is correct and proceed to Screen 6
9. Access Section 1 and change the Bill Type to an adjustment claim
10. Proceed to Screen 10
11. Access Section 1 and enter the ICN from the MRA
12. Add any information needed to complete the claim
13. Authorize the claim
14. Transmit the claim immediately using SEND option or wait for regularly scheduled claims transmission
15. Access the VPE option after the claim has been transmitted

### Expected Outcomes

1. The VPE will contain the following:

* COB1, Piece 7 = ICN from the MRA
* No other COB data is copied to the new claim

## COB Data in CLON’d Claims (Secondary) – TS39

### Requirements

2.6.11.1 Functional Requirement: Copy and Cancel - COB Data

### Menu Path

IB🡪SUP🡪TPB🡪CLON

### Objective

1. Ensure that the COB data is copied from the MRA of the primary Medicare claim when a secondary commercial claim is copied and cancelled (CLON) to create a new secondary claim

### Prerequisites

1. A primary non-Medicare claim with an EOB in VistA

### Scenario

A secondary commercial claim is rejected by the secondary payer because the patient no longer has that insurance. A biller needs to CLON the claim and change the secondary payer to the patient’s new secondary insurer

### Test Steps

1. Access the Copy and Cancel option
2. Enter BILL NUMBER or Patient NAME: prompt, enter **patient name or bill number**
3. At the ARE YOU SURE YOU WANT TO CANCEL THIS BILL? No// prompt, enter **YES**
4. At the CANCEL BILL?: NO// prompt, enter **YES**
5. At the REASON CANCELLED prompt: enter a **free text reason**
6. At the Reason Not Billable prompt: enter the necessary **RNR code**
7. At the IS THE ABOVE INFORMATION CORRECT AS SHOWN? Yes// prompt, press **Enter** to accept the default of Yes
8. At the screens displaying the new bill verify the information is correct and proceed to Screen 3
9. Access Section 1 and change the secondary payer to the **new secondary insurer**
10. Add any information needed to complete the claim
11. Authorize the claim
12. Transmit the claim immediately using SEND option or wait for regularly scheduled claims transmission
13. Access the VPE option after the claim has been transmitted

### Expected Outcomes

1. The VPE will contain the following:

* COB1, Piece 7 = ICN from the MRA
* CCAS = Claim Level Adjustments from the MRA
* LCOB, Piece 4 = Service Line Paid Amount from the MRA
* LCOB, Piece 17 = Remaining Liability
* LCAS = Line Level Adjustments from the MRA

## COB Data in CLON’d Claims (Primary) – TS40

### Requirements

2.6.11.1 Functional Requirement: Copy and Cancel - COB Data

### Menu Path

IB🡪SUP🡪TPB🡪CLON

### Objective

1. Ensure that the COB data is not copied from the primary payer when a primary Medicare claim is copied and cancelled (CLON) to create a new primary claim

### Prerequisites

1. A primary non-Medicare claim with a DENIED EOB in VistA

### Scenario

A primary non-Medicare claim is denied by the primary payer. A biller needs to CLON the claim and change the Bill Type to an adjustment claim, add correct data and resubmit.

### Test Steps

1. Access the Copy and Cancel option
2. Enter BILL NUMBER or Patient NAME: prompt, enter **patient name or bill number**
3. At the ARE YOU SURE YOU WANT TO CANCEL THIS BILL? No// prompt, enter **YES**
4. At the CANCEL BILL?: NO// prompt, enter **YES**
5. At the REASON CANCELLED prompt: enter a **free text reason**
6. At the Reason Not Billable prompt: enter the necessary **RNB code**
7. At the IS THE ABOVE INFORMATION CORRECT AS SHOWN? Yes// prompt, press **Enter** to accept the default of Yes
8. At the screens displaying the new bill verify the information is correct and proceed to Screen 6
9. Access Section 1 and change the Bill Type to an adjustment claim
10. Proceed to Screen 10
11. Access Section 1 and enter the ICN from the MRA
12. Add any information needed to complete the claim
13. Authorize the claim
14. Transmit the claim immediately using SEND option or wait for regularly scheduled claims transmission
15. Access the VPE option after the claim has been transmitted

### Expected Outcomes

1. The VPE will contain the following:

* COB1, Piece 7 = ICN from the EOB
* No other COB data is copied to the new claim

## COB Management Worklist (CBW) – TS41

### Requirements

2.6.12.1 Functional Requirement: COB Management Worklist – Search  
2.6.12.2 Functional Requirement: COB Management Worklist – Sort  
2.6.12.3 Functional Requirement: COB Management Worklist – CARC/RARC

### Menu Path

IB🡪SUP🡪EDI🡪CBW

### Objective

1. Ensure users can search for claims on the COB Management Worklist to include:

* Primary Payer, or
* Secondary or
* Both

1. Ensure users can sort claims on the COB Management Worklist by:

* Secondary/Tertiary Insurance Company
* Primary Insurance Company

1. Ensure users can view the complete CARC and RARC descriptions from the following Actions:

* Print EOB
* View EOB

### Prerequisites

1. One or more non-Medicare primary claims on the CBW that failed the automatic processing to the secondary payer
2. One or more non-Medicare secondary claims on the CBW that failed the automatic processing to the tertiary payer

### Scenario

A biller is assigned to work the CBW worklist and decides to first work primary claims and then later secondary claims so he/she uses the new search and sort criteria

### Test Steps

1. Access the COB Management Worklist option
2. At the SELECT BILLER: ALL// prompt, press **Enter** to accept default of ALL.
3. At the INCLUDE ALL DIVISIONS OR SELECTED DIVISIONS? All// prompt, press **Enter** to accept the default
4. At the Select (P)rimary Claims, (S)econdary claims, or (B)oth: Both\\ Enter **??** to see all options
5. At: Select (P)rimary Claims, (S)econdary claims, or (B)oth: Both\\ prompt, press **P** for primary claims
6. At the SORT BY: BILLER// prompt, press enter **I** to select Secondary/Tertiary Insurance Company
7. Do you want to include Denied EOB’s for Duplicate Claim/Service? No// prompt, press **Enter** to accept default
8. At the SELECT ACTION: Next Screen// prompt, enter **PE** for Print EOB/MRA
9. Return to the COB Management Worklist
10. At the SELECT ACTION: Next Screen// prompt, enter **VE** for View an EOB

### Expected Outcomes

1. The following Help text is displayed

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

1. Only primary claims are displayed
2. The primary claims are displayed in the alphabetical order of the secondary payer
3. Users are able to view the complete CARC/RARC descriptions

***Note:*** Repeat test above to include each possible combination of criteria:

Search criteria:

* Secondary/Tertiary Claims
* Both

Sort criteria:

* Secondary Insurance Company

**Note:** Whether or not the following RFAI Management Worklist can be tested in Production at the IOC sites, depends or whether there are payers using the 277RFAI transactions.

## RFAI Management Worklist – Create – TS42 (Development Only)

### Requirements

2.6.13.1 Functional Requirement: Request for Additional Information (RFAI) (277) Worklist – Search

2.6.13.2 Functional Requirement: Request for Additional Information (RFAI) (277) Worklist – Primary Sort

2.6.13.3 Functional Requirement: Request for Additional Information (RFAI) (277) Worklist – Secondary Sort

### Menu Path

IB🡪SUP🡪EDI🡪RFAI

### Objective

1. Ensure users are able to search for 277 messages associated with specific authorizing billing clerks or by all clerks
2. Ensure users are able to sort the list of messages by one of the following criterion:

* Chronological order (earliest transmission date first)
* Reverse chronological order (oldest transmission date first)
* Chronological order (earliest date due first)
* Reverse chronological order (oldest date due first)
* Insurance company name
* Patient name
* Authorizing biller
* Logical Observation Identifiers Names and Codes (LOINC )🡨 This is the default

1. Ensure users are able to sort the list of messages within the primary sort by one of the following criterion:

* Chronological order (earliest transmission date first)
* Reverse chronological order (oldest transmission date first)
* Chronological order (earliest date due first)
* Reverse chronological order (oldest date due first) 🡨Default
* Insurance company name
* Patient name
* Authorizing biller
* LOINC Code

### Prerequisites

1. Numerous claims for different patients that were authorized by different billing clerks and sent to different payers for which 277RFAI transactions have been received which contain different documentation LOINC codes

### Scenario

Either a billing clerk or AR clerk has been assigned to work the RFAI Worklist and respond to the payer’s requests for additional supporting documentation for specific healthcare claims

### Test Steps

1. Access the RFAI Management Worklist option
2. At the Select Authorizing Biller: ALL// prompt, enter an **authorizing biller’s name**
3. At the Select Authorizing Biller: prompt, enter another **authorizing biller’s name**
4. At the Select Authorizing Biller: prompt, press **Enter** to leave blank
5. At the Select Primary Sort: LOINC Code:// prompt, enter **??** to view Help text
6. At the Select Primary Sort: LOINC Code:// prompt, press **Enter** to accept the default
7. At the Select Primary Sort: Earliest Due Date First// prompt, enter **??** to view Help text
8. At the Select Primary Sort: Earliest Due Date First// prompt, press **Enter** to accept the default
9. At the Select Action: Next Screen//: prompt, enter **EX** to exit

### Expected Outcomes

1. Users are able to create a RFAI Management Worklist containing 277RFAI messages
2. The following Help text is displayed

Enter the code that determines the primary sort criterion

for the worklist.

Select one of the following:

N Earliest Date Received First

O Latest Date Received First

E Earliest Date Due First

D Latest Date Due First

I Insurance Company Name

P Patient Name

B Authorizing Biller

L LOINC Code

Select Primary Sort: LOINC Code//

Select Secondary Sort: Earliest Date Received//??

Enter the code that determines the secondary sort criterion

for the worklist.

Select one of the following:

N Earliest Date Received First

O Latest Date Received First

E Earliest Date Due First

D Latest Date Due First

I Insurance Company Name

P Patient Name

B Authorizing Biller

The Primary sort default value = LOINC Code

1. The Secondary Sort default value = Earliest Date Due First (unless this was the primary sort)
2. The list is displayed by oldest 277RFAI within each LOINC code within each biller

Example – Sorted By LOINC code and Earliest Date Received First:

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

Bill # Payer Name Patient Name SSN Svc Date Curr Bal

1 K100XXX MEDICARE (WNR) IB,PATIENT 333 XXXX 06/29/15 $43851.78

LOINC Code: XXX1

2 K100XXX MEDICARE (WNR) IB,PATIENT 22 XXXX 11/05/15 $1226.18

LOINC Code: XXX1

3 K100XXX UNITEDHEALTHCARE IB,PATIENT 765 XXXX 11/05/14 $9.65

LOINC Code: XXX2

4 K100XXX MEDICARE (WNR) IB,PATIENT 22 XXXX 11/05/15 $1226.18

LOINC Code: XXX2

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:*** Repeat test above to include each possible combination of criteria:

Authorizing Biller:

* ALL
* SELECTED

Primary Sort criteria:

* Earliest Date Received First
* Latest Date Received First
* Earliest Date Due First
* Latest Date Due First
* Insurance Company Name
* Patient Name
* Authorizing Biller

Secondary Sort criteria:

* Earliest Date Received First
* Latest Date Received First
* Earliest Date Due First
* Latest Date Due First
* Insurance Company Name
* Patient Name
* Authorizing Biller

## RFAI Management Worklist – Initial Actions (Development Only) – TS43

### Requirements

2.6.13.4 Functional Requirement: Request for Additional Information (RFAI) (277) Worklist –Actions

2.6.13.5 Functional Requirement: Request for Additional Information (RFAI) (277) Worklist – Visual Indicator

2.6.13.6 Functional Requirement: Request for Additional Information (RFAI)(277) Worklist – Comment History

### Menu Path

IB🡪SUP🡪EDI🡪RFAI

### Objective

1. Ensure users are able to select a 277RFAI transaction from the worklist
2. Ensure users are able to re-sort the transactions from within the worklist

### Prerequisites

1. Multiple 277RFAI messages

### Scenario

Either a billing clerk or AR clerk has been assigned to work the RFAI Worklist and respond to the payer’s requests for additional supporting documentation for specific healthcare claims

### Test Steps

1. Access the RFAI Management Worklist option
2. At the Select Authorizing Biller: ALL//: prompt, press **Enter** to accept the default
3. At the Select Primary Sort: LOINC Code:// prompt, press **Enter** to accept the default
4. At the Select Primary Sort: Earliest Date Due First// prompt, press **Enter** to accept the default
5. From within the worklist:
6. At the Select Action: Next Screen//: prompt, enter **RM** for ReSort Messages
7. At the Select Authorizing Biller: ALL//: prompt, press **Enter** to accept the default
8. At the Select Primary Sort: LOINC Code:// prompt, press **Enter** to accept the default
9. At the Select Primary Sort: Earliest Date Due First // prompt, enter **Latest Date Due First**
10. From within the worklist:
11. At the Select Action: Next Screen//: prompt, enter **SM** for Select Message
12. At the Select RFAI message: (1-n) prompt, enter the **number** of the message you want to select

### Expected Outcomes

1. The 277RFAI messages related to any claims entered by any authorizing biller are displayed
2. The RFAI Management worklist are initially displayed grouped by LOINC Code and within LOINC Code, by earliest date due messages first
3. The RFAI Management worklist is then redisplayed grouped by LOINC Code and within LOINC Code, by newest messages first
4. Users can select a message to expand and view the actual transaction

## RFAI Message Screen – Message Actions (Development Only) – TS44

### Requirements

2.6.13.4 Functional Requirement: Request for Additional Information (RFAI) (277) Worklist –Actions

2.6.13.5 Functional Requirement: Request for Additional Information (RFAI) (277) Worklist – Visual Indicator

2.6.13.6 Functional Requirement: Request for Additional Information (RFAI)(277) Worklist – Comment History

### Menu Path

IB🡪SUP🡪EDI🡪RFAI

### Objective

1. Ensure users are able to execute the following Actions from within the RFAI Message screen:

* Mark as being worked by a user
* Add comments

### Prerequisites

1. Multiple 277RFAI messages on the RFAI Management Worklist

### Scenario

Either a billing clerk or AR clerk has been assigned to work the RFAI Worklist and respond to the payer’s requests for additional supporting documentation for specific healthcare claims

### Test Steps

1. Access the RFAI Management Worklist option
2. At the Select Authorizing Biller: ALL//: prompt, press **Enter** to accept the default
3. At the Select Primary Sort: LOINC Code:// prompt, press **Enter** to accept the default
4. At the Select Primary Sort: Earliest Date Due First // prompt, press **Enter** to accept the default
5. From within the worklist:

* At the Select Action: Next Screen//: prompt, enter **SM** for Select Message
* At the Select RFAI message: (1-n) prompt, enter the **number** of the message you want to select

1. From within the RFAI Message screen:

* At the Select Action: Next Screen:// prompt, enter **RS** for Review Status
* At the RFAI Message Review Status: Review in Process:// prompt, enter **0** for Not Being Reviewed

1. From within the RFAI Message screen:

* At the Select Action: Next Screen// prompt, Enter **EC** (Enter/Edit comment)
* At the No existing text Edit? NO// prompt, enter **Y** for Yes
* In the text editor, enter a free text message - **This is a test of the new RFAI comment field**
* Exit the editor and save the comment
* At the RFAI Review Status: Review in Process//prompt, press **Enter** to accept the default

1. From within the RFAI Message screen:

* At the Select Action: Next Screen// prompt, Enter **EC** (Enter/Edit comment) to view existing comments

1. From the RFAI Message Screen, review the 277RFAI message content

### Expected Outcomes

1. Users are able to select a message from the worklist and expand it to see the 277RFAI
2. Users are able to mark an entry on the worklist as being worked by a user
3. The system places a visual indicator (\*) next to an entry on the worklist that is being worked by a user
4. The system automatically captures the name of the user who adds a comment and the date and time when the comment was entered
5. The 277RFAI displays the following potential data elements depending on what the payer transmitted:

Example:

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

Payer Claim Control Number: XXXXXXXXXXXXXXXXXXXXXXXXXXXX

Claim Level Status Information

Patient Control #: K100XXX

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:

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:

Status Information Effective Date: XX/XX/XX

Response Due Date: XX/XX/XX

## RFAI Message Screen – More Message Actions (Development Only) – TS45

### Requirements

2.6.13.4 Functional Requirement: Request for Additional Information (RFAI) (277) Worklist –Actions

2.6.13.5 Functional Requirement: Request for Additional Information (RFAI) (277) Worklist – Visual Indicator

2.6.13.6 Functional Requirement: Request for Additional Information (RFAI)(277) Worklist – Comment History

### Menu Path

IB🡪SUP🡪EDI🡪RFAI

### Objective

1. Ensure users are able to execute the following Actions from within the RFAI Message:

* Remove entry
* Jump to TPJI

### Prerequisites

1. Multiple 277RFAI messages on the RFAI Management Worklist

### Scenario

Either a billing clerk or AR clerk has been assigned to work the RFAI Worklist and respond to the payer’s requests for additional supporting documentation for specific healthcare claims

### Test Steps

1. Access the RFAI Management Worklist option
2. At the Select Authorizing Biller: ALL//: prompt, press **Enter** to accept the default
3. At the Select Primary Sort: LOINC Code:// prompt, press **Enter** to accept the default
4. At the Select Primary Sort: Oldest Message First:// prompt, press **Enter** to accept the default
5. From within the worklist:

* At the Select Action: Next Screen//: prompt, enter **SM** for Select Message
* At the Select RFAI message: (1-n) prompt, enter the **number** of the message you want to select

1. From within the RFAI Message screen:

* At the Select Action: Next Screen:// prompt, enter **TPJI** to jump to claim information associated to the claim associated with the 277RFAI
* Return to the RFAI Management Worklist 🡪 RFAI Message screen

1. From within the RFAI Message screen:

* At the Select Action: Next Screen// prompt, Enter **RE** for Remove Entry
* At the Enter Reason for Removal: prompt, press **Enter** to attempt to leave the reason blank
* At the Enter Reason for Removal: prompt, enter Clinical documentation sent to payer via secure Fax

### Expected Outcomes

1. Users are able to jump to TPJI from within the RFAI Message screen
2. Users are able to remove an entry from the RFAI Management Worklist
3. The system automatically captures the name of the user who removes and entry and the date and time when the reason was entered
4. Users cannot remove any entry without adding a free text Reason for Removal

## Transmit All Rate Types – Institutional – TS46

### Requirements

2.6.14.2 Functional Requirement: Transmit All Rate Types – Responsible Party Equals Insurer - Institutional

### Menu Path

1. IB 🡪SUP🡪BILL 🡪Enter patient’s name or Claim #

### Objective

1. Ensure users can transmit claims for any of the following Rate Types if the destination payer accept electronic claims:

* Tort Feasor
* No Fault Ins
* Crime Victim

### Prerequisites

1. An institutional claim which has the Rate Type = Tort Feasor
2. An institutional claim which is to a destination payer who accepts electronic claims

### Scenario

A biller creates an inpatient institutional claim for a patient with a specific rate type

### Test Steps

1. Access the option BILL - Enter/Edit Billing Information
2. At the Enter BILL NUMBER or PATIENT NAME prompt, enter a **patient name** or a **bill number**
3. Proceed to Screen 3
4. Access Section 1:

* Add the payer(s) to the claim
* Verify the Rate Type = Tort Feasor

1. Add any information needed to complete the claim
2. Authorize the claim
3. Transmit the claim immediately using SEND option or wait for regularly scheduled claims transmission

### Expected Outcomes

1. Users are able to transmit a claim with a Rate Type = Tort Feasor

***Note:*** Repeat test above to include each possible Rate Type:

* No Fault Ins
* Crime Victim

## Transmit All Rate Types – Professional – TS47

### Requirements

2.6.14.3 Functional Requirement: Transmit All Rate Types – Responsible Party Equals Insurer - Professional

### Menu Path

IB 🡪SUP🡪BILL 🡪Enter patient’s name or Claim #

### Objective

1. Ensure users can transmit claims for any of the following Rate Types if the destination payer accept electronic claims:

* Tort Feasor
* No Fault Ins
* Crime Victim

### Prerequisites

1. An professional claim which has the Rate Type = Tort Feasor
2. An professional claim which is to a destination payer who accepts electronic claims

### Scenario

A biller creates an outpatient professional claim for a patient with a specific rate type

### Test Steps

1. Access the Enter/Edit Billing Information option
2. At the Enter BILL NUMBER or PATIENT NAME prompt, enter a **patient name** or a **bill number**
3. Proceed to Screen 3
4. Access Section 1:

* Add the payer(s) to the claim
* Verify the Rate Type = Tort Feasor

1. Add any information needed to complete the claim
2. Authorize the claim
3. Transmit the claim immediately using SEND option or wait for regularly scheduled claims transmission

### Expected Outcomes

1. Users are able to transmit a claim with a Rate Type = Tort Feasor

***Note:*** Repeat test above to include each possible Rate Type:

* No Fault Ins
* Crime Victim

## Transmit 25 Procedures/12 External Cause of Injury Diagnoses (DX) – TS48

### Requirements

2.6.14.4 Transmit up to 25 Procedures - Institutional

2.6.14.5 Transmit Up To 12 External Cause of Injury Diagnoses - Institutional

### Menu Path

IB🡪SUP🡪 BILL 🡪Enter patient’s name/Claim #

### Objective

1. Ensure users can transmit an institutional claim with up to 25 Procedures
2. Ensure users can transmit an institutional claim with up to 12 External Cause of Injury Diagnoses

### Prerequisites

1. A patient with a 26 procedures that require institutional billing
2. A patient with 13 external cause of injury DXs associated with the above institutional claim

### Scenario

A biller must create a claim for a patient that had 26 procedures performed as a result of 13 External Cause of Injury Diagnoses

### Test Steps

1. Access the Enter/Edit Billing Information option
2. At the Enter BILL NUMBER or PATIENT NAME prompt, enter a **patient name** or a **bill number**
3. Enter any needed information on Screens 1-3 for a UB04 claim and proceed to Screen 4
4. Access Section 3:

* At the SELECT DIAGNOSIS FROM THE PTF RECORD TO INCLUDE ON THE BILL: prompt, selected the DXs from the PTF record or add a principal ICD-10 DX, **S72.309A** that will be used as the Admitting DX
* At the Edit POA indicators? NO// prompt, enter **Y** for Yes
* At each DX: prompt, enter **Y** for POA
* At the Prospective Payment System Code (DRG): XXX// prompt, press **Enter** accept the default
* At the Select ICD-10 DIAGNOSIS: prompt, enter **Y92.63** for factory as place of accident
* At the Diagnosis: Y92.63// prompt, press **Enter** to confirm DX
* At the POA Indicator: prompt, enter **Y** for POA
* At the Order: n// prompt, press **Enter** to confirm order
* At the next Select ICD DIAGNOSIS: prompt, repeat 13 times entering a total of 14 External Cause of Injury DXs

1. Access Section 4:

* At the PROCEDURE CODING METHOD: ICD// prompt, press **Enter** to accept default
* At the SELECT DIAGNOSIS FROM THE PTF RECORD TO INCLUDE ON THE BILL: prompt, select the procedures from the PTF record or
* At the Select PROCEDURE DATE (Date to Date): Enter **the correct date** for the inpatient claim
* At the Select Procedure: prompt, enter **BQ230ZZ** for x-ray of femur
* At the PROCEDURES: BQ230ZZ// prompt, press **Enter** to confirm procedure
* At the PRINT ORDER: prompt, enter the **Print Order Number**
* At the next Select Procedure: prompt, repeat 25 times entering a total of 26 procedures

1. Add any information needed to complete the claim
2. Authorize the claim
3. Transmit the claim immediately using SEND option or wait for regularly scheduled claims transmission
4. Access the VPE option after the claim has been transmitted

### Expected Outcomes

1. The VPE contains the following:

* PC1-PC12, Piece 4 = BBR for principal procedure
* PC1-PC12, Piece 3 = Principal Procedure
* PC1-PC12, Piece 4 = BBQ for other procedures – There are 24 of theses
* PC1-PC12, Piece 3 = Other Procedure – There are 24 of these
* DC1-DC12, Piece 3 = ABK for principal DX
* DC1-DC12, Piece 2 = Principal DX
* DC1-DC12, Piece 3 = ABN for External Cause of Injury DX – There are 13 of these
* DC1-DC12, Piece 2 = External Cause of Injury DX – There are 13 of these
* CL1a, Piece 15 = ABJ for admitting DX
* CL1A, Piece 16 = Admitting DX

## Transmit Maximum Field Lengths – Professional (Development Only) – TS49

### Requirements

2.6.14.9 Transmit Admission Date – Inpatient Professional

2.6.14.11 Transmission Field Lengths – Professional

### Menu Path

1. IB🡪SUP🡪 BILL 🡪Enter patient’s name/Claim #

### Objective

1. Users will transmit a Professional bill where the patient is the subscriber and the fields listed in prerequisites do not exceed their maximum field lengths

### Prerequisites

1. A patient with active insurance where the patient is the subscriber and each of the following fields contain the following length:

* 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

### Scenario

A biller creates an inpatient professional claim for a patient where subscriber information is a maximum length

### Test Steps

1. Access the option BILL - Enter/Edit Billing
2. At the Enter BILL NUMBER or PATIENT NAME prompt, enter a **patient name** or a **bill number**
3. At the Enter BILLING LOCATION OF CARE prompt, enter **1** for Hospital
4. At the BILLING EVENT INFORMATION EVENT SOURCE prompt, enter **outpatient**
5. At the BILLING TIMEFRAME: prompt, enter **admit thru discharge**
6. At the BILLING IS THIS A SENSITIVE RECORD?: NO// prompt, press **Enter** to accept default of NO
7. At the BILLING RATE TYPE: prompt, enter **8** for REIMBURSABLE INS.
8. At the BILLING OUTPATIENT EVENT DATE: prompt, enter **T** for today or the date of the encounter you want
9. Enter any needed information on Screens 1-3 for a CMS 1500 claim
10. Authorize the claim
11. Transmit the claim immediately using SEND option or wait for regularly scheduled claims transmission

### Expected Outcomes

1. The VPE contains the following:

* CI3, Piece 2 = Insured Group or Policy #
* CI3, Piece 3 = Insured Group Name
* CI6, Piece 3 = Subscriber Primary Id
* CI6, Piece 5 = Subscriber Secondary ID (1) Identifier
* PT1,Piece 4= Insured Last Name
* PT1,Piece 5= Insured First Name
* PT1,Piece 7= Insured Address line
* PT1,Piece 8= Insured Address Line

## Transmit Maximum Field Lengths – Institutional (Development Only) – TS50

### Requirements

2.6.14.8 Transmit Admission Date – Inpatient Institutional

2.6.14.10 Transmission Field Lengths – Institutional

### Menu Path

1. IB🡪SUP🡪 BILL 🡪Enter patient’s name/Claim #

### Objective

1. Users will transmit an admission date on an Inpatient Institutional claim
2. Users will transmit an inpatient bill where the patient is the subscriber and the fields listed in prerequisites do not exceed their maximum field lengths

### Prerequisites

1. A patient with active insurance where the patient is the subscriber and each of the following fields contain the following length:
2. Subscriber Group or Policy Number (SBR03) – Maximum 50 Alphanumeric
3. Subscriber Group Name (SBR04) – Maximum 60 Alphanumeric
4. Subscriber Primary Identifier (NM109) – Maximum 80 Alphanumeric
5. Subscriber Supplemental Identifier (REF02) – Maximum 50 Alphanumeric
6. Subscriber Last Name (NM103) – Maximum 60 Alphanumeric
7. Subscriber First Name (NM104) – Maximum 35 Alphanumeric
8. Subscriber Address Line (N301) – Maximum 55 Alphanumeric
9. Subscriber Address Line (N302) – Maximum 55 Alphanumeric

### Scenario

A biller creates an inpatient institutional claim for a patient where subscriber information is a maximum length

### Test Steps

1. Access the option BILL - Enter/Edit Billing Information
2. At the Enter BILL NUMBER or PATIENT NAME prompt, enter a **patient name** or a **bill number**
3. At the Enter BILLING LOCATION OF CARE prompt, enter **1** for Hospital
4. At the BILLING EVENT INFORMATION EVENT SOURCE prompt, enter **inpatient**
5. At the BILLING TIMEFRAME: prompt, enter **admit thru discharge**
6. At the BILLING IS THIS A SENSITIVE RECORD?: NO// prompt, press **Enter** to accept default of NO
7. At the BILLING RATE TYPE: prompt, enter **8** for REIMBURSABLE INS.
8. At the elect INPATIENT EVENT (ADMISSION) DATE: prompt, select the **admission** you want
9. Enter any needed information on Screens 1-3 for a UB04 claim and proceed to Screen 4
10. Access Section 3:

* At the SELECT DIAGNOSIS FROM THE PTF RECORD TO INCLUDE ON THE BILL: prompt, enter the **diagnoses**
* At the YOU HAVE SELECTED n-n TO BE ADDED TO THE BILL IS THIS CORRECT? YES// prompt. press **Enter**
* At the Edit POA indicators? NO// prompt, press return to accept the default
* At the next Diagnosis Number: prompt, press **Enter**
* At the Prospective Payment System Code (DRG): n // prompt, press **Enter** to accept the default
* At the Select ICD DIAGNOSIS: prompt, press **Enter** to leave blank

1. Add any information needed to complete the claim
2. Authorize the claim
3. Transmit the claim immediately using SEND option or wait for regularly scheduled claims transmission

### Expected Outcomes

1. The VPE contains the following:

* CI3, Piece 2 = Insured Group or Policy #
* CI3, Piece 3 = Insured Group Name
* CI6, Piece 3 = Subscriber Primary Id
* CI6, Piece 5 = Subscriber Secondary ID (1) Identifier
* PT1,Piece 4= Insured Last Name
* PT1,Piece 5= Insured First Name
* PT1,Piece 7= Insured Address line
* PT1,Piece 8= Insured Address Line

## Accredited Standards Committee (ASC ) X12N Health Care Claim Request For Additional Information (RFAI) (277) Transactions (Development Only) – TS51

### Requirements

2.6.15.1 Receive Health Care Claim RFAI (277)

2.6.15.2 Store Health Care Claim RFAI (277)

### Menu Path

1. IB🡪SUP🡪EDI🡪RFAI

### Objective

1. To receive Health Care Claim Request For Additional Information (RFAI) (277) transaction and store it for a specified length of time

### Prerequisites

1. An incoming ASC X12 Health Care Claim Request for Additional Information (277) from the FSC

### Scenario

A user wants to review status of a bill received and stored within a specified timeframe

### Test Steps

1. Access the option – RFAI – COB Request for Additional Information Worklist
2. At the SELECT AUTHORIZING BILLER: ALL//: prompt, enter in an **authorizing biller’s** name
3. At the SELECT AUTHORIZING BILLER:prompt, press **ENTER** to skip
4. At the Select Primary Sort: LOINC CODE:// prompt, press **ENTER** to accept the default of LOINC CODE
5. At the Select Secondary Sort: OLDEST MESSAGE FIRST:// prompt, press **ENTER** to accept the default of the oldest message
6. Review list to ensure that the message is displayed

### Expected Outcomes

1. Users are able to view the RAFI worklist and see that that the transactions are present and accounted for
2. The system stores the Health Care Claim RFAI (277) for the allotted time period denoted in the IB site parameters in the Health Care Claim RFAI file

## Display Insurance Company Addresses –TS52

### Requirements

2.6.16.1- Insurance Company Address

### Menu Path

1. IB🡪PI🡪VI

### Objective

1. Ensure users are able to view whatever is defined in the Insurance Company file (#36) for the following address fields via the Insurance Company Enter/Edit option summary screens: CLAIMS (INPT) STREET ADDRESS 1

* CLAIMS (INPT) STREET ADDRESS 2
* CLAIMS (INPT) STREET ADDRESS 3
* CLAIMS (INPT) PROCESS CITY
* CLAIMS (INPT) PROCESS STATE
* CLAIMS (INPT) PROCESS ZIP
* APPEALS ADDRESS ST. [LINE 1]
* APPEALS ADDRESS ST. [LINE 2]
* APPEALS ADDRESS ST. [LINE 3]
* APPEALS ADDRESS CITY
* APPEALS ADDRESS STATE
* APPEALS ADDRESS ZIP
* INQUIRY ADDRESS ST. [LINE 1]
* INQUIRY ADDRESS ST. [LINE 2]
* INQUIRY ADDRESS ST. [LINE 3]
* INQUIRY ADDRESS CITY
* INQUIRY ADDRESS STATE
* INQUIRY ADDRESS ZIP CODE
* CLAIMS (OPT) STREET ADDRESS 1
* CLAIMS (OPT) STREET ADDRESS 2
* CLAIMS (OPT) STREET ADDRESS 3
* CLAIMS (OPT) PROCESS CITY
* CLAIMS (OPT) PROCESS STATE
* CLAIMS (OPT) PROCESS ZIP
* CLAIMS (RX) STREET ADDRESS 1
* CLAIMS (RX) STREET ADDRESS 2
* CLAIMS (RX) STREET ADDRESS 3
* CLAIMS (RX) CITY
* CLAIMS (RX) STATE
* CLAIMS (RX) ZIP

### Prerequisites

1. An insurance company with a complete Main Mailing Address
2. An insurance company that is missing at least one of the following addresses
   * Outpatient Claims Office Information
   * Inpatient Claims Office Information
   * Prescription Claims Office Information
   * Appeals Office Information
   * Inquiry Office Information
3. Insurance company with an incomplete address different than the Main Mailing Address in one of the following areas:
   * Outpatient Claims Office Information
   * Inpatient Claims Office Information
   * Prescription Claims Office Information
   * Appeals Office Information
   * Inquiry Office Information

### Scenario

A user wants to view insurance file address information to see why not all of the addresses are being added to claims

### Test Steps

1. Access the option – VI– View Insurance Company
2. At the Select INSURANCE COMPANY NAME: prompt, enter an **Insurance Company’s name**
3. At the Select Action: Next Screen//:prompt, press **ENTER** to accept the default of Next Screen
4. View Main Mailing Address to ensure that it is complete
5. At the Select Action: Next Screen//: prompt, press **ENTER** to accept the default of Next Screen
6. View Outpatient Claims Office Information and Inpatient Claims Office Information to ensure that the address fields display correctly
7. At the Select Action: Next Screen//:prompt, press **ENTER** to accept the default of Next Screen
8. View Prescription Claims Office Information and Appeals Office Information

to ensure that the address fields display correctly

1. At the Select Action: Next Screen//:prompt, press **ENTER** to accept the default of Next Screen
2. View Inquiry Office Information to ensure that the address fields displays correctly

### Expected Outcomes

1. Users are able to view the address information as it was entered in the Insurance Company file. This includes incomplete addresses and null addresses.

## Display of Complete and Correct Insurance Address –TS53

### Requirements

2.6.16.1- Insurance Company Address

### Menu Path

1. IB🡪PI🡪EV

### Objective

1. Ensure users are able to view whatever is defined in the Insurance Company file (#36) for the following address fields via the Insurance Company Enter/Edit option summary screens: CLAIMS (INPT) STREET ADDRESS 1

* CLAIMS (INPT) STREET ADDRESS 2
* CLAIMS (INPT) STREET ADDRESS 3
* CLAIMS (INPT) PROCESS CITY
* CLAIMS (INPT) PROCESS STATE
* CLAIMS (INPT) PROCESS ZIP
* APPEALS ADDRESS ST. [LINE 1]
* APPEALS ADDRESS ST. [LINE 2]
* APPEALS ADDRESS ST. [LINE 3]
* APPEALS ADDRESS CITY
* APPEALS ADDRESS STATE
* APPEALS ADDRESS ZIP
* INQUIRY ADDRESS ST. [LINE 1]
* INQUIRY ADDRESS ST. [LINE 2]
* INQUIRY ADDRESS ST. [LINE 3]
* INQUIRY ADDRESS CITY
* INQUIRY ADDRESS STATE
* INQUIRY ADDRESS ZIP CODE
* CLAIMS (OPT) STREET ADDRESS 1
* CLAIMS (OPT) STREET ADDRESS 2
* CLAIMS (OPT) STREET ADDRESS 3
* CLAIMS (OPT) PROCESS CITY
* CLAIMS (OPT) PROCESS STATE
* CLAIMS (OPT) PROCESS ZIP
* CLAIMS (RX) STREET ADDRESS 1
* CLAIMS (RX) STREET ADDRESS 2
* CLAIMS (RX) STREET ADDRESS 3
* CLAIMS (RX) CITY
* CLAIMS (RX) STATE
* CLAIMS (RX) ZIP

### Prerequisites

1. An insurance company with a complete Main Mailing Address
2. An insurance company that is missing at least one of the following addresses
   * Outpatient Claims Office Information
   * Inpatient Claims Office Information
   * Prescription Claims Office Information
   * Appeals Office Information
   * Inquiry Office Information
3. Insurance company with an incomplete address different than the Main Mailing Address in one of the following areas:
   * Outpatient Claims Office Information
   * Inpatient Claims Office Information
   * Prescription Claims Office Information
   * Appeals Office Information
   * Inquiry Office Information

### Scenario

A user wants to view insurance file address information to see why not all of the addresses are being added to claims

### Test Steps

1. Access the option – VI– View Insurance Company
2. At the Select INSURANCE COMPANY NAME: prompt, enter in an **Insurance Company’s name**
3. At the Select Action: Next Screen//:prompt, press **ENTER** to accept the default of Next Screen
4. View Main Mailing Address to ensure that it is complete
5. At the Select Action: Next Screen//:prompt, press **ENTER** to accept the default of Next Screen
6. View Outpatient Claims Office Information and Inpatient Claims Office Information to ensure that it displays correctly
7. At the Select Action: Next Screen//:prompt, press **ENTER** to accept the default of Next Screen
8. View Prescription Claims Office Information and Appeals Office Information

to ensure that it displays correctly

1. At the Select Action: Next Screen//:prompt, press **ENTER** to accept the default of Next Screen
2. View Inquiry Office Information to ensure that it displays correctly

### Expected Outcomes

1. Users are able to view the address information as it was entered in the Insurance Company file. This includes incomplete addresses and null addresses.

## EDI – UMO (Utilization Management Organization) Identifier – TS53

### Requirements

2.6.3.4 Functional Requirement: UMO Identifier

### Menu Path

IB🡪PI🡪EI🡪Enter Insurance Company Name

### Objective

1. Ensure users can define an EDI UMO Identifier by insurance company

### Prerequisites

1. n/a

### Scenario

A user needs to define a UMO Identifier which will be used as the payer ID number in 278 transactions

### Test Steps

1. Access the option Insurance Company Entry/Edit
2. At the Select INSURANCE COMPANY NAME: prompt, enter **Aetna** as the insurance company name
3. At the Select Action: Next Screen// prompt, enter **BP** for Billing/EDI Param
4. Press **Enter** until you get to the new EDI-UMO (278) ID: prompt, enter **??** to view HELP text
5. At the EDI- UMO (278) ID: prompt, enter a **2-80 free text UMO ID**

### Expected Outcomes

1. User is able to add an UMO Identifier – 2-80 characters of free text
2. User is able to edit an UMO Identifier
3. User is able to delete an UMO Identifier
4. The following HELP Text appears

Enter a 2-80 character U Utilization Management Organization identifier which will be sent in the 278 transaction with the qualifier of PI.