Medical Care Collection Fund (MCCF) eBilling Compliance Phase 3

Requirements Specification Document

Patch IB\*2\*547



Department of Veterans Affairs

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# Introduction

## Purpose

The purpose of this Requirements Specification Document (RSD) is to outline the requirements for the MCCF eBilling Compliance Phase 3 project related to Integrated Billing (IB) Patch IB\*2\*547.

The target audience for this RSD includes Product Development (PD), Product Support (PS), Software Quality Assurance (SQA), the Program Management Office (PMO), the Chief Business Office (CBO), the Office of Enterprise Development (OED), the Financial Services Center (FSC), and the end-users.

## Scope

Integrated Billing is a software module within Veterans Health Information Systems and Technology Architecture (VistA) that provides the ability for billing personnel to submit claims in either a paper or electronic format to third-party payers. The IB module uses data from other modules within VistA such as the Admission/Discharge and Transfer software, the Scheduling software, the Accounts Receivable (AR) software, and the Registration software.

**Enter/Edit Billing Information**

* Make any necessary changes to the logic for determining Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) code service lines and revenue codes to ensure that identical codes either:
  + Combine and calculate the correct number of units – no Print Order
  + Do not combine – Print Order
* Remove the fatal error that prevents the authorization of a claim for a patient with only a last name in the Patient file
* Remove the fatal error that prevents the authorization of a claim for a subscriber with only a last name
* Remove the obsolete Present on Admission (POA) code option of Blank/Exempt from POA Reporting

**Printed Claims**

* Add the ability to print the amount paid on a claim by the previous payer(s) in Box 29 of the CMS-1500 claim form when a secondary/tertiary claim is printed locally
* Remove the printing of the admission date and time from the UB04 claim form (FL12/13) when an outpatient, institutional claim is printed locally
* Remove the printing of the discharge time from the UB04 claim form (FL16) when an outpatient, institutional claim is printed locally

**Insurance Company Entry/Edit/View Insurance Company**

* Add the ability to define multiple Additional Primary Payer Identification numbers for an insurance company for the purpose of routing claims to different administrative contractors for both Medicare Will Not Reimburse (WNR) and commercial [non-Medicare (WNR)] insurance companies
* Add the ability to view what is defined as the insurance company addresses in Insurance Company Entry/Edit and View Insurance Company even if the address is incomplete or blank
* Add the ability to define a Utilization Management Organization (UMO) identifier to be transmitted in the X12N 5010 Health Care Services Review – Request for Review and Response (278) transaction

**Integrated Billing Site Parameters**

* Add a parameter that controls how long the VistA system will store American Standard Code (ASC) X12N Health Care Claim Request For Additional Information (277) transactions (default = infinity)
* Add a parameter that controls how long an ASC X12N Health Care Claim Request For Additional Information (277) transaction will display on the ASC X12N Health Care Claim Request For Additional Information (277) worklist
* Add the ability to maintain a list of revenue codes that will be used to make some printed claims exempt from tracking
* Add ability to define Alternate Primary Payer ID Types to be used to qualify Alternate Primary Payer IDs

**Claims Status Awaiting Resolution (CSA)**

* Add the ability to view through CSA, the Health Care Clearing House (HCCH) that sent a Claim Status (277) message for a claim when the message source is an HCCH

**Third Party Joint Inquiry (TPJI)**

* Add the ability to view through TPJI, the HCCH that sent a Claim Status (277) message for a claim when the message source is an HCCH
* Modify the Electronic Explanation of Benefits (EEOB) view within the Claim Information action to display the Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) descriptions from the new AR EDI CARC DATA and AR EDI RARC DATA files (345 and 346)
* Add the ability to view comments added to the Request for Additional Information (RFAI) Worklist for a claim

**EDI Menu For Electronic Bills ...**

* Modify the Electronic Explanation of Benefits (EEOB) to display the Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) descriptions from the new AR EDI CARC DATA and AR EDI RARC DATA files (345 and 346) from the following locations:
* Print EOB [IBCE PRINT EOB]

**View/Resubmit Claims - Live or Test (RCB)**

* Add the ability to look up claims for an insurance company by Electronic Data Interchange (EDI) Payer ID in addition to the name of the insurance company
* Add the ability to search for claims that were previously printed and transmit them via the test queue

**Medicare-equivalent Remittance Advice (MRA)/Medicare Management Worklist (MRW)**

* Modify the EEOB view to display the CARCs and Remittance Advice Remark Codes (RARCs) descriptions from the new AR EDI CARC DATA and AR EDI RARC DATA files (345 and 346) from the following options:
* View MRA EOB [IBCEM VIEW MRA EOB]
* MRW [IBCE MRA MANAGEMENT]

**Billing Reports**

* Add the ability to track claims that are printed locally based on specific search criteria for CPAC and TRICARE/CHAMPVA claims
* Modify the Re-generate Unbilled Amounts report summary to display the summary totals before divisional totals and to provide the ability to select whether or not the report is sorted by division

**Copy and Cancel (CLON)**

* Modify the existing logic associated with copying a claim to ensure the Coordination of Benefits (COB) data associated with the cancelled claim is associated with the new copy

**COB Management Worklist (CBW)**

* Add the ability to search for claims on the COB Management Worklist by payer sequence and to sort the claims by payer sequence
* Modify the EEOB to display the CARCs and RARCs descriptions from the new CARC and RARC files (344 and 345) from the following CBW actions:
* Print EOB/MRA
* View EOB

**Request For Additional Information Worklist**

* Add the ability to view and manage manually, requests for additional claim information (ASC X12N Health Care Claim Request For Additional Information (277) transactions) received from payers

**ASC X12N Health Care Claim (837) Transactions**

* Add the ability to transmit all claims with a rate type for which the insurer is responsible in an ASC X12N Health Care Claim (837) transaction
* Add the ability to transmit up to 25 procedures codes in an institutional ASC X12N Health Care Claim (837) transaction
* Add the ability to transmit up to 12 External Cause of Injury diagnosis codes in an institutional ASC X12N Health Care Claim (837) transaction
* Modify the ASC X12N Health Care Claim (837) layout to include maximum allowable data element lengths for the insurance fields whose lengths were increased by the eInsurance Patch IB\*2\*497
* Modify the ASC X12N Health Care Claim (837) layout to only transmit an admission date on inpatient claims
* Modify the ASC X12N Health Care Claim (837) layout to only transmit a discharge date/time on inpatient claims

**ASC X12N Health Care Claim Request For Additional Information (277) Transactions**

* Add the ability to receive a ASC X12N Health Care Claim Request For Additional Information (277) equivalent transaction from FSC

## Assumptions and Dependencies

Emdeon will provide resources to support both integration and site testing for this software development effort.

The Financial Services Center (FSC) will provide resources to support both integration and site testing for this software development effort.

The Health Level 7 (HL7) team will provide resources to support development, integration, and site testing for this software development effort.

Patch PRCS\*4.5\*303 will be nationally released which will make the CARC/RARC files (#345 and 346) available for use by the Patch IB\*2\*547 software.

## References

| Name | Location | Date |
| --- | --- | --- |
| ASC X12N/005010X221 Health Care Claim Payment/Advice (835) – Technical Report Type 3 | <http://www.wpc-edi.com/> | May 2006 |
| ASC X12N/005010X222 Health Care Claim - Professional (837) – Technical Report Type 3 | <http://www.wpc-edi.com/> | May 2006 |
| ASC X12N/005010X223 Health Care Claim - Institutional (837) – Technical Report Type 3 | <http://www.wpc-edi.com/> | May 2006 |
| ASC X12N/005010X213 Health Care Claim Request for Additional Information (277) – Technical Report Type 3 | <http://www.wpc-edi.com/> | May 2006 |
| Draft Phase IV CAQH CORE 450 Health Care Claim (837) Infrastructure Rule version 4.0.0 | <http://www.caqh.org/CORESTRAW/DraftPAInfraRule_RWGReview.pdf> |  |
| Patch IB\*2\*516 ICD (5010) | <http://your_srver.domain.ext/warboard/anotebk.asp?proj=1646&Type=Active> | June 2010 |

# Overall Description

## Accessibility Specifications

The user interface for the VistA IB module is composed of two color, roll and scroll screens developed in M. The VistA modules are exempt from the standards for the 508 Section of the Rehabilitation Act.

## Business Rules Specification

The electronic claims transactions are based on the following specifications:

* ASC X12N/005010X221 Health Care Claim Payment/Advice (835)
* ASC X12N/005010X222 Health Care Claim Professional (837)
* ASC X12N/005010X223 Health Care Claim Institutional (837)
* ASC X12N/005010X213 Health Care Claim Request for Additional Information (277)

## Design Constraints Specification

The design constraints for this project are those imposed by the existing VistA system, which was developed in M.

## Disaster Recovery Specification

There are no disaster recovery requirements specific to this development effort. The affected modules are integrated parts of the overall VistA system that exists at each site and will be subject to the normal backup and recovery procedures.

## Documentation Specifications

The following documents will be delivered as part of this project:

* Current Workflow Analysis Document
* Future Workflow Analysis Document
* Requirements Specification Document (RSD)
* Requirements Traceability Matrix (RTM)
* System Design Document (SDD)
* Updated Interface Control Document (ICD) (Note: includes additional data mapping)
* Entity Relationship Diagrams (ERD)
* Release Notes/Installation Guide
* Technical/Security Manual
* Updated User Guide

***In addition to the above documentation, this project will also include the following documents:***

* An analysis of the availability/accessibility within VistA of patient related data such as nursing notes, treatment plans and consultations that will potentially be used in the Health Level Seven (HL7) Clinical Documentation Architecture (CDA) within the X12N Health Care Claims Request for Additional Information (275) transaction
* An analysis of the feasibility of meeting the requirements for a variety of Certificates of Medical Necessity by populating specific segments/data elements within the X12N Health Care Claims (837) Institutional and Professional transaction
* The team will provide a limited sampling of Medicare (WNR) institutional and professional claims for testing with Novitas when Novitas is ready to test claims with ICD-10 codes. (BN 10)

## Functional Specifications

### System Feature: Enter/Edit Billing Information

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

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

#### Functional Requirement: Last Name Only

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

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

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

* Y – Yes
* N – No
* U – No Information in the Record
* W – Clinically Undetermined

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

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

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

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

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

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

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

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

#### *Added 8/20/15* Functional Requirement: Last Name Only – Subscriber

The IB system shall provide the ability for users to authorize a claim for a subscriber with only a last name.

### System Feature: Printed Claims

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

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

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

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

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

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

#### *Added 1/7/2016* Functional Requirement: Discharge Hour – UB04 – Inpatient Only

The IB system shall provide the ability to print the Discharge Hour in Form Locator of the UB04 form for inpatient admissions only.

### System Feature: Insurance Company Entry/Edit

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

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

* Additional ID Type, and
* Additional ID

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

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

* Additional ID Type, and
* Additional ID

#### *Added 10/12/15* Functional Requirement: Insurance Company Addresses

The IB system shall display the stored values for the following address fields in the Insurance Company file (#36) from within the Insurance Company Entry/Edit option:

* 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

#### *Added 10/12/15* Functional Requirement: UMO Identifier

The IB system shall provide the ability for users to define a Utilization Management Organization (UMO) identifier to be transmitted in the X12N 5010 Health Care Services Review – Request for Review and Response (278) transaction (NM109).

### System Feature: Integrated Billing Site Parameters

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

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

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

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

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

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

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

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

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

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

* MX – Medicare A or B, or
* Not MX – Medicare A or B

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

The IB system shall create the Additional Primary Payer ID Type for Medicare (WNR) claims equal to Durable Medical Equipment (DME) when the software is installed. (BN 8.2)

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

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

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

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

* 270 through 279
* 290 through 299

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### *Deleted 1/7/15* Functional Requirement: Duplicate Medicare-equivalent Remittance Advice – Line Level

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

#### *Deleted 1/7/15* Functional Requirement: Duplicate Medicare-equivalent Remittance Advice – Claim Level

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

#### *Modified 10/12/15* Functional Requirement: EEOB View – CARC/RARC

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

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

### System Feature: Billing Reports

#### *Modified 10/12/15* Functional Requirement: Printed Claims Report – Create

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

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

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

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

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

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

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

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

#### *Modified 10/12/15* Functional Requirement: Printed Claims Report – Inclusions CPAC

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

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

#### *Modified 10/12/15* Functional Requirement – Printed Claims Report – Inclusions – TRICARE/CHAMPVA

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

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

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

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

* All Divisions, or
* Select Divisions

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

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

* Division
* Patient name (alphabetical)

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

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

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

#### *Modified 8/20/2015* Functional Requirement: Copy and Cancel – COB Data

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

* Copy Primary commercial with EOB to Primary – primary COB/no copy
* Copy Secondary commercial claim with EOB to Secondary – primary and secondary COB/copy primary
* Copy Secondary commercial claim with no EOB to Secondary – primary COB/no secondary COB/copy primary
* Copy Primary Medicare with EOB to Primary – primary COB/no copy
* Copy Secondary Medicare claim with EOB to Secondary – primary and secondary COB/copy primary
* Copy Secondary Medicare claim with no EOB to Secondary – primary COB/no secondary COB/copy primary

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

#### *Modified 10/12/15* Functional Requirement: COB Management Worklist - Search

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

* Primary Payer, or
* Secondary, or
* Both

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

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

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

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

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

* Print EOB
* View EOB

### System Feature: Request for Additional Information Worklist

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

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

* Authorizing Biller

#### *Modified 8/20/2015* Functional Requirement: Request for Additional Information (RFAI) (277) Worklist – Primary Sort

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

* Chronological order
* Reverse chronological order
* Insurance company name
* Patient name
* Authorizing Biller
* Logical Observation Identifiers Names and Codes (LOINC) - Default

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

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

* Chronological order
* Reverse chronological order - Default
* Insurance company name
* Patient name
* Authorizing Biller
* LOINC

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

The IB system shall provide the ability for users to perform the following actions for an ASC X12N Health Care Claim Request For Additional Information (RFAI) (277) transaction:

* Mark as being worked by a user
* Add comments – automatically capture user name and date/time
* Remove entry – automatically capture user name and date/time

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

The IB system shall place a visual indicator on an entry on the RFAI Worklist when a user marks the entry as being worked on by a user.

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

The IB system shall capture the following data when an entry is removed from the RFAI Worklist:

* User Name
* Date
* Time
* Reason Removed – Free Text

### System Feature: ASC X12N Health Care Claim (837) Transactions

#### Functional Requirement: Transmit Blank POA Value – Institutional Inpatient

The IB system shall provide the ability for users to transmit a diagnosis with a blank POA value in an inpatient, institutional ASC X12N Health Care Claim (837) transaction.

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

The IB system shall provide the ability for users to transmit all claims with a Rate Type for which the insurer is responsible, in an institutional ASC X12N Health Care Claim (837) transaction.

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

The IB system shall provide the ability for users to transmit all claims with a Rate Type for which the insurer is responsible, in a professional ASC X12N Health Care Claim (837) transaction.

#### Functional Requirement: Transmit up to 25 Procedures - Institutional

The IB system shall provide the ability for users to transmit up to 25 procedures codes in an institutional ASC X12N Health Care Claim (837) transaction.

#### Functional Requirement: Transmit Up To 12 External Cause of Injury Diagnoses - Institutional

The IB system shall provide the ability for users to transmit up to 12 External Cause of Injury diagnosis codes in an institutional ASC X12N Health Care Claim (837) transaction.

#### *Deleted 6/10/2015* Functional Requirement: Transmission Field Lengths - Institutional

The IB system shall provide the ability for the data elements in the ASC X12N Health Care Claim (837) transaction to accept data in the maximum length allowed in the 837 - I Health Care Claim: Institutional ASC X12 Standards for Electronic Data Exchange Technical Report Type 3 – May 2006 manual.

#### *Deleted 6/10/2015* Functional Requirement: Transmission Field Lengths - Professional

The IB system shall provide the ability for the data elements in the ASC X12N Health Care Claim (837) transaction to accept data in the maximum length allowed in the 837 - P Health Care Claim: Professional ASC X12 Standards for Electronic Data Exchange Technical Report Type 3 – May 2006 manual.

#### Functional Requirement: Transmit Admission Date – Inpatient Institutional

The IB system shall provide the ability for users to transmit an Admission Date in an inpatient only institutional ASC X12N Health Care Claim (837) transaction.

#### Functional Requirement: Transmit Admission Date – Inpatient Professional

The IB system shall provide the ability for users to transmit an Admission Date in an inpatient only professional ASC X12N Health Care Claim (837) transaction.

#### *Added 6/10/2015* Functional Requirement: Transmission Field Lengths – Institutional

The IB system shall provide the ability for the following data elements in the ASC X12N Health Care Claim (837) transaction to accept data in the maximum length allowed in the 837 - I Health Care Claim: Institutional ASC X12 Standards for Electronic Data Exchange Technical Report Type 3 – May 2006 manual:

* Subscriber Group or Policy Number (SBR03) – Maximum 50 Alphanumeric
* Subscriber Group Name (SBR04) – Maximum 60 Alphanumeric
* Subscriber Primary Identifier (NM109) – Maximum 80 Alphanumeric
* Subscriber Supplemental Identifier (REF02) – Maximum 50 Alphanumeric
* Subscriber Last Name (NM103) – Maximum 60 Alphanumeric
* Subscriber First Name (NM104) – Maximum 35 Alphanumeric
* Subscriber Address Line (N301) – Maximum 55 Alphanumeric
* Subscriber Address Line (N302) – Maximum 55 Alphanumeric

#### *Added 6/10/2015* Functional Requirement: Transmission Field Lengths – Professional

The IB system shall provide the ability for the following data elements in the ASC X12N Health Care Claim (837) transaction to accept data in the maximum length allowed in the 837 - P Health Care Claim: Institutional ASC X12 Standards for Electronic Data Exchange Technical Report Type 3 – May 2006 manual:

* Subscriber Group or Policy Number (SBR03) – Maximum 50 Alphanumeric
* Subscriber Group Name (SBR04) – Maximum 60 Alphanumeric
* Subscriber Primary Identifier (NM109) – Maximum 80 Alphanumeric
* Subscriber Supplemental Identifier (REF02) – Maximum 50 Alphanumeric
* Subscriber Last Name (NM103) – Maximum 60 Alphanumeric
* Subscriber First Name (NM104) – Maximum 35 Alphanumeric
* Subscriber Address Line (N301) – Maximum 55 Alphanumeric
* Subscriber Address Line (N302) – Maximum 55 Alphanumeric

**Note:** The 837 map already allows for the maximum lengths for Subscriber Middle Name and Subscriber City so no changes are needed for those elements.

#### *Added 1/7/2016* Functional Requirement: Transmit Discharge Hour – Inpatient Institutional

The IB system shall provide the ability for users to transmit a Discharge Hour in an inpatient only institutional ASC X12N Health Care Claim (837) transaction.

#### *Added 1/7/2016* Functional Requirement: Transmit Discharge Date – Inpatient Professional

The IB system shall provide the ability for users to transmit an Discharge Date in an inpatient only professional ASC X12N Health Care Claim (837) transaction.

### System Feature: ASC X12N Health Care Claim Request For Additional Information (RFAI) (277) Transactions

#### Functional Requirement: Receive Health Care Claim RFAI (277)

The IB system shall provide the ability to receive an ASC X12N Health Care Claim Request For Additional Information (277) from the FSC which includes the data specified in the 277 Health Care Claim Request for Additional Information: ASC X12 Standard for Electronic Data Exchange Technical Report Type 3 – May 2006 manual.

#### Functional Requirement: Store Health Care Claim RFAI (277)

The IB system shall provide the ability to store an ASC X12N Health Care Claim Request For Additional Information (277) from the FSC for the length of time specified in the IB Site Parameters.

### System Feature: View Insurance Company

#### *Added 10/12/15* Functional Requirement: Insurance Company Addresses

The IB system shall display the stored values for the following address fields in the Insurance Company file (#36) from within the View Insurance Company option:

* 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

## Graphical user Interface (GUI) Specifications

There are no GUI specifications associated with this effort.

## Multi-divisional Specifications

There are no multi-divisional specifications associated with this project other than the report requirements specified in Section 2.6.

## Performance Specifications

There are no performance requirements specific to this development effort.

## Quality Attributes Specification

The code for these patches will conform to all VA M coding standards and name spacing conventions.

## Reliability Specifications

There are no reliability requirements specific to this development effort. The IB modules are integrated parts of the overall VistA system that exists at each site and will be subject to the normal reliability standards.

## Scope Integration

The IB modules are integrated parts of the overall VistA system that exists at each site. The IB module makes use of Fileman and Mailman. The IB module transmits flat file 837 Health Care Claim data to the VA Financial Service Center in Austin, TX via Mailman. The IB module will accept and process 277 Health Care Claim Request for Additional Information using HL7.

## Security Specifications

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

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

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

## System Features

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

**Integrated Billing**

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

## Usability Specifications

The following usability specifications pertain to this development effort:

* Training: 1-2 hour training is required for both normal and super-users to become productive with the enhancements in these patches

There are no common usability standards for the M roll and scroll user interface.

# Applicable Standards

The following standards apply to these development efforts:

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

# Interfaces

The IB module currently transmits Mailman messages to and receives Mailman messages from the Financial Services Center (FSC) in Austin, TX.

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

## Communications Interfaces



## Hardware Interfaces

There are no new hardware interfaces applicable to this effort.

## Software Interfaces

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

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

## User Interfaces

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

# Legal, Copyright, and Other Notices

This project has been granted a waiver from compliance with the Section 508 Amendment to the Rehabilitation Act of 1973.

# Purchased Components

There are no purchased components associated with this effort.

# User Class Characteristics

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

# Estimation

The Function Point estimation will be completed by the Function Point team and posted separately to the project notebook after the RSD is approved.

# Approval Signatures

REVIEW DATE:

SCRIBE:

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Integrated Project Team (IPT) Chair Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Sponsor Date

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IT Program Manager Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Project Manager Date

1. Use Case Specification

There are no Use Cases associated with this document.

1. Acronym List and Glossary
   1. Acronyms

| Term | Definition |
| --- | --- |
| AR | Accounts Receivable |
| ASC | American Standard Code |
| CARC | Claim Adjustment Reason Code |
| COB | Coordination of Benefits |
| CBO | Chief Business Office |
| CBW | COB Management Worklist |
| CDA | Clinical Documentation Architecture |
| CLON | Copy and Cancel |
| CPAC | Consolidated Patient Account Center |
| CPT | Current Procedural Terminology |
| CSA | Claim Status Awaiting Resolution |
| DME | Durable Medical Equipment |
| EDI | Electronic Data Interchange |
| EOB/EEOB | Explanation of Benefits/Electronic Explanation of Benefits |
| ERD | Entity Relationship Diagram |
| FSC | Financial Services Center – Austin, Texas |
| HCCH | Health Care Clearing House |
| HCPCS | Healthcare Common Procedure Coding System |
| HL7 | Health Level Seven |
| IB | Integrated Billing software version 2.0 |
| ICD | Interface Control Document |
| LOINC | Logical Observation Identifiers Names and Codes |
| MCCF | Medical Care Collection Fund |
| MRA | Medicare-equivalent Remittance Advice |
| MRW | MRA Management Work List |
| M (MUMPS) | Massachusetts General Hospital Utility Multi-Programming System |
| NUBC | National Uniform Billing Committee |
| NUCC | National Uniform Claim Committee |
| OED | Office of Enterprise Development |
| PD | Product Development |
| PMO | Product Management Office |
| POA | Present on Admission Indicator |
| PS | Product Support |
| RARC | Remittance Advice Remark Code |
| RCB | View/Resubmit Claims – Live or Test |
| RFAI | Request for additional information |
| RSD | Requirements Specification Document |
| RTM | Requirements Traceability Matrix |
| SDD | System Design Document |
| SQA | Software Quality Assurance |
| TPJI | Third Party Joint Inquiry |
| VistA | Veterans Health Information Systems and Technology Architecture |
| WNR | Will Not Reimburse |

* 1. Definitions

| Term | Definition |
| --- | --- |
| 277 (RFAI) | Transaction set for Health Care Claims Request for Additional Information – an unsolicited request that is sent by the payer to the provider |
| 837 | Transaction set for Health Care Claims, used to send a claim to a trading partner |
| 835 | Transaction set for Health Care Claim Payment Advice (or remittance advice). This is returned from the insurer to the billing facility. Generally this is referred to as an Explanation of Benefits (EOB or MRA) |
| CMS-1500 | Preprinted forms to which professional third-party claims can be printed |
| Emdeon | The clearinghouse which handles both VA claims printing and the transmission of claims to electronic payers |
| EOB | This is the return file (835) from non-Medicare payers that provides data pertaining to the claim adjudication and the amounts paid by the payer. |
| MRA Request claim | This is the initial claim request to Medicare that is submitted for the purpose of obtaining MRA notice only. |
| MRA | This is the return file (835) from Medicare that provides data on allowable amounts. MRA reports are normally required for creation of secondary claims. |
| MRA Secondary Claim | This secondary claim is a result of the primary claim being an MRA Request claim. |
| Non-MRA Secondary Claim | This secondary claim is a result of the primary claim being to any insurer other than Medicare WNR. |
| Payer | An insurance company, fiscal intermediary, government agency, other agency, or individual responsible for the payment of health care claims |
| Translator | A software package owned and residing at the Austin Services Center that allows reformatting data in internal VA formats to EDI formats and Vice Versa. This includes the ability to simultaneously handle multiple versions of EDI. The FSC translator also provides for non ASC X12 formats |
| UB04 | Preprinted forms to which institutional third-party claims can be printed |
| User | The person or persons who operate or interact directly with VistA |