

Purchased Care Claims Compliance Phase 3

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Business Requirements Document



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Revision History

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

Date	Version	Description	Author
10/29/2014	0.0.0	Initial version.	

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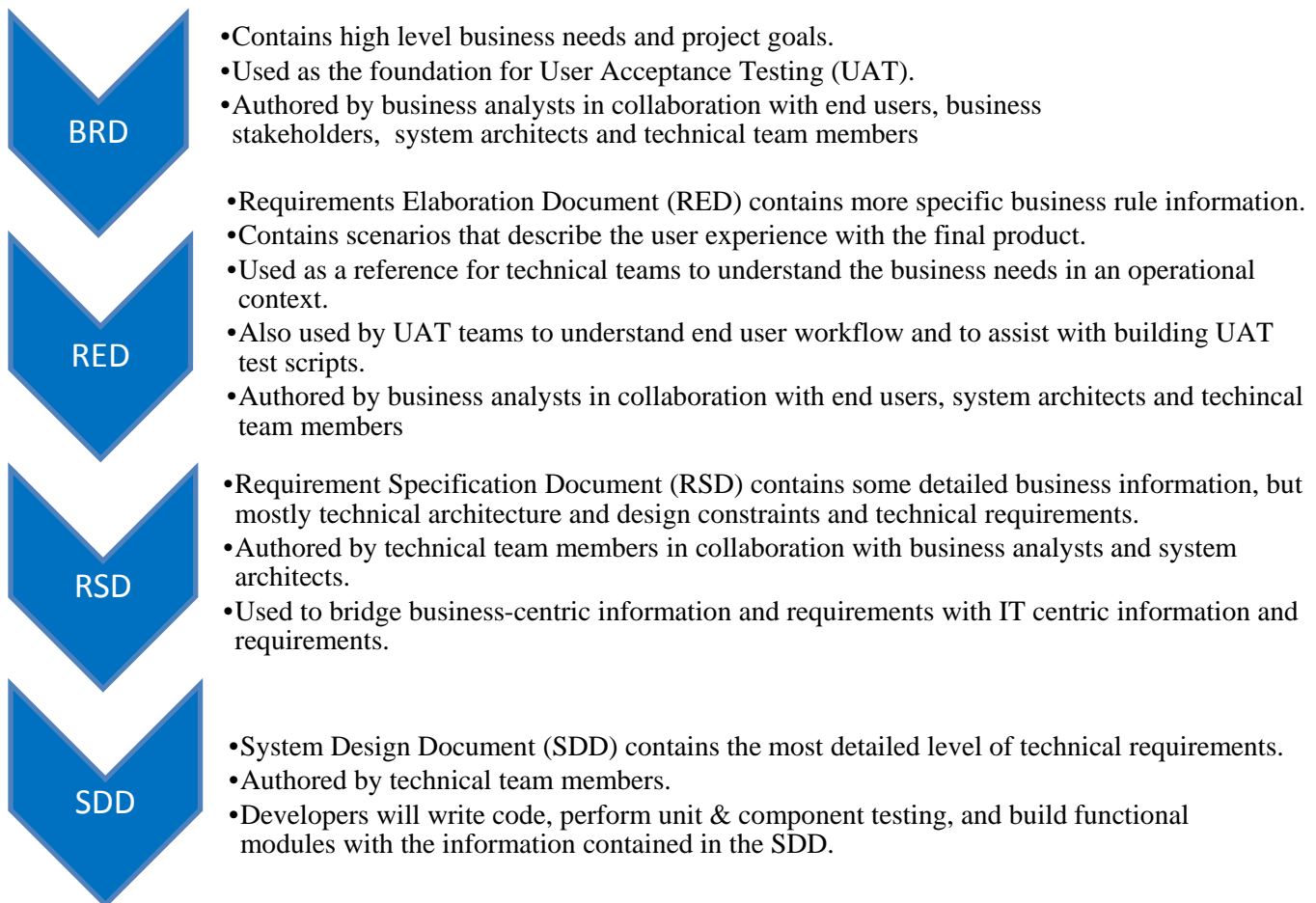
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Business Requirements Document

1. Purpose

The Business Requirements Document (BRD) is authored by the business community for the purpose of capturing and describing the business needs of the customer/business owner. The BRD provides insight into the AS IS and TO BE business area, identifying stakeholders and profiling primary and secondary user communities. It identifies what capabilities the stakeholders and the target users need and why these needs exist, providing a focused overview of the request requirements, constraints, and Information Technology (IT) options considered. This document does not state the development methodology. The intended audience for this document is the Office of Information and Technology (OI&T).

This BRD is written at a level of detail and abstraction that directly conveys the business goals, needs, and expectations from the perspective of the end users and key business stakeholders, without consideration to specific design and solution details. All requirements in this document shall be elaborated upon in order for system architects to design a solution, for developers to write and test software code, and for other technical team members to perform system integration and testing. The collection of documents that will house the set of all elaborated requirements for this project is depicted in the figure below. Note that all requirements at all levels of detail must be present in the



2. Overview

The Department of Veterans Affairs (VA) is obligated under Affordable Care Act (ACA) Section 1104 to implement health claims or equivalent encounter information operating rules. These rules apply to use, conduct, or processing of the Accredited Standards Committee (ASC) X12 transactions for:

- Additional information to support healthcare claim billing information, encounter information, or both (837)

The Veterans Access, Choice, and Accountability Act of 2014 became law on August 7th, 2014 and requires that any medical record submitted to the Department shall, to the extent possible, be in an electronic format.

The National Committee on Vital and Health Statistics (NCVHS) was established by Congress to serve as an advisory body to HHS on health data, statistics and national health information policy and has been assigned a significant role in the Secretary's adoption of operating rules under section 1173(g) (3) of the Act (as added by section 1104(b) (2) of the ACA). NCVHS reviewed and recommended that Centers for Medicare and Medicaid Services (CMS) implement the Council for Affordable Quality Healthcare (CAQH) CORE rules as a certification measure.

The ACA-mandated CAQH CORE EFT & ERA Operating Rules include five rules that specify data content and infrastructure requirements applicable to the X12 v5010 835 (the fifth CAQH CORE Rule applies to the HIPAA-mandated healthcare EFT standard transaction). Previous work effort has been completed to implement the modifications to the transactions related to these rules:

- CAQH CORE 350: Health Care Claim Payment/Advice (835) Infrastructure Rule - Requires that health plans make appropriate use of the standard acknowledgements, support the CORE "safe harbor" connectivity requirement, use the CORE v5010 Master Companion Guide template when publishing their v5010 X12 835 companion guide, and continue to provide dual delivery of their proprietary claim remittance advices along with the v5010 X12 835 transaction for a period of time during which providers can ensure that their financial system can successfully use it to post payments.
- CAQH CORE 360: Uniform Use of *Claim Adjustment Reason Code* (CARC)s and Remittance Advice Remark Code (RARC)s (835) Rule – Establishes data content rule requirements for conducting the v5010 X12 835 transaction. This rule builds upon and extends the Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0 by requiring the v5010 X12 835 to use a uniform set of Claim Adjustment Group Code (CAGC), CARC, RARC or CARC/ National Council for Prescription Drug Programs (NCPDP) Reject Code/CAGC codes for specified CORE-defined Claim Adjustment/Denial Business Scenarios.
- CAQH CORE 370: EFT & ERA Re-association (CCD+/835) Rule - Establishes the minimum data needs of a provider to re-associate the EFT with the ERA and define the maximum elapsed time between the receipt of the v5010 X12 835 and the corresponding Healthcare EFT Standards.
- CAQH CORE 380: EFT Enrollment Data Rule – Addresses the maximum set of data elements required for providers enrolling for receipt of the EFT from a health plan.

- CAQH CORE 382: ERA Enrollment Data Rule - Addresses the maximum set of data elements required for providers enrolling for receipt of the ERA from a health plan.

Separate work efforts will address the ACA health plan certification.

3. Customer and Primary Stakeholders

The Chief Business Office Purchased Care (CBOPC), Operations (OPS) Directorate is the primary customer and owner of the business processes that are being impacted by the requested updates/changes. The Electronic Data Interchange (EDI) Program Manager, is the Business Sponsor. The Director of OPS, Deputy Director of OPS and Chief, Healthcare Reimbursement, are the primary stakeholders for this request. Review [Appendix C](#) for the complete list of primary and secondary stakeholders.

4. Scope

The payer healthcare EDI component within VHA is managed within the CBOPC business line. Two payer entities fall within the CBOPC - the Non-VA Purchased Care and the Veteran Family Services (VFS). The business needs and requirements identified in this document must be applied to the Veterans Health Information Systems and Technology Architecture (VistA) systems, related components, and interfacing systems utilized in both entities in order to provide improved health benefits for deserving Veterans and their families.

Currently local users' at facilities have the ability to modify the Denial Reason Table in the VistA Fee Basis Unauthorized Claims module. The VistA Fee Basis Unauthorized Claims module provides for the documentation of claims denial through the selection of a Denial Reason from a table of reasons that are federally regulated. Users have the ability to modify and add Denial Reasons to the Denial Reason Table in this module, leading to inconsistent Denial Reason utilization and potential for local Denial Reasons to be added that are not supported by federal regulation.

The scope is to ensure compliance with operating rules and standards and result in improved functionality, improved timeliness, and simplification of user processes. This includes reporting on denied claims as well as reporting on payment methodology.

As a covered entity payer organization, all new operating rules and standards apply to both the Veteran Family Services (VFS) and Non-VA Purchased Care programs. These requirements include all existing systems, interfaces, and applications used for receiving, sending, creating, processing, storing, reporting, and displaying data transferred between CBO-Purchased Care and its trading partners (Health Care Clearing House (HCCH), other payer entities, and providers).

5. Goals, Objectives and Outcome Measures

Goal/Objective and Desired Outcome	Impact	Measurement
This project provides the ability for	Increased use of electronic	15% reduction of paper medical

Goal/Objective and Desired Outcome	Impact	Measurement
CBO Purchased Care claims applications to process additional information to support healthcare claim billing information, encounter information, or both according to the operating rules and standards.	transactions by providers resulting in a reduction of paper or telephonic inquiries from non-VA provider communities.	documentation required to support a health care claim or health care services review.
	Meet the letter and intent of the regulatory language.	100% compliance with the letter and intent of regulatory language.
	Alignment to Purchased Care's strategic mission which includes: <ul style="list-style-type: none"> • Improve customer satisfaction. • Improved decision support • Standardization /reduced variation 	100% of the development increments advance Purchased Care positively towards its strategic mission.
Implementation of Denial Reason table in the VistA Fee Basis Unauthorized Claims module that have four CORE-defined Claim Adjustment/Denial Business Scenarios	Reduction of unauthorized claims in the payment system	An estimated \$25,000 cost avoidance in labor costs per year associated with performing 835 transaction follow-up activities.

6. Enterprise Need/Justification

Software development and modification to VHA healthcare claims processing systems to comply with Operating Rules and EDI Transactions. The enhancements will allow VHA to comply with the legislative mandate for compliance with national standardized operating rules and standards for additional information to support healthcare claim billing information, encounter information, or both.

Enhancements requested in the New Service Request support the Eight for Excellence goal to promote excellence in business practices through administrative, financial, and clinical efficiencies.

7. Requirements

7.1. Business Needs

The following definitions apply to requirements in this BRD. All requirements shall have an associated priority as determined by business stakeholders in collaboration with project team partners.

While all requirements are "important" (hence the very existence of the project), some functionality and features are more important than others. Therefore, Low or Medium Priority requirements shall *not* be

construed to be *unimportant*, but rather just not as immediate or critical a need as the High Priority requirements.

Finally, the business recognizes that only the smallest and simplest projects are completed in a single iteration or increment. Therefore, determination of priority is made carefully to ensure that the most-needed features are delivered first.

- **High Priority:** A mission-critical function or feature. The lack of this feature makes the overall application useless, low value, or otherwise not worth deploying to a live/production environment. This feature absolutely must be in the 1st delivered iteration.
- **Medium Priority:** A very important or useful feature. The lack of this feature is not a show-stopper, but does significantly reduce the overall usefulness of the application. Generally, medium priority describes features that the business would like to see in the 1st iteration, but recognizes that we might have to wait until the 2nd iteration.
- **Low Priority:** These requirements describe useful, nice-to-have features of functions of the software. All requirements are "important" and this includes Low Priority requirements. But, the business is willing, and able, to wait until future iterations to obtain this functionality. We would prefer that technical teams focus their time and energy to develop and rigorously unit-test the High Priority and Medium Priority requirements before addressing any Low Priority requirements.

BN	Business Need (BN) Requirement	Priority*
BN 1	The system shall process additional information to support healthcare claim billing information (837) operating rules	High
BN 1.1	The system shall process healthcare claims according to all approved operating rules concerning processing mode and connectivity.	High
BN 1.2	The system shall process healthcare claims according to all approved operating rules concerning system availability.	High
BN 1.3	The system shall process healthcare claims according to all approved operating rules concerning system response time.	High
BN 1.4	The system shall process healthcare claims according to all approved operating rules concerning batch and real time standard acknowledgements.	High
BN 1.5	CBOPC companion guides shall be published according to all approved operating rules for companion guides.	High
BN 2	Associate and track denied claims for Non-VA Purchased Care	High
BN 2.1	The system shall provide the ability for a user to report unauthorized claims.	High
BN 2.2	The system shall provide the ability for a user to report unpaid unauthorized claims.	High
BN 2.3	The system shall provide the ability for a user to report on the date and time of process steps in Non-VA Purchased Care claims processing.	High
BN 2.4	The system shall provide the ability for a user to report unauthorized Non-VA Purchased Care claim activity on predefined data points.	High

BN	Business Need (BN) Requirement	Priority*
BN 2.5	The system shall transmit unpaid unauthorized Non-VA Purchased Care claim information from the local VistA Non-VA Purchased Care Package to the RSD/Central Fee at the end of the business cycle.	High
BN 2.6	The system shall provide the ability for a user to create a report of the transmitted number of formal Non-VA Purchased Care claims appeals received at the local level to Central Fee.	High
BN 2.7	The system shall provide the ability for a user to create a report of the numbers processed monthly at the local level to Central Fee for local and national reporting purposes.	High
BN 2.8	The system shall provide the ability for a user to select regulated reasons for claims denials.	High
BN 2.9	The system shall provide the ability for a user to report on the claims payment methodology identifier within the Fee VistA system.	High

7.2. Non-Functional Requirements

ReqPro Tag	Operational Environment Requirements
NONF2357	The primary and back-up sites used for data storage prior to implementation of these enhancements shall be located at the same sites for the VistA Fee Basis application, EDI Repository, Fee Payment Processing System (FPPS) Database, Fee Basis Claims System (FBCS) Central Server, and the Claims Processing and Eligibility (CP&E) System, which is the adjudication database for CHAMPVA programs located at the HAC after implementation.
NONF2360	Maintenance, including maintenance of externally developed software incorporated into the VistA Fee Basis and CP&E applications, shall be scheduled during off peak hours or in conjunction with relevant VistA maintenance schedules.
NONF2361	Information about response time degradation resulting from unscheduled system outages and other events that degrade system functionality and/or performance shall be disseminated to the user community within 30 minutes of the occurrence. The notification shall include the information described in the current Automated Notification Reporting (ANR) template maintained by the VA Service Desk. The business impact must be noted. This would not be applicable for claims status or CHAMPVA. However, it would be applicable for Fee eligibility, which would require coordination with the Austin Information Technology Center (AIRC).
NONF2362	For all VA systems impacted by these enhancements, provide a real-time monitoring and reporting solution that provides information about the current status (fully operational versus down for scheduled maintenance versus unscheduled down-time) of the application(s).
NONF2363	If the maintenance solution fails, the system can be restored to its previous state prior to the maintenance action.
NONF1610	Notification of scheduled maintenance periods that require the service to be offline or that may degrade system performance shall be disseminated to the user community a minimum of 48 hours prior to the scheduled event.
	Training Requirements

NONF2364	User acceptance testing personnel shall include Purchased Care staff that is able to confirm acceptable changes to their workflow.
NONF2227	The application shall include user prompts to guide the use of the application so that minimal technical support is needed by the user.
NONF1612	A technical training curriculum shall be developed and delivered to all levels of staff users.
NONF2365	The training curriculum shall state the expected training time for primary and secondary users to become productive at using the systems utilized to submit EDI transactions within the Purchased Care Program Office.
NONF2366	All training curricula, user manuals and other training tools shall be updated by the Purchased Care Program Office and the Software Development Team, and delivered to all levels of users prior to implementation of these enhancements. The curricula shall include all aspects of the enhanced VistA software packages and all changes to processes and procedures.
NONF2367	The training curriculum shall state the expected task completion time for any new enhancements created by the new mandated standards and operating rules that directly impact primary and secondary end users.
NONF2368	All technical training curricula and other documentation shall be updated by the Software Development Team to reflect the changes/modifications made to VistA, VA maintained, and Class I systems. All updates must be approved by the VA/OIT resources as defined in the Project Management Accountability System.
Documentation Requirements	
NONF2369	Updates shall be made, as necessary, to the applicable user manuals, applicable technical documentation, and Operations and Maintenance (OM) manuals related to the VistA Fee Basis application, EDI Repository, FPPS Database, FBCS Central Server, and CP&E System located on the VA Software Documentation Library. If no User or OM documentation exists, it shall be produced.
Implementation Requirements	
NONF2370	An implementation plan shall be developed for all aspects of EDI transactions utilized by the Purchased Care Program Office. This plan shall document the deployment process over the various systems and technical groups involved for these enhancements.
NONF2371	Help Desk Support technical documentation shall be created or updated for enhancements to existing applications, systems, and/or processes for compliance with the new mandated standards and operating rules.
NONF2372	Help Desk Support technical documentation shall be created for new applications, systems, and/or processes developed for compliance with the new mandated standards and operating rules.
NONF1614	The IT solution shall be designed to comply with the applicable approved Enterprise Service Level Agreements (SLAs). Additional information regarding SLAs can be obtained from the VA's OIT/PD Teams.
NONF2373	Deployment must be coordinated with the various system owners and trading partners. An implementation plan must be developed/followed that accounts for the complexities of the systems involved, the effective dates, and available resources. If completed, enhancements could be implemented into systems earlier than the effective dates. A highly coordinated, single cut-over event per transaction type is acceptable in the event that all transaction types cannot be released simultaneously.
NONF2374	Although not anticipated based on prior testing in a non-production environment, if

	downtime is required during the switchover(s), it should be equivalent to the time typically allocated for patches to this application enterprise-wide.
NONF2375	The implementation must be complete by the deadlines specified by CMS. (Refer to Section 7 – Requirements for effective dates for each of the new operating standards and rules).
	Data Protection/Back-up/Archive Requirements
NONF1615	Provide a back-up plan for when the system is brought off-line for maintenance or technical issues/problems.
NONF2376	Data protection measures, such as back-up intervals and redundancy shall be consistent with systems categorized as critical.
	User Access/Security Requirements
NONF1617	Ensure the proposed solution meets all VHA Security, Privacy and Identity Management requirements including VA Handbook 6500 . (See Enterprise Requirements Appendix).

7.2.1. Performance, Capacity, and Availability Requirements

7.2.1.1. Performance

If this is a system modification, how many users does the current system support?
Currently, Fee Programs are utilized within 152 medical centers. It is estimated that 2,000-2,500 users (at a minimum) utilize the VistA Fee Basis software application currently.
There are an estimated 125,000 potential users/providers of CHAMPVA EDI transactions.
There were 200,000 unique billing providers this part year (includes CHAMPVA and Fee).
How many users will the new system (or system modification) support?
The system modification would support the same number of staff currently using the system. No new users are expected.
What is the predicted annual growth in the number of system users?
Annual growth is expected to be very minimal. Increased system usage typically occurs as additional staff are approved and hired.

7.2.1.2. Capacity

What is the predicted size (average) of a typical business transaction?
The average size of a single professional claim (EDI 837 file) is 1,500 bytes per record, with an upper limit of approximately 1,900 bytes per record.
The average size of a single institutional claim (EDI 837 file) is 2,200 bytes per record, with an upper limit of approximately 3,000 bytes per record.
The average size of a single dental claim (EDI 837 file) is 1,100 bytes per record.
What is the predicted number of transactions per hour (day, or other time period)?
In FY 2011, there were 353,000 claims status requests and 960,000 eligibility requests for CHAMPVA. The average number of eligibility requests per month is 57,000. The average number of claims status requests per month is 22,000.
In FY 2011, there were 63,000 claims status requests and 102,000 eligibility requests

for the Fee Program. The average number of claims status requests per month is 5,200. The average number of eligibility requests per month is 8,600.
Is the transaction profile expected to change (grow) over time?
From 2009 to 2010, 270/271 transactions for Purchased Care (Fee and HAC) increased 49%. For the same time period, 276/277 transactions for Purchased Care (Fee and HAC) increased 110%. Between 2010 and 2011, 270/271 transactions for Purchased Care (Fee and HAC) increased 5%; 276/277 transactions increased 318%. Based on the nature of the request, claim status and eligibility inquiries are expected to increase exponentially with the increased usage of EDI transactions as driven by implementation of the new standards and operating rules. Therefore, using the percent increase values between 2009 and 2011 to estimate future growth would be inaccurate.
What are the dependencies-interactions-interfaces with other systems?
Systems include (but are not limited to) hardware and software that are owned and maintained by different OIT groups [CBOPC OI&T and Product Development (PD)], Central Fee, Financial Management Systems (FMS), and two Commercial-Off-The-Shelf (COTS) customized third party applications [FBCS and VA Payment Manager (VAPM)]. These systems are primarily involved with the acceptance and processing of claims payments. This effort will not include the wholesale replacement of these systems. Instead, the emphasis is on coordinated remediation/enhancement to bring the overall system into compliance with current standards and planned industry operating rules.
What is the process for planning/adjusting capacity?
Currently, there are processes in place for monitoring EDI transactions. For eligibility and claims status, the VA receives responses from the clearinghouse to monitor. For Fee eligibility, there are reports to monitor capacity as well. No alarms have been formally established at this time, but would be tied to Emdeon's limitations; Emdeon controls these resources. The VA would not have much influence and doesn't have enough information to formulate a response regarding what the system would be able to handle to build an alarm associated with this. VA would monitor the Automated Eligibility Tool (AET) to understand at what point the tool is able to process before it fails. At this time, this system is not mature enough to provide this information. Some monitoring is available, but it is 100% manual at this time.
Does the update require a surge capacity that would be different from the base application?
A surge in activity is expected with the AET Tool due to the Caregiver's Legislation. Under the Caregiver's Legislation, caregivers will be able to receive reduced group rates for commercial dental insurance. Those carriers can verify a patient's eligibility as a Veteran or a CHAMPVA beneficiary. This tool would be available in the future for the commercial providers to use. Based on this and the annual open season (typically in December), an increased number of eligibility query type transactions during this open eligibility period is anticipated as more caregivers are expected to sign on and query. However, it is not possible to estimate the percentage increase at this time. This will have no impact on the claims status.

7.2.1.3. Availability

Describe when the envisioned system will need to be available (business hours only, weekends, holidays, etc.) to support the business.
The enhancements requested will need to be available 24 hours a day, 7 days a week, 365 days per year (minus time needed for scheduled maintenance/upgrades which should be completed during non-peak times). Minimally, the system needs to be available 100% of the time.

7.3. Known Interfaces

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

VistA Fee Basis Software Package – This package supports VHA's Fee for Service program, which is care authorized for Veterans who are legally eligible and are in need of care that cannot feasibly be provided by a VA facility. The Fee Basis package provides for more efficient and accurate operation of the fee for service program with reduction of paperwork, savings in staff hours, minimization of errors, and by allowing medical facilities to have greater control over disbursement of fee medical, pharmacy, and travel monies.¹

EDI Repository – This is the front end data repository for EDI claims/payment records for Purchased Care. After 837 files are processed through the HAC's EDI Gateway, claim data is mapped into relational fields in the EDI Repository database (Oracle).

FPPS is a web-based system designed to modify the current VistA Fee Basis processing methods to meet the governmental mandated HIPAA compliance deadlines. When the HAC receives a request for a claim payment by a non-VA provider or institution (via a clearinghouse) in the form of a HIPAA 837 transaction, the request is processed through the FPPS where a replica of the claim is generated from the electronic data and provided to the VistA clerk via web browser technology. The VistA clerk utilizes the existing VistA Fee Basis Software (with modifications) to operationally process the claim. Payment data is returned to FPPS from the local VistA system, resulting in a new electronic interface and an associated VistA interface database. The VistA to FPPS transmission utilizes the existing VistA Health Level 7 (HL7) application as the interface mechanism to an enterprise messaging application. This provides the necessary data to FPPS to complete a HIPAA 835 transaction, which is sent back to the initiating provider or institution.²

¹ VistA Monograph, Fee Basis, July 2008, page 94

² Fee Payment Processing System (FPPS) Help, August 29, 2003

FBCS is a Document Storage Systems, Inc. COTS Class 1 product that has been rolled-out to all Fee processing sites, except those within Veterans Integrated Service Network (VISN) 6 (see VAPM below). The FBCS product was designed to improve Fee Basis claims management and adjudication timeliness. It brings efficiencies to the processing of claims beginning with creating, tracking, and managing authorizations and ends with the final claim payment posting from the AITC. It also provides a knowledge base of information needed to strategically guide the decisions made about non-VA care. It does not replace the VistA Fee package, but serves as a supplement.³

VAPM Software is a COTS product utilized by the Mid-Atlantic Health Care Network (VISN 6). It is a complement to the existing CBO-Purchased Care Fee Basis Program, which intends to significantly improve the functionality, capability, and operational efficiency of the vendor payment operations compared to the current Fee Basis Program. It begins with creation, tracking and management of authorizations and ends with the final claim payment posting from the AITC. One of the features of VAPM includes automation of the receipt and processing of EDI provider claims from the HAC. This substantially reduces the printing and keying of claims data from the HAC and reduces the backlog of unprocessed provider claims.⁴

The **Non-VA Fee Basis Medical System** (commonly referred to as **Central Fee**) is a repository of VHA enterprise-level Fee Basis data stored electronically that is obtained either from VHA data collection activities or derived from such data, maintained by VA or VHA offices, and shared between VA facilities and business partners. This system is housed at the AITC, which is the VA's centralized computer-processing center. Central Fee authorizes and pays private physicians, hospitals, and pharmacists for products and services provided to Veterans approved for the program. It interfaces with FMS, the Beneficiary Identification and Records Locator System (BIRLS), and the VA Work Measurement (VWM) database to produce payments, accounting updates, and reports. Other downstream databases include the VHA Support Service Center (VSSC), the Allocation Resource Center (ARC), and Decision Support Systems (DSS). It provides tracking of patient, program, and vendor-specific information, provides the cost and quantity of non-VA inpatient and outpatient care given to Fee for Service eligible Veterans, and provides online reporting capability. Several reports assist in the management of the Fee Basis Program at the VA Medical Centers (VAMCs) and identify workload incurred by each Primary Service Area (PSA).⁵

FMS is a standardized, integrated, VA-wide system that interfaces externally with the Department of the Treasury, the General Services Administration, the Internal Revenue Service, the Defense Logistics Agency, and various commercial vendors and banks for electronic billing and payment purposes. This system supports the collection, processing, and dissemination of several billion dollars of financial information and transactions each fiscal year. FMS Service ensures that financial systems comply with government wide accounting principles and standards; and are in compliance with financial policy and automated financial exchange requirements.⁶ For this request, FMS services are not utilized for claims status or eligibility, but for 835s and EFTs.

³ Fee Basis Claims System Request For Information (RFI) Solicitation, October 30, 2008

⁴ 3M VA Payment Manager Product Description, October 30, 2008

⁵ [Veterans Health Administration Corporate Databases Monograph, June 2009](#), pg. 87

⁶ [FMS Website](#)

The **Department of Treasury** receives the pay files from FMS for final payment, cuts the check or EFT, and sends payment metadata back to FMS. For this request, the Treasury's services are not utilized for claims status or eligibility, but for 835s and EFTs.

Emdeon is the clearinghouse used both by VHA as a provider and a payer community to ensure that payer transaction requirements, both HIPAA and contractual, are maintained in EDI transactions initiated by VHA. Emdeon will validate that Fee reimbursement claims maintain the level of HIPAA and payer contractual requirements for transmission to business partners.

Sybase is the software vendor for "EDI Server", which functions as the EDI Gateway by providing translation, mapping, compliance checking, and archiving for Fee claims processing.

VSSC Financial Clinical Data Mart (FCDM) is an interactive information management system that uses Structured Query Language (SQL) and On-Line Analytic Processing (OLAP) cube technology to build large, customized national databases. This technology allows VHA to integrate clinical and financial data designed for rapid queries and reporting.⁷ Fee Basis workload data is available in this datawarehouse.

The **Health Eligibility Center (HEC)** is VHA's authoritative source for enrollment and eligibility activities which supports the delivery of VA health care benefits.⁸ The full impact on business processes and/or systems utilized by the HEC will not be realized until completion of the assessment, which is one the requirements for this request.

AET is a non-user centric Fee application/system. It receives automated eligibility inquiries from the clearinghouse. It queries the identity management person search web service for the Veteran Personal Identifier (VPID). Using that VPID, it queries the Enrollment System to obtain enrollment information for the 271 automated eligibility response.

The **CP&E System** is an adjudication database/system for the CHAMPVA program and other ancillary programs run by Purchased Care at the HAC. It is a customized Massachusetts General Hospital Utility Multi-Programming System (MUMPS) application enhanced that is located and maintained by the OIT Field Office at the HAC.

- The **CHAMPVA Datawarehouse** is an Ensemble OLAP database used to collect and report data for the CHAMPVA program.

7.4. Related Projects or Work Efforts

- 1) **NSR #20110507 EDI New Standards and Operating Rules – VHA Payer-Side Technical Compliance Requirements**



Section 1104 of the PPACA requires HIPAA covered entities, such as VHA, to adopt standard operating rules for the electronic exchange and use of health information for the purposes of financial and administrative transactions. The standard operating rules will require changes in current EDI implementations. The expected completion date for this request is unknown at this time.

⁷ [Veterans Health Administration Corporate Databases Monograph](#), page 128

⁸ [HEC Website](#)

8. Other Considerations

8.1. Alternatives

No alternatives have been identified for these enhancements.

8.2. Assumptions

- VHA would have successfully completed development and implementation of HIPAA 5010, including the final status.
- The National Fee Program Office is utilizing the AET Tool.
- The Department of Treasury is already involved, knowledgeable and aware of the standardization efforts as it relates to EFT and will become compliant by the effective date.
- These modifications will be made to Purchased Care IT systems currently in use (i.e., CP&E, EDI Repository, etc).
- Various development groups will be available and able to coordinate efforts to complete these enhancements by the predetermined effective dates.
- Trading partner (Emdeon) has proprietary flat file formats that relate to X12 transactions. These flat files formats would have to be shared in order to ensure data flow assessment.
- It is assumed that adequate funding will be allocated to this project to allow it to span multiple fiscal years, if necessary.
- The adjudication process involves many interfaces and interactions [i.e., Artificial Intelligence (AI)] that would require additional requirements elaboration).
- The Purchased Care Program Office will work with the contractor (as appropriate) to identify the applicable Fee business processes and IT systems to be assessed. (**Note:** Purchased Care Staff have already identified some business process and IT system related deficiencies. These items would be expected to be included in the overall, but not limited to weaknesses identified for the assessment/remediation recommendations. A preliminary list will be provided when appropriate.)

8.3. Dependencies

- VHA would have successfully completed development and implementation of HIPAA 5010, including the final status. The HIPAA 5010 transaction standards must be implemented on January 1, 2012.⁹ The EDI New Standards and Operating Rules project depends on HIPAA 5010-compliant transactions to be able to send, receive, and utilize the updated standardized formats.
- External software utilized to support Purchased Care processing is updated to enable the use of the new standards and operating rules data content requirements.

⁹ At the time of this document, production deployment for the HIPAA 5010 Project is expected to be February 2012.
Purchased Care Claims Compliance Phase 3
Business Requirements Document

- Business data flows, diagrams, and other supporting documentation will be available to support the assessment component of this request.
- CMS' publication of final rules regarding the new EDI standards and operating rules.
- The 277 claims acknowledgement final update/status will not be implemented until the completion of the "Service Line Level Adjudication Project" anticipated to be completed in April 2012.
- Technical expertise within VA's PD Office that will be available to design and implement the desired solutions.
- Resources needed for these enhancements (including people, equipment, and data that are internal and external to the VA) will be available to coordinate development over multiple systems and work across multiple projects.

8.4. Constraints

- VHA needs to complete and implement requirements associated with the HIPAA 5010 projects, including the final status.
- Development groups for Central Fee, FBCS, HAC OI&T, Treasury and any other identified internal/external group to the VA must be available and able to coordinate efforts to complete these enhancements.

8.5. Business Risks and Mitigation

Business Risk: VA does not comply with the proposed EDI standards and operating rules or obtain certification of compliance to CMS relative to EDI transactions by the established compliance dates.

Mitigation: CBO deems this business risk as unacceptable. Inaction puts the VA and Purchased Care Program at great risk of incurring substantial civil and monetary fines and penalties as well as possible criminal sentences for non-compliance [per HR 3590 PPACA of 2010].

Business Risk: Multiple projects being performed within the same domain may negatively affect resource availability.

Mitigation: Ensure Program Managers are aware of the status and needs of all projects. An Integration Call includes Project Managers across the portfolios who report the status of their patches within VistA. Based on the schedule efforts, potential collisions can be identified via this mechanism.

Business Risk: Prioritization with other strategic initiatives may negatively affect this requests.

Mitigation: Communicate with all resources and interfacing development groups that this work is related to a mandate.

Business Risk: Service Line Level Adjudication Project failing to be completed as scheduled.

Mitigation: Identify the touch points between the Service Line Level Adjudication Project and the 835 work (standards and operating rules) and monitor the Service Line Level Adjudication Project schedule.

Business Risk: Dependencies on multiple internal/external development, updates, and resources.

Mitigation: Include development groups in Integrated Project Team (IPT) meetings in the beginning to develop schedules based on their resources. Regarding resources associated with the licensed software, improve flows of communication (such as by developing a Communication Plan).

Business Risk: If the enhancing and maintenance activities among cross-dependent VistA packages and other applications are not carefully coordinated and orchestrated among the different project teams, then development, maintenance and testing work will be in collision leading to immense disruption, schedule slippage, and cost overrun.

Mitigation: Project planning must be done with a keen understanding of dependencies and sequences among the application packages, routines, maintenance patches, testing schedules and release management process. Constant vigil and control must be provided to avoid cross-project or process collision.

Business Risk: If adequate resources and priority are not given to the EDI New Standards and Operating Rules project to meeting the mandated dates by CMS and Public Law, then VA faces diminished ability to promptly reimburse vendors that provide health care services to Veterans and their dependents, and a diminished ability to exchange standardized data with such third parties such as CMS and all other trading partners.

Mitigation: Educate and inform senior leadership on the importance of the effort to ensure that the project receives resources commensurate with the effort. Develop alternate sourcing strategies in the event that VA staff cannot be obtained.

Business Risk: Prior to the completion of analysis and evaluation of Purchased Care business processes and IT systems, the technical solution cannot be defined. Without identification of areas of improvement, the technical solution and time for implementation are highly uncertain.

Mitigation: This risk will dissipate by the end of Planning Phase (anticipated to be February 2012).

Appendix A. References

[PPACA \[Public Law 111-148, Section 1104 \(g\) \(3\) of House of Representatives \(HR\) 3590](#)

[Health Care and Education Reconciliation Act \(Public Law 111-152\),](#)

[Phase III CORE 350 Health Care Claim Payment Advice \(835\)](#)

[Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes \(835\) Rule](#)

[Phase III CORE 370 EFT ERA Re-association \(CCD+835\) Rule](#)

[Phase III CORE 382 ERA Enrollment Data Rule](#)

[EDI New Standards and Operating Rules VHA Payer-Side TCR BRD](#)

[NSR 20080121 Re-priced Claims and Medicare Payment Identifiers BRD](#)

[NSR 20090417 Fee Basis Batch Numbers BRD](#)

[NSR 20080614 Denied Claims Reports BRD](#)

VA Handbook 6500 – Information Security Program

[REDACTED]

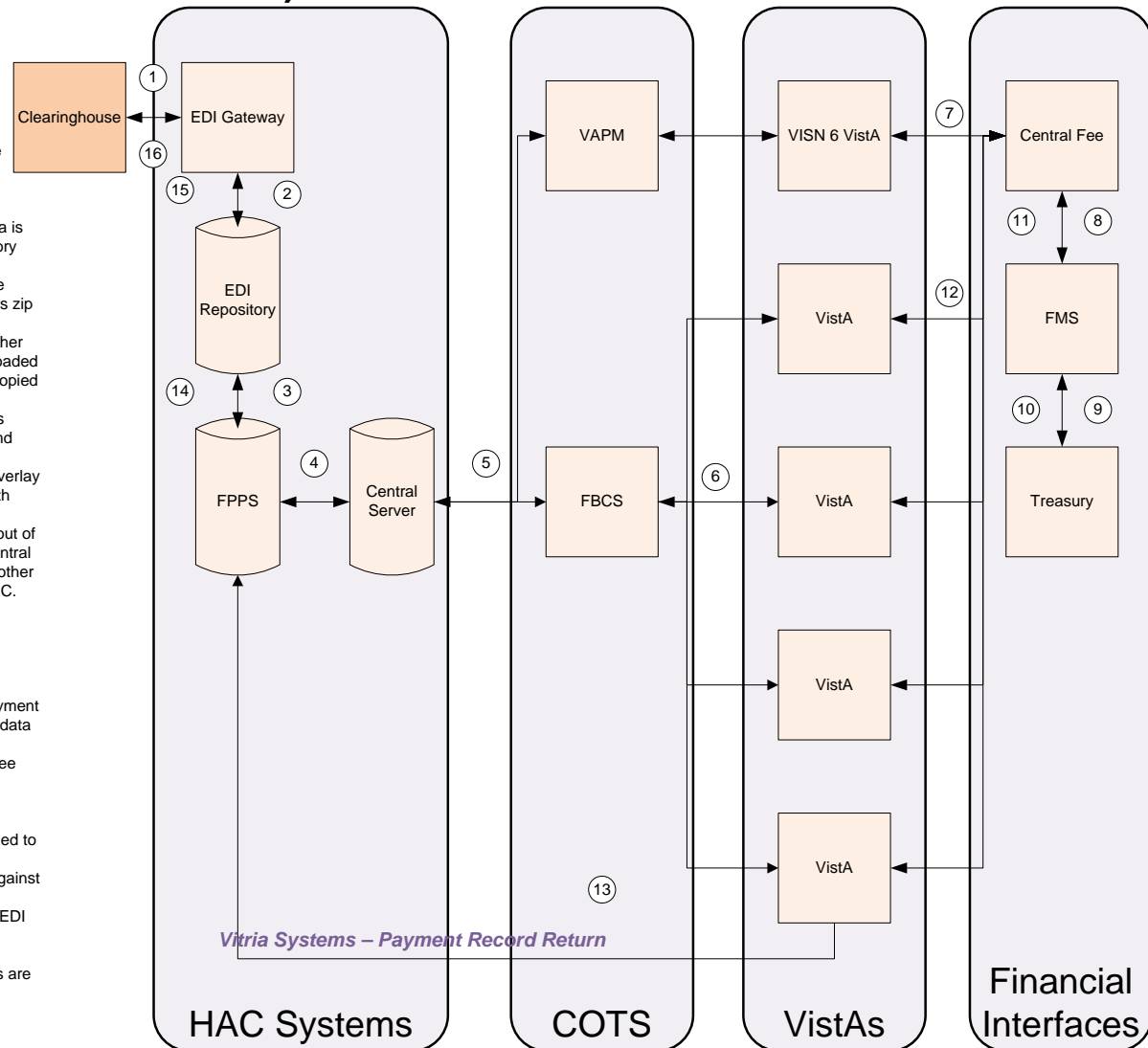
Due to the volume and size of references provided for this document, a list of all references used in this document can be found at the following link:

[REDACTED]

Appendix B. Models (As Is and To Be)

Claim and Payment Workflow

1. The HAC picks up a raw 837 test file from the clearinghouse.
2. The file is processed through the HAC's EDI Gateway. This includes compliance checks, archiving, and mapping activities. The claim data is mapped into relational fields in the EDI Repository database (Oracle).
3. The Fee claims are moved into FPPS and are assigned a facility number based on the patient's zip code.
4. Medical claims (not dental) are marked for either FBSC or VAPM based on which application is loaded at the owning facility. These claim records are copied into a Central Server (MS SQL).
5. FBSC or VAPM server will copy claim records down to local servers based upon flag values and facility numbers in the Central Server.
6. FBSC and VAPM are GUI applications that overlay and enhance the VistA Fee Basis package. Both have read/write capabilities into Fee Basis.
7. Fee invoice payment batches are forwarded out of the local VistA financial package and sent to Central Fee for parsing, formatting and transmission to other external data users – including FMS, VSSC, ARC.
8. Central Fee forwards pay files to FMS for additional financial processing.
9. FMS forwards pay files to Treasury for final payment. They cut the check or EFT.
10. Treasury sends payment metadata to FMS.
11. FMS creates a paper EOB based on the payment data from Treasury and forwards payment metadata to Central Fee.
12. Among other payment processes, Central Fee formats and sends a transmission back to the originating local VistA system that contains the payment metadata.
13. Payment metadata for EDI claims is forwarded to FPPS using Vitria. The records are loaded into staging tables in preparation for reconciliation against the original claim.
14. Reconciled payment data is moved into the EDI Repository in preparation for creation of 835s.
15. The EDI Gateway maps the data out of the repository to create outbound 835 files. The files are archived and checked for compliance.
16. The raw 835 files are transmitted to the clearinghouse.



Appendix C Stakeholders, Users, and Workgroups

Stakeholders

Type of Stakeholder	Description	Responsibilities
Endorser		Endorsed this request. Provides strategic direction to the program. Elicits executive support and funding. Monitors the progress and time lines.
Business Owner		Provides final approval of BRD with Sign Off Authority. Provides strategic direction to the program. Elicits executive support and funding. Monitors the progress and time lines.
Requester		Submitted request. Submits business requirements. Monitors progress of request. Contributes to BRD development.
Business Subject Matter Experts (SMEs)		Provide background on current system and processes. Describe features of current systems, including known problems. Identify features of enhancement.
User SMEs		Ensure that the enhancements will account for current business processes and existing software capabilities.

Type of Stakeholder	Description	Responsibilities
Security Requirements SME		Responsible for determining the Certification and Accreditation (CA) and other security requirements for the request.
Requirements Analyst		Responsible for working with all stakeholders to ensure the business requirements have been accurately recorded for this request.

Stakeholder Support Team (BRD Development)

Type of Stakeholder	Description	Responsibilities
Security Requirements SME(s)	<ul style="list-style-type: none"> Name, Title, Organization 	Responsible for determining the Certification and Accreditation (C&A) and other security requirements for the request.
Service Coordination SME(s)	<ul style="list-style-type: none"> Name, Title, Organization 	Responsible for ensuring all aspects of non-functional requirements have been accurately recorded for this request.
Health Systems Informatics (HSI) Health Enterprise Systems Manager (ESM) Manager and Staff	<ul style="list-style-type: none"> Name, Title, Organization 	Serve as the liaison between the Program Office (Business Owner) and Product Development throughout the lifecycle.
Strategic Investment Management (SIM) Requirements Development and Management (RDM) Staff	<ul style="list-style-type: none"> Name, Title, Organization 	Responsible for working with all stakeholders to ensure the business requirements have been accurately recorded for this request.

Appendix D Enterprise Requirements

Below is a subset of Enterprise-level Requirements that are of particular interest to the business community. These requirements **MUST** be addressed within each project resulting from this work effort. If OIT cannot address these Enterprise-level requirements, the Business Owners responsible for each area **MUST** be engaged in any waiver discussions prior to any decisions being made. This section is not meant to be a comprehensive list of all Enterprise-level requirements that may apply to this work effort and should not preclude the technical community from reviewing all Enterprise-level requirements, and identifying others that should apply to this work effort as well.

Enterprise-level requirements are contained in the VA Enterprise Requirements Management (ERM) Repository . To contact the ERM program personnel, gain access to the ERM repository and to obtain the comprehensive allocation of Enterprise-level requirements for the project development iteration, contact



Requirement Type	Description
Security	<p>All VA security requirements will be adhered to. Based on Federal Information Processing Standard (FIPS) 199 and National Institute of Standards and Technology (NIST) SP 800-60, recommended Security Categorization is High.</p> <p>The Security Categorization will drive the initial set of minimal security controls required for the information system. Minimum security control requirements are addressed in NIST SP 800-53 and VA Handbook 6500, Appendix D.</p>
Privacy	All VA Privacy requirements will be adhered to. Efforts that involve the collection and maintenance of individually identifiable information must be covered by a Privacy Act system of records notice.
508 Compliance	All Section 508 requirements will be adhered to. Compliance with Section 508 will be determined by fully meeting the applicable requirements as set forth in the VHA Section 508 checklists (1194.21, 1194.22, 1194.24, 1194.31 and 1194.41) located at: http://www.ehealth.va.gov/508/resources_508.html or as otherwise specified. Checkpoints will be established to ensure that accessibility is incorporated from the earliest possible design or acquisition phase and successfully implemented throughout the project.
Executive Order	All executive order requirements will be adhered to.
Identity Management	All Enterprise Identity Management requirements will be adhered to. These requirements are applicable to any application that adds, updates, or performs lookups on persons.
Terminology Services	Application/services shall reference the Standard Data Services (SDS) as the authoritative source to access non-clinical reference terminology.
Terminology	Application/Services shall use the VA Enterprise Terminology Services

Services	(VETS) as the authoritative source to access clinical reference terminology.
Terminology Services	Applications recording the assessments and care delivered in response to an Emergency Department visit shall conform to standards defined by the VHA-endorsed version of C 28 – Health Information Technology Standards Panel (HITSP) Emergency Care Summary Document Using Integrating the Healthcare Enterprise (IHE) Emergency Department Encounter Summary (EDES) Component.
Terminology Services	Applications exchanging data summarizing a patient’s medical status shall conform to standards defined by the VHA-endorsed version of C 32 – HITSP Summary Documents Using HL7 CCD Component.

Appendix E Acronyms and Abbreviations

Include terms used in the document and process models other than instructional text.

OIT Master Glossary:

Term	Definition
ACA	Affordable Care Act
AET	Automated Eligibility Tool
AI	Artificial Intelligence
AITC	Austin Information Technology Center
ANR	Automated Notification Reporting
ANSI	American National Standards Institute
AR	Accounts Receivable
ARC	Allocation Resource Center
ASC	Accredited Standards Committee
BIRLS	Beneficiary Identification and Records Locator System
BN	Business Need
BRD	Business Requirements Document
CA	Certification and Accreditation
CAQH	Council for Affordable Quality Healthcare
CASE	Certification and Accreditation Security Engineering
CBO	Chief Business Office
CDW	Corporate Data Warehouse
CFR	Code of Federal Regulations

Term	Definition
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CMS	Centers for Medicare and Medicaid Services
CORE®	Committee on Operating Rules for Information Exchange
COTS	Commercial-Off-The-Shelf
CP&E	Claims Processing and Eligibility
DRG	Diagnosis Related Group
DSS	Decision Support Systems
EDI	Electronic Data Interchange
EFT	Electronic Fund Transfer
ERM	Enterprise Requirements Management
ESI	Eligibility System Improvement
ESM	Enterprise Systems Management
ESR	Eligibility System Redesign
FBCS	Fee Basis Claims System
FCDM	Financial Clinical Data Mart
FIPS	Federal Information Processing Standard
FMS	Financial Management Systems
FPPS	Fee Payment Processing System
HAC	Health Administration Center
HEC	Health Eligibility Center
HERO	Healthcare Effectiveness through Resource Optimization
HHS	Department of Health and Human Services
HIG	Health Information Governance
HIPAA	Healthcare Portability and Accountability Act of 1996
HL7	Health Level 7
HPID	Health Plan Identifier
HR	House of Representatives
HTTPS	Hypertext Transfer Protocol Secure
IB	Integrated Billing
ICD-10	International Classification of Diseases, Tenth Edition
IG	Inspector General

Term	Definition
IPT	Integrated Project Team
IT	Information Technology
MFS	Management and Financial Systems
MQAS	Management Quality Assurance Service
MUMPS	Massachusetts General Hospital Utility Multi-Programming System
NCVHS	National Committee on Vital and Health Statistics
NIST	National Institute of Standards and Technology
NSR	New Service Request
OHI	Office of Health Information
OIG	Office of the Inspector General
OIT	Office of Information and Technology
OLAP	On-Line Analytic Processing
OM	Operations and Maintenance
OWNR	Owner Requirement
PCBL	Purchased Care Business Line
PD	Product Development
PPACA	Patient Protection and Affordable Care Act
PSA	Primary Service Area
RAEM	Requirements Analysis and Engineering Management
RFI	Request For Information
SEP	Stakeholder Enterprise Portal
SLA	Service Level Agreement
SME	Subject Matter Expert
SQL	Structured Query Language
UN/EDIFACT	United Nations/Electronic Data Interchange for Administration, Commerce and Transport
VA	Department of Veterans Affairs
VAMC	VA Medical Center
VAPM	VA Payment Manager
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information Systems and Technology Architecture

Term	Definition
VPID	Veteran Personal Identifier
VSSC	VHA Support Service Center
VWM	VA Work Measurement

Appendix F Approval Signatures

The requirements defined in this document are the high level business requirements necessary to meet the strategic goals and operational plans of the Non-VA Purchased Care BSM Directorate. Further elaboration to these requirements will be done in more detailed artifacts.

Business Owner

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

Signed: _____ Date: _____

_____, Director, Operations

Business Liaison

Signifies appropriate identification and engagement of necessary stakeholders and the confirmation and commitment to quality assurance and communication of business requirements to meet stakeholder expectations.

Signed: _____ Date: _____

_____, Chief, BPRO

Signed: _____ Date: _____

_____ Veteran Family Systems Program Manager, BSM

Signed: _____ Date: _____

_____, Veteran Family Systems Program Manager, BSM

Signed: _____ Date: _____

EDI Program Manager

Office of Information and Technology (OIT)

Indicates agreement that the requirements have been received, are clear, understandable, and are documented sufficiently to facilitate project planning when the project is approved and funded. It is understood that negotiations may need to occur with the business during project planning as a result of technical reviews and feasibility.

Signed: _____ Date: _____

Chief Information Officer
CBOPC OI&T

Signed: _____ Date: _____

Program Manager
Product Development – Office of Information and Technology