RESOURCE AND PATIENT MANAGEMENT SYSTEM

Third Party Billing

(ABM)

Addendum to User Manual

Version 2.6 Patch 37
August 2023

Office of Information Technology
Division of Information Resource Management

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Preface

The purpose of this addendum is to provide information about the Third Party Billing (ABM) package. The system is designed to automate the creation of a claim using existing Resource and Patient Management System (RPMS) visit data.

Please review and distribute this addendum to your Third Party Billing staff prior to installation of the patch.

Refer to the notes file released with this patch for all other technical documentation.

References to "Change Requests" (CRs), "HEAT", "Service Now" (or SNOW), and "ADO" (or Azure DevOps) will be seen throughout the document. A Change Request refers to a request to update or modify the software to correct or add additional functionality that will support the mission and goals of the Indian Health Service. HEAT is the retired software previously used to document issues reported by the field. SNOW has replaced HEAT as a means of tracking reported issues and documenting support requests. ADO is a system used to track software change requests and has replaced Serena, which was originally used to document the software change requests.

Note:	This addendum is not intended to be a billing/process guide. Consult your Business Office Manager or Area Business Office Coordinator for questions regarding insurer billing requirements and processes regarding billing.

1.0 Introduction

1.1 Summary of Changes

Patch 37 provides enhancements and minor corrections to Version 2.6 of the Third Party Billing application. This patch is not cumulative of prior released patches. Please refer to those patch addendums for additional information.

1.1.1 Patch 37

ADO75349 / CR8900 – Correction to <SUBSCR>18+213^ABMDF28Y – Reported by Chinle (HEAT239743)

A field was added to the 3P Bill file called EXPORT DATE to store the date that a bill was exported in an 837 file or on paper. This corrects a programming error (<SUBSCR>18+213^ABMDF28Y) that occurred when reprinting a UB-04 that had a status of Completed and the user selected the Original Print Date. For 3P Bills that were exported prior to Patch 37 being installed, the new EXPORT DATE field will be automatically populated with the date found in the EXPORT NUMBER field.

ADO75502 / CR9172 – Correction to Assignment of Benefits in the Claim Editor – Reported by Riverside (HEAT327459)

A correction was made to the claim generator to ensure that the correct Assignment of Benefits date from patient registration is populated on page 3 of the claim editor. Prior to Patch 37, the claim generator used the most recent AOB date in patient registration, which wasn't always the appropriate AOB for a claim's visit date. Patch 37 changes this so that the AOB populated on a claim will be the one that matches by date of service. If there's more than one AOB that matches a claim's date of service, the most recent AOB date will be used. AOB dates that fall after a claim's visit date will not be populated on the claim.

ADO75923 / CR11357 – Updates to the 3P TX Status file to store additional data

Changes were made to the 3P TX Status file to provide better information when an 837 batch is created or recreated and when an 837 3P Bill is re-exported. This information can be viewed in the Inquire about an Approved Bill option (MGTP > IQMG).

ADO75953 / CR11586 – Updates to the External Cause of Injury fields in the Claim Editor

A correction was made to the claim generator to ensure that up to three External Cause of Injury (accident) codes are populated on page 5A of the Edit Claim Data option (EDTP > EDCL) when present on the PCC visit. Prior to Patch 37, only one accident code was crossing over from PCC regardless of how many were populated on the visit. In addition, the External Cause of Injury field on page 5A was renamed from E-CODE to EXTERNAL CAUSE.

ADO75981 / CR11670 – Fix to reports to correctly report HCPCS codes

A correction was made to several reports to ensure that they include HCPCS charges approved on Edit Claim Data pages 8H (Misc. Services) and 8K (Ambulance Services) and to ensure that the CPT RANGE parameter provides data when a range of HCPCS codes is entered. The corrected reports are:

- Bill Listing (RPTP > BLRP)
- Listing of Billed Primary Diagnosis (RPTP > DXRP)
- Billing Activity for a Specific Patient (RPTP > PTRP)
- Listing of Billed Procedures (RPTP > PXRP)
- Statistical Billed-Payment Report (RPTP > STRP)

An additional correction was made to the Billing Activity for a Specific Patient report to ensure that the report provides data, as appropriate, when run for a Date Range of T for Today.

ADO76009 / CR11825 – Fix to secondary claims and the reporting of charges

Corrections were made to Coordination of Benefits billing in the Edit Claim Data option (EDTP > EDCL) to ensure that the correct prior payment information is being populated for all export modes when a patient has the same primary and secondary coverage. The CLM and SV# segments of the 837 export modes were also updated to ensure they are populated with the correct dollar amounts.

ADO76036 / CR11880 – Display of COB Page for Dental Claims

A correction was made to the Edit Claim Data option (EDTP > EDCL) to ensure that the Coordination of Benefits (COB) page is displayed when billing an 837D secondary claim. Prior to Patch 37, the COB page wasn't displayed for 837D secondary claims.

ADO76062 / CR11911 – Fix for <UNDEF>START+24^ABMEF32 error

A correction was made to the Re-Create an EMC File option (EMTP > RCEM) to prevent a programming error (<UNDEF>START+24^ABMEF32) when an 837 batch is selected to re-export and that batch was originally exported in a file containing multiple batches.

ADO76301 / CR12408 – Removal of Leading Zero on Tooth Number – Reported by Shingle Springs (INC0119418)

A field called TOOTH NUMBER LEADING ZERO was added to the Dental Remap Table Maintenance option (TMTP > DMTM) to allow for adding a leading zero to tooth numbers (operative sites) numbered 1 through 9 on page 6 of the claim editor and in the 837D, the ADA-2019, and the ADA-2012. If this new field is left blank or is set to No, a leading zero will not be added to tooth numbers.

ADO77131 – Update to Rollback option to display POS Claim Status – Reported by Fort Defiance (INC0030210)

A change was made to the 3P rollback message that's displayed when posting to Pharmacy POS bills in Accounts Receivable to provide more accurate information. Prior to Patch 37, when posting to a cancelled Pharmacy POS bill, the following message was displayed: 'CLAIM #### HAS BEEN CANCELLED', but Pharmacy POS bills do not have claims associated with them. To clarify this, the message was changed to "Billed Pharmacy POS so no claims exist".

ADO78452 – Correction to Bill Type Automatically Updating in the Claim Editor – Reported by Phoenix Indian Medical Center (INC0119803)

Corrections were made to Page 1 of the Claim Editor to ensure that the bill type doesn't change when the Visit Type is edited, even if there is a bill type specified in EDIN for the newly selected visit type. It will be up to the user to change the bill type as needed. In addition, a correction was made to the 837P and to the 837D to ensure that the CLM05-3 segment is correctly populated with the third digit of the bill type that was approved on the claim. Prior to Patch 37, the CLM05-3 was always populated with '1'.

ADO80078 – corrections were made to box 54 of the UB-04 to ensure the correct prior payment amount is reflected - Reported by Gallup Indian Medical Center (INC0161183)

This change impacts the claim form when printing a secondary or tertiary paper claim and ensures that the correct billed amount prints so that the claim is able to balance correctly.

ADO80643 – Corrections to the Claim Editor to correctly display the CPT Modifier – Reported by Kayenta Health Center (INC0181345)

A correction was made to the following pages of the claim editor to ensure that modifiers are correctly displayed on the charge summary screen: 8A, 8B, 8E, 8F, 8G, and 8H. Prior to Patch 37, modifiers comprised of alpha or alpha-numeric characters were displayed using the Internal Entry Number (IEN) rather than the actual modifier.

ADO81491 – Additional updates to display the Patient Preferred Name (PPN)

Updated all the fields and reports in Third Party Billing that display the Patient Preferred Name (PPN), if populated in Patient Registration. This application uses the "AUPN DISPLAY PPN" parameter functionality and is defaulted to OFF until Patient Preferred Name (PPN) is available across the enterprise. NOTE: While this parameter is turned off, the Patient Preferred Name will not display in this application. This allows the Patient Preferred Name to be turned on at once without requiring a coordinated release of all applications. Once all applications support the display of the PPN, instructions will be sent out on how to enable this parameter system-wide.

ADO84370 – New Place of Service Codes

Updates were made to the 3P Codes file to accommodate Centers for Medicare & Medicaid Services (CMS) Place of Service billing requirements for Telehealth. These updates include changing the description for Place of Service code 02 from 'Telemedicine' to 'Telehealth Provided Other than in Patient's Home' and adding Place of Service code 10 'Telehealth Provided in Patient's Home'.

ADO89299 – Updates to the claim forms regarding reporting of the DEA Number

Changes were made to pages 8A, 8D, and 8H of the Edit Claim Data option (EDTP > EDCL) to check a new parameter in the Visit Type portion of the Add/Edit Insurer (TMTP > INTM > EDIN) that allows for requiring a DEA# for controlled substances. The new field, called 'DEA# required for controlled substances?', will only be displayed when the export mode is set to 837P or CMS-1500 (02/12). When it's set to Yes and controlled substance or NDC number for a controlled substance is populated on page 8A, 8D, or 8H, the claim editor will look for an ordering provider. If there isn't an ordering provider, or if the ordering provider does not have a DEA#, one or both of the following warnings will be displayed as appropriate: 259 – The DEA number may be required for this medication and/or 261: The Ordering Provider is missing from this medication.

2.0 Patch 37

2.1 Billing Controlled Substances with the DEA Number

A field was added to the Visit Type portion of the Add/Edit Insurer option (TMTP > INTM > EDIN) to allow for requiring a DEA# when a controlled substance is present on page 8A, 8D or 8H of the Edit Claim Data option (EDTP > EDCL). The new field, 'DEA# required for controlled substances', will only be displayed when the Visit Type Mode of Export is set to 837P or CMS-1500(02/12).

Sites that bill the Veterans Administration under the IHS-VA Agreement will need to set up their insurer file to send the DEA number for all controlled substances to ensure compliance with DEA Number reporting. It is not necessary to set up for other insurers if billing is managed by the Pharmacy POS system but the user may set up for other payers that require the DEA number when submitting claims via Third Party Billing.

```
Visit                       Mode of     Mult  Fee    ------- Flat Rate --------
Type - Description           Export     Form Sched   Start      Stop       Rate
================================================================================
111   INPATIENT           837I (UB) 5010NO
131   OUTPATIENT          837P (HCFA) 5010NO

Select VISIT TYPE..: 131    OUTPATIENT
         ...OK? Yes//   (Yes)

Billable (Y/N/E)....: YES//
Reporting purposes only:
Do you want to replace with another insurer/visit type?
Start Billing Date (create no claims with visit date before)..: JAN 1,2018
         //
Procedure Coding....: CPT//
Fee Schedule........:
Add Zero Fees?...:
Multiple Forms?.....: NO//
Payer Assigned Provider Number.....:
EMC Submitter ID #..:
EMC Reference ID....:
Auto Approve?.......:
Mode of Export......: 837P (HCFA) 5010//
Billing Prv Taxonomy:
DEA# required for controlled substances?: ?
     Answer YES if DEA# is required for controlled substance on 837P or
     CMS-1500(02/12)
     Choose from:
       Y        YES
DEA# required for controlled substances?:
```

Figure 2-1: DEA# field added to the EDIN option for export modes 837P and CMS-1500(02/12)

Setting the new field to Yes will prompt the Claim Editor to check for an Ordering Providers DEA# when a controlled substance or NDC for a controlled substance is populated on Pages 8A, 8D, or 8H. If the Ordering Provider does not have a DEA#, the Claim Editor will use the Facility DEA# that's populated in the Institution file. If neither Ordering Provider nor the facility has a DEA#, Warning 259 will be populated indicating a DEA number may be required.

In addition, Warning 261 will be displayed when a controlled substance does not include an Ordering Provider.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8D  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN:111]                              Claim: 123456
Mode of Export: 837P (HCFA) 5010
.............................. (MEDICATIONS) ..............................

     REVN  CHARGE                                        DAYS            TOTAL
     CODE  DATE               MEDICATION               SUPPLY   QTY     CHARGE
     ====  ============================================  ====  =======  ==========
[1]  0250  03/10/2023@09:00     Rx:12345
    00406-8315-01 MORPHINE SULFATE 15MG TAB,ER            5        10      12.37
                                                                          ==========
     TOTAL                                                                 $12.37

------------------------------------------------------------------------------
WARNING:259 - The DEA number may be required for this medication (1)
WARNING:261 - The Ordering Provider is missing from this medication (1,1)
------------------------------------------------------------------------------

Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N//
```

Figure 2-2: Potential warnings displayed for controlled substances

When an Ordering Provider is present on page 8D and the provider has a DEA#, the provider name and DEA# will be displayed below the REVN CODE, CHARGE DATE, and Rx line.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8D  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN:13578]                            Claim: 123456
Mode of Export: 837P (HCFA) 5010
.............................. (MEDICATIONS) ..............................

     REVN  CHARGE                                        DAYS            TOTAL
     CODE  DATE               MEDICATION               SUPPLY   QTY     CHARGE
     ====  ============================================  ====  =======  ==========
[1]  0250  03/29/2023@09:00     Rx:12345
           (PROVIDER,DEMO-D)  DEA# AP1234567
    00406-8315-01 MORPHINE SULFATE 15MG TAB,ER            5        10      12.37
[2]  0250  03/29/2023@09:00     Rx:12346
           (PROVIDER,DEMO-D)  DEA# AP1234567
    00406-0512-01 OXYCODONE/ACETAMINOPHEN 5/325MG
                  TAB                                     1         3       5.83
                                                                          ==========
     TOTAL                                                                 $18.20
```

```
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N//
```

Figure 2-3: Page 8D example when an Ordering Provider with a DEA# is present

2.2 UB-04 Bill Type

CMS defines the UB-04 Bill Type as:

- This four-digit alphanumeric code gives three specific pieces of information after a leading zero. CMS will ignore the leading zero. CMS will continue to process three specific pieces of information. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.
- Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.
- Code Structure
- 2nd Digit-Type of Facility (CMS will process this as the 1st digit)
- 3rd Digit-Bill Classification (Except Clinics and Special Facilities) (CMS will process this as the 2nd digit)
- 3rd Digit-Classification (Clinics Only) (CMS will process this as the 2nd digit)
- 3rd Digit-Classification (Special Facilities Only) (CMS will process this as the 2nd digit)
- 4th Digit-Frequency - Definition (CMS will process this as the 3rd digit)
- Guidance is provided in the Medicare Claims Processing Manual.

Patch 37 corrected the logic that was incorrectly displaying the Bill Type when the billing technician edited the Visit Type on Page 1 in the Claim Editor. Prior to the patch, the system would use the Visit Type number as the Bill Type, resulting in incorrect reporting of the Bill Type on the UB-04 and the 837 Institutional file.

> **Note**: Bill Type '999' is an invalid bill type used mainly on the CMS-1500 and 837 Professional. The Billing Technician will need to ensure the correct bill type is used for all claim forms.

A change was also made to the 837 Professional that allows the bill type to be used to communicate to the payer on the claim frequency. The third digit of the bill type is used to report the frequency code in the CLM05-3 element.

In the example below, the billing technician is using bill type '135' to indicate they are submitting a claim with late charges.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 1  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT - NICKNAME*  [HRN:999999]             Claim: 403097
.............................. (CLAIM IDENTIFIERS) ..............................

                 [1] Clinic.............: GENERAL
                 [2] Visit Type.........: OUTPATIENT
                 [3] Bill Type..........: 131
                 [4] Billing From Date..: 04/23/2023
                 [5] Billing Thru Date..: 04/23/2023
                 [6] Super Bill #.......:
                 [7] Mode of Export.....: 837P (HCFA) 5010
                 [8] Visit Location.....: 2017 DEMO HOSPITAL
------------------------------------------------------------------------------
WARNING:075 - EMPLOYER LOCATION UNSPECIFIED
------------------------------------------------------------------------------

Desired ACTION (Edit/View/Next/Jump/Back/Quit): N// E

Desired FIELDS:  (1-8): 1-8// 3

[3] Bill Type.......: 131// 135
```

Figure 2-4: Claim Editor, Page 1 Displaying the Editing of the Bill Type

As a result, the system will print the third digit of the bill type on the 837.

```
CLM*403097A-DH-999999*162.00***22:B:5*Y*A*N*Y~
REF*EA*999999~
```

Figure 2-5: Display of 837 Professional showing the 3rd Digit of the Bill Type in CLM05-3

As a reminder, the system will also allow the claim frequency code to be added using the Enter Resubmission Number option (3PB > PRTP > RESB). This is used after the bill had been approved and submitted to the payer. This option is usually used when resubmitting a processed bill and allows the Resubmission or payers control number to be added to the bill along with reprinting the bill. In this case, if the bill is printed to paper, the resubmission information will print in Item Number 22.

2.3 Dental Billing Operative Site (Tooth Number)

A new field labeled TOOTH NUMBER LEADING ZERO was added to the Dental Remap Table Maintenance option (TMTP > DMTM) to allow for adding a leading zero to any tooth number/operative site that is numbered 1 through 9. When this field is set to yes, a leading zero will be populated on page 6 of the Edit Claim Data option (EDTP > EDCL), in the TOO02 segment of the 837D, and in Box 27 of the ADA-2019 and the ADA-2012. If the new field is left blank or is set to No, a leading zero will not be added to tooth numbers.

> **Note:** A change was released in patch 29 that added a leading zero to the operative site for all payers in the 837D and on the ADA paper forms. Patch 37 removes the leading zero for all payers. If there are any payers that require a leading zero for operative sites numbered 1 through 9, the new TOOTH NUMBER LEADING ZERO prompt will have to be set to Yes in the Dental Remap Table Maintenance option.

To set the TOOTH NUMBER LEADING ZERO prompt to yes, access the Dental Remap Table Maintenance option and enter the insurer name. Press Enter until you get to the TOOTH NUMBER LEADING ZERO prompt. Type '**?**' and press Enter to display help text, if desired, then type **Yes** and press Enter. It is not necessary to populate this field if the payer does not require a leading zero be added to the operative site.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |        THIRD PARTY BILLING SYSTEM - VER 2.6p37          |
          +             Dental Remap Table Maintenance              +
          |                  2017 DEMO HOSPITAL                     |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: BILLER,SUPER                       16-FEB-2023 11:34 AM

Select 3P DENTAL RECODE TABLE NAME (INSURER): DELTA DENTAL( DELTA DENTAL/DENTALS
)
.....................................
DELTA DENTAL OF NEW MEXICO INC       - 2101 SAN PEDRO NE # D          Domain: NM
                                       ALBUQUERQUE, NM 87110
OK? Y//

CODE PREFIX: D//
TOOTH NUMBER LEADING ZERO: ?
     Answer YES to allow a leading zero when reporting tooth numbers on paper
     ADA or 837D in the TOO segment. If a leading zero is not required, leave
     blank or NO.
     Choose from:
       Y        YES
       N        NO
TOOTH NUMBER LEADING ZERO: YES
Select IHS CODE:
```

Figure 2-6: TOOTH NUMBER LEADING ZERO prompt in the DRTM option

When the TOOTH NUMBER LEADING ZERO prompt is set to Yes, page 6 of the Edit Claim Data option will automatically add a leading zero to operative sites numbered 1 through 9. The leading zero will also be displayed on the ADA FORM DENTAL CHARGE SUMMARY screen when the claim is approved.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 6  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,DENTAL  [HRN:143229]                          Claim: 403054
.............................. (DENTAL SERVICES) ..............................

    VISIT                                            ORAL  OPER
    DATE                DENTAL SERVICE               CAV   SITE SURF     CHARGE
```

```
    =====  ======================================== ====  ==== =====  ==========
[1] 01/12  1353 SEALANT REPAIR - PER TOOTH                 06           160.00
[2] 01/12  2330 RESIN-BASED COMPOSITE - ON                 A            186.00
                                                                      ==========
                                                                        $346.00

Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit): N//
```

Figure 2-7: Leading zero displayed on page 6 of the Edit Claim Data option

```
              ***** ADA FORM DENTAL CHARGE SUMMARY *****

Active Insurer: DELTA DENTAL OF NEW MEXICO INC


                 Description
Tooth Surface    Of Service             Date      ADA Code             Fee
-------------------------------------------------------------------------------

  06             SEALANT REPAIR - PER  01-12-23  1353                   160.00
  A              RESIN-BASED COMPOSIT  01-12-23  2330                   186.00


                                                                  =============
          TOTAL CHARGE                                                  346.00
```

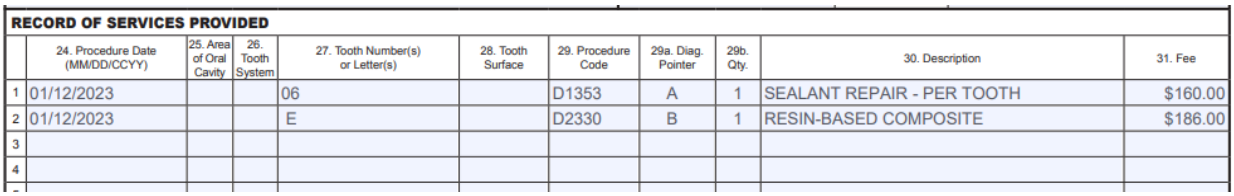
Figure 2-8: Leading zero displayed on the ADA Form Dental Charge Summary

The leading zero will be populated in the TOO02 segment of the 837D and in Box 27 of the ADA-2019 and the ADA-2012.

```
SV3*AD:D1353*160.00*********1~
TOO*JP*06~
REF*6R*000000006486330001~
LX*1~
SV3*AD:D2330*186.00*********2~
TOO*JP*E~
REF*6R*000000006486330002~
LX*2~
TOO02 segments of the 837D

SV3*AD:D1353*160.00*********1~
TOO*JP*06~
REF*6R*000000006486330001~
LX*1~
SV3*AD:D2330*186.00*********2~
TOO*JP*E~
REF*6R*000000006486330002~
LX*2~
```

Figure 2-9: TOO-02 Segments Displaying the Tooth Number



RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	01/12/2023			06		D1353	A	1	SEALANT REPAIR - PER TOOTH	$160.00
2	01/12/2023			E		D2330	B	1	RESIN-BASED COMPOSITE	$186.00
3										
4										

Figure 2-10:Box 27 of the ADA-2019

2.4 837 File Export Information

Changes were made to the 3P TX Status file to provide better information when an 837 file is created using the Create EMC File option (EMTP > CREM) or recreated using the Re-Create EMC File option (EMTP > RCEM), or when a 3P Bill is re-exported into a new EMC file using the Re-Export Bills option (EMTP > REEX). The 837 export information that's generated when these options are used can be viewed in the Inquire about an Approved option (MGTP > IQMG).

Prior to Patch 37, the 837 export information looked similar to the example below:

```
EXPORT NUMBER RE-EXPORT: SEP 27, 2022@10:56:17
  STATUS: ORIGINAL                      GROUP CONTROL NUMBER: 100381
EXPORT NUMBER RE-EXPORT: SEP 27, 2022@10:56:17
  STATUS: RECREATED                     GROUP CONTROL NUMBER: 100382
EXPORT NUMBER RE-EXPORT: NOV 14, 2022@14:46:30
  STATUS: REFILE                        GROUP CONTROL NUMBER: 100383
```

Figure 2-11:837 export information as displayed in the IQMG option prior to Patch 37

The changes to the 837 export information displayed in the IQMG option include the following and will look similar to the example below:

- The **EXPORT NUMBER RE-EXPORT** field has been renamed to **BATCHED DATE/TIME**
- A field called **EXPORT DATE/TIME** has been added for each export and is populated with the date/time that the file was created
- The **STATUS** field for the Re-Export Bills option has been changed from 'Refile' to 'Recreate from REEX'

```
BATCHED DATE/TIME: DEC 28, 2022@08:56:41
  STATUS: ORIGINAL                      GROUP CONTROL NUMBER: 100897
  EXPORT DATE/TIME: DEC 28, 2022@08:56:41
BATCHED DATE/TIME: DEC 28, 2022@08:56:41
  STATUS: RECREATED                     GROUP CONTROL NUMBER: 100898
  EXPORT DATE/TIME: FEB 02, 2023@07:30:44
BATCHED DATE/TIME: FEB 13, 2023@12:31:42
  STATUS: Recreate from REEX            GROUP CONTROL NUMBER: 100899
  EXPORT DATE/TIME: FEB 13, 2023@12:31:42
```

Figure 2-12: 837 export information as displayed in the IQMG option in Patch 37

2.5 3P Rollback Message for Pharmacy POS Bills

The rollback message displayed when rolling back after posting to a Pharmacy POS bill in Accounts Receivable has been updated to provide more accurate information. Prior to Patch 37, when posting to a Pharmacy POS bill, the following message was displayed: 'CLAIM #### HAS BEEN CANCELLED', but Pharmacy POS bills do not have claims associated with them because a paid POS bill will only create a bill entry and bypass the claim creation process. To clarify this, the message was changed to "Billed Pharmacy POS so no claims exist".

```
Select Action (P/M/C): POST TO A/R

Please wait... Posting Transactions..
CHECKING A/R BILL 123456A-DH-111
Reviewing Bill 123456A-DH-111

BILL      123456A-DH-1111 >PAYMENTS<             >ADJUSTMENTS<
BILLED          4.25     3-P CRD         0.00     NON-PAY         0.00
PAY TOT         4.25     PAYMENTS        0.00     DED             0.00
ADJ TOT         0.00     PAY CRD         0.00     CO-PAY          0.00
                         WR OFFS         4.25     PENALTY         0.00
                         GROUPER         0.00     STC             0.00
                         REFUND          0.00     TOTAL ADJ*      0.00
ROLLOVER        0.00     TOTAL PAY*      4.25

Pat:      DEMO,PATIENT                 Visit Type.: PHARMACY POS
                                       Bill Status:

  Original bill approved with the following:

     P: RX-DEMO INSURANCE
     S:
     T:


Enter RETURN to continue:


Billed Pharmacy POS so no claim exists
```

Figure 2-13: 3P Rollback Message Displayed when Posting to the Pharmacy POS Bill

2.6 Patient Preferred Name (PPN) Update

The fields in Third Party Billing system that display the Patient Preferred Name (PPN) were updated to accommodate a change to how the name is located and displayed to the user. If a preferred name is present on page 7 of Patient Registration and the PPN display parameter is set to Yes, a PPN can be used to look up a patient and will also be displayed in some of the 3PB options. If the PPN display parameter is blank or set to no, a PPN can be used to look up a patient but the PPN will only be displayed in the patient search results.

These changes were made to accommodate the 2015 regulation for Certified Health Information Technology (CHIT) from the Office of the National Coordination for Health Information Technology (ONC) which requires all Electronic Health Record (EHR) systems to allow users to record, change, and access structured data on Sexual Orientation and Gender Identity (SOGI).

> **Note**: The PPN Display Parameter is set at the RPMS Administration level. Coordination with clinical and administrative applications is required to determine if and when the PPN Display will be turned on for the entire RPMS system. Consult your RPMS Systems Administrator or Clinical Applications Coordinator (CAC) for additional information.

Once all RPMS applications have released the PPN display functionality, instructions will be sent out system-wide on how to turn on the PPN display. In the meantime, if a preferred name is present in patient registration, it will be displayed as part of the patient search results and will look similar to the example below. The patient's name will be displayed as usual followed by a dash, the preferred name, and an asterisk.

```
Select CLAIM or PATIENT: DEMO,P
   1    DEMO,PAT                        M 01-02-1970 XXX-XX-1111   DH 1234
   2    DEMO,PATIENT  DEMO,PATIENT - PREFERRED*
                                        F 02-03-1980 XXX-XX-2222   DH 5678
   3    DEMO,STAN                       M 03-04-1990 XXX-XX-3333   DH 9012

CHOOSE 1-3: ^
Select CLAIM or PATIENT:
```

Figure 2-14: Preferred name displayed in patient search results with PPN parameter turned off

After the PPN display parameter is turned on, it will also be displayed in many of the Third Party Billing Exclusion Parameters when the patient's name is entered as the Specific Patient under Billing Entity. It will not be displayed on report headers or within the body of the reports.

```
   EXCLUSION PARAMETERS Currently in Effect for RESTRICTING the EXPORT to:
   ========================================================================
   - Billing Entity.....: DEMO,PATIENT - PREFERRED*
   - Visit Dates from...: 01/01/2023  to: 01/31/2023
   - Claim Status.......: Flagged as Billable
   - Report Type........: BRIEF LISTING (80 Width)

     Select one of the following:

          1         LOCATION
          2         BILLING ENTITY
          3         DATE RANGE
          4         CLAIM STATUS
          5         PROVIDER
          6         ELIGIBILITY STATUS
          7         REPORT TYPE
```

```
Select ONE or MORE of the above EXCLUSION PARAMETERS:
```

Figure 2-15: Preferred name displayed in report Exclusion Parameters with PPN parameter turned on

Appendix A Patch Installation Checklist for the Business Office

Table A-1 provides a list of items that are recommended to be reviewed or completed as soon as patch installation occurs.

Table A-1: Recommended Installation Item review

Item No.	Section	Description	Completed By
1		Review Addendum for Patch Updates	
2	2.1	Update Insurer File with DEA Parameter for VAMB	
3	2.2	Review Bill Type Documentation and Ensure all Staff Comply	
4	2.3	Set Up Tooth Number if Leading Zero is Required by Dental Payers	

Appendix B UB-04 Type of Bill Frequency Codes

The following is a list of the third digit frequency codes. For a complete list, consult the UB-04 manual or the Medicare Administrative Contractor (MAC).

B.1 Type of bill frequency codes

0 Non-payment/zero

1 Admit through discharge claim

2 Interim - first claim

3 Interim - continuing claim

4 Interim - last claim

5 Late charge(s) only

7 Replacement of prior claim

8 Void/Cancel of prior claim

9 Final Claim for a home health PPS episode

A Admission/election notice

B Hospice/CMS Coordinated Care Demonstration/Religious Non-Medical Health Care Institution/Centers of Excellence Demonstration/Provider Partnerships Demonstration

C Hospice change of provider notice

D Hospice/CMS Coordinated Care Institution/Centers of Excellence Demonstration/Provider Partnerships Demonstration Void/Cancel

E Hospice change of ownership

F Beneficiary initiated adjustment claim

G CWF initiated adjustment claim

H CMS initiated adjustment

I Intermediary adjustment claim

J Initiated adjustment claim - other

K OIG initiated adjustment claim

M MSP initiated adjustment claim

O Nonpayment/zero claims

P QIO adjustment claim

Q Claim submitted for reconsideration/reopening outside of timely limits

X Void/Cancel a prior abbrev. Encounter submission

Y Replacement a prior abbrev. Encounter submission

Z New abbrev. encounter submission

Acronym List

Acronym	Meaning
837D	Electronic Health Care Claim: Dental
3PB	Third Party Billing
ADA	American Dental Association
ADO	Azure DevOps (OIT Change Request Repository)
AOB	Assignment of Benefits
API	Application Programming Interface
AUPN	IHS Dictionaries (Patient)
AVA	IHS VA Support
BJPC	Patient Care Component (PCC) Suite
COB	Coordination of Benefits
CR	Change Request
CPT	Current Procedural Terminology
DEA	Drug Enforcement Administration
HEAT	OIT Helpdesk Ticketing System (Retired)
HRN	Health Record Number
ICD	International Classification of Diseases
IHS	Indian Health Service
IT	Information Technology
MAC	Medicare Administrative Contractor
OIT	Office of Information Technology
PCC	Patient Care Component
POS	Point of Sale
RPMS	Resource and Patient Management System
SNOW	Service Now (OIT Helpdesk Ticketing System)
UFMS	United Financial Management System
VA	Veteran’s Administration

Contact Information

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