

# **EDI Billing User Guide**



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Department of Veterans Affairs (VA)

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## 1. INTRODUCTION

In 1996, Congress passed into law the Health Insurance Portability and Accountability Act (HIPAA). This Act directs the federal government to adopt national electronic standards for automated transfer of certain health care data between health care payers, plans, and providers. Now that these standards are in place, the Veterans Health Administration (VHA) will submit claims containing the required standard data content to all payers accepting electronic data interchange (EDI).

### 1.1. Revenue Process

The overall patient billing revenue process for the VHA is summarized in the table below:

<b>Revenue Cycle</b>				
<b>Intake</b>	<b>UR</b>	<b>Billing</b>	<b>Collection</b>	<b>UR</b>
Patient Registration Insurance Identification Insurance Verification	Pre-certification & Certification Continued Stay	Documentation EDI Bill Generation MRA Claim status messages	Establish Receivables A/R Follow-up Lockbox Collection Correspondence	Appeals

During the Intake phase, the patient is registered. Insurance information is identified and/or verified.

In the Utilization Review phase, the patient is pre-certified and certified, and continued stay reviews are performed.

In the Billing phase, the patient encounter is documented and coded. An electronic data interchange (EDI) bill and/or Medicare Remittance Advice (MRA) request is generated and sent to the payer. Claim status messages include information that appears on the Claims Status Awaiting Resolution (CSA) report.

During the Collections phase, establishment of receivables, accounts receivables follow-up, lockbox, and any collection correspondence take place.

Another Utilization Review can take place if there are any appeals.

EDI Billing provides the VHA with the capability to submit electronic Institutional & Professional claims, rather than printing and mailing claims from each facility.

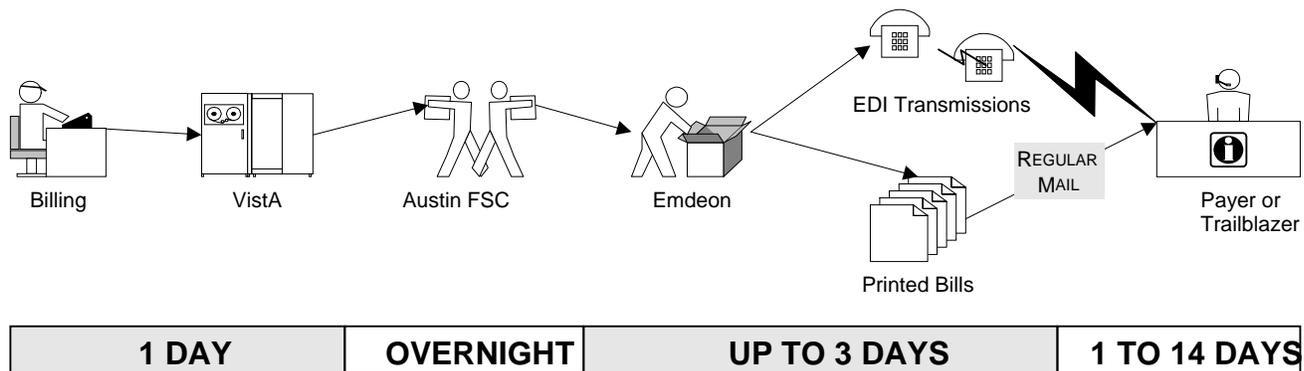
## 1.2. Critical EDI Process Terms

- 835 - The HIPAA adopted standard for electronic remittance advice to report the processing of all claim types (including retail pharmacy). The term “835” represents the data set that is sent from health plans to health care providers and contains detailed information about the processing of the claim. This includes payment information and reduction or rejection reasons. All health plans are required to use the same explanation of benefit codes (adjustment reason codes) and adhere to very specific reporting requirements. The term “835” is used interchangeably with electronic remittance advice (ERA) and Medicare remittance advice (MRA).
- 837 - The HIPAA adopted standard for electronic submission of hospital, outpatient and dental claims. The term “837” represents the data set that is sent from health care providers to insurance companies (payers). The 837 standard includes the data required for coordination of benefits and is used for primary and secondary payer claims submission. The term “837” is used interchangeably with electronic claim.
- Claim Status Message – Electronic messages returned to the VAMC providing status information on a claim from the Financial Service Center (FSC) in Austin, Texas. These messages can originate at FSC, at the payer or at Emdeon.
- Clearinghouse - A company that provides batch and real-time transaction processing services and connectivity to a payer or provider. Transactions include insurance eligibility verification, claims submission processing, electronic remittance processing and payment posting for electronic claims.
- eClaim - A claim that is transmitted to FSC electronically.
- EDI – Electronic Data Interchange (EDI) is the process of transacting business electronically. It includes submitting claims electronically (paperless claims processing), as well as electronic funds transfer and electronic inquiry for claim status and patient eligibility.
- Emdeon – The clearinghouse used by VA.
- EOB – An Explanation of Benefits (EOB) reports the disposition of an individual claim. Many EOBs may be contained within a single 835 Electronic Remittance Advice (ERA) file.
- ePayer - Payer that accepts electronic claims from the clearinghouse.
- Express Bill – An Emdeon printing service that prints and mails claims to payers who do not have the capability to accept electronic claims or in specific circumstances when a paper claim is required.
- Fiscal Intermediary – A fiscal intermediary performs services on behalf of health care payers. These services include claim adjudication, reimbursement and collections. Trailblazer Health Enterprises is an example of a fiscal intermediary that acts on behalf of Medicare. Trailblazer receives claims from the VA in the form of an 837 file and then adjudicates the claims to create a MRA 835 file.
- FSC – The Financial Service Center (Austin, Texas) receives 837 claims transmissions from VistA and transmits this data to Emdeon. FSC also receives

error/informational messages and 835 data from Emdeon and transmits this data to VistA.

- HIPAA – In 1996 Congress passed into law the Health Insurance Portability and Accountability Act (HIPAA). This Act is comprised of two major legislative actions: Health Insurance Reform and Administrative Simplification. The Administrative Simplification provisions of HIPAA direct the federal government to adopt national electronic standards for automated transfer of certain health care data between health care payers, plans, and providers. This will enable the entire health care industry to communicate electronic data using a single set of standards thus eliminating all non-standard formats currently in use. Once these standards are in place, a health care provider will be able to submit a standard transaction for eligibility, authorization, referrals, claims, or attachments containing the same standard data content to any health plan. This will "simplify" many clinical, billing, and other financial applications and reduce costs.

### 1.3. EDI Process Flow



The above flowchart (EDI Process Flow) represents the path electronic claims follow. The objective of electronic billing is to submit completely correct claims. Claims sent electronically reach the payer faster, are processed faster, and are paid faster than claims submitted on paper via the mail.

From the user’s desktop, the claim goes to the FSC in Austin, TX as a VistA Mailman message. The FSC translates the claim into the HIPAA 837 format and forwards it to Emdeon.

From Emdeon, the arrow pointing upwards represents the path claims travel if they can be submitted electronically to the payer. If Emdeon does not have an electronic connection with a payer or if specific claims must be submitted on paper, the claim is printed at Express Bill and mailed to the payers.

Electronic claims status messages from ePayers return to the VAMCs along the same path. Payers receiving printed claims do not return electronic messages. However, Emdeon will return a message indicating that the claim was printed and mailed.

Different electronic edits are in place at each transmission point that may initiate the sending of a claims status message. Claim status messages returned by the clearinghouse and/or payer will provide information on a specific claim. There is no standard content for messages. The information contained within a claim status message varies from payer to payer.

## 2. INSURANCE COMPANY SET-UP

The most common cause of claims rejection is the improper setup of the insurance company and/or provider IDs within VistA. With EDI Billing, there are fields in an 837 claim transmission that are auto-populated with the data defined in VistA. This information must be accurate to generate a clean electronic claim.

### 2.1. Insurance Company Setup

#### 2.1.1 Activate New Payer To Transmit eClaims

The typical business process for setting up new payers is:

1. The Insurance Verification Office initially enters a new payer into VistA.
2. Lists of new payers are printed and provided to the medical center's billing office on a regular basis (daily/weekly). Some individuals become members of the IB New Insurance mail group so they receive e-mail bulletins whenever a new insurance policy is added to VistA.
3. Billing staff use the Insurance Company Editor to define Provider IDs: Type of Coverage; Electronic Insurance Type and Electronic Transmit? by Insurance Company. The Profession/Institutional Payer Primary and Secondary IDs are also defined using the Insurance Company Editor.
4. Billing staff use the Insurance Company Editor to specify the correct Electronic Plan Type for each Insurance Plan.



*Selecting the correct electronic plan type is important. This field may determine which provider IDs are transmitted and/or printed by Express Bill. Choosing the wrong electronic plan type for an Insurance Plan could result in claims being rejected by Emdeon or by the payer.*

#### 2.1.1.1 Define EDI settings for a Blue Cross/Blue (BC/BS) Shield Insurance Company.

Step	Procedure
1	At the Billing Parameters screen in the Insurance Company Editor, enter <b>BP – Billing/EDI Param.</b>

```

Insurance Company Editor      Oct 01, 2007@10:15:14      Page:      1 of      9
Insurance Company Information for: BLUE CROSS
Type of Company: HEALTH INSURANCE      Currently Active

                                Billing Parameters
Signature Required?: NO      Filing Time Frame:
Reimburse?: WILL REIMBURSE      Type Of Coverage: HEALTH INSURAN
Mult. Bedsections:      Billing Phone: 800/933-9146
Diff. Rev. Codes:      Verification Phone: 800/933-9146
One Opt. Visit: NO      Precert Comp. Name:
Amb. Sur. Rev. Code:      Precert Phone: 800/274-7767
Rx Refill Rev. Code:

                                EDI Parameters
Transmit?: NO      Insurance Type:
+      Enter ?? for more actions      >>>
BP Billing/EDI Param      IO Inquiry Office      EA Edit All
MM Main Mailing Address      AC Associate Companies      AI (In)Activate Company
IC Inpt Claims Office      ID Prov IDs/ID Param      CC Change Insurance Co.
OC Opt Claims Office      PA Payer      DC Delete Company
PC Prescr Claims Of      RE Remarks      VP View Plans
AO Appeals Office      SY Synonyms      EX Exit
Select Action: Next Screen//BP Billing/EDI Param
    
```

The following prompts will display.

```

SIGNATURE REQUIRED ON BILL?: NO//
REIMBURSE?: WILL REIMBURSE//
ALLOW MULTIPLE BEDSECTIONS:
DIFFERENT REVENUE CODES TO USE:
ONE OPT. VISIT ON BILL ONLY:
AMBULATORY SURG. REV. CODE:
PRESCRIPTION REFILL REV. CODE:
FILING TIME FRAME:
TYPE OF COVERAGE: HEALTH INSURANCE//
BILLING PHONE NUMBER: 800/933-9146//
VERIFICATION PHONE NUMBER: 800/933-9146//
Are Precerts Processed by Another Insurance Co.?:
PRECERTIFICATION PHONE NUMBER: 800/274-7767//
EDI - Transmit?: NO// YES-LIVE
EDI - Inst Payer Primary ID: 12B30
EDI - 1ST Inst Payer Sec. ID Qualifier:
EDI - Prof Payer Primary ID: SB960
EDI - 1ST Prof Payer Sec. ID Qualifier:
// EDI - Insurance Type: GROUP POLICY
EDI - Bin Number: .....
    
```

- | Step  | Procedure   |
|---|---|
|  | <i>Patch IB*2.0*320 added a new security key, <b>IB EDI INSURANCE EDIT</b>. A user must hold this key to edit the EDI-Transmit, EDI Prof Payer ID; EDI Inst Payer ID and EDI-Insurance Type fields.</i> |
| 2   | At the <b>EDI - Transmit?</b> : prompt, enter <b>1</b> to change the field to <b>YES-LIVE</b> .   |
| 3   | At the <b>EDI - Inst Payer Primary ID</b> : prompt, enter the <b>Payer Primary ID</b> provided by Emdeon.   |



*When editing the Payer Primary ID fields for a commercial payer, (not BC/BS) these fields may be left blank. Emdeon will try to match the VistA payer name and address to an entry in its Payer Lookup Table and auto-populate these fields. Payer ID numbers are available at [www.emdeon.com](http://www.emdeon.com).*

- 4 At the **EDI - 1ST Inst Payer Sec. ID Qualifier:** prompt, press **Return** to leave field blank.



*Patch IB\*2\*371 added the ability to define Payer Secondary IDs. They are unusual and should only be populated if the insurance company provides you with a secondary ID number.*

- 5 At the **EDI - Prof Payer Primary ID:** prompt, enter the **Payer Primary ID** provided by Emdeon.
- 6 At the **EDI - 1ST Prof Payer Sec. ID Qualifier:** prompt, press **Return** to leave field blank.
- 7 At the **EDI - Insurance Type:** prompt, enter **??** to see the choices available. For this example, select **Group Policy**. This will result in a checkmark in the **GROUP** insurance box of the CMS-1500/BOX 1.
- 8 Press the **Return** key until the Billing Parameters screen reappears.



*When Patch IB\*2\*371 is loaded, the patch will automatically define a Professional Payer Secondary for Medicare WNR that will have a Qualifier = Payer ID Number and an ID = VA plus the site's ID.*

```
EDI - Transmit?: YES-LIVE//  
EDI - Inst Payer Primary ID: 12M61//  
EDI - 1ST Inst Payer Sec. ID Qualifier:  
EDI - Prof Payer Primary ID: SMTX1//  
EDI - 1ST Prof Payer Sec. ID Qualifier: PAYER ID #  
//  
EDI - 1ST Prof Payer Sec. ID: VA442//
```

**2.1.1.2 Define EDI settings for a Blue Cross/Blue Shield Group Insurance Plan:**

**Step Procedure**

- 1 At the Billing Parameters Screen in the Insurance Company Editor, enter **VP - View Plans** and press the **Return** key.

```

Insurance Company Editor      Oct 01, 2007@10:15:14      Page:      1 of      9
Insurance Company Information for: BLUE CROSS
Type of Company: HEALTH INSURANCE      Currently Active

      Billing Parameters
Signature Required?: NO      Filing Time Frame:
      Reimburse?: WILL REIMBURSE      Type Of Coverage: HEALTH INSURAN
Mult. Bedsections:      Billing Phone: 800/933-9146
Diff. Rev. Codes:      Verification Phone: 800/933-9146
      One Opt. Visit: NO      Precert Comp. Name:
Amb. Sur. Rev. Code:      Precert Phone: 800/274-7767
Rx Refill Rev. Code:

      EDI Parameters
Transmit?: YES-LIVE      Insurance Type: GROUP POLICY
+      Enter ?? for more actions      >>>
BP Billing/EDI Param      IO Inquiry Office      EA Edit All
MM Main Mailing Address      AC Associate Companies      AI (In)Activate Company
IC Inpt Claims Office      ID Prov IDs/ID Param      CC Change Insurance Co.
OC Opt Claims Office      PA Payer      DC Delete Company
PC Prescr Claims Of      RE Remarks      VP View Plans
AO Appeals Office      SY Synonyms      EX Exit
Select Action: Next Screen//VP View Plans
    
```

**Step Procedure**

- 2 The Insurance Plan List appears. In this example, Plan 1 is selected by typing **VP=1** and pressing the **Return** key.

```

Insurance Plan List      Mar 31, 2004@16:12:52      Page:      1 of      1
All Plans for: BLUE CROSS BLUE SHIELD DEMO Insurance Company

# + => Indiv. Plan      * => Inactive Plan      Pre- Pre- Ben
  Group Name      Group Number      Type of Plan      UR? Ct? ExC? As?
1 DEMO FOR TRAINING      87654      COMPREHENSIVE      NO YES YES YES

      Enter ?? for more actions
VP View/Edit Plan      IP (In)Activate Plan
AB Annual Benefits      EX Exit
Select Action: Quit// VP=1
    
```

**Step Procedure**

- 3 The View/Edit Plan screen appears. To edit plan information, type **PI** and press the **Return** key.

```

View/Edit Plan           Mar 31, 2004@16:19:51           Page:    1 of    3
Plan Information for: BLUE CROSS Insurance Company
                        ** Plan Currently Active **

Plan Information                               Utilization Review Info
  Is Group Plan: YES                           Require UR: NO
  Group Name: DEMO FOR TRAINING                 Require Amb Cert: YES
  Group Number: 87654                           Require Pre-Cert: YES
  Type of Plan: COMPREHENSIVE MAJOR MED         Exclude Pre-Cond: YES
  Plan Filing TF:                               Benefits Assignable: YES

Plan Coverage Limitations
Coverage           Effective Date   Covered?   Limit Comments
-----
INPATIENT         02/10/04       YES
OUTPATIENT        02/10/04       YES
PHARMACY          02/10/04       NO
+               Enter ?? for more actions
PI Change Plan Info           IP (In)Activate Plan
UI UR Info                   AB Annual Benefits
CV Add/Edit Coverage         CP Change Plan
PC Plan Comments             EX Exit
Select Action: Next Screen// PI Change Plan Info
    
```

Step	Procedure
------	-----------

- |   |   |
|---|---|
| 4 | For this scenario <b>NO</b> is typed in for the <b>Do you wish to change this plan to an Individual Plan?</b> field.                          |
| 5 | Continue to press the <b>Return</b> key until <b>Electronic Plan Type</b> field is displayed.   |
| 6 | Type in the appropriate code and press the <b>Return</b> key. The chosen plan will be displayed. In this example <b>BL</b> has been selected. |

*Selecting the correct electronic plan type is critical. The electronic plan type for BC/BS payers should usually be set to **BL** - not commercial. Choosing the wrong electronic plan type for a Group Insurance Plan could result in claims being rejected by Emdeon or by the payer.*



```
This plan is currently defined as a Group Plan.
Do you wish to change this plan to an Individual Plan? NO
No change was made.

GROUP PLAN NAME: DEMO GROUP//
GROUP PLAN NUMBER: 7878787878//
TYPE OF PLAN: COMPREHENSIVE MAJOR MED
ELECTRONIC PLAN TYPE: ?
Enter the appropriate type of plan to be used for electronic billing.
  Choose from:
    16      HMO MEDICARE
    MX      MEDICARE A or B
    TV      TITLE V
    MC      MEDICAID
    BL      BC/BS
    CH      TRICARE
    15      INDEMNITY
    CI      COMMERCIAL
    HM      HMO
    DS      DISABILITY
    12      PPO
    13      POS
    ZZ      OTHER
ELECTRONIC PLAN TYPE: BL BCBS
```

The following screen will display.

```
View/Edit Plan           Mar 31, 2004@16:19:51           Page: 1 of 3
Plan Information for: BLUE CROSS Insurance Company
                        ** Plan Currently Active **

Plan Information                Utilization Review Info
  Is Group Plan: YES                Require UR: NO
   Group Name: DEMO FOR TRAINING    Require Amb Cert: YES
   Group Number: 87654              Require Pre-Cert: YES
   Type of Plan: COMPREHENSIVE MAJOR MED  Exclude Pre-Cond: YES
   Electronic Type: BC/BS            Benefits Assignable: YES

+          Enter ?? for more actions

Select Action: Next Screen//
```

## 2.1.2 Activate Existing Commercial Payer To Transmit eClaims

To activate a payer to receive electronic claims, use the Billing Parameters screen in the Insurance Company Editor. The **EDI - Transmit?** field on this screen must be set to **YES-LIVE**. In the Live mode, bills are automatically sent electronically and cannot be printed until the confirmation of a receipt message has been received from the FSC.

Follow these steps to change the **EDI - Transmit?** Field:

Step	Procedure
------	-----------

- |   |   |
|---|---|
| 1 | On the Billing Parameters screen in the Insurance Company Editor, type <b>BP</b> and press the <b>Return</b> key. |
|---|---|

```

Insurance Company Editor      Oct 01, 2007@10:40:16      Page: 1 of 8
Insurance Company Information for: AETNA
Type of Company: HEALTH INSURANCE      Currently Inactive

                                Billing Parameters
Signature Required?: NO      Filing Time Frame: 12 MOS
Reimburse?: WILL REIMBURSE      Type Of Coverage: HEALTH INSURAN
Mult. Bedsections:      Billing Phone:
Diff. Rev. Codes:      Verification Phone:
One Opt. Visit: NO      Precert Comp. Name:
Amb. Sur. Rev. Code:      Precert Phone:
Rx Refill Rev. Code:

                                EDI Parameters
Transmit?: NO      Insurance Type:
+ Enter ?? for more actions      >>>
BP Billing/EDI Param      IO Inquiry Office      EA Edit All
MM Main Mailing Address      AC Associate Companies      AI (In)Activate Company
IC Inpt Claims Office      ID Prov IDs/ID Param      CC Change Insurance Co.
OC Opt Claims Office      PA Payer      DC Delete Company
PC Prescr Claims Of      RE Remarks      VP View Plans
AO Appeals Office      SY Synonyms      EX Exit
Select Action: Next Screen//BP Billing/EDI Param
    
```

Step	Procedure
------	-----------



*Patch IB\*2.0\*320 added a new security key, **IB EDI INSURANCE EDIT**. A user must hold this key to edit the EDI-Transmit, EDI Prof Payer ID; EDI Inst Payer ID and EDI-Insurance Type fields.*

- 2 At the **EDI - Transmit?** field, type **1** to change the field to **YES-LIVE**.
- 3 At the **EDI - Insurance Type** field, enter the correct response for the Insurance Company being edited. For this example, the correct Electronic Insurance Type is **Group**.



Except for the testing of Primary BC/BS and AARP claims, it is no longer necessary to change the **EDI - Transmit?** field to **YES-TEST**. Instead, use the new option, **RCB – View/Resubmit Claims-Live or Test**. Refer to **Section 4**.

```

SIGNATURE REQUIRED ON BILL?: NO//
REIMBURSE?: WILL REIMBURSE//
ALLOW MULTIPLE BEDSECTIONS: YES//
DIFFERENT REVENUE CODES TO USE:
ONE OPT. VISIT ON BILL ONLY: NO//
AMBULATORY SURG. REV. CODE:
PRESCRIPTION REFILL REV. CODE: 253//
FILING TIME FRAME: ONE YEAR//
TYPE OF COVERAGE: HEALTH INSURANCE//
BILLING PHONE NUMBER: 800-555-5298//
VERIFICATION PHONE NUMBER: 800-555-5298//
Are Precerts Processed by Another Insurance Co.?: NO
//
PRECERTIFICATION PHONE NUMBER: 800-555-7799//
EDI - Transmit?: ??
    This is the flag that says whether or not an insurance company is ready
    to be billed electronically via 837/EDI functions.

    Choose from:
    0          NO
    1          YES-LIVE
    2          YES-TEST
EDI - Transmit?: 1 YES-LIVE
EDI - Inst Payer Primary ID: Available from Emdeon
EDI - 1ST Inst Payer Sec. ID Qualifier:
EDI - Prof Payer Primary ID: Available from Emdeon
EDI - 1ST Prof Payer Sec. ID Qualifier:
EDI - Insurance Type: ??
    Choose from:
    1          HMO
    2          COMMERCIAL
    3          MEDICARE
    4          MEDICAID
    5          GROUP POLICY
    9          OTHER
EDI - Insurance Type: 5 GROUP POLICY
BIN NUMBER:

```

The following steps show you how to enter the Electronic Plan Type for a **Commercial Group Insurance Plan**:

Step	Procedure
1	At the Billing Parameters Screen in the Insurance Company Editor type in <b>VP</b> (View Plans) and press the <b>Return</b> key.

```

Insurance Company Editor      Oct 01, 2007@10:40:16      Page:      1 of      8
Insurance Company Information for: AETNA
Type of Company: HEALTH INSURANCE      Currently Inactive

      Billing Parameters
Signature Required?: NO      Filing Time Frame: 12 MOS
      Reimburse?: WILL REIMBURSE      Type Of Coverage: HEALTH INSURAN
Mult. Bedsections:      Billing Phone:
Diff. Rev. Codes:      Verification Phone:
      One Opt. Visit: NO      Precert Comp. Name:
Amb. Sur. Rev. Code:      Precert Phone:
Rx Refill Rev. Code:

      EDI Parameters
      Transmit?: YES-LIVE      Insurance Type: GROUP POLICY
+      Enter ?? for more actions      >>>
BP Billing/EDI Param      IO Inquiry Office      EA Edit All
MM Main Mailing Address      AC Associate Companies      AI (In)Activate Company
IC Inpt Claims Office      ID Prov IDs/ID Param      CC Change Insurance Co.
OC Opt Claims Office      PA Payer      DC Delete Company
PC Prescr Claims Of      RE Remarks      VP View Plans
AO Appeals Office      SY Synonyms      EX Exit
Select Action: Next Screen//VP View Plans
    
```

Step	Procedure
2	The Insurance Plan List appears. In this example, Plan 1 is selected by typing <b>VP=1</b> and pressing the <b>Return</b> key.

```

Insurance Plan List      Apr 14, 2004@09:21:12      Page:      1 of      1
All Plans for: AETNA Insurance Company

# + => Indiv. Plan      * => Inactive Plan      Pre- Pre- Ben
  Group Name      Group Number      Type of Plan      UR? Ct? ExC? As?
1  MANAGED CHOICE      55555-111-00001      COMPREHENSIVE      YES YES UNK YES

      Enter ?? for more actions
VP View/Edit Plan      IP (In)Activate Plan
AB Annual Benefits      EX Exit
Select Action: Quit// VP=1
    
```

Step	Procedure
3	The View/Edit Plan screen appears. To edit plan information, type <b>PI</b> and press the <b>Return</b> key.

```

View/Edit Plan                Apr 14, 2004@09:22:11                Page:    1 of    3
Plan Information for: AETNA Insurance Company
                                ** Plan Currently Active **

Plan Information                                Utilization Review Info
  Is Group Plan: YES                            Require UR: YES
  Group Name:  MANAGED CHOICE                    Require Amb Cert:
  Group Number: 55555-111-00001                Require Pre-Cert: YES
  Type of Plan: COMPREHENSIVE MAJOR MED        Exclude Pre-Cond:
  Plan Filing TF:                               Benefits Assignable: YES

Plan Coverage Limitations
Coverage          Effective Date    Covered?      Limit Comments
-----          -
INPATIENT        02/01/04          YES
OUTPATIENT       02/01/04          YES
PHARMACY         02/01/04          NO
+               Enter ?? for more actions
PI  Change Plan Info          IP  (In)Activate Plan
UI  UR Info                   AB  Annual Benefits
CV  Add/Edit Coverage         CP  Change Plan
PC  Plan Comments             EX  Exit
Select Action: Next Screen//  PI  Change Plan Info
    
```

Step	Procedure
------	-----------

- |   |   |
|---|---|
| 4 | For this scenario, <b>NO</b> is entered for the <b>Do you wish to change this plan to an Individual Plan?</b> field.                          |
| 5 | Continue to press the <b>Return</b> key until <b>Electronic Plan Type</b> field is activated.   |
| 6 | Type in the appropriate code and press the <b>Return</b> key. The chosen plan will be displayed. In this example <b>CI</b> has been selected. |



*Selecting the correct electronic plan type is important. Choosing the wrong electronic plan type for a Group Insurance Plan could result in claims being rejected by Emdeon or by the payer.*

```

This plan is currently defined as a Group Plan.
Do you wish to change this plan to an Individual Plan? NO
No change was made.

GROUP PLAN NAME: MANAGED CHOICE//
GROUP PLAN NUMBER: 55555-111-00001//
TYPE OF PLAN: COMPREHENSIVE MAJOR MEDICAL//
ELECTRONIC PLAN TYPE: ?
Enter the appropriate type of plan to be used for electronic billing.
  Choose from:
    16      HMO MEDICARE
    MX      MEDICARE A or B
    TV      TITLE V
    MC      MEDICAID
    BL      BC/BS
    CH      TRICARE
    15      INDEMNITY
    CI      COMMERCIAL
    HM      HMO
    DS      DISABILITY
    12      PPO
    13      POS
    ZZ      OTHER
ELECTRONIC PLAN TYPE: CI COMMERCIAL
PLAN FILING TIME FRAME: .....

```

The following screen will display.

```

View/Edit Plan          Apr 14, 2004@09:24:02          Page:    1 of    3
Plan Information for: AETNA DEMO INSURANCE Insurance Company
                               ** Plan Currently Active **

Plan Information                Utilization Review Info
Is Group Plan: YES              Require UR: YES
Group Name: MANAGED CHOICE      Require Amb Cert:
Group Number: 55555-111-00001   Require Pre-Cert: YES
Type of Plan: COMPREHENSIVE MAJOR MED  Exclude Pre-Cond:
Electronic Type: COMMERCIAL      Benefits Assignable: YES

+          Enter ?? for more actions

Select Action: Next Screen//

```

### 2.1.3 Activate Existing Payer To Test Primary Blue Cross/Blue Shield eClaims

Blue Cross and Blue Shield payers require the submission of test claims before accepting live claims. Contact the EDI Implementation Manager at Emdeon to coordinate this testing.



*When testing the electronic submission of secondary claims using the RCB – View/Resubmit Claims-Live or Test, it is not necessary to change Electronic Transmit? to YES-TEST nor is it necessary to print and mail claims sent using RCB.*

To enable a BC/BS payer to receive primary claims electronically but in a testing mode, use the Billing Parameters screen in the Insurance Company Editor. The **EDI - Transmit?** field on this screen must be set to **YES-TEST**. In testing mode, bills are automatically sent electronically and cannot be printed until the confirmation of receipt message has been received from the FSC.

The following steps show you how to change the **Electronic Transmit?** field:

- | Step | Procedure  |
|------|--|
| 1    | On the Billing Parameters screen in the Insurance Company Editor type <b>BP</b> and press the <b>Return</b> key. |

```

Insurance Company Editor      Oct 01, 2007@10:15:14      Page:      1 of      9
Insurance Company Information for: BLUE CROSS
Type of Company: HEALTH INSURANCE                      Currently Active

                                Billing Parameters
Signature Required?: NO          Filing Time Frame:
  Reimburse?: WILL REIMBURSE    Type Of Coverage: HEALTH INSURAN
Mult. Bedsections:              Billing Phone: 800/933-9146
  Diff. Rev. Codes:             Verification Phone: 800/933-9146
  One Opt. Visit: NO            Precert Comp. Name:
Amb. Sur. Rev. Code:            Precert Phone: 800/274-7767
Rx Refill Rev. Code:

                                EDI Parameters
Transmit?: NO                    Insurance Type:
+ Enter ?? for more actions      >>>
BP Billing/EDI Param             IO Inquiry Office          EA Edit All
MM Main Mailing Address         AC Associate Companies    AI (In)Activate Company
IC Inpt Claims Office          ID Prov IDs/ID Param     CC Change Insurance Co.
OC Opt Claims Office           PA Payer                 DC Delete Company
PC Prescr Claims Of            RE Remarks               VP View Plans
AO Appeals Office              SY Synonyms              EX Exit
Select Action: Next Screen//BP Billing/EDI Param
  
```

- | Step | Procedure  |
|------|--|
| 2    | At the <b>EDI - Transmit?</b> field, type <b>2</b> to change the field to <b>YES-TEST</b> . Continue to press the <b>Return</b> key until the Billing Parameters screen reappears. |



*When using the TEST mode setting for BC/BS claims for which payment is expected, it is important to note the carrier will not process bills sent in test mode. These bills **must be printed locally and mailed** in order to receive payment.*

```
SIGNATURE REQUIRED ON BILL?: NO//
REIMBURSE?: WILL REIMBURSE//
ALLOW MULTIPLE BEDSECTIONS: YES//
DIFFERENT REVENUE CODES TO USE:
ONE OPT. VISIT ON BILL ONLY: NO//
AMBULATORY SURG. REV. CODE: 490//
PRESCRIPTION REFILL REV. CODE: 250//
FILING TIME FRAME: ONE YEAR FROM DATE OF SERVICE
TYPE OF COVERAGE: HEALTH INSURANCE//
BILLING PHONE NUMBER: 205-988-2213//
VERIFICATION PHONE NUMBER: ITS:800-253-9307//
Are Precerts Processed by Another Insurance Co.?: NO
//
PRECERTIFICATION PHONE NUMBER: 800-248-2342//
EDI - Transmit?: NO// ??
    This is the flag that says whether or not an insurance company is
    ready to be billed electronically via 837/EDI functions.

    Choose from:
    0      NO
    1      YES-LIVE
    2      YES-TEST
EDI - Transmit?: YES-TEST//
EDI - Inst Payer Primary ID: Available from Emdeon
EDI - 1ST Inst Payer Sec. ID Qualifier:
EDI - Prof Payer Primary ID: Available from Emdeon
EDI - 1ST Prof Payer Sec. ID Qualifier:
EDI - Insurance Type: 5 GROUP POLICY
BIN NUMBER:
```

### 3. PROVIDER ID SET-UP

Payers require the use of a variety of provider identifiers on claims submitted for adjudication. Printed claim forms have boxes where these IDs can be printed.

The general term, Provider ID, can refer to an ID that belongs to human being such as an Attending physician or it can refer to an ID that belongs to an organization that provides healthcare services to a veteran such as a VAMC or outside laboratory. Both VA and non-VA people and organizations have IDs.

IDs have qualifiers that identify what type of ID is being transmitted. An Attending physician's primary ID is his/her Social Security Number. This SSN is transmitted with a qualifier (34) which indicates that this number is an SSN. A Blue Cross ID is transmitted with a qualifier (1A) which indicates that this number is a Blue Cross number. Appendix C has a list of qualifiers and which ones can be transmitted in which 837 records. The NPI (National Provider Identifier) is a Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirement with a usage requirement date beginning May 23, 2007. It is transmitted on 837 records along with treating specialty taxonomies from the National Uniform Claims Committee (NUCC) published code list.

Patch IB\*2.0\*343 added the ability to define the National Provider Identifier (NPI) and Taxonomy Codes for the VAMC, Non-VA facilities and both VA and Non-VA human providers.

Patches IB\*2.0\*348 and 349 added the ability to print the NPI on the new UB-04 and CMS-1500 claim forms.

Eventually, when all payers are prepared to accept the NPI, the NPI will become a provider's primary ID. In the interim, both the NPI and the legacy IDs will be transmitted to Emdeon and printed on locally printed claims.

The HIPAA 837 transaction set includes a number of segments in which to transmit multiple IDs and qualifiers for a single claim. The list below indicates the VistA record name, the type of information being transmitted, the maximum number of IDs that can go in that record for one claim and if the IDs will print on a paper claim (P), transmit electronically (T), or do both (B).

Segment	Type of ID	Max # of IDs	(P)rint (T)ransmit (B)oth
PRV:9	Billing Provider Primary ID (Federal Tax Number)	1	B
CL1A:2-17	Billing Provider Secondary IDs	8	B
OPR1	Attending, Other or Operating Physician Primary ID	1/Physician	B
OPR1	Rendering or Referring Provider Primary ID	1/Provider	B
OPR7	Supervising Provider's Primary ID	1/Provider	B
OPR2	Attending Physician or Rendering Provider Secondary ID	5	B
OPR3	Operating Physician Secondary IDs	5	B
OPR4	Other Physician Secondary IDs	5	B

OPR5	Referring Provider Secondary IDs	5	B
OPR8	Supervising Provider Secondary IDs	5	B
NPI	National Provider Identifier (Billing Provider, Service Facility and Performing Providers)	1/Provider	B
SUB	Laboratory or Facility Primary ID	1	B
SUB1	Purchased Service Secondary IDs	5	T
SUB2	Laboratory or Facility Secondary IDs	5	T

### 3.1. Table of IDs

The following table shows where IDs are defined in VistA; where they are stored in VistA; where they appear on billing forms; and where they appear in the VistA option View/Print EDI Bill Extract Data (VPE) and the EDI 837 transaction record location.

#### Billing Provider NPI

VistA Option	The Institution file is not available to Billing personnel
VistA File	Institution (#4)
UB-04	FL 56
CMS -1500	Box 33a (Box 32a unless there is an outside facility)
VPE (837 Record)	NPI, Piece 12

#### Billing Provider Taxonomy Code

VistA Option	The Institution file is not available to Billing personnel
VistA File	Institution (#4)
UB-04	N/A
CMS -1500	N/A
VPE (837 Record)	NPI, Piece 13

#### Billing Provider Primary ID (Federal Tax Number of the VAMC) - Legacy

VistA Option	MCCR Site Parameter Display/Edit
VistA File	IB SITE PARAMETERS (#350.9)
UB-04	FL 5
CMS-1500	Box 25
VPE (837 Record)	PRV, Piece 9

#### Billing Provider Secondary IDs - Legacy

Note: If none are defined, the default is the Federal Tax ID.

VistA Option	Insurance Company Entry/Edit→ID Prov IDs/ID Param
VistA File	FACILITY BILLING ID (#355.92)
UB-04	FL 57
CMS -1500	Box 33b
VPE (837 Record)	CI1A, Pieces 2-17

#### VA - Attending, Other or Operating Physician NPI

VistA Option	Provider Self Entry (Not available to Billing personnel) Add/Edit NPI values for Providers
VistA File	NEW PERSON (#200)
UB-04	FL 76-79
CMS -1500	N/A
VPE (837 Record)	NPI, Piece 2, 4, or 6

#### VA – Attending, Other or Operating Physician Taxonomy Code

VistA Option	Add a New User to the System (Not available to Billing personnel) Edit an Existing User Person Class Edit
VistA File	PERSON CLASS (#8932.1)
UB-04	N/A

CMS -1500	N/A
VPE (837 Record)	NPI, Piece 3, 5, or 7

#### **VA - Attending, Other or Operating Physician Primary ID (SSN) - Legacy**

VistA Option	Add a New User to the System Edit an Existing User
VistA Files	NEW PERSON (#200)
UB-04	N/A
CMS -1500	N/A
VPE (837 Record)	OPR1, Pieces 3, 6, or 9

#### **VA - Rendering or Referring Provider NPI**

VistA Option	Provider Self Entry (Not available to Billing personnel) Add/Edit NPI values for Providers
VistA File	NEW PERSON (#200)
UB-04	N/A
CMS-1500	Box 17b (Referring), 24J (Rendering)
VPE (837 Record)	NPI, Piece 2 or 10

#### **VA - Rendering or Referring Provider Taxonomy Code**

VistA Option	Add a New User to the System (Not available to Billing personnel) Edit an Existing User Person Class Edit
VistA File	PERSON CLASS (#8932.1)
UB-04	N/A
CMS -1500	N/A
VPE (837 Record)	NPI, Piece 3 or 11

#### **VA – Rendering or Referring Provider Primary ID (SSN) - Legacy**

VistA Option	Add a New User to the System (Not available to Billing personnel) Edit an Existing User
VistA Files	NEW PERSON (#200)
UB-04	N/A
CMS -1500	N/A
VPE (837 Record)	OPR1, Pieces 3 or 12

#### **VA - Supervising Provider NPI**

VistA Option	Provider Self Entry (Not available to Billing personnel) Add/Edit NPI values for Providers
VistA File	NEW PERSON file #200
UB-04	N/A
CMS -1500	N/A
VPE (837 Record)	NPI, Piece 8

#### **VA - Supervising Provider Taxonomy Code**

VistA Option	Add a New User to the System (Not available to Billing personnel) Edit an Existing User Person Class Edit
VistA File	PERSON CLASS file #8932.1
UB-04	N/A
CMS -1500	N/A

VPE (837 Record)            NPI, Piece 9

#### **VA – Supervising Provider Primary ID (SSN) - Legacy**

VistA Option            Add a New User to the System (Not available to Billing personnel)  
                                  Edit an Existing User  
 VistA Files            NEW PERSON (#200)  
 UB-04                    N/A  
 CMS -1500            N/A  
 VPE (837 Record)      OPR7, Piece 7

#### **Non-VA - Attending, Other or Operating Physician NPI**

VistA Option            Provider ID Maintenance→Non/Other VA Provider→Individual  
 VistA File            IB NON VA/OTHER BILLING PROVIDER (#355.93)  
 UB-04                    FL 76-79  
 CMS -1500            N/A  
 VPE (837 Record)      NPI, Piece 2, 4, or 6

#### **Non-VA - Attending, Other or Operating Physician Taxonomy Code**

VistA Option            Provider ID Maintenance→Non/Other VA Provider→Individual  
 VistA File            IB NON VA/OTHER BILLING PROVIDER (#355.93)  
 UB-04                    FL 76-79  
 CMS -1500            N/A  
 VPE (837 Record)      NPI, Piece 3, 5 or 7

#### **Non-VA – Attending, Other or Operating Physician Primary ID (SSN) - Legacy**

VistA Option            Provider ID Maintenance→Non/Other VA Provider→Individual  
 VistA Files            IB BILLING PRACTITIONER ID (#355.9)  
 UB-04                    N/A  
 CMS-1500            N/A  
 VPE (837 Record)      OPR1, Pieces 3, 6, or 9

#### **Non-VA – Rendering or Referring Provider NPI**

VistA Option            Provider ID Maintenance→Non/Other VA Provider→Individual  
 VistA Files            IB NON VA/OTHER BILLING PROVIDER (#355.93)  
 UB-04                    N/A  
 CMS-1500            17b (Referring), 24J (Rendering)  
 VPE (837 Record)      NPI, Piece 2 or 10

#### **Non-VA – Rendering or Referring Provider Taxonomy Code**

VistA Option            Provider ID Maintenance→Non/Other VA Provider→Individual  
 VistA Files            IB NON/OTHER VA BILLING PROVIDER (#355.93)  
 UB-04                    N/A  
 CMS-1500            N/A  
 VPE (837 Record)      NPI, Piece 3 or 11

#### **Non-VA – Rendering or Referring Provider Primary ID (SSN) - Legacy**

VistA Option            Provider ID Maintenance→Non/Other VA Provider→Individual  
 VistA Files            IB BILLING PRACTITIONER ID (#355.9)  
 UB-04                    N/A  
 CMS-1500            N/A  
 VPE (837 Record)      OPR1, Pieces 3 or 12

**Non-VA – Supervising Provider NPI**

VistA Option	Provider ID Maintenance→Non/Other VA Provider→Individual
VistA Files	IB NON VA/OTHER BILLING PROVIDER (#355.93)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	NPI, Piece 8

**Non-VA – Supervising Provider Taxonomy Code**

VistA Option	Provider ID Maintenance→Non/Other VA Provider→Individual
VistA Files	IB NON VA/OTHER BILLING PROVIDER (#355.93)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	NPI, Piece 9

**Non-VA – Supervising Provider Primary ID (SSN) - Legacy**

VistA Option	Provider ID Maintenance→Non/Other VA Provider→Individual
VistA Files	IB BILLING PRACTITIONER ID (#355.9)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	OPR7, Piece 7

**VA - Attending, Other or Operating Physician Secondary IDs - Legacy**

VistA Option	Provider ID Maintenance→ Provider Specific IDs→ Provider's Own IDs Provider IDs Furnished by Insurance Co
VistA Files	IB Billing Practitioner ID (#355.9)
UB-04	FL 76-79
CMS-1500	N/A
VPE (837 Record)	OPR2, OPR3, OPR4 Pieces 3, 5, 7, 9 or 11

**VA – Rendering or Referring Provider Secondary IDs - Legacy**

VistA Option	Provider ID Maintenance→ Provider Specific IDs→ Provider's Own IDs Provider IDs Furnished by Insurance Co
VistA Files	IB Billing Practitioner ID (#355.9)
UB-04	N/A
CMS-1500	Box 17a (Referring), Box 24J
VPE (837 Record)	OPR2, OPR5, Pieces 3, 5, 7, 9 or 11

**VA – Supervising Provider Secondary IDs - Legacy**

VistA Option	Provider ID Maintenance→ Provider Specific IDs→ Provider's Own IDs Provider IDs Furnished by Insurance Co
VistA Files	IB Billing Practitioner ID (#355.9)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	OPR 8, Pieces 3, 5, 7, 9 or 11

**Non - VA - Attending, Other or Operating Physician Secondary IDs - Legacy**

VistA Option	Provider ID Maintenance→ Non/Other VA Provider ID Information
--------------	---

	Provider ID Maintenance→ Provider Specific IDs→ Provider's Own IDs Provider IDs Furnished by Insurance Co
VistA Files	IB Billing Practitioner ID (#355.9)
UB-04	FL 76-79
CMS-1500	N/A
VPE (837 Record)	OPR2, OPR3, OPR4 Pieces 3, 5, 7, 9 or 11

#### **Non - VA – Rendering or Referring Provider Secondary IDs - Legacy**

VistA Option	Provider ID Maintenance→ Non/Other VA Provider ID Information Provider ID Maintenance→ Provider Specific IDs→ Provider's Own IDs Provider IDs Furnished by Insurance Co
VistA Files	IB Billing Practitioner ID (#355.9)
UB-04	N/A
CMS-1500	FL 17a (Referring), 24J (Rendering)
VPE (837 Record)	OPR2, OPR5, Pieces 3, 5, 7, 9 or 11

#### **Non - VA – Supervising Provider Secondary IDs - Legacy**

VistA Option	Provider ID Maintenance→ Non/Other VA Provider ID Information Provider ID Maintenance→ Provider Specific IDs→ Provider's Own IDs Provider IDs Furnished by Insurance Co
VistA Files	IB Billing Practitioner ID (#355.9)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	OPR8, Pieces 3, 5, 7, 9 or 11

#### **VA - Service Facility – Laboratory or Facility NPI**

VistA Option	The Institution file is not available to Billing personnel
VistA File	INSTITUTION (#4)
UB-04	N/A
CMS-1500	Box 32a
VPE (837 Record)	NPI, Piece 16

#### **VA - Service Facility – Laboratory or Facility Taxonomy Code**

VistA Option	The Institution file is not available to Billing personnel
VistA File	INSTITUTION (#4)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	NPI, Piece 17

#### **VA - Service Facility – Laboratory or Facility Primary ID (Federal Tax ID)**

VistA Option	MCCR Site Parameter Display/Edit Insurance Company Entry/Edit – ID Parameter can be set by Insurance Co. to not transmit this for VA main facility
VistA File	IB SITE PARAMETERS (#350.9)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	SUB, Piece 9 and SUB2, Piece 6

**VA - Service Facility – Laboratory or Facility Secondary IDs - Legacy**

VistA Option	Insurance Company Entry/Edit →ID Prov IDs/ID Param →VA-Lab/Facility IDs
VistA File	FACILITY BILLING ID (#355.92)
UB-04	N/A
CMS-1500	Box 32b
VPE (837 Record)	SUB1, Pieces 3, 5, 7, 9, and 11 and SUB2, Pieces 8, 10, 12, 14, 16

**Non-VA - Service Facility – Laboratory or Facility NPI**

VistA Option	Provider ID Maintenance→ Non/Other VA Provider ID Information→Facility→Facility Info
VistA File	IB NON VA/OTHER BILLING PROVIDER file #355.93
UB-04	N/A
CMS-1500	Box 32a
VPE (837 Record)	NPI, Piece 16

**Non-VA - Service Facility – Laboratory or Facility Primary ID (Federal Tax ID) - Legacy**

VistA Option	Provider ID Maintenance→ Non/Other VA Provider ID Information→Facility→Provider Info
VistA File	IB NON/OTHER VA BILLING PROVIDER (#355.93)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	SUB, Piece 9 and SUB2, Piece 6

**Non-VA - Service Facility – Laboratory or Facility Taxonomy Code**

VistA Option	Provider ID Maintenance→ Non/Other VA Provider ID Information→Facility→Facility Info
VistA File	IB NON/OTHER VA BILLING PROVIDER (#355.93)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	NPI, Piece 17

**Non-VA - Service Facility – Laboratory or Facility Secondary IDs - Legacy**

VistA Option	Provider ID Maintenance→ Non/Other VA Provider ID Information→Facility→Secondary ID Maint
VistA File	IB BILLING PRACTITIONER ID (#355.9)
UB-04	Not Printed
CMS-1500	32b
VPE (837 Record)	SUB1, Pieces 3, 5, 7, 9, and 11 and SUB2, Pieces 8, 10, 12, 14, 16

### 3.2. Billing Provider IDs

The Billing Provider Primary ID and the Billing Provider Secondary IDs are IDs which identify the entity which is seeking payment for a claim (who will receive the payment). For claims generated by the VA, the Billing Provider is the VA.

#### 3.2.1 Define the Billing Provider Primary ID/NPI

For all claims generated by the VA, the Billing Provider Primary ID is always the Federal Tax Number of the site. Once defined, the IB software will automatically assign this ID to a claim.

Eventually, the Billing Provider NPI will become the Billing Provider Primary ID. The Billing Provider NPI is defined in the Institution file. The Federal Tax ID will become a secondary ID and payers will stop required legacy secondary IDs.

Beginning with Patch IB\*2.0\*343, the Billing Provider NPI will be transmitted in the 837 claim transmission along with the legacy Primary ID.

Beginning with Patches IB\*2.0\*348 and 349, the Billing Provider NPI will be printed on locally printed claims.

The VA Billing Provider NPI and Taxonomy Code will not be entered or maintained by Billing personnel.

Step	Procedure
1	Access the option <b>SITE→MCCR Site Parameter Display/Edit.</b>
2	From the <b>MCCR Site Parameters</b> screen, enter the action, <b>IB Site Parameters.</b>
3	Press <b>Return</b> for Next Screen until Page 2 is displayed.
4	From the <b>IB Site Parameters screen</b> , enter the action, <b>EP Edit Set.</b>
5	Enter the number <b>9.</b>
6	At the <b>Federal Tax Number</b> prompt, enter the site's Federal Tax Number.

```

IB Site Parameters          Oct 20, 2005@16:23:16          Page:    2 of    6
Only authorized persons may edit this data.
+
[5] Medical Center      : LOMA LINDA VAMC      Default Division   : JERRY L PETTI
    MAS Service         : PATIENT ELIGIBILITY  Billing Supervisor  : KYDFES,SHUUN

[6] Initiator Authorize: YES                Xfer Proc to Sched : NO
    Ask HINQ in MCCR   : YES                Use Non-PTF Codes  : YES
    Multiple Form Types: YES                Use OP CPT screen  : YES

[7] UB-04 Print IDs    : YES                UB-04 Address Col  :
    CMS-1500 Print IDs : YES                CMS-1500 Addr Col  : 28

[8] Default RX DX Cd   : 780.99              Default ASC Rev Cd : 490
    Default RX CPT Cd   :                    Default RX Rev Cd   : 251

[9] Bill Signer Name   : <No longer used>      Federal Tax #       :
    Bill Signer Title   : <No longer used>
    Remark on Each Bill: BILL # MUST BE ON ALL REMITTANCE

+          Enter ?? for more actions
EP  Edit Set                      EX  Exit Action
Select Action: Next Screen// ep  Edit Set
Select Parameter Set(s): (5-9): 9
NAME OF CLAIM FORM SIGNER: BUSINESS OFFICE//
TITLE OF CLAIM FORM SIGNER:
FEDERAL TAX NUMBER: XXX123456

```

### 3.2.2 Define the Billing Provider Secondary IDs

The Billing Provider Secondary IDs are IDs and Qualifiers that are provided to a site by the insurance company. There can be a total of eight Billing Provider Secondary IDs per claim. The first ID is calculated by the system and used by Emdeon to sort claims. The remaining seven IDs must be defined by the IB staff if required.

Users may define one Billing Provider Secondary ID for a CMS-1500 and another for a UB-04 for the main division. If no other Billing Provider Secondary IDs are defined, these two IDs will be the default IDs for all claims.

Billing Provider Secondary IDs can be defined by Division, Form Type and Care Unit.

#### 3.2.2.1 Define Default Billing Provider Secondary IDs by Form Type

Step	Procedure
1	Access the option <b>MCCR SYSTEM DEFINITION MENU</b> → <b>Insurance Company Entry/Edit</b> .
2	At the <b>Select Insurance Company Name</b> : prompt, enter <b>Blue Cross of California</b> for this example.
3	From the <b>Insurance Company Editor</b> screen, enter the action, <b>ID Prov IDs/ID Param</b> .
4	From the <b>Billing Provider IDs</b> screen, enter the action <b>Add an ID</b> .
5	At the <b>Define Billing Provider Secondary IDs by Care Units? No//</b> prompt, press <b>Return</b> to accept the default of <b>No</b> .

- 6 At the **Division** prompt, accept the default for the main Division.
- 7 At the **ID Qualifier: Electronic Plan Type//** prompt, enter **Blue Shield** to override the default value for this example.



*Note: The default value for the Billing Provider Secondary ID Qualifier is still based upon the Electronic Plan Type of the patient's insurance plan. Users now have the ability to override this default.*

- 8 At the **Form Type** prompt, enter **CMS-1500** for this example.
- 9 At the **Billing Provider Secondary ID** prompt, enter the ID **XXXXXXXX1B** for this example.

- 10 Repeat these steps for the Form Type = **UB-04**, Qualifier = **Blue Cross** and ID = **XXXXXXXX1A**.



*Note: If no Billing Provider Secondary IDs are defined, the Federal Tax ID is used as a default value.*

```

Billing Provider IDs (Parent)          May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA  Billing Provider Secondary IDs
ID Qualifier                          ID #                          Form Type

No Billing Provider IDs found

          Enter ?? for more actions
Add an ID          Additional IDs          Exit
Edit an ID         ID Parameters
Delete an ID       VA-Lab/Facility IDs

Select Action: Quit// a Add ID
Define Billing Provider Secondary IDs by Care Units? No///??

Enter No to define a Billing Provider Secondary ID
for the Division.
Enter Yes to define a Billing Provider Secondary ID
for a specific Care Unit.
If no Care Unit is entered on Billing Screen 3, the
Billing Provider Secondary ID defined for the Division will
be transmitted in the claim.

0  No
1  Yes

Define Billing Provider Secondary IDs by Care Units? No//No
Division: Main Division// Main Division
ID Qualifier: Electronic Plan Type//Blue Shield
Enter Form Type for ID: CMS-1500
Billing Provider Secondary ID: XXXXXX1B
    
```

The following screen will display. These two IDs will be the default IDs for all claims and will appear on Billing Screen 3.

```

Billing Provider IDs (Parent)          May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA  Billing Provider Secondary IDs
ID Qualifier                          ID #                          Form Type
Division: Name of Main Division/Default for All Divisions
1   Blue Cross                         XXXXXX1A                      UB04
2   Blue Shield                        XXXXXX1B                      1500

Enter ?? for more actions
Add an ID                             Additional IDs                 Exit
Edit an ID                             ID Parameters
Delete an ID                           VA-Lab/Facility IDs

Select Action: Quit//

```

### 3.2.2.2 Define Billing Provider Secondary IDs by Division and Form Type

If an insurance company requires different Billing Provider Secondary IDs for each division, then users must define more than just the default IDs.

Step	Procedure
1	Access the option <b>MCCR SYSTEM DEFINITION MENU</b> → <b>Insurance Company Entry/Edit</b> .
2	At the <b>Select Insurance Company Name:</b> prompt, enter <b>Blue Cross of California</b> for this example.
3	From the <b>Insurance Company Editor</b> screen, enter the action, <b>ID Prov IDs/ID Param</b> .
4	From the <b>Billing Provider IDs</b> screen, enter the action <b>Add an ID</b> .
5	At the <b>Define Billing Provider Secondary IDs by Care Units? No//</b> prompt, press <b>Return</b> to accept the default of <b>No</b> .
6	At the <b>Division</b> prompt, override the default for the main division by entering the name of another division, <b>Remote Clinic</b> for this example.
7	At the <b>ID Qualifier: Electronic Plan Type//</b> prompt, enter <b>Blue Shield</b> to override the default value for this example.
8	At the <b>Form Type</b> prompt, enter CMS-1500 for this example.
9	At the <b>Billing Provider Secondary ID</b> prompt, enter the ID <b>1XXXXX1B</b> for this example.
10	Repeat these steps for the Form Type = <b>UB-04</b> , Qualifier = <b>Blue Cross</b> and ID = <b>1XXXXX1A</b> .



*Note: Users may repeat these steps to define different Billing Provider Secondary IDs for each division if required by the insurance company.*

```

Billing Provider IDs (Parent)      May 27, 2005@12:48:29      Page: 1 of 1
Insurance Co: BLUE CROSS OF CALIFORNIA      Billing Provider Secondary IDs
ID Qualifier      ID #      Form Type
Division: Name of Main Division/Default for All Divisions
1  Blue Cross      XXXXXX1A      UB04
2  Blue Shield     XXXXXX1B      1500

Enter ?? for more actions
Add an ID      Additional IDs      Exit
Edit an ID     ID Parameters
Delete an ID   VA-Lab/Facility IDs

Select Action: Quit// a Add ID
Define Billing Provider Secondary IDs by Care Units? No//No
Division: Main Division// Remote Clinic
ID Qualifier: Electronic Plan Type//Blue Shield
Enter Form Type for ID: CMS-1500
Billing Provider Secondary ID: 1XXXXX1B
    
```

The following screen will display.



Note: The two IDs for the Remote Clinic division will be available to the clerk on Billing Screen 3 for claims for services provided by this division.

```

Billing Provider IDs      May 27, 2005@12:48:29      Page: 1 of 1
Insurance Co: BLUE CROSS OF CALIFORNIA      Billing Provider Secondary IDs
ID Qualifier      ID #      Form Type
Division: Name of Main Division/Default for All Divisions
1  Blue Cross      XXXXXX1A      UB04
2  Blue Shield     XXXXXX1B      HCFA

Division: Remote Clinic
3  Blue Cross      1XXXXX1A      UB04
4  Blue Shield     1XXXXX1B      1500

Enter ?? for more actions
Add an ID      Additional IDs      Exit
Edit an ID     ID Parameters
Delete an ID   VA-Lab/Facility IDs

Select Action: Quit//
    
```

### 3.2.2.3 Define Billing Provider Secondary IDs by Division, Form Type and Care Unit

If an insurance company requires different Billing Provider Secondary IDs for services provided by particular Care Units, users can define them by Division, Form Type and Care Unit.

Step	Procedure
1	Access the option <b>MCCR SYSTEM DEFINITION MENU</b> →Insurance Company

**Entry/Edit.**

- 2 At the **Select Insurance Company Name:** prompt, enter **Blue Cross of California** for this example.
- 3 From the **Insurance Company Editor** screen, enter the action, **ID Prov IDs/ID Parameters.**
- 4 From the **Billing Provider IDs** screen, enter the action **Add an ID.**
- 5 At the **Define Billing Provider Secondary IDs by Care Units? No//** prompt, enter **YES** to override the default.
- 6 At the **Division** prompt, press **Return** to accept the default for the **Main Division.**
- 7 At the **Care Unit:** prompt, enter **??** to see a pick list of available Care Units. Refer to **Section 3.4.2** to learn how to create this list of available Care Units.
- 8 At the **Care Unit:** prompt, enter **Anesthesia** for this example.
- 9 At the **ID Qualifier: Electronic Plan Type//** prompt, enter **Blue Shield** to override the default value for this example.
- 10 At the **Form Type** prompt, enter **CMS-1500** for this example.
- 11 At the **Billing Provider Secondary ID** prompt, enter the ID **11XXXX1B** for this example.
- 12 Repeat these steps for the Form Type = **UB-04**, Qualifier = **Blue Cross** and ID = **11XXXX1A.**
- 13 Repeat these steps for Care Units **Reference Lab** and **Home Health.**

```

Billing Provider IDs          May 27, 2005@12:48:29          Page: 1 of 1
Insurance Co: BLUE CROSS OF CALIFORNIA  Billing Provider Secondary IDs
ID Qualifier                ID #                Form Type
Division: Name of Main Division/Default for All Divisions
1  Blue Cross                XXXXXX1A           UB04
2  Blue Shield                XXXXXX1B           1500

Division: Remote Clinic
3  Blue Cross                1XXXXX1A           UB04
4  Blue Shield                1XXXXX1B           1500

Enter ?? for more actions
Add an ID                    Additional IDs      Exit
Edit an ID                   ID Parameters
Delete an ID                 VA-Lab/Facility IDs

Select Action: Quit// a    Add ID
Define Billing Provider Secondary IDs by Care Units? No//??

Enter No to define a Billing Provider Secondary ID
for the Division.
Enter Yes to define a Billing Provider Secondary ID
for a specific Care Unit.
If no Care Unit is entered on Billing Screen 3, the
Billing Provider Secondary ID defined for the Division will
be transmitted in the claim.

0  No
1  Yes

Define Billing Provider Secondary IDs by Care Units? No//1 Yes
    
```

```

Division: Main Division// Main Division
Care Unit:??
  Select a Care Unit from the list:
    1 Anesthesia
    2 Reference Lab
    3 Home Health
Care Unit: 1 Anesthesia
ID Qualifier: Electronic Plan Type//Blue Shield
Enter Form Type for ID: CMS-1500
Billing Provider Secondary ID: 11XXXX1B

```

The following screen will display.

```

Billing Provider IDs          May 27, 2005@12:48:29          Page: 1 of 1
Insurance Co: BLUE CROSS OF CALIFORNIA Billing Provider Secondary IDs
  ID Qualifier              ID #              Form Type
Division: Name of Main Division/Default for All Divisions
1   Blue Cross              XXXXXX1A        UB04
2   Blue Shield             XXXXXX1B        1500
  Care Unit: Anesthesia
3   Blue Cross              11XXXX1A        UB04
4   Blue Shield             11XXXX1B        1500
  Care Unit: Reference Lab
5   Blue Cross              12XXXX1A        UB04
6   Blue Shield             12XXXX1B        1500
  Care Unit: Home Health
7   Blue Cross              13XXXX1A        UB04
8   Blue Shield             13XXXX1B        1500
+
      Enter ?? for more actions
Add an ID                    Additional IDs      Exit
Edit an ID                   ID Parameters
Delete an ID                 VA-Lab/Facility IDs

Select Action: Quit//

```



*If users want a default Billing Provider Secondary ID to populate Billing Screen 3, define a default ID for the division and define IDs for the division and specific care units. Users will have the ability to either accept the default ID or override it with one of the Care Unit IDs during the creation of a claim. Refer to **Section 4.1.2**.*

### 3.2.2.4 Define Additional Billing Provider Secondary IDs by Division and Form Type

In addition to the Billing Provider Secondary ID that appears on Billing Screen 3 for each insurance company on the bill, there can be six additional Billing Provider Secondary IDs that will be transmitted with claims for an insurance company.

Prior to Patch IB\*2.0\*320, the IDs defined in IB Site Parameters, Section 14 and Provider ID Maintenance, Number 3, were transmitted with all claims to all payers. These options for defining IDs were removed with Patch IB\*2.0\*320.

If an insurance company requires additional Billing Provider Secondary IDs, users can define them in Insurance Company Entry/Edit.

- | Step | Procedure   |
|------|---|
| 1    | Access the option <b>MCCR SYSTEM DEFINITION MENU</b> → <b>Insurance Company Entry/Edit</b> .  |
| 2    | At the <b>Select Insurance Company Name:</b> prompt, enter <b>Blue Cross of California</b> for this example.  |
| 3    | From the <b>Insurance Company Editor</b> screen, enter the action, <b>ID Prov IDs/ID Param</b> .  |
| 4    | From the <b>Billing Provider IDs</b> screen, enter the action <b>Additional IDs</b> .   |
| 5    | From the <b>Billing Provider IDs – Additional Billing Provider Sec. IDs</b> screen, enter the action <b>Add an ID</b> .   |
| 6    | At the <b>ID Qualifier:</b> prompt, enter <b>Medicare</b> for this example.<br><i>Note: There can not be two Billing Provider Secondary IDs on a claim with the same Qualifier. If you enter an ID with the same Qualifier here as one defined under Billing Provider Secondary IDs for the Division on a claim, the Additional Billing Provider Secondary ID with the same Qualifier will not be transmitted on the claim.</i> |
| 7    | At the <b>Form Type</b> prompt, enter <b>CMS-1500</b> for this example.   |
| 9    | At the <b>Billing Provider Secondary ID</b> prompt, enter the ID <b>14XXXX1C</b> for this example.  |
| 10   | Repeat these steps for the Form Type = <b>UB-04</b> , Qualifier = <b>Medicare</b> , ID = <b>14XXXX1C</b> .  |
|      | <i>Note: Users may repeat these steps to define multiple additional Billing Provider Secondary IDs if required by the insurance company.</i>  |

```

Billing Provider IDs (Parent) May 27, 2005@12:48:29           Page: 1 of 1
Insurance Co: BLUE CROSS OF CALIFORNIA Additional Billing Provider Sec. IDs
ID Qualifier          ID #          Form Type

No Additional Billing Provider IDs found

Enter ?? for more actions
Add an ID             Delete an ID       Exit
Edit an ID            Copy IDs

Select Action: Quit// Add an ID
Type of ID: Medicare
Form Type: 1500
Billing Provider Secondary ID: 14XXXX1C
    
```

The following screen will display.

```

Billing Provider IDs (Parent) May 27, 2005@12:48:29          Page: 1 of 1
Insurance Co: BLUE CROSS OF CALIFORNIA Additional Billing Provider Sec. IDs
  ID Qualifier          ID #          Form Type
Division: Name of Main Division/Default for All Divisions
1 Medicare             14XXXX1C          UB04
2 Medicare             14XXXX1C          1500

Enter ?? for more actions
Add an ID              Delete an ID       Exit
Edit an ID             Copy IDs

Select Action: Quit// Add an ID
Type of ID: Medicare
Form Type: UB-04
Billing Provider Secondary ID: XXXXXXXX11

```

### 3.3. Service Facility IDs (Laboratory or Facility IDs)

The 837 claims transmission has records that contain Service Facility data like the name and address of a facility and primary and secondary IDs for that facility. Often this is a division other than the actual VAMC or an outside, non-VA facility. These IDs are called the Laboratory or Facility Primary ID and the Laboratory or Facility Secondary IDs.

If there is a non-VA facility on a claim because a veteran received care at an outside laboratory or a private hospital or clinic, an insurance company may require the claim to contain primary and secondary Laboratory or Facility IDs for the organization that provided the care.

If there is not an outside facility on a claim, but the care was provided by the VA at a facility other than the main hospital (a clinic), an insurance company may require the claim to contain primary and secondary Laboratory or Facility IDs for the clinic.

If there is not an outside facility on a claim and the care was provided by the VAMC, an insurance company may require the data for the billing provider (the VAMC) be repeated in the Service Facility record.

Some insurance companies want no data for the VAMC repeated in the Service Facility section. A new parameter has been added to the Insurance Company Editor that users can set to prevent VAMC data from being sent in the Service Facility records. Refer to **Section 3.6.4**.

Patch IB\*2.0\*320 provided enhancements to allow users to more easily define Laboratory or Facility IDs for the VA or non-VA.

Beginning with Patch IB\*2.0\*343, the VA will define each VA Service Facility NPI which will be transmitted in the 837 claim transmission along with the legacy Primary ID.

Beginning with Patches IB\*2.0\*348 and 349, the Service Facility NPI will be printed on locally printed CMS-1500 claims.

The VA Service Facility NPI and Taxonomy Code will not be entered or maintained by Billing personnel. The VA will obtain an NPI for the VAMC's divisions (clinics and CBOCs) and pharmacies.

The Non-VA Service Facility NPI and Taxonomy Code will be entered and maintained by Billing personnel.

### 3.3.1 Define Non-VA Laboratory or Facility Primary IDs/NPI

For outside, non-VA facilities such as an independent laboratory, the Laboratory or Facility Primary ID should be the entity's Federal Tax ID.

In addition to the Federal Tax ID, an NPI and one or more Taxonomy Codes can be defined for outside, non-VA facilities.

Step	Procedure
1	Access the option <b>MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance</b> .
2	At the <b>Select Provider ID Maintenance Option:</b> prompt, enter <b>NF</b> for Non-VA Facility .
3	At the <b>Select a NON/Other VA Provider:</b> prompt, enter <b>IB Outside Facility</b> for this example.
4	From the <b>Non-VA Lab or Facility Info screen</b> , enter the action <b>FI</b> for Lab/Facility Info.
5	At the <b>Name:</b> prompt, enter <b>IB Outside Facility</b> for this example.
6	At the <b>Street Address:</b> prompt, enter <b>123 Westbend Street</b> for this example.
7	At the <b>Street Address Line 2:</b> prompt, press <b>Return</b> to leave blank.
8	At the <b>City</b> prompt, enter <b>Long Beach</b> for this example.
9	At the <b>State:</b> prompt, enter <b>California</b> for this example.
10	At the <b>Zip Code</b> prompt, enter <b>92060</b> for this example.
11	At the <b>ID Qualifier:</b> prompt, press <b>Return</b> to accept the default.
12	At the <b>Lab or Facility Primary ID:</b> prompt, enter <b>11111112</b> .
13	At the <b>X12 Type of Facility:</b> prompt, enter <b>FA - Facility</b> for this example.  <i>With Patch IB*2*371, FA will be sent as the Type of Facility on all institutional claims regardless of what is defined. HIPAA only allows FA on institutional claims.</i>
14	At the <b>Mammography Certification Number:</b> prompt, press <b>Return</b> to leave it blank. If you know the Mammography number you can enter it here.
15	At the <b>NPI:</b> prompt, enter <b>XXXXXXXXXX</b> for this example.
16	At the <b>Select Taxonomy Code:</b> prompt, enter <b>954</b> for this example.
17	At the <b>OK?</b> Prompt, press <b>RETURN</b> to accept the default.

- 18 At the **Are you adding 'General Acute Care Hospital' as a new TAXONOMY CODE (the 1ST for this IB NON/OTHER VA BILLING PROVIDER)? No//** prompt, enter **Yes**.
- 19 At the **Primary Code:** prompt, enter **Yes** for this example.
- 20 At the **Status:** prompt, enter **Active**.
- 21 At the **Select Taxonomy Code:** prompt, press **Return**.

```

NAME: IB OUTSIDE FACILITY//
STREET ADDRESS: 123 Westbend Street
STREET ADDRESS LINE 2:
CITY: CHEYENNE// Long Beach
STATE: CALIFORNIA
ZIP CODE: 82001// 92060
ID Qualifier: 24 - EMPLOYER'S IDENTIFICATION #
Lab or Facility Primary ID: 11111112//
X12 TYPE OF FACILITY: FACILITY//
MAMMOGRAPHY CERTIFICATION #:
NPI: XXXXXXXXXXXX
Select TAXONOMY CODE: 954 General Acute Care Hospital      282N000
00X
      ...OK? Yes//      (Yes)

Are you adding 'General Acute Care Hospital' as
a new TAXONOMY CODE (the 1ST for this IB NON/OTHER VA BILLING PROVIDER)? No/
/ y (Yes)
PRIMARY CODE: y YES
STATUS: a ACTIVE
Select TAXONOMY CODE:

```

The following screen will display.

```

Non-VA Lab or Facility Info   Dec 05, 2006@17:04:07           Page:      1 of      1

      Name: IB OUTSIDE FACILITY
      Address: 123 Westbend Street
              Long Beach, CALIFORNIA  92060

      Type of Facility: FACILITY
      Primary ID: 11111112
      ID Qualifier: 24 - EMPLOYER'S IDENTIFICATION #
Mammography Certification #:
      NPI: XXXXXXXXXXXX
      Taxonomy Code: 261QV0200X (Primary)

Enter ?? for more actions
FI  Lab/Facility Info           LI  Lab/Facility Ins ID
LO  Lab/Facility Own ID        EX  Exit
Select Action: Quit//

```

### 3.3.2 Define Non-VA Laboratory or Facility Secondary IDs

For outside, non-VA facilities users can define multiple Laboratory or Facility Secondary IDs. These IDs can be either the facility's own IDs such as a Clinical Laboratory

Improvement Amendment (CLIA) number or IDs assigned to the facility by an insurance company.

### 3.3.2.1 Define a non-VA Facility's Own Laboratory or Facility Secondary IDs

Step	Procedure
1	Access the option <b>MCCR System Definition Menu</b> → <b>Provider ID Maintenance</b> .
2	At the <b>Select Provider ID Maintenance Option:</b> prompt, enter <b>NF</b> for Non-VA Facility .
3	From the <b>Non-VA Lab or Facility Info</b> screen, enter the action <b>LO</b> for Lab/Facility Own ID
4	From the <b>Secondary Provider ID</b> screen, enter the action <b>AI</b> for Add an ID.
5	At the <b>Enter Provider ID Qualifier</b> prompt, enter <b>X5 CLIA Number</b> for this example.
6	At the <b>Form Type Applied to:</b> prompt, enter <b>CMS-1500 FORMS ONLY</b> for this example.
7	At the <b>Care Type:</b> prompt, enter <b>OUTPATIENT ONLY</b> for this example.
8	At the <b>Enter Lab or Facility Secondary ID</b> prompt, enter <b>DXXXXX</b> for this example.

 *Note: Users may repeat these steps to define more Laboratory or Facility Secondary IDs.*

```

Secondary Provider ID          May 11, 2005@11:17:20          Page: 1 of 1
      ** Lab or Facility's Own IDs (No Specific Insurance Co) **

Provider: IB Outside Facility (Non-VA Lab or Facility)

ID Qualifier          Form    Care Type          ID#
No ID's found for provider

      Enter ?? for more actions
AI  Add an ID          DI  Delete an ID
EI  Edit an ID         EX  Exit
Select Action: Quit// AI Add an ID
Select Provider ID Qualifier: X5 CLIA Number
FORM TYPE APPLIED TO: CMS-1500 FORMS ONLY
BILL CARE TYPE: OUTPATIENT ONLY

THE FOLLOWING WAS CHOSEN:
  INSURANCE: ALL INSURANCE
  PROV TYPE: CLIA #
  FORM TYPE: CMS-1500 FORM ONLY
  CARE TYPE: OUTPATIENT ONLY

Provider ID: DXXXXX
  
```

The following screen will display.

```

Secondary Provider ID      May 11, 2005@11:17:20      Page:      1 of      1
      ** Lab or Facility's Own IDs (No Specific Insurance Co) **

Provider: IB Outside Facility (Non-VA Lab or Facility)

      ID Qualifier      Form  Care Type      ID#
1  CLIA #                1500  OUTPT      DXXXXX

      Enter ?? for more actions
AI  Add an ID              DI  Delete an ID
EI  Edit an ID             EX  Exit
Select Action: Quit//

```

### 3.3.2.2 Define a non-VA Facility's Laboratory or Facility Secondary IDs Assigned by an Insurance Company

Step	Procedure
1	Access the option <b>MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance</b> .
2	At the <b>Select Provider ID Maintenance Option:</b> prompt, enter <b>NF</b> for Non-VA Facility.
3	From the <b>Non-VA Lab or Facility Info screen</b> , enter the action <b>LI</b> for Lab/Facility Ins ID.
4	From the <b>Secondary Provider ID</b> screen, enter the action <b>AI</b> for Add an ID.
5	At the <b>Enter Provider ID Qualifier</b> prompt, enter <b>Blue Shield</b> for this example.
6	At the <b>Form Type Applied to:</b> prompt, enter <b>CMS-1500 FORMS ONLY</b> for this example.
7	At the <b>Care Type:</b> prompt, enter <b>BOTH</b> for this example.
8	At the <b>Enter Lab or Facility Secondary ID</b> prompt, enter <b>111XXX1B</b> for this example.
	<i>Note: Users may repeat these steps to define more Laboratory or Facility Secondary IDs. A maximum of 5 Laboratory or Facility Secondary IDs can be defined per insurance company. A maximum of 5 Laboratory or Facility Secondary IDs can be transmitted in a claim.</i>



*Note: Users may repeat these steps to define more Laboratory or Facility Secondary IDs. A maximum of 5 Laboratory or Facility Secondary IDs can be defined per insurance company. A maximum of 5 Laboratory or Facility Secondary IDs can be transmitted in a claim.*

```

Secondary Provider ID      May 11, 2005@11:17:20      Page:    1 of    1
      ** Lab or Facility Secondary IDs from Insurance Co **

Provider: IB Outside Facility (Non-VA Lab or Facility)
Insurance Co: BLUE CROSS OF CALIFORNIA

      ID Qualifier          Form   Care Type          ID#

No ID's found for provider and selected insurance co

      Enter ?? for more actions
AI   Add an ID              DI   Delete an ID
EI   Edit an ID             EX   Exit
Select Action: Quit// AI   Add an ID
Select Provider ID Qualifier: BLUE SHIELD ID
FORM TYPE APPLIED TO: 1500 FORMS ONLY
BILL CARE TYPE: b BOTH INPATIENT AND OUTPATIENT

THE FOLLOWING WAS CHOSEN:
INSURANCE: BLUE CROSS OF CALIFORNIA
PROV TYPE: BLUE SHIELD ID
FORM TYPE: 1500 FORM ONLY
CARE TYPE: BOTH INPATIENT AND OUTPATIENT

Provider ID: 111XXX1B
    
```

The following screen will display.

```

Secondary Provider ID      May 11, 2005@11:17:20      Page:    1 of    1
      ** Lab or Facility Secondary IDs from Insurance Co **

Provider: IB Outside Facility (Non-VA Lab or Facility)
Insurance Co: BLUE CROSS OF CALIFORNIA

      ID Qualifier          Form   Care Type          ID#
1   BLUE SHIELD ID         1500   INPT/OUTPT        111XXX1B

      Enter ?? for more actions
AI   Add an ID              DI   Delete an ID
EI   Edit an ID             EX   Exit
Select Action: Quit//
    
```

### 3.3.3 Define VA Laboratory or Facility Primary IDs/NPI

The Laboratory or Facility Primary ID for all VA divisions is the site's Federal Tax Number. This number will be automatically retrieved from the IB Site Parameters.

The VA Service Facility NPI and Taxonomy Code will not be entered or maintained by Billing personnel. The VA will obtain an NPI for the VAMC's divisions (clinics and

CBOCs) and pharmacies. These values will be stored in the Institution file. They will be added to the claim automatically.

### 3.3.4 Define VA Laboratory or Facility Secondary IDs

For each insurance company, users can define multiple Laboratory or Facility Secondary IDs for the VA by division and form type.

Step	Procedure
1	Access the option <b>Patient Insurance Menu ... → Insurance Company Entry/Edit.</b>
2	At the <b>Select Insurance Company Name:</b> prompt, enter <b>Blue Cross of California</b> for this example.
3	From the <b>Insurance Company Editor</b> screen, enter the action, <b>ID Prov IDs/ID Parameters.</b>
4	From the <b>Billing Provider IDs</b> screen, enter the action <b>VA-Lab/Facility IDs.</b>
5	From the <b>VA-Lab/Facility IDs</b> screen, enter the action <b>Add an ID.</b>
6	At the <b>Division</b> prompt, accept the default for the main Division.
7	At the <b>ID Qualifier:</b> prompt, enter <b>Blue Shield</b> for this example.
8	At the <b>Form Type</b> prompt, enter <b>CMS-1500</b> for this example.
9	At the <b>VA Lab or Facility Secondary ID</b> prompt, enter the ID <b>1212XX1B</b> for this example.
10	Repeat these steps for the Form Type = <b>UB-04</b> , Qualifier = <b>Blue Cross</b> and ID = <b>1212XX1A.</b>
11	Repeat these steps for the Form Type = <b>UB-04</b> , Qualifier = <b>Commercial</b> and ID = <b>1313XXG2.</b>



*Note: Users may repeat these steps to define more Laboratory or Facility Secondary IDs. A maximum of 5 Laboratory or Facility Secondary IDs can be defined per division, form and insurance company.*

```

VA-Lab/Facility IDs                               May 27, 2005@12:48:29           Page:    1 of    1
Insurance Co.: BLUE CROSS OF CALIFORNIA

VA-Lab/Facility Primary ID: XX123456

VA-Lab/Facility Secondary IDs
  ID Qualifier          ID #          Form Type

No Laboratory or Facility IDs found

          Enter ?? for more actions
Add an ID              Delete an ID
Edit an ID             Exit

Select Action: Add an ID
    
```

The following screen will display.

VA-Lab/Facility IDs	May 27, 2005@12:48:29	Page:	1 of 1
Insurance Co.: BLUE CROSS OF CALIFORNIA			
VA-Lab/Facility Primary ID: Federal Tax ID			
VA-Lab/Facility Secondary IDs			
ID Qualifier	ID#	Form Type	
Division: Name of Main Division/Default for All Divisions			
1	Blue Cross	1212XX1A	UB04
2	Blue Shield	1212XX1B	1500
Division: CBOC			
3	Commercial	1313XXG2	UB04
Enter ?? for more actions			
Add an ID	Delete an ID		
Edit an ID	Exit		
Select Action: Edit//			

### 3.4. Attending, Operating and Other Physicians and Rendering, Referring and Supervising Providers

A physician can appear on a UB-04 claim form as an Attending, Operating or Other Physician. A health care provider (physician, nurse, physical therapist, etc.) can appear on a 1500 claim form as a Rendering, Referring or Supervising Provider.

All of these health care providers have a primary ID. Their primary ID is their Social Security Number (SSN). These physicians/providers can also have multiple secondary IDs that are either their own IDs or IDs provided by an insurance company.

The VA Physician's or Provider's NPI is stored in the New Person file. This file is not maintained by Billing personnel. The Non-VA Physician's or Provider's NPI is defined in Provider ID Maintenance.

Eventually, the NPI will become the provider's primary ID. It is transmitted in the 837 claim transmission and beginning with Patches IB\*2.0\*348 and 349, it will be printed on locally printed claim forms.

All of these types of health care providers can be either VA or non-VA employees.

#### 3.4.1 Define a VA Physician/Provider's Primary ID/NPI

The VA Physician's or Provider's SSN and NPI are stored in the New Person file (#200). These IDs should be entered when the user is originally added to the system. The provider's Taxonomy code is entered along with the Person Class.

#### 3.4.2 Define a VA Physician/Provider's Secondary IDs

Physicians and Providers can have both their own ID, such as a state medical license, or an ID provided by an insurance company.

### 3.4.2.1 Define a VA Physician/Provider's Own Secondary IDs

Physicians and other health care providers are assigned IDs that identify them. These IDs include a Social Security Number which serves as their primary ID. In addition to their SSN, they may also have one or more of the following types of secondary IDs:

- OB - State License Number
- EI – EIN
- SY - SSN (VA SSNs are defined in the New Person file)
- X5 – State Industrial Accident Provider Number
- 1G – UPIN Number

Step	Procedure
1	Access the option <b>MCCR SYSTEM DEFINITION MENU</b> → <b>Provider ID Maintenance</b> .
2	At the <b>Select Provider ID Maintenance Option:</b> prompt, enter <b>PO</b> for Provider Own IDs.
3	At the <b>(V)A or (N)on-VA provider: V//:</b> prompt, press <b>Return</b> to accept the default.
4	At the <b>Select V.A. PROVIDER NAME:</b> prompt, enter <b>IB,DOCTOR 1</b> .

 *This screen can be accessed through the **MCCR System Definition Menu**. Users must hold the **IB PROVIDER EDIT** security key to access this option.*

```

Provider ID Maintenance Main Menu

Enter a code from the list.

      Provider IDs
PO  Provider Own IDs
PI  Provider Insurance IDs

      Insurance IDs
BI  Batch ID Entry
II  Insurance Co IDs

      Care Units
CP  Care Units for Providers
CB  Care Units for Billing Provider

      Non-VA Items
NP  Non-VA Provider
NF  Non-VA Facility

Select Provider ID Maintenance Option: PO  Provider Own IDs

(V)A or (N)on-VA provider: V// A PROVIDER
Select V.A. PROVIDER NAME: IB,DOCTOR 1

```

Step	Procedure
6	At the <b>Select Action:</b> prompt, enter <b>AI</b> for Add an ID.
7	At the <b>Select ID Qualifier:</b> prompt, enter <b>State License</b> for this example.
8	At the <b>Select LICENSING STATE:</b> prompt, enter <b>California</b> for this example.
9	When asked if you are entering California as the 1 <sup>st</sup> state for this provider, enter <b>Yes</b> .
10	At the <b>LICENSING STATE:</b> prompt, press <b>Return</b> to accept the default.
11	At the <b>LICENSING NUMBER:</b> prompt, enter <b>XXXXSTATE</b> for this example.

```

Physician/Provider ID          Nov 02, 2005@10:24:46          Page: 1 of 1
      ** Physician/Provider's Own IDs (No Specific Insurance Co) **
Provider      : IB,DOCTORB (VA PROVIDER)

      ID Qualifier      Form      Care Type      Care Unit      ID#

No ID's found for provider

      Enter ?? for more actions
AI  Add an ID          DI  Delete an ID
EI  Edit an ID          EX  Exit
Select Action: Quit// AI  Add an ID
Select ID Qualifier: ??

Choose from:
EIN      EI
SOCIAL SECURITY NUMBER      SY
STATE INDUSTRIAL ACCIDENT PROV      X5
STATE LICENSE      0B
UPIN      1G

Enter the Qualifier that identifies the type of ID.

Select Provider ID Type: 0B  State License
Select LICENSING STATE: CALIFORNIA
Are you adding 'CALIFORNIA' as a new LICENSING STATE (the 1ST for this NEW PER
SON)? No// y (Yes)
LICENSING STATE: CALIFORNIA//
LICENSE NUMBER: XXXXSTATE

```

The following screen will display.

```

Physician/Provider ID      Nov 02, 2005@10:24:46      Page:      1 of      1
      ** Physician/Provider's Own IDs (No Specific Insurance Co) **
Provider      : IB,DOCTORB (VA PROVIDER)

      ID Qualifier      Form      Care Type      Care Unit      ID#
1  CA STATE LICENSE #
                                     XXXXSTATE

      Enter ?? for more actions
AI  Add an ID                      DI  Delete an ID
EI  Edit an ID                      EX  Exit
Select Action: Quit//

```

### 3.4.2.2 Define a VA Physician/Provider's Insurance Company Secondary IDs

Physicians and other health care providers can be assigned secondary IDs by insurance companies. Some insurance companies assign one ID to be used by every physician/provider at a site. Other insurance companies assign each physician/provider his or her own ID. In addition to their SSN, they may also have one or more of the following types of secondary IDs:

- 1A - Blue Cross
- 1B - Blue Shield
- 1C - Medicare
- 1H - CHAMPUS
- G2 - Commercial
- LU - Location #
- N5 - Provider Plan Network
- 1G - UPIN

Step	Procedure
1	Access the option <b>MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance</b> .
2	At the <b>Select Provider ID Maintenance Option:</b> prompt, enter <b>PI</b> for Provider Insurance IDs.
3	At the <b>(V)A or (N)on-VA provider: V//:</b> prompt, press <b>Return</b> to accept the default.
4	At the <b>Select V.A. PROVIDER NAME:</b> prompt, enter <b>IB,DOCTOR 1</b> .
5	At the <b>Select Insurance Co.:</b> prompt, enter <b>Blue Cross of California</b> for this example.

## Provider ID Maintenance Main Menu

Enter a code from the list.

Provider IDs

PO Provider Own IDs  
PI Provider Insurance IDs

Insurance IDs

BI Batch ID Entry  
II Insurance Co IDs

Care Units

CP Care Units for Providers  
CB Care Units for Billing Provider

Non-VA Items

NP Non-VA Provider  
NF Non-VA Facility

Select Provider ID Maintenance Option: **PI Provider Insurance IDs**

(V)A or (N)on-VA provider: **V// A PROVIDER**

Select V.A. PROVIDER NAME: **IB, DOCTOR 1**

Select INSURANCE CO: **BLUE CROSS OF CALIFORNIA**

Step	Procedure
6	At the <b>Select Action:</b> prompt, enter <b>AI</b> for Add an ID.
7	At the <b>Select ID Qualifier:</b> prompt, enter <b>1B – Blue Shield</b> for this example.
8	At the <b>FORM TYPE APPLIED TO:</b> prompt, enter <b>CMS-1500 Only</b> for this example.
9	At the <b>BILL CARE TYPE:</b> prompt, enter <b>0</b> for this example.
10	At the <b>CARE UNIT:</b> prompt, enter <b>Surgery</b> for this example.
11	At the <b>PROVIDER ID:</b> prompt, enter <b>XXXXBSHIELD</b> for this example.
	<i>Defining an insurance company provided ID for a particular Care Unit is only necessary when the insurance company assigns physician/provider IDs by care unit.</i>
	<i>Users can repeat these steps for this Physician/Provider adding more IDs from this insurance company or change insurance company or change physician/provider. Refer to <b>Section 3.7</b> to learn about copying IDs to multiple insurance companies.</i>
	<i>Note: If you do not define a <b>Network ID</b> for <b>TRICARE</b> claims, the system will automatically include the provider's <b>SSN</b> as the Network ID.</i>

```

Physician/Provider ID          Nov 02, 2005@10:24:46          Page:    1 of    1
      ** Physician/Provider's IDs from Insurance Co **
Provider      : IB,DOCTORB (VA PROVIDER)
INSURANCE CO: BLUE CROSS OF CALIFORNIA (Parent)

      ID Qualifier      Form      Care Type      Care Unit      ID#
No ID's found for provider

      Enter ?? for more actions
AI  Add an ID              DI  Delete an ID
EI  Edit an ID             EX  Exit
Select Action: Quit// AI  Add an ID
Select ID Qualifier: ??
Choose from:
BLUE CROSS          1A
BLUE SHIELD         1B
CHAMPUS             1H
COMMERCIAL          G2
LOCATION NUMBER      LU
MEDICARE PART A    1C
MEDICARE PART B    1C
PROVIDER PLAN NETWORK      N5
UPIN                1G

Enter the Qualifier that identifies the type of ID.

Select Provider ID Type: Blue Shield
FORM TYPE APPLIED TO: CMS-1500 FORMS ONLY
BILL CARE TYPE: 0 BOTH INPATIENT AND OUTPATIENT
Select IB PROVIDER ID CARE UNIT: Surgery

THE FOLLOWING WAS CHOSEN:
INSURANCE: BLUE CROSS OF CALIFORNIA
PROV TYPE: BLUE SHIELD ID
FORM TYPE: CMS-1500 FORM ONLY
CARE TYPE: BOTH INPATIENT AND OUTPATIENT
CARE UNIT: Surgery

PROVIDER ID: XXXXBSHIELD
    
```

The following screen will display.

```

Physician/Provider ID          Nov 02, 2005@10:24:46          Page:    1 of    1
      ** Physician/Provider's IDs from Insurance Co **
Provider      : IB,DOCTORB (VA PROVIDER)
INSURANCE CO: BLUE CROSS OF CALIFORNIA (Parent)

      ID Qualifier      Form      Care Type      Care Unit      ID#
1  BLUE SHIELD ID      1500      INPT/OUTPT      XXXXBSHIELD

      Enter ?? for more actions
AI  Add an ID              DI  Delete an ID
EI  Edit an ID             EX  Exit
Select Action: Quit//
    
```

### 3.4.3 Define non-VA Physician and Provider Primary IDs/NPI

Non-VA physicians and other health care providers are not VistA users so they are not normally in the New Person file unless they are also current/previous VA employees. Even if a physician/provider functions in both a VA and non-VA role, the SSN, NPI and Taxonomy Code of a non-VA Physician/Provider must be entered by Billing personnel using Provider ID Maintenance. Non-VA physician/provider primary and secondary legacy IDs are both defined the same way and the system knows to look for and use the SSN as the primary ID. Refer to the following **Section 3.4.4.1**.



*Note: Non-VA Physician/Provider IDs can be defined through Provider ID Maintenance through **1 > PROVIDER SPECIFIC IDS** or through **6 > NON/OTHER VA PROVIDER ID INFORMATION**.*

#### 3.4.3.1 Define a non-VA Physician/Provider's NPI

The NPI and Taxonomy Code for a non-VA Physician or Provider can be entered by Billing personnel using Provider ID Maintenance.

Step	Procedure
1	Access the option <b>MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance</b> .
2	At the <b>Select Provider ID Maintenance Option:</b> prompt, enter <b>NP</b> for Non-VA Provider.
3	At the Select a Non-VA Provider: prompt, enter <b>IB,OUTSIDEPROV</b> for this example.

*Users must hold the **IB PROVIDER EDIT** security key to access this option.*

```

Provider ID Maintenance Main Menu

Enter a code from the list.

      Provider IDs
PO  Provider Own IDs
PI  Provider Insurance IDs

      Insurance IDs
BI  Batch ID Entry
II  Insurance Co IDs

      Care Units
CP  Care Units for Providers
CB  Care Units for Billing Provider

      Non-VA Items
NP  Non-VA Provider
NF  Non-VA Facility

Select Provider ID Maintenance Option: NP Non-VA Provider
Select a NON-VA PROVIDER: IB,OUTSIDEPROV INDIVIDUAL

```

The following screen will display.

```

NON-VA PROVIDER INFORMATION   Dec 07, 2006@12:40:51           Page:    1 of    1

      Name: IB,OUTSIDEPROV
      Type: INDIVIDUAL PROVIDER
  Credentials: MD
      Specialty: 30
          NPI:
  Taxonomy Code:

      Enter ?? for more actions
  ED  Edit Demographics           PI  Provider Ins ID
  PO  Provider Own ID            EX  Exit
  Select Action: Quit//

```

Step	Procedure
4	At the <b>Select Action:</b> prompt, enter <b>ED</b> for Edit Demographics.
5	At the <b>Name:</b> prompt, press <b>Return</b> to accept the default.
6	At the <b>Credentials:</b> prompt, press <b>Return</b> to accept the default.
7	At the <b>Specialty:</b> prompt, press <b>Return</b> to accept the default.
8	At the <b>NPI:</b> prompt, enter <b>000000006</b> for this example.
9	At the <b>Taxonomy:</b> prompt, enter <b>15 Allopathic and Osteopathic Physicians Internal Medicine Cardiovascular Disease 207RC0000X</b> for this example.
10	At the <b>Are you adding 'Allopathic and Osteopathic Physicians' as a new TAXONOMY CODE (the 1ST for this IB NON/OTHER VA BILLING PROVIDER)? No//</b> prompt, enter <b>Yes</b> for this example.
11	At the <b>Primary Code:</b> prompt, enter <b>Yes</b> for this example.
12	At the <b>Status:</b> prompt, enter <b>Active</b> for this example.
	 <i>A provider may have more than one Taxonomy Code.</i>

```

NAME: IB,OUTSIDEPROV//
CREDENTIALS: MD//
SPECIALTY: 30//
NPI: 000000006
Select TAXONOMY CODE: 15 Allopathic and Osteopathic Physicians 207RC0000X
                        Internal Medicine
                        Cardiovascular Disease
Are you adding 'Allopathic and Osteopathic Physicians' as
a new TAXONOMY CODE (the 1ST for this IB NON/OTHER VA BILLING PROVIDER)? No/
/ y (Yes)
PRIMARY CODE: y YES
STATUS: a ACTIVE
Select TAXONOMY CODE:

```

The following screen will display.

```

NON-VA PROVIDER INFORMATION   Dec 07, 2006@13:10:53           Page:    1 of    1

      Name: IB,OUTSIDEPROV
      Type: INDIVIDUAL PROVIDER
      Credentials: MD
      Specialty: 30
      NPI: 0000000006
      Taxonomy Code: 207RC0000X (Primary)

      Enter ?? for more actions
      ED  Edit Demographics           PI  Provider Ins ID
      PO  Provider Own ID            EX  Exit
      Select Action: Quit//

```

### 3.4.4 Define a non-VA Physician/Provider's Secondary IDs

#### 3.4.4.1 Define a non-VA Physician/Provider's Own IDs

Non-VA Physicians and other health care providers are assigned IDs that identify them. These IDs include a Social Security Number which serves as a primary ID. In addition to their SSN, they may also have one or more of the following types of secondary IDs:

- OB - State License Number
- EI - EIN
- TJ – Federal Taxpayer's Number
- X5 – State Industrial Accident Provider Number
- 1G – UPIN
- SY - SSN

Step	Procedure
1	Access the option <b>MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance</b> .
2	At the <b>Select Provider ID Maintenance Option:</b> prompt, enter <b>PO</b> for Provider Own IDs.
3	At the <b>(V)A or (N)on-VA provider: V//:</b> prompt, enter <b>N</b> for Non-VA provider.
4	At the <b>Select Non V.A. PROVIDER NAME:</b> prompt, enter <b>IB,OUTSIDEDOC</b> for this example.
	<i>Note: For non-VA physicians and provider, be sure to define an SSN with the Qualifier SY as this will be used as the Attending, Operating, Other, Rendering, Referring or Supervising primary legacy ID.</i>

## Provider ID Maintenance Main Menu

Enter a code from the list.

Provider IDs

PO Provider Own IDs  
PI Provider Insurance IDs

Insurance IDs

BI Batch ID Entry  
II Insurance Co IDs

Care Units

CP Care Units for Providers  
CB Care Units for Billing Provider

Non-VA Items

NP Non-VA Provider  
NF Non-VA Facility

Select Provider ID Maintenance Option: **PO Provider Own IDs**

(V)A or (N)on-VA provider: V// **n NON-VA PROVIDER**

Select Non V.A. PROVIDER NAME: **IB,OUTSIDEDOC**

Step	Procedure
5	At the Select Action: prompt, enter <b>AI</b> for Add an ID.
6	At the <b>Enter Provider ID Qualifier:</b> prompt, enter <b>Social Security Number</b> for this example.
7	At the <b>FORM TYPE APPLIED TO:</b> prompt, enter <b>0</b> for this example.
8	At the <b>BILL CARE TYPE:</b> prompt, enter <b>0</b> for this example.
9	At the <b>PROVIDER ID:</b> prompt, enter <b>XXXXX1212</b> for this example.
	Note: Users may repeat the above steps to enter additional IDs for a physician/provider.

```

Performing Provider ID          Nov 02, 2005@10:24:46          Page:    1 of    1
          ** Performing Provider's Own IDs (No Specific Insurance Co) **
Provider      : IB,OUTSIDEDOC (NON-VA PROVIDER)

      ID Qualifier      Form      Care Type      Care Unit      ID#

No ID's found for provider

      Enter ?? for more actions
AI  Add an ID          DI  Delete an ID
EI  Edit an ID        EX  Exit
Select Action: Quit// AI  Add an ID
Select ID Qualifier: ??

Choose from:
EIN      EI
SOCIAL SECURITY NUMBER          SY
STATE INDUSTRIAL ACCIDENT PROV          X5
STATE LICENSE          0B
UPIN          1G

Enter the Qualifier that identifies the type of ID.

Select ID Qualifier: SY Social Security Number
FORM TYPE APPLIED TO: 0 BOTH UB-04 AND CMS-1500 FORMS
BILL CARE TYPE: 0 BOTH INPATIENT AND OUTPATIENT

THE FOLLOWING WAS CHOSEN:
INSURANCE: ALL INSURANCE
PROV TYPE: SOCIAL SECURITY NUMBER
FORM TYPE: BOTH UB-04 & CMS-1500 FORMS
CARE TYPE: BOTH INPATIENT AND OUTPATIENT

PROVIDER ID: XXXXX1212
    
```

The following screen will display.

```

Performing Provider ID          Nov 02, 2005@10:24:46          Page:    1 of    1
          ** Performing Provider's Own IDs (No Specific Insurance Co) **
Provider      : IB,OUTSIDEDOC (NON-VA PROVIDER)

      ID Qualifier      Form      Care Type      Care Unit      ID#
1  SOCIAL SECURITY NUMB  BOTH      INPT/OUTPT      XXXXX1212

      Enter ?? for more actions
AI  Add an ID          DI  Delete an ID
EI  Edit an ID        EX  Exit
Select Action: Quit//
    
```

### 3.4.4.2 Define a non-VA Physician/Provider's Insurance Company Secondary IDs

Physicians and other health care providers are assigned secondary IDs by insurance companies. In addition to their SSN, they may also have one or more of the following types of secondary IDs:

- 1A - Blue Cross
- 1B - Blue Shield
- 1C - Medicare
- 1G - UPIN
- 1H - CHAMPUS
- G2 - Commercial
- LU - Location #
- N5 - Provider Plan Network

Step	Procedure
1	Access the option <b>MCCR SYSTEM DEFINITION MENU</b> → <b>Provider ID Maintenance</b> .
2	At the <b>Select Provider ID Maintenance Option:</b> prompt, enter <b>NP</b> for Non-VA Provider.
3	At the <b>Select a NON-VA PROVIDER:</b> prompt, enter <b>IB,OUTSIDEDOC</b> .

```

Provider ID Maintenance Main Menu

Enter a code from the list.

      Provider IDs
PO  Provider Own IDs
PI  Provider Insurance IDs

      Insurance IDs
BI  Batch ID Entry
II  Insurance Co IDs

      Care Units
CP  Care Units for Providers
CB  Care Units for Billing Provider

      Non-VA Items
NP  Non-VA Provider
NF  Non-VA Facility

Select Provider ID Maintenance Option: NP Non-VA Provider

(V)A or (N)on-VA provider: V// N Non-VA PROVIDER
Select a NON-VA PROVIDER: IB,OUTSIDEDOC
Select INSURANCE CO: BLUE CROSS OF CALIFORNIA

```

Step	Procedure
4	At the <b>Select Action:</b> prompt, enter <b>PI</b> for Provider Ins ID.
5	At the <b>Select INSURANCE CO:</b> prompt, enter <b>Blue Cross of California</b> for this example.
6	At the <b>Select Action:</b> prompt, enter <b>AI</b> for Add an ID.

- 6 At the **Select ID Qualifier**: prompt, enter **1B – Blue Shield** for this example.
  - 7 At the **FORM TYPE APPLIED TO**: prompt, enter **CMS-1500 Only** for this example.
  - 8 At the **BILL CARE TYPE**: prompt, enter **0** for this example.
  - 9 At the **PROVIDER ID**: prompt, enter **XXBSHIELD** for this example.
- Users can repeat these steps for this Physician/Provider adding more IDs from this insurance company or change insurance company or change physician/provider.*



```

Performing Provider ID      Nov 02, 2005@10:24:46      Page:      1 of      1
      ** Performing Provider's IDs from Insurance Co **
Provider      : IB,OUTSIDEDOC (Non-VA PROVIDER)
INSURANCE CO: BLUE CROSS OF CALIFORNIA (Parent)

      ID Qualifier      Form      Care Type      Care Unit      ID#

No ID's found for this insurance co.

      Enter ?? for more actions
AI  Add an ID          DI  Delete an ID
EI  Edit an ID         EX  Exit
Select Action: Quit// AI  Add an ID
Select ID Qualifier: ??

Choose from:
BLUE CROSS          1A
BLUE SHIELD         1B
CHAMPUS             1H
COMMERCIAL          G2
LOCATION NUMBER      LU
MEDICARE PART A    1C
MEDICARE PART B    1C
PROVIDER PLAN NETWORK      N5
UPIN               1G

Enter the Qualifier that identifies the type of ID.
Select Provider ID Type: Blue Shield
FORM TYPE APPLIED TO: CMS-1500 FORMS ONLY
BILL CARE TYPE: 0 BOTH INPATIENT AND OUTPATIENT

THE FOLLOWING WAS CHOSEN:
INSURANCE: BLUE CROSS OF CALIFORNIA
PROV TYPE: BLUE SHIELD ID
FORM TYPE: CMS-1500 FORM ONLY
CARE TYPE: BOTH INPATIENT AND OUTPATIENT
PROVIDER ID: XXBSHIELD
    
```

The following screen will display.

```

Performing Provider ID          Nov 02, 2005@10:24:46          Page:    1 of    1
      ** Performing Provider's IDs from Insurance Co **
Provider      : IB,OUTSIDEDOC (Non-VA PROVIDER)
INSURANCE CO: BLUE CROSS OF CALIFORNIA (Parent)

   ID Qualifier      Form   Care Type   Care Unit   ID#
1  BLUE SHIELD ID   1500   INPT/OUTPT   XXXXBSHIELD

Enter ?? for more actions
AI  Add an ID              DI  Delete an ID
EI  Edit an ID             EX  Exit
Select Action: Quit//

```

### 3.4.5 Define Insurance Company IDs

Both individual Physician/Provider secondary IDs and insurance company default Physician/Provider secondary IDs provided by an insurance company can be entered and copied from within Insurance Company IDs.

There are 3 options:

- I – Individual IDs
- A – Individual and Default IDs
- D – Default IDs

Option A is the basically the same as I and D combined so users can add Physician/Provider secondary IDs and/or default secondary IDs.

#### 3.4.5.1 Define Default Physician/Provider Insurance Company Secondary IDs

Users can use the Provider ID Maintenance option, Insurance Company IDs, to enter numbers that are assigned by an insurance company to be used as default Attending, Operating, Other, Rendering, Referring and Supervising Secondary IDs for all physicians and health care providers. These IDs will be automatically sent with all 837 claims to the insurance company for which the default IDs are defined.

Step	Procedure
1	Access the option <b>MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance</b> .
2	At the <b>Select Provider ID Maintenance Option:</b> prompt, enter <b>II</b> for Insurance Co IDs.
3	At the <b>Select Insurance Company Name:</b> prompt, enter <b>Blue Cross of California</b> for this example.
4	At the <b>Select Display Content:</b> prompt, enter <b>D</b> .

```

Provider ID Maintenance Main Menu

Enter a code from the list.

      Provider IDs
PO Provider Own IDs
PI Provider Insurance IDs

      Insurance IDs
BI Batch ID Entry
II Insurance Co IDs

      Care Units
CP Care Units for Providers
CB Care Units for Billing Provider

      Non-VA Items
NP Non-VA Provider
NF Non-VA Facility

Select Provider ID Maintenance Option: II Insurance Co IDs
Select INSURANCE COMPANY NAME: BLUE CROSS OF CALIFORNIA PO BOX 60007 LOS
ANGELES CALIFORNIA Y
SELECT DISPLAY CONTENT: A//D INSURANCE CO DEFAULT IDS
    
```

**Step Procedure**

5 At the **Select Action:** prompt, enter **AI** for Add an ID.

```

INSURANCE CO PROVIDER ID      Dec 19, 2005@12:24:41      Page: 1 of 2
Insurance Co: BLUE CROSS OF CALIFORNIA (Parent)
PROVIDER NAME      FORM      CARE TYPE      CARE UNIT      ID#

Provider ID Type: BLUE SHIELD
1  <<INS CO DEFAULT>>      BOTH      INPT/OUTPT      BSDEFAULT

Provider ID Type: COMMERCIAL
2  <<INS CO DEFAULT>>      BOTH      INPT/OUTPT      COMDEFAULT

Provider ID Type: PROVIDER PLAN NETWORK
3  <<INS CO DEFAULT>>      BOTH      INPT/OUTPT      NETDEFAULT

Provider ID Type: UPIN
4  <<INS CO DEFAULT>>      BOTH      INPT/OUTPT      UPINDEFAULT

+      Enter ?? for more actions
AI  Add an ID      DP      Display Ins Params      VI  View IDs by Type
DI  Delete an ID      CI      Change Ins Co      CU  Care Unit Maint
EI  Edit an ID      CD      Change Display      EX  Exit
Select Action: Next Screen//AI Add an ID
    
```

**Step Procedure**

- 6 At the **Select Provider (optional):** prompt, press **Return** to leave the prompt blank.
- 7 At the **YOU ARE ADDING A PROVIDER ID THAT WILL BE THE INSURANCE CO DEFAULT IS THIS OK?:** prompt, enter **YES**.
- 8 At the **Select Provider ID Type:** prompt, enter **Blue Cross** for this example.

- 9 At the **FORM TYPE APPLIED TO:** prompt, enter **UB-04 Forms Only** for this example.
- 10 At the **BILL CARE TYPE:** prompt, enter **0** for BOTH INPATIENT AND OUTPATIENT for this example.
- 11 At the **PROVIDER ID:** prompt, enter **BCDEFAULT** for this example.

```

YOU ARE ADDING A PROVIDER ID THAT WILL BE THE INSURANCE CO DEFAULT

Select Provider ID Type: BLUE CROSS 1A

FORM TYPE APPLIED TO: UB-04// UB-04 FORMS ONLY
BILL CARE TYPE: 0 BOTH INPATIENT AND OUTPATIENT

THE FOLLOWING WAS CHOSEN:
  INSURANCE: BLUE CROSS OF CALIFORNIA
  PROV TYPE: BLUE CROSS
  FORM TYPE: UB-04 FORM ONLY
  CARE TYPE: BOTH INPATIENT AND OUTPATIENT

PROVIDER ID: BCDDEFAULT

```

The following screen will display.

```

INSURANCE CO PROVIDER ID      Dec 19, 2005@12:34:01      Page: 1 of 2
Insurance Co: BLUE CROSS OF CALIFORNIA (Parent)
PROVIDER NAME                FORM   CARE TYPE   CARE UNIT   ID#

Provider ID Type: BLUE CROSS
1  <<INS CO DEFAULT>>      UB-04  INPT/OUTPT      BCDDEFAULT

Provider ID Type: BLUE SHIELD
2  <<INS CO DEFAULT>>      BOTH   INPT/OUTPT      DEFALLProv

Provider ID Type: COMMERCIAL
3  <<INS CO DEFAULT>>      BOTH   INPT/OUTPT      COMDEFAULT

Provider ID Type: PROVIDER PLAN NETWORK
4  <<INS CO DEFAULT>>      BOTH   INPT/OUTPT      NETDEFAULT

+          Enter ?? for more actions
AI  Add an ID                DP  Display Ins Params  VI  View IDs by Type
DI  Delete an ID             CI  Change Ins Co       CU  Care Unit Maint
EI  Edit an ID               CD  Change Display      EX  Exit
Select Action: Next Screen//

```



*Note: This default ID will be transmitted on all claims where Blue Cross of California is the payer as a Physician/Provider secondary ID.*

### 3.4.5.2 Define Individual Physician/Provider Insurance Company Secondary IDs

Users can use the Provider ID Maintenance option, Insurance Company IDs, to enter numbers that are assigned by an insurance company as individual Attending, Operating, Other, Rendering, Referring and Supervising Secondary IDs.

- | Step | Procedure  |
|------|--|
| 1    | Access the option <b>MCCR SYSTEM DEFINITION MENU</b> → <b>Provider ID Maintenance</b> .                      |
| 2    | At the <b>Select Provider ID Maintenance Option:</b> prompt, enter <b>II</b> for Insurance Co IDs.           |
| 3    | At the <b>Select Insurance Company Name:</b> prompt, enter <b>Blue Cross of California</b> for this example. |

```

Provider ID Maintenance Main Menu

Enter a code from the list.

          Provider IDs
PO  Provider Own IDs
PI  Provider Insurance IDs

          Insurance IDs
BI  Batch ID Entry
II  Insurance Co IDs

          Care Units
CP  Care Units for Providers
CB  Care Units for Billing Provider

          Non-VA Items
NP  Non-VA Provider
NF  Non-VA Facility

Select Provider ID Maintenance Option: ii  Insurance Co IDs

Select INSURANCE COMPANY NAME:  BLUE CROSS OF CALIFORNIA  PO BOX 60007  LOS
ANGELES  CALIFORNIA  Y

```

- | Step | Procedure   |
|------|---|
| 4    | At the <b>Select Display Content:</b> prompt, enter <b>I</b> for this example.                              |
| 5    | At the <b>Do you want to display IDs for a Specific Provider:</b> prompt, enter <b>No</b> for this example. |

```

SELECT DISPLAY CONTENT: A// ??

(D) DISPLAY CONTAINS ONLY THOSE IDS ASSIGNED AS DEFAULTS TO THE FACILITY BY
THE INSURANCE COMPANY
(I) DISPLAY CONTAINS ONLY THOSE IDS ASSIGNED TO INDIVIDUAL PROVIDERS BY THE
INSURANCE COMPANY
(A) DISPLAY CONTAINS ALL IDS ASSIGNED BY THE INSURANCE COMPANY FOR ONE OR ALL PROVIDER
ID TYPES

Select one of the following:

D          INSURANCE CO DEFAULT IDS
I          INDIVIDUAL PROVIDER IDS FURNISHED BY THE INS CO
A          ALL IDS FURNISHED BY THE INS CO BY PROVIDER TYPE

SELECT DISPLAY CONTENT: A// I  INDIVIDUAL PROVIDER IDS FURNISHED BY THE INS CO
DO YOU WANT TO DISPLAY IDS FOR A SPECIFIC PROVIDER?: NO//

```

Step	Procedure
6	At the <b>Select Action:</b> prompt, enter <b>AI</b> for Add an ID.

```

INSURANCE CO PROVIDER ID      Dec 15, 2005@15:36:31      Page:    1 of   89
Insurance Co: BLUE CROSS OF CALIFORNIA (Parent)
PERFORMING PROV ID MAY REQUIRE CARE UNIT

PROVIDER ID TYPE      FORM      CARE TYPE      CARE UNIT      ID#
Provider: IB,DOCTOR3
1  PROVIDER PLAN NETWOR  BOTH      INPT/OUTPT      MDXXXXXA
Provider: IB,DOCTOR9
2  PROVIDER PLAN NETWOR  BOTH      INPT/OUTPT      GXXXXXA
Provider: IB,DOCTOR10
3  PROVIDER PLAN NETWOR  BOTH      INPT/OUTPT      GXXXXXX
Provider: IB,DOCTOR76
4  PROVIDER PLAN NETWOR  BOTH      INPT/OUTPT      GXXXXXX
+      Enter ?? for more actions
AI  Add an ID              DP      Display Ins Params  VI  View IDs by Type
DI  Delete an ID           CI      Change Ins Co       CU  Care Unit Maint
EI  Edit an ID             CD      Change Display      EX  Exit
Select Action: Next Screen// AI  Add an ID

```

Step	Procedure
7	At the <b>Select ID Qualifier:</b> prompt, enter <b>1B – Blue Shield</b> for this example.
8	At the <b>FORM TYPE APPLIED TO:</b> prompt, enter <b>CMS-1500 Only</b> for this example.
9	At the <b>BILL CARE TYPE:</b> prompt, enter <b>0</b> for this example.
10	At the <b>CARE UNIT:</b> prompt, enter <b>Surgery</b> for this example.
11	At the <b>PROVIDER ID:</b> prompt, enter <b>BSXXXXX</b> for this example.

```

Select PROVIDER: IB,DOCTOR7
Select Provider ID Type: BLUE SHIELD 1B
FORM TYPE APPLIED TO: CMS-1500 FORMS ONLY
BILL CARE TYPE: 0 BOTH INPATIENT AND OUTPATIENT
Select IB PROVIDER ID CARE UNIT: Surgery

THE FOLLOWING WAS CHOSEN:
INSURANCE: BLUE CROSS OF CALIFORNIA
PROV TYPE: BLUE SHIELD
FORM TYPE: CMS-1500 FORM ONLY
CARE TYPE: BOTH INPATIENT AND OUTPATIENT
CARE UNIT: Surgery

PROVIDER ID: BSXXXXX

```

The following screen will display.

```

INSURANCE CO PROVIDER ID      Dec 15, 2005@16:11:31      Page:  49 of  89
Insurance Co: BLUE CROSS OF CALIFORNIA (Parent)
PERFORMING PROV ID MAY REQUIRE CARE UNIT

PROVIDER ID TYPE      FORM      CARE TYPE      CARE UNIT      ID#
+
Provider: IB,DOCTOR15
194 PROVIDER PLAN NETWOR  BOTH      INPT/OUTPT      GXXXXX

Provider: IB,DOCTOR54
195 PROVIDER PLAN NETWOR  BOTH      INPT/OUTPT      G4XXXXX

Provider: IB,DOCTOR7
196 BLUE CROSS              UB-04      INPT/OUTPT      BCXXXXXX2
197 BLUE SHIELD              1500      INPT/OUTPT      Surgery      BSXXXXX

Provider: IB,DOCTOR6
+      Enter ?? for more actions
AI  Add an ID              DP  Display Ins Params  VI  View IDs by Type
DI  Delete an ID           CI  Change Ins Co       CU  Care Unit Maint
EI  Edit an ID             CD  Change Display      EX  Exit
Select Action: Next Screen//
    
```

### 3.4.6 Define either a Default or Individual Physician/Provider Secondary ID

Step	Procedure
1	Access the option <b>MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance</b> .
2	At the <b>Select Provider ID Maintenance Option:</b> prompt, enter <b>II</b> for Insurance Co IDs.
3	At the <b>Select Insurance Company Name:</b> prompt, enter <b>Blue Cross of California</b> for this example (the Parent company).
4	At the <b>Select Display Content:</b> prompt, enter <b>A</b> for this example.
5	At the <b>DO YOU WANT TO DISPLAY IDS FOR A SPECIFIC PROVIDER ID TYPE?: NO//</b> prompt, accept the default.

```

Provider ID Maintenance Main Menu

Enter a code from the list.

      Provider IDs
PO  Provider Own IDs
PI  Provider Insurance IDs

      Insurance IDs
BI  Batch ID Entry
II  Insurance Co IDs

      Care Units
CP  Care Units for Providers
CB  Care Units for Billing Provider

      Non-VA Items
NP  Non-VA Provider
NF  Non-VA Facility

Select Provider ID Maintenance Option: II Insurance Co IDs

Select INSURANCE COMPANY NAME: BLUE CROSS OF CALIFORNIA PO BOX 60007
LOS ANGELES CALIFORNIA Y

SELECT DISPLAY CONTENT: A// LL IDS FURNISHED BY THE INS CO BY PROVIDER TYPE

DO YOU WANT TO DISPLAY IDS FOR A SPECIFIC PROVIDER ID TYPE?: NO//
    
```

**Step Procedure**

**6 At the Select Action: prompt, enter AI for Add an ID.**

```

INSURANCE CO PROVIDER ID      Dec 15, 2005@16:18:07      Page: 1 of 31
Insurance Co: BLUE CROSS OF CALIFORNIA (Parent)
PERFORMING PROV ID MAY REQUIRE CARE UNIT

      PROVIDER NAME          FORM    CARE TYPE    CARE UNIT    ID#

Provider ID Type: BLUE CROSS
1  IB,DOCTOR7                UB-04  INPT/OUTPT   BCXXXXX

Provider ID Type: BLUE SHIELD
2  <<INS CO DEFAULT>>        BOTH   INPT/OUTPT   DEFALLProv
3  IB Outside Facility        BOTH   INPT/OUTPT   BSFACXXXX
4  IB,DOCTOR8                 BOTH   INPT/OUTPT   BSINDOUT
5  IB,DOCTOR33                BOTH   INPT/OUTPT   BSLIM
6  IB,DOCTOR7                 1500   INPT/OUTPT   BSXXXXX

Provider ID Type: PROVIDER PLAN NETWORK
7  IB,DOCTOR64                BOTH   INPT/OUTPT   MD22356A
+  Enter ?? for more actions

AI  Add an ID                  DP    Display Ins Params  VI  View IDs by Type
DI  Delete an ID               CI    Change Ins Co       CU  Care Unit Maint
EI  Edit an ID                  CD    Change Display      EX  Exit

Select Action: Next Screen//AI Add an ID
    
```

**Step Procedure**

At the *Select Provider (optional)* prompt, enter a Provider's Name to enter an individual ID or leave it blank to enter a default ID and then continue to define the ID as before.

```
Select PROVIDER (optional): IB,DOCTOR7

Searching for a VA PROVIDER
IB,DOCTOR7  1XXXX  LZZ  114  RESIDENT PHYSICIAN
...OK? Yes// (Yes)

Select Provider ID Type: COMMERCIAL G2

FORM TYPE APPLIED TO: 0 BOTH UB-04 AND CMS-1500 FORMS
BILL CARE TYPE: 0 BOTH INPATIENT AND OUTPATIENT

THE FOLLOWING WAS CHOSEN:
INSURANCE: BLUE CROSS OF CALIFORNIA
PROV TYPE: COMMERCIAL
FORM TYPE: BOTH UB-04 & CMS-1500 FORMS
CARE TYPE: BOTH INPATIENT AND OUTPATIENT

PROVIDER ID: CMXXXXXX
```

**3.5. Care Units**

Some insurance companies assign the same IDs to multiple Physician/Providers, based upon Care Units, to be used as *Physician/Provider Secondary IDs* on claims. This allows more than one person to have the same ID without everyone having the same ID.

Example: Insurance Company A assigns the number XXXXXX1 to a care unit called Care Unit A and assigns this number and care unit to Dr. A, Dr. B, Dr. C and Dr. E. as their Physician/Provider Secondary ID. The same insurance company assigns the number XXXXXX2 to a care unit called Care Unit B and assigns this number and care unit to Dr. F, Dr. G, Dr. H and Dr. I. as their Physician/Provider Secondary IDs.

Some insurance companies assign IDs to be used as *Billing Provider Secondary IDs* on claims for services performed for specific types of care.

Example: Insurance Company A assigns the number XXXXHH to be used as the Billing Provider Secondary ID (Billing Screen 3) when Home Health services are provided. The same insurance company assigns the number XXXXER as the Billing Provider Secondary ID (Billing Screen 3) when Emergency services are provided.

The names of the “care unit” used by insurance companies are specified by the insurance companies and do not relate directly to the medical services or departments of the medical center. For this reason, users must define these Care Units in Provider ID Maintenance.

### 3.5.1 Define Care Units for Physician/Provider Secondary IDs

Step	Procedure
1	Access the option <b>MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance</b> .
2	At the <b>Select Provider ID Maintenance Option:</b> prompt, enter <b>CP</b> for Care Units for Providers.
3	At the <b>Select INSURANCE CO:</b> prompt, enter <b>Blue Cross of California</b> for this example.

```

Provider ID Maintenance Main Menu

Enter a code from the list.

      Provider IDs
PO  Provider Own IDs
PI  Provider Insurance IDs

      Insurance IDs
BI  Batch ID Entry
II  Insurance Co IDs

      Care Units
CP  Care Units for Providers
CB  Care Units for Billing Provider

      Non-VA Items
NP  Non-VA Provider
NF  Non-VA Facility

Select Provider ID Maintenance Option: CP Care Units for Providers
Select INSURANCE CO: Blue Cross of California

```

Step	Procedure
4	At the <b>Select Action:</b> prompt, enter <b>AU</b> for Add a Unit.
5	At the <b>SELECT CARE UNIT FOR THE INSURANCE CO:</b> prompt, enter Surgery for this example. Confirm Surgery.
6	At the <b>IB PROVIDER ID CARE UNIT DESCRIPTION:</b> prompt, enter a free text description of the Care Unit.
7	At the <b>ID Qualifier:</b> prompt, enter <b>Blue Shield</b> for this example.
8	At the <b>FORM TYPE APPLIED TO:</b> prompt, enter <b>0</b> for <b>BOTH UB-04 &amp; CMS-1500 FORMS</b> .
9	At the <b>BILL CARE TYPE:</b> prompt, enter <b>0</b> for <b>BOTH INPATIENT AND OUTPATIENT</b> .



*Remember, 'Blue Cross' ID can only be used on Institutional claims.*

```

PROVIDER ID CARE UNITS          Nov 03, 2005@11:56:45          Page:    1 of    1

Insurance Co: BLUE CROSS OF CALIFORNIA

      CARE UNIT NAME                DESCRIPTION
No CARE UNITS Found for Insurance Co

      Enter ?? for more actions
AU  Add a Unit                      DU  Delete a Unit
EU  Edit a Unit                     EX  Exit
Select Action: Quit// AU  Add a Unit
SELECT CARE UNIT FOR THE INSURANCE CO: Surgery
Are you adding 'Surgery' as a new IB PROVIDER ID CARE UNIT? No// y (Yes)
  IB PROVIDER ID CARE UNIT DESCRIPTION: Ambulatory Surgery

ID TYPE: BLUE SHIELD
FORM TYPE APPLIED TO: 0 BOTH UB-04 & CMS-1500 FORMS
BILL CARE TYPE: 0 BOTH INPATIENT AND OUTPATIENT
CARE UNIT: Surgery

  >> CARE UNIT COMBINATION FILED FOR THE INSURANCE CO
PRESS ENTER TO CONTINUE
    
```

The following screen will display.

```

PROVIDER ID CARE UNITS          Nov 03, 2005@11:56:45          Page:    1 of    1

Insurance Co: BLUE CROSS OF CALIFORNIA

      CARE UNIT NAME                DESCRIPTION
1  Surgery                          Ambulatory Surgery
                                     o BLUE SHIELD ID          Both form types Inpt/Outpt

      Enter ?? for more actions
AU  Add a Unit                      DU  Delete a Unit
EU  Edit a Unit                     EX  Exit
Select Action: Quit//
    
```



Once you have defined a Care Unit, when you go to define physician/provider's IDs furnished by an insurance company, you will be prompted to enter the name of the Care Unit if you enter the same ID Qualifier, Form Type and Bill Care Type as those for which you previously defined a Care Unit.

```

PROVIDER ID          Nov 21, 2005@09:52:39          Page:    1 of    1
                    ** Provider IDs Furnished by Insurance Co **
PROVIDER      : IB,DOCTOR7 (VA PROVIDER)
INSURANCE CO: BLUE CROSS OF CALIFORNIA
PROVIDER ID TYPE   FORM   CARE TYPE   CARE UNIT   ID #

No ID's found for provider and selected insurance co

Enter ?? for more actions
AU  Add a Unit          DU  Delete a Unit
EU  Edit a Unit        EX  Exit
Select Action: Quit// AU  Add a Unit
CHOOSE 1-2: 2  BLUE SHIELD ID
FORM TYPE APPLIED TO: 0  BOTH UB-04 AND CMS-1500 FORMS
BILL CARE TYPE: 0  BOTH INPATIENT AND OUTPATIENT
Select IB PROVIDER ID CARE UNIT: Surgery  Ambulatory Surgery  BLUE CROSS
OF CALIFORNIA

THE FOLLOWING WAS CHOSEN:
INSURANCE: BLUE CROSS OF CALIFORNIA
PROV TYPE: BLUE SHIELD ID
FORM TYPE: BOTH UB-04 & CMS-1500 FORMS
CARE TYPE: BOTH INPATIENT AND OUTPATIENT
CARE UNIT: Surgery

PROVIDER ID: XXXXBS
    
```



*When creating a bill for a patient with this payer, if IB,Doctor7 is entered on Screen 8, this ID for the Care Unit, Surgery, will be one of the Physician/Provider's Secondary IDs available.*

```

***** SECONDARY PERFORMING PROVIDER IDs *****

PRIMARY INSURANCE CO: BLUE CROSS OF CALIFORNIA
PROVIDER: IB,DOCTOR7 (RENDERING)

SELECT A SECONDARY ID OR ACTION FROM THE LIST BELOW:

1  - NO SECONDARY ID NEEDED
2  - ADD AN ID FOR THIS CLAIM ONLY
3  - XXXXBS          BLUE SHIELD ID  Surgery

Selection: 1//
    
```

### 3.5.2 Define Care Units for Billing Provider Secondary IDs

Step	Procedure
1	Access the option <b>MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance</b> .
2	At the <b>Select Provider ID Maintenance Option:</b> prompt, enter <b>CB</b> for Care Units for Billing Provider.

- At the **Select INSURANCE CO:** prompt, enter **Blue Cross of California** for this example.

```

Provider ID Maintenance Main Menu

Enter a code from the list.

      Provider IDs
PO  Provider Own IDs
PI  Provider Insurance IDs

      Insurance IDs
BI  Batch ID Entry
II  Insurance Co IDs

      Care Units
CP  Care Units for Providers
CB  Care Units for Billing Provider

      Non-VA Items
NP  Non-VA Provider
NF  Non-VA Facility

Select Provider ID Maintenance Option: CB Care Units for Billing Provider
Select INSURANCE CO: Blue Cross of California
    
```

Step	Procedure
6	At the <b>Select Action:</b> prompt, enter <b>AU</b> for Add a Unit.
7	At the <b>Enter the Division for this Care Unit:</b> prompt, press <b>Return</b> to accept the default.
8	At the <b>Enter Care Unit Name:</b> prompt, enter <b>Anesthesia</b> for this example.
9	At the <b>Enter a Care Unit Description:</b> prompt, enter a free text description.
	<i>Users may repeat these steps to create multiple Care Units for multiple divisions.</i>
	<i>Refer to <b>Section 3.1.2.3</b> to learn how to assign Billing Provider Secondary IDs to Care Units.</i>

```

Care Units - Billing Provider  May 27, 2005@11:17:46          Page: 1 of 0

Insurance Co: BLUE CROSS OF CALIFORNIA

Care Unit Name          Division          Description
No Care Units defined for this Insurance Co.

      Enter ?? for more actions
AU  Add a Unit          DU  Delete a Unit
EU  Edit a Unit         EX  Exit
Select Action: Quit// AU Add a Unit
Enter the Division for this Care Unit: Main Division//
Enter Care Unit name: Anesthesia
Are you adding 'Anesthesia' as
a new Care Unit for Main Division? No// y (Yes)
Enter a Care Unit Description: Free Text Description

Care Unit combination filed for this Insurance Co.
    
```

The following screen will display.

```

Care Units - Billing Provider May 27, 2005@11:17:46          Page: 1 of 0
Insurance Co: BLUE CROSS/BLUE SHIELD

  Care Unit Name          Description
-----
Division: Main Division
  Anesthesia             Free Text Description
  Reference Lab          Free Text Description
  Home Health            Free Text Description

Division: Remote Clinic
  Reference Lab          Free Text Description

          Enter ?? for more actions
AU   Add a Unit          DU   Delete a Unit
EU   Edit a Unit        EX   Exit
Select Action: Quit//   QUIT

```

### 3.6. ID Parameters by Insurance Company

In addition to defining Care Units and Physician/Provider IDs in Provider ID Maintenance, there are also ID parameters that can be set for an insurance company that effect which IDs get sent on 837 claims transmissions to an insurance company.

Users need to be aware of these parameters so they can be set *if needed*. They do not need to be set unless there is a specific need for a particular insurance company.

Step	Procedure
1	Access the option <b>Insurance Company Entry/Edit</b> .
2	At the <b>Select INSURANCE COMPANY NAME:</b> prompt, enter <b>BLUE CROSS OF CALIFORNIA</b> for this example.
3	From the <b>Insurance Company Editor</b> , enter the <b>Prov IDs/ID Param</b> action.

```

Insurance Company Editor      Oct 01, 2007@14:27:13      Page:      1 of      9
Insurance Company Information for: BLUE CROSS OF CALIFORNIA
Type of Company: HEALTH INSURANCE      Currently Active

                        Billing Parameters
Signature Required?: NO      Filing Time Frame:
Reimburse?: WILL REIMBURSE      Type Of Coverage: HEALTH INSURAN
Mult. Bedsections:      Billing Phone: 800/933-9146
Diff. Rev. Codes:      Verification Phone: 800/933-9146
One Opt. Visit: NO      Precert Comp. Name:
Amb. Sur. Rev. Code:      Precert Phone: 800/274-7767
Rx Refill Rev. Code:

                        EDI Parameters
Transmit?: YES-LIVE      Insurance Type: HMO
+      Enter ?? for more actions      >>>
BP Billing/EDI Param      IO Inquiry Office      EA Edit All
MM Main Mailing Address AC Associate Companies      AI (In)Activate Company
IC Inpt Claims Office      ID Prov IDs/ID Param      CC Change Insurance Co.
OC Opt Claims Office      PA Payer      DC Delete Company
PC Prescr Claims Of      RE Remarks      VP View Plans
AO Appeals Office      SY Synonyms      EX Exit
Action: Next Screen// ID Prov IDs/ID Param
    
```

Step	Procedure
4	From the <b>Billing Provider IDs</b> screen, enter the <b>ID Parameters</b> action.

```

Billing Provider IDs (Parent) May 27, 2005@12:48:29      Page:      1 of      1
Insurance Co: BLUE CROSS OF CALIFORNIA      Billing Provider Secondary IDs
ID Qualifier      ID #      Form Type
Division: Name of Main Division/Default for All Divisions
1      Electronic Plan Type      XXXXXXXXXX      UB-04
2      Electronic Plan Type      XXXXXXXXX1X      1500

                        Enter ?? for more actions
Add an ID      Additional IDs      Exit
Edit an ID      ID Parameters
Delete an ID      VA-Lab/Facility IDs

Select Action: Edit// ID Parameters
    
```

Step	Procedure
4	From the <b>Billing Provider IDs</b> screen, enter the <b>ID Parameters</b> action.
	The ID Parameter Maint. Screen displays the current parameter values.
5	At the <b>Select Action:</b> prompt, enter the <b>Edit Params</b> action.

```

ID Parameter Maint.          May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co.: BLUE CROSS OF CALIFORNIA

Attending/Rendering Provider Secondary ID
Default ID (1500): PROVIDER PLAN NETWORK
Default ID (UB-04):
Require ID on Claim: CMS-1500 REQUIRED

Referring Provider Secondary ID
Default ID (1500):
Require ID on Claim:

Billing Provider Secondary IDs
Use Attending/Rendering ID as Billing Provider Sec. ID?: NO
Transmit no Billing Provider Sec ID for the following Electronic Plan Types:

+          Enter ?? for more actions
  Edit Params      Edit Billing Prov Params      Exit

Select Action: Next Screen// Edit Params

```

The following screen will display.

```

Attending/Rendering Provider Secondary ID
Default ID (1500): PROVIDER PLAN NETWORK
Default ID (UB04):
Require ID on Claim: CMS-1500 REQUIRED

Referring Provider Secondary ID
Default ID (1500): UPIN//
Require ID on Claim:

Billing Provider Secondary IDs
Send Attending/Rendering ID as Billing Provider Sec. ID?: No//

VA-Laboratory or Facility IDs
Send VA Lab/Facility IDs or Facility Data?: Yes//

Performing Provider Care Unit
Care Unit prompt: Surgery

Note: Use Provider ID Maintenance to define individual provider's IDs.

```

### 3.6.1 Define Attending/Rendering Provider Secondary ID Parameters

Users can define the type of ID that will be the default secondary ID for the Rendering Provider or Attending Physician during the creation of a claim.

A type of default secondary ID can be defined for a CMS-1500 claim and/or a UB-04 claim.

Users can also set a parameter which will make these IDs required on a claim. If they are required and the physician/provider on the claim does not have a secondary ID of the type required, the claim can not be authorized.

```

Attending/Rendering Provider Secondary ID
Default ID (1500): BLUE SHIELD ID
Default ID (UB04): BLUE CROSS ID
Require ID on Claim: BOTH

```

### 3.6.2 Define Referring Provider Secondary ID Parameters

Users can define the type of ID that will be the default secondary ID for the Referring Provider during the creation of a CMS-1500 claim.

A type of default secondary ID can be defined for a CMS-1500 claim.

Users can also set a parameter which will make this ID required on a claim. If it is required and the referring provider on the claim does not have a secondary ID of the type required, the claim can not be authorized.

The default type of ID for a Referring Provider is a UPIN but users may override this default.

```

Referring Provider Secondary ID
Default ID (1500): UPIN// BLUE SHIELD ID
Require ID on Claim: CMS-1500 REQUIRED

```

### 3.6.3 Define Billing Provider Secondary ID Parameters

If an insurance company wants the Billing Provider Secondary ID (Billing Screen 3) to be the same as the Attending Physician's or the Rendering Provider's ID, users can set the Send Attending/Rendering ID as Billing Provider Sec. ID?: parameter to Yes. The default value is No.

```

Billing Provider Secondary IDs
Send Attending/Rendering ID as Billing Provider Sec. ID?: No// Yes

```



*If the payer requires the Attending/Rendering Physician/Provider's Secondary ID as the Billing Provider Secondary ID, this parameter can be set and a default Attending/Rendering ID type can be set and then users can just accept the default ID on Billing Screen 8 and it will be transmitted as the Physician/Provider's Secondary ID and the Billing Provider Secondary ID.*

### 3.6.4 Define VA Service Facility Parameters

Some insurance companies want the IDs and the facility data such as the address for the VAMC repeated in the Service Facility segments of the 837 claim transmission. There are some insurance companies that do not want IDs or facility data for the VAMC repeated. For these insurance companies, set the Send VA Lab/Facility IDs or Facility Data?: Yes// parameter to No. The default value is Yes.

```

VA-Laboratory or Facility IDs
Send VA Lab/Facility IDs or Facility Data?: Yes//

```

### 3.6.5 Define No Billing Provider Secondary IDs by Plan Type

Some insurance companies do not want any Billing Provider Secondary IDs to be transmitted in the 837 claim transmission for claims to specific plan types.

To define which plan types require no Billing Provider Secondary IDs, users must enter the plan types.

Step	Procedure
1	From the <b>ID Parameter Maint.</b> screen, enter the <b>Edit Billing Prov Params</b> action.
	 The first Billing Provider Secondary ID will still be sent with the claim regardless of this parameter. The first ID is a calculated value used by Emdeon for sorting purposes.
2	At the <b>Select Action:</b> prompt, enter <b>Add Plan</b> .
3	At the <b>Enter Electronic Plan Type:</b> prompt, enter <b>PPO</b> for this example.

```

Billing Provider Parameters   May 27, 2005@12:48:29           Page:    1 of    1
Insurance Co.: BLUE CROSS OF CALIFORNIA

Transmit No Billing Provider Sec ID for the following Electronic Plan Types:
1 HMO

                Enter ?? for more actions
Add Plan      Delete Plan      Exit

Select Action: Add Plan
Enter Electronic Plan Type: PPO

```

The following screen will display.

```

Billing Provider Parameters   May 27, 2005@12:48:29           Page:    1 of    1
Insurance Co.: BLUE CROSS OF CALIFORNIA

Transmit No Billing Provider Sec ID for the following Electronic Plan Types:
1 HMO
2 PPO

                Enter ?? for more actions
Add Plan      Delete Plan      Exit

Select Action: Add Plan

```

### 3.6.6 View Associated Insurance Companies, Provider IDs, and ID Parameters

When in the Insurance Company Editor, users can scroll through the information that has been defined for a particular insurance company.

Patch IB\*2.0\*320 added sections to display: Associated Insurance Companies; Provider IDs and ID Parameters.

Insurance Company Editor Nov 22, 2005@10:26:11 Page: 5 of 7  
Insurance Company Information for: BLUE CROSS OF CALIFORNIA  
Type of Company: BLUE CROSS Currently Active  
+

**Associated Insurance Companies**

This insurance company is defined as a Parent Insurance Company.  
There are 4 Child Insurance Companies associated with it.  
Select the "AC Associate Companies" action to enter/edit the children.

**Provider IDs**

Billing Provider Secondary ID  
Main Division and Default for All Divisions/1500:  
Main Division and Default for All Divisions/UB-04:  
Main Division Care Units:  
Anesthesia/1500:  
Reference Lab/1500:  
Reference Lab/UB-04:  
Home Health/UB-04:  
2<sup>nd</sup> Division Name/1500:  
2<sup>nd</sup> Division Name/UB-04:

Additional Billing Provider Secondary IDs  
Main Division and Default for All Divisions/1500:  
1<sup>st</sup> ID  
2<sup>nd</sup> ID  
3<sup>rd</sup> ID  
Maximum of 6 additional IDs  
Main Division and Default for All Divisions/UB-04:  
1<sup>st</sup> ID  
2<sup>nd</sup> ID  
3<sup>rd</sup> ID  
Maximum of 6 additional IDs

VA-Laboratory or Facility Secondary IDs  
Main Division and Default for All Divisions/1500:  
1<sup>st</sup> ID  
2<sup>nd</sup> ID  
3<sup>rd</sup> ID  
Maximum of 5 additional IDs

**ID Parameters**

Attending/Rendering Provider Secondary ID Qualifier (1500):  
Attending/Rendering Provider Secondary ID Qualifier (UB-04):  
Attending/Rendering Secondary ID Requirement: NONE REQUIRED  
Referring Provider Secondary ID Qualifier (1500):  
Referring Provider Secondary ID Requirement:  
Use Attending/Rendering ID as Billing Provider Sec. ID: No  
Transmit no Billing Provider Sec. ID for the Electronic Plan Types:  
HMO  
PPO  
Send VA Lab/Facility IDs or Facility Data: No

### 3.7. Associated Insurance Companies and Copying Physician/Provider Secondary IDs and Additional Billing Provider Secondary IDs.

Patch IB\*2.0\*320 provides the ability for users to associate multiple Insurance Company entries with each other. If, for example, there are 45 Blue Cross/Blue Shield entries in

the Insurance Company file, users can make one of these entries the Parent company and make 1 to 44 of the other entries a Child company.

Making these associations will caused the software to automatically make the Physician/Provider Secondary IDs and the Additional Billing Provider Secondary IDs the same for all associated companies.

Once these associations are made and the IDs synchronized for all the associated companies, users will be able to Add, Edit and/or Delete IDs for the associated companies from the Parent company. Changes to the IDs from a Child company will be prohibited.

If a situation changes and it becomes necessary for a Child company to have IDs that differ from those of the Parent company, users may disassociated the Child company from the Parent company.

### 3.7.1 Designate a Parent Insurance Company

Step	Procedure
1	Access the <b>Insurance Company Editor</b> .
2	At the <b>Select INSURANCE COMPANY NAME:</b> prompt, enter <b>Blue Cross of California</b> for this example.
3	At the <b>Define Insurance Company as Parent or Child:</b> prompt, enter <b>Parent</b> .

```

Insurance Company Editor      Oct 01, 2007@14:27:13      Page: 1 of 9
Insurance Company Information for: BLUE CROSS OF CALIFORNIA
Type of Company: HEALTH INSURANCE      Currently Active

          Billing Parameters
Signature Required?: NO      Filing Time Frame:
      Reimburse?: WILL REIMBURSE      Type Of Coverage: HEALTH INSURAN
Mult. Bedsections:      Billing Phone: 800/933-9146
Diff. Rev. Codes:      Verification Phone: 800/933-9146
      One Opt. Visit: NO      Precert Comp. Name:
Amb. Sur. Rev. Code:      Precert Phone: 800/274-7767
Rx Refill Rev. Code:

          EDI Parameters
Transmit?: YES-LIVE      Insurance Type: GROUP
+      Enter ?? for more actions      >>>
BP Billing/EDI Param      IO Inquiry Office      EA Edit All
MM Main Mailing Address      AC Associate Companies      AI (In)Activate Company
IC Inpt Claims Office      ID Prov IDs/ID Param      CC Change Insurance Co.
OC Opt Claims Office      PA Payer      DC Delete Company
PC Prescr Claims Of      RE Remarks      VP View Plans
AO Appeals Office      SY Synonyms      EX Exit
Select Action: Next Screen//AC Associate Companies

Define Insurance Company as Parent or Child: P PARENT
  
```

- | Step  | Procedure   |
|---|---|
| 4   | At the Select Action: prompt, enter <b>Associate Companies</b> for this example.  |
| 5   | At the <b>Select INSURANCE COMPANY NAME:</b> prompt, enter <b>BLUE CROSS/BLUE SHIELD 801 PINE ST. CHATTANOOGA,TN</b> for this example.  |
|  | <i>Steps 2 - 4 can be repeated to associate additional Insurance Companies with Blue Cross of California.</i>   |
|  | <i>A Parent – Child association can be removed using the Disassociate Companies action.</i>   |
|  | To stop an insurance company from being a Parent, all associations with any Child entries must be removed. After disassociating all the Child entries, users may delete the Parent using the '@' sign at the <b>Define Insurance Company as Parent or Child: PARENT//</b> prompt. |

```

Associated Insurance Co's      Nov 21, 2005@11:13:53      Page:      1 of      1
Parent Insurance Company:
  BLUE CROSS OF CALIFORNIA    PO BOX 60007                LOS ANGELES,CA
  Ins Company Name           Address                      City
  No Children Insurance Companies Found

  Enter ?? for more actions
  Associate Companies                Exit
  Disassociate Companies
Select Action: Quit// as Associate Companies
Select Insurance Company: BLUE CROSS/BLUE SHIELD801 PINE ST. CHATTANOOGA, TN
    
```

The following screen will display.

```

Associated Insurance Co's      Nov 21, 2005@11:30:25      Page:      1 of      1
Parent Insurance Company:
  BLUE CROSS OF CALIFORNIA    PO BOX 60007                LOS ANGELES,CA
  Ins Company Name           Address                      City
  1 BLUE CROSS FEP            PO BOX 70000                VAN NUYS,CA
  2 BLUE CROSS/BLUE SHIELD    9901 LINN STA RD           LOUISVILLE,KY
  3 BLUE CROSS/BLUE SHIELD    801 PINE ST.               CHATTANOOGA, TN

  Enter ?? for more actions
  Associate Companies                Exit
  Disassociate Companies
Select Action: Quit//
    
```

### 3.7.2 Designate a Child Insurance Company

An insurance company can be designated as a Child, from the Parent insurance company as demonstrated in **Section 3.7.1**.

If users want to quickly define a single insurance company as a Child, they can do this from the Insurance Company Editor.

- | Step | Procedure  |
|------|--|
| 1    | Access the <b>Insurance Company Editor</b> .   |
| 2    | At the <b>Select INSURANCE COMPANY NAME</b> : prompt, enter <b>Aetna</b> for this example.   |
| 3    | At the <b>Define Insurance Company as Parent or Child</b> : prompt, enter <b>Child</b> for this example.                               |
| 4    | At the <b>Associate with which Parent Insurance Company</b> : prompt, enter the name of the insurance company that will be the Parent. |
-  *'??' will provide a list of available Parent insurance companies.*

```

Insurance Company Editor      Oct 01, 2007@14:33:41      Page: 1 of 8
Insurance Company Information for: AETNA
Type of Company: HEALTH INSURANCE      Currently Inactive

      Billing Parameters
Signature Required?: NO      Filing Time Frame: 12 MOS
      Reimburse?: WILL REIMBURSE      Type Of Coverage: HEALTH INSURAN
Mult. Bedsections:      Billing Phone:
Diff. Rev. Codes:      Verification Phone:
      One Opt. Visit: NO      Precert Comp. Name:
Amb. Sur. Rev. Code:      Precert Phone:
Rx Refill Rev. Code:

      EDI Parameters
      Transmit?: YES-LIVE      Insurance Type: GROUP POLICY
+      Enter ?? for more actions      >>>
BP Billing/EDI Param      IO Inquiry Office      EA Edit All
MM Main Mailing Address      AC Associate Companies      AI (In)Activate Company
IC Inpt Claims Office      ID Prov IDs/ID Param      CC Change Insurance Co.
OC Opt Claims Office      PA Payer      DC Delete Company
PC Prescr Claims Of      RE Remarks      VP View Plans
AO Appeals Office      SY Synonyms      EX Exit
Select Action: Next Screen// ac Associate Companies

Define Insurance Company as Parent or Child: Child CHILD
Associate with which Parent Insurance Company: AetNA LIFE INSURANCE      3541 W
INCHESTER RD.      ALLENTOWN      PENNSYLVANIA      Y.....
    
```

### 3.7.3 Copy Physician/Provider Secondary IDs

Individual Physician/Provider Secondary IDs can be entered, edited or deleted one time from the Parent insurance company and these changes will be copied to all associated insurance companies (Child).

This can be done using the following Provider ID Maintenance options:

- Provider ID Maint→PI Provider Insurance IDs;
- Provider ID Maint→II Insurance Co IDs; and
- Provider ID Maint→BI Batch ID Entry

#### **3.7.4 Copy Additional Billing Provider Secondary IDs**

When users are done adding, editing or deleting Additional IDs from the Parent insurance company, the changes will be copied to all associated insurance companies.

#### **3.7.5 Synchronizing Associated Insurance Company IDs**

There is an IRM option for synchronizing the IDs of a Parent insurance company with all of the associated Child companies. This option is intended as a backup option if the IDs of a Parent have become out of synch with the Child companies due to a system problem.

## 4. SUBSCRIBER AND PATIENT ID SET-UP

Insurance Companies issue identification numbers to the people that they insure. The person who pays for the insurance policy or whose employer pays for the insurance policy or who receives Medicare is referred to as the subscriber. A veteran can be the subscriber or a veteran can be insured through an insurance policy that belongs to some other subscriber such as the veteran's spouse or parent.

### 4.1. Subscriber and Patient Insurance Provided IDs

Some insurance companies issue identification numbers only to the subscriber. Some others issue unique identification numbers to each person covered by the subscriber's policy.

Insurance companies can issue both Subscriber Primary and Secondary ID numbers and Patient Primary and Secondary ID numbers.

These ID numbers can be entered when a policy is initially added in VistA through Add a policy. Sometimes the primary IDs will be added during the initial Patient Registration process and placed in the insurance company buffer.

Both Patient and Subscriber, Primary and Secondary IDs can be added or edited at any time using the option Patient Insurance Info View/Edit.

#### 4.1.1 Define Subscriber Primary ID

When the patient is the subscriber, users will be prompted for the Subscriber's Primary ID.

Step	Procedure
1	Access the option <b>Patient Insurance Info View/Edit</b> .
2	At the <b>Select Patient Name:</b> prompt, enter <b>IB,PATIENT TWO</b> .
3	At the <b>Select Items:</b> prompt, enter <b>Policy Edit/View</b> .
4	At the <b>Select Policy(s):</b> prompt, enter <b>1</b> for this example.

Patient Insurance Management Sep 24, 2007@10:18:49				Page: 1 of 1		
Insurance Management for Patient: IB,PATIENT TWO IXXXX						
	Insurance Co.	Type of Policy	Group	Holder	Effect.	Expires
1	AETNA US HEALTH	COMPREHENSIVE M	655555-19-	SELF	03/06/07	
2	BLUE CROSS CA (	PREFERRED PROVI	173084	SPOUSE	05/15/07	
3	IB INSURANCE CO	COMPREHENSIVE M	XXXPLANNUM	OTHER	05/16/07	
4	NEW YORK LIFE	MEDIGAP (SUPPLE	F	OTHER	09/29/06	
Enter ?? for more actions						>>>
AP	Add Policy	EA	Fast Edit All	CP	Change Patient	
VP	Policy Edit/View	BU	Benefits Used	WP	Worksheet Print	
DP	Delete Policy	VC	Verify Coverage	PC	Print Insurance Cov.	
AB	Annual Benefits	RI	Personal Riders	EX	Exit	

```
Select Item(s): Quit// VP Policy Edit/View
Select Policy(s): (1-4): 1.....
```

The following screen will display.

```
Patient Policy Information      Sep 24, 2007@11:20:54      Page: 1 of 6
Expanded Policy Information for: IB,PATIENT TWO XXX-XX-XXXX
AETNA US HEALTHCARE Insurance Company      ** Plan Currently Active **

Plan Information                Insurance Company
Is Group Plan: YES             Company: AETNA US HEALTHCARE
Group Name: FT JAMES CORP      Street: PO BOX 2561
Group Number: 655555-19-230    City/State: FT. WAYNE, IN 46801
BIN:                           Billing Ph: 800/367-4552
PCN:                           Precert Ph:

Type of Plan: COMPREHENSIVE MAJOR MED
Electronic Type: COMMERCIAL
Plan Filing TF: 2 YRS

Utilization Review Info        Effective Dates & Source
Require UR:                    Effective Date: 03/06/07
+ Enter ?? for more actions

PI Change Plan Info           IC Insur. Contact Inf.   CP Change Policy Plan
UI UR Info                   EM Employer Info       VC Verify Coverage
ED Effective Dates           CV Add/Edit Coverage    AB Annual Benefits
SU Subscriber Update         AC Add Comment         BU Benefits Used
IP Inactivate Plan          EA Fast Edit All       EX Exit
Select Action: Next Screen// SU Subscriber Update
```

Step	Procedure
------	-----------

- |    |   |
|----|---|
| 5  | At the Select Action: prompt, enter <b>Subscriber Update</b> .  |
| 6  | At the <b>Pt. Relationship to Insured</b> : prompt, enter <b>Patient</b> .  |
|    |  <i>With Patch IB*2*371, the Whose Insurance? prompt was removed.</i>  |
|    |  <i>With Patch IB*2*377, the list of available choices for Pt. Relationship to Insured was modified to have an expanded list of HIPAA valid choices.</i>   |
| 7  | At the <b>Name of Insured</b> : prompt, press <b>Return</b> to accept the default of IB,Patient Two.  |
|    |  <i>With Patch IB*2*371, users will have the ability to update the patient's name for any patient and any insurance company. This will allow users to make the patient's name match what is on file at the payer even when it is different from what is in the VistA patient file.</i> |
| 8  | At the <b>Effective Date of Policy</b> : prompt, press <b>Return</b> to accept the default of MAR 6, 2007.  |
| 9  | At the <b>Coordination of Benefits</b> : prompt, enter <b>Primary</b> for this example.   |
| 10 | At the <b>Source of Information</b> : prompt, press <b>Return</b> to accept the default of Interview.   |
| 11 | At the <b>Subscriber Primary ID</b> : prompt, enter <b>IDXXXXX</b> for this example.  |
| 12 | At the <b>Do you want to enter/update Subscriber Secondary IDs?</b> Prompt, press <b>Return</b> to accept the default of No.  |

13 At the **Insured's DOB**: prompt, press **Return** to accept the default.

14 At the **Insured's Sex**: prompt, press **Return** to accept the default.



*With Patch IB\*2\*361, the Insured's Sex prompt was added. This is required by HIPAA as is the Insured's DOB.*



*The Insured's address is not required by HIPAA but HIPAA will not accept a partial address. When the insured is the patient, the patient's address will be defaulted from the patient file.*

```
Select Action: Next Screen// Subscriber Update
PT. RELATIONSHIP TO INSURED: PATIENT
NAME OF INSURED: IB,PATIENT TWO//
EFFECTIVE DATE OF POLICY: MAR 6,2007
INSURANCE EXPIRATION DATE:
PRIMARY CARE PROVIDER:
PRIMARY PROVIDER PHONE:
COORDINATION OF BENEFITS: PRIMARY
SOURCE OF INFORMATION: INTERVIEW//

SUBSCRIBER PRIMARY ID: IDXXXXX

Do you want to enter/update Subscriber Secondary IDs? No// NO

INSURED'S DOB: XXX XX,XXXX//
INSURED'S SEX: MALE//
INSURED'S BRANCH: NAVY//
INSURED'S RANK:
INSURED'S STREET 1: 123 E.TEST BLVD//
INSURED'S STREET 2:
INSURED'S CITY: CHEYENNE//
INSURED'S STATE: WYOMING//
INSURED'S ZIP: 82001//
```



*Patch IB\*2\*377 will provide the ability for the Name of the Subscriber and the Subscriber's primary ID (HIC#) to be automatically updated in the Patient's Medicare (WNR) Insurance when an MRA is received in VistA that contains a corrected name and/or ID. The PATIENT file will not be changed.*

#### 4.1.2 Define Subscriber and Patient Primary IDs

When the patient is not the subscriber, users will be prompted for the Patient's Primary ID as well as the Subscriber's Primary ID.

Step	Procedure
1	Access the option <b>Patient Insurance Info View/Edit</b> .
2	At the <b>Select Patient Name</b> : prompt, enter <b>IB,PATIENT TWO</b> .
3	At the <b>Select Items</b> : prompt, enter <b>Policy Edit/View</b> .
4	At the <b>Select Policy(s)</b> : prompt, enter <b>3</b> for this example.

```

Patient Insurance Management Sep 24, 2007@10:18:49 Page: 1 of 1
Insurance Management for Patient: IB,PATIENT TWO I4444

Insurance Co. Type of Policy Group Holder Effect. Expires
1 AETNA US HEALTH COMPREHENSIVE M 655555-19- SELF 03/06/07
2 BLUE CROSS CA ( PREFERRED PROVI 173084 SPOUSE 05/15/07
3 IB INSURANCE CO COMPREHENSIVE M XXXPLANNUM SPOUSE 05/16/07
4 NEW YORK LIFE MEDIGAP (SUPPLE F OTHER 09/29/06

Enter ?? for more actions >>>
AP Add Policy EA Fast Edit All CP Change Patient
VP Policy Edit/View BU Benefits Used WP Worksheet Print
DP Delete Policy VC Verify Coverage PC Print Insurance Cov.
AB Annual Benefits RI Personal Riders EX Exit
Select Item(s): Quit// VP Policy Edit/View
Select Policy(s): (1-4): 3.....
    
```

The following screen will display.

```

Patient Policy Information Sep 24, 2007@10:33:49 Page: 2 of 6
Expanded Policy Information for: IB,PATIENT TWO XXX-XX-XXXX
IB INSURANCE CO Insurance Company ** Plan Currently Active **
+
Subscriber Information Subscriber's Employer Information
Whose Insurance: SPOUSE Emp Sponsored Plan: No
Subscriber Name: Employer:
Relationship: Employment Status:
Primary ID: Retirement Date:
Coord. Benefits: Claims to Employer: No, Send to Insurance
Primary Provider: Street:
Prim Prov Phone: City/State:
Phone:

Insured Person's Information (use Subscriber Update Action)
Insured's DOB: XX/XX/XXXX Str 1: 123 E.TEST BLVD
+
Enter ?? for more actions
PI Change Plan Info IC Insur. Contact Inf. CP Change Policy Plan
UI UR Info EM Employer Info VC Verify Coverage
ED Effective Dates CV Add/Edit Coverage AB Annual Benefits
SU Subscriber Update AC Add Comment BU Benefits Used
IP Inactivate Plan EA Fast Edit All EX Exit
Select Action: Next Screen// SU Subscriber Update
    
```

- | Step  | Procedure   |
|---|---|
| 5   | At the <b>Select Action:</b> prompt, enter <b>Subscriber Update</b> .   |
| 6   | At the <b>PT. RELATIONSHIP TO INSURED:</b> prompt, enter <b>SPOUSE</b> for this example.                          |
|  | <i>With Patch IB*2*377, an expanded list of HIPAA compliant codes for Pt. Relationship to Insured, was added.</i> |
|  | <i>With Patch IB*2*371, the Whose Insurance? prompt was removed.</i>  |
| 7   | At the <b>Name of Insured:</b> prompt, enter <b>IB,Spouse Two</b> for this example.                               |
| 8   | At the <b>Effective Date of Policy:</b> prompt, press <b>Return</b> to accept the default of May 15, 2007.        |

- 9 At the **Coordination of Benefits**: prompt, enter **Secondary** for this example.
- 10 At the **Source of Information**: prompt, press **Return** to accept the default of Interview.
- 11 At the **Subscriber Primary ID**: prompt, enter **XXXXXID** for this example.
- 12 At the **Do you want to enter/update Subscriber Secondary IDs?** Prompt, press **Return** to accept the default of No.
- 13 At the **Patient Primary ID**: prompt, enter **XXXXXID2** for this example.
- 14 At the **Do you want to enter/update Patient Secondary IDs?** Prompt, press **Return** to accept the default of No.
- 15 At the **Insured's DOB**: prompt, enter **August 12, 1945** for this example.
- 16 At the **Insured's Sex**: prompt, enter **Female** for this example.



*With Patch IB\*2\*361, the Insured's Sex prompt was added. This is required by HIPAA as is the Insured's DOB.*



*If the Patient's Relationship to the Insured is spouse, then the patient's address will be the default address of the Insured. Users may enter different values if the spouse's address is different from the patient's.*



*The Insured's address is not required by HIPAA but HIPAA will not accept a partial address.*

```
Select Action: Next Screen// SU Subscriber Update
PT. RELATIONSHIP TO INSURED: SPOUSE//
NAME OF INSURED: IB,SPOUSE TWO
EFFECTIVE DATE OF POLICY: MAY 15,2007
INSURANCE EXPIRATION DATE:
PRIMARY CARE PROVIDER:
PRIMARY PROVIDER PHONE:
COORDINATION OF BENEFITS: SECONDARY
SOURCE OF INFORMATION: INTERVIEW//

SUBSCRIBER PRIMARY ID: XXXXXID

Do you want to enter/update Subscriber Secondary IDs? No// NO

PATIENT PRIMARY ID: XXXXXID2

Do you want to enter/update Patient Secondary IDs? No// NO

INSURED'S DOB: AUG 12,1945
INSURED'S SEX: FEMALE
INSURED'S BRANCH:
INSURED'S RANK:
INSURED'S STREET 1: 123 E.TEST BLVD//
INSURED'S STREET 2:
INSURED'S CITY: CHEYENNE//
INSURED'S STATE: WYOMING//
INSURED'S ZIP: 82001//
```

### 4.1.3 Define Subscriber and Patient Secondary IDs

In addition to Subscriber and Patient Primary IDs, it is possible for insurance companies to issue secondary IDs, though this is very unusual. A subscriber or a patient may also have one or more secondary IDs of the following types:

- 23 Client Number
- IG Insurance Policy Number
- SY Social Security Number

```

SUBSCRIBER PRIMARY ID: XXXXXID//

Do you want to enter/update Subscriber Secondary IDs? No// y YES

SUBSCRIBER'S SEC QUALIFIER(1):??
  Enter a Qualifier to identify the type of ID number.
  Choose from:
    23      Client Number
    IG      Insurance Policy Number
    SY      Social Security Number
SUBSCRIBER'S SEC QUALIFIER(1): IG Insurance Policy Number
SUBSCRIBER'S SEC ID(1): XXXXID2
SUBSCRIBER'S SEC QUALIFIER(2):

PATIENT PRIMARY ID: IDXXXXX//

Do you want to enter/update Patient Secondary IDs? No// y YES

PATIENT'S SEC QUALIFIER(1): IG Insurance Policy Number
PATIENT'S SECONDARY ID(1): ID2XXXX
PATIENT'S SEC QUALIFIER(2):

```

Step	Procedure
1	Access <b>Subscriber Update</b> again.
2	At the <b>Do you want to enter/update Subscriber Secondary IDs? No//:</b> prompt, enter <b>Yes</b> .
3	At the <b>Subscriber's Sec Qualifier (1)::</b> prompt, enter <b>IG</b> for this example.
	<i>23 Client Number is used for claims to the Indian Health Service/Contract Health Services (HIS/CHS).</i>
	<i>VistA will not allow users to enter SY for SNN if the payer is Medicare. Medicare will not accept the SSN as a subscriber's secondary ID.</i>
4	At the <b>Subscriber's Sec ID (1):</b> prompt, enter <b>XXXXID2</b> for this example.
5	At the <b>Subscriber's Sec Qualifier (2)::</b> prompt, press <b>Return</b> if you do not want to add another ID.
6	At the <b>Patient Primary ID (1):</b> prompt, press <b>Return</b> to accept the default.
7	At the <b>Do you want to enter/update Patient Secondary IDs? No//:</b> prompt, enter <b>Yes</b> .
8	At the <b>Patient's Sec Qualifier (1)::</b> prompt, enter <b>IG</b> for this example.
9	At the <b>Patient's Sec ID (1):</b> prompt, enter <b>ID2XXXX</b> for this example.
10	At the <b>Patient's Sec Qualifier (2)::</b> prompt, press <b>Return</b> if you do not want to add another ID.

## 5. ENTERING ELECTRONIC CLAIMS

This section briefly identifies the screens used in the billing process that contain fields critical to EDI billing. It is important that all the data transmitted in an electronic claim be accurate and appropriate. This section is just meant to highlight some specific fields that pertain to electronic processing.

### 5.1. Screen 3 – Payer Information

#### 5.1.1 EDI Fields

Section 1 – Transmit	When a payer has been set up to transmit claims electronically, this field will say “Yes”. If the field says “No” the claim will be printed locally.
Section 2 – Primary, Secondary and Tertiary Payer	These fields display the Billing Provider Secondary IDs for the payers on the bill. These IDs are defined in the Insurance Company Editor. <i>Note: If users set the ID Parameter: Send Attending/Rendering ID as Billing Provider Sec. ID? to Yes for a payer on the claim, the Attending/Rendering ID will be sent.</i>
Section 3 – Mailing Address	This field should contain a valid mailing address for the current payer. In order to avoid EDI errors, there should be no periods or dashes such as P.O. Box, Winston-Salem, St. Paul, etc. <i>Exception: Medicare does not have a valid address.</i>
Section 3 – Electronic ID	This field contains the Inst Payer Primary ID or Prof Payer Primary ID defined in the Insurance Company Editor. Payer Primary IDs are provided by Emdeon and can be found at <a href="http://www.emdeon.com">www.emdeon.com</a> .

```

IB,PATIENT 1   XXX-XX-XXXX   BILL#: K501XXX - Inpat/1500   SCREEN <3>
=====
                                PAYER INFORMATION
[1] Rate Type   : REIMBURSABLE INS.           Form Type: CMS-1500
    Responsible: INSURER                     Payer Sequence: Primary
    Bill Payer  : MRA NEEDED FROM MEDICARE   Transmit: Yes

    Ins 1: MEDICARE (WNR)           WILL NOT REIMBURSE   Policy #: XXXXXXXXA
    Grp #: PART A                   Whose: VETERAN       Rel to Insd: PATIENT
    Grp Nm: PART A                  Insd Sex: MALE       Insured: IB,PATIENT 1

    Ins 2: BLUE CROSS OF CA        Policy #: MES3456
    Grp #: PLAN 2                   Whose: VETERAN       Rel to Insd: PATIENT
    Grp Nm: PROTECTION PLUS        Insd Sex: MALE       Insured: IB,PATIENT 1

[2] Billing Provider Secondary IDs:
    Primary Payer: 670899
    Secondary Payer: XXXXXX1X           Tertiary Payer:

[3] Mailing Address :                       Electronic ID: XXXXID
    NO MAILING ADDRESS HAS BEEN SPECIFIED! (Patient has Medicare)
    Send Bill to PAYER listed above.
<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT:
    
```



*The 3-line mailing address displayed here is used also used by Emdeon to look up the Electronic ID for the payer when a claim is sent without a defined Electronic Bill ID.*

### 5.1.2 Using Care Units for Billing Provider Secondary IDs

Section 3 of Billing Screen 3 contains fields for the Billing Provider Secondary IDs for the primary, secondary and tertiary payers on a claim. Normally the default values for the site or the defined values for the division on the claim populate these fields. If any insurance company on the claim requires different Billing Provider Secondary IDs based upon Care Units, users can change the default values to the value defined for the Care Unit where the services were provided.

Step	Procedure
1	At the <RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT: prompt, enter <b>2</b> .
2	At the <b>Current Bill Payer Sequence:</b> prompt, press <b>Return</b> to accept the default.
3	At the <b>Define Primary Payer ID by Care Unit?:</b> prompt, press <b>Return</b> to accept the default.
4	At the <b>Primary Payer ID:</b> prompt, press <b>Return</b> to accept the default.
5	At the <b>Define Secondary Payer ID by Care Unit?:</b> prompt, enter <b>Yes</b> for this example.
6	At the <b>Division:</b> prompt, press <b>Return</b> to accept the default for this example.
7	At the <b>Care Unit:</b> prompt, enter <b>Anesthesia</b> for this example.
8	At the <b>Secondary Payer ID:</b> prompt, press <b>Return</b> to accept the default.



*Note: The Care Units must be defined in Provider ID Maintenance and the ID numbers must be defined in the Insurance Company Editor. Refer to*

**Section 3.2.2.3 and Section 3.5.2**

```

IB,PATIENT 1   XXX-XX-XXXX   BILL#: K501XXX - Inpat/1500   SCREEN <3>
=====
                                PAYER INFORMATION
[1] Rate Type   : REIMBURSABLE INS.           Form Type: CMS-1500
    Responsible: INSURER                       Payer Sequence: Primary
    Bill Payer  : MRA NEEDED FROM MEDICARE     Transmit: Yes

    Ins 1: MEDICARE (WNR)           WILL NOT REIMBURSE   Policy #: XXXXXXXXXA
    Grp #: PART A                   Whose: VETERAN       Rel to Insd: PATIENT
    Grp Nm: PART A                  Insd Sex: MALE       Insured: IB,PATIENT 1

    Ins 2: BLUE CROSS OF CA        Policy #: MES3456
    Grp #: PLAN 2                   Whose: VETERAN       Rel to Insd: PATIENT
    Grp Nm: PROTECTION PLUS        Insd Sex: MALE       Insured: IB,PATIENT 1

[2] Billing Provider Secondary IDs:
    Primary Payer: 670899
    Secondary Payer: XXXXXX1X           Tertiary Payer:

[3] Mailing Address :                               Electronic ID: XXXXID
    NO MAILING ADDRESS HAS BEEN SPECIFIED!   (Patient has Medicare)
    Send Bill to PAYER listed above.
<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT: 2
Current Bill Payer Sequence: PRIMARY INSURANCE//
Define Primary Payer ID by Care Unit? No//
Primary Payer ID: 670899//
Define Secondary Payer ID by Care Unit? No//Yes
Division: Main Division//
Care Unit: ??
    1 Anesthesia
    2 Reference Lab
    3 Home Health
Care Unit: 1 Anesthesia
Secondary Payer ID: XXXXXXXX//

```

**5.2. Screen 8 – Physician/Provider and Print Information****5.2.1 EDI Fields UB-04/CMS-1500**

- Section 2/3 – Providers** When a Physician/Provider is entered here, the system finds the appropriate IDs and Taxonomy Codes for him/her. The Primary IDs are the providers' SSNs and their secondary IDs are those IDs that users have defined as the provider's own or as those provided by an insurance company.
- Section 8 – Other Facility** These are the sections through which outside facilities are entered. The primary and secondary Laboratory or Facility  
**Section 4 – Other Facility,** IDs and Taxonomy Codes are then transmitted with the  
**CLIA#, Mammography** claim.  
**Certification Number** The CLIA# and Mammography Certification Number can also be sent with a professional laboratory claim or mammography claim.
- Section 6 – Force to Print** Users can set this field to force a claim to print either locally

or at the clearinghouse.  
 Section 7 – Provider ID Maint This is a link to the Provider ID Maintenance function.

```

IB,PATIENT2 000-00-0000 BILL#: K300XX - Outpat/UB-04 SCREEN<8>
=====
                                BILLING - SPECIFIC INFORMATION
[1] Bill Remark      : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)       : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s) : UNSPECIFIED [NOT REQUIRED]
    Admitting Dx     : UNSPECIFIED [NOT REQUIRED]
    Admission Source  : UNSPECIFIED
[2] Providers       :
    - ATTENDING (MD) : IB,DOCTOR 2 Taxonomy: UNSPECIFIED
[3] Form Locator 2  : UNSPECIFIED [NOT REQUIRED]
    Form Locator 11  : UNSPECIFIED [NOT REQUIRED]
[4] Form Locator 31 : UNSPECIFIED [NOT REQUIRED]
[5] Form Locator 56 : UNSPECIFIED [NOT REQUIRED]
    Form Locator 78  : UNSPECIFIED [NOT REQUIRED]
[6] Force To Print? : NO FORCED PRINT
[7] Provider ID Maint : (Edit Provider ID information)
[8] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED] Taxonomy: UNSPECIFIED

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

```

IB,PATIENT 3 000-00-0000 BILL#: K600XX - Outpat/1500 SCREEN <8>
=====
                                BILLING - SPECIFIC INFORMATION
[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]
    Unable To Work To   : UNSPECIFIED [NOT REQUIRED]
[2] Admitting Dx       : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)         : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)   : UNSPECIFIED [NOT REQUIRED]
[3] Providers         :
    - RENDERING (MD)   : IB,DOCTOR 1 Taxonomy: UNSPECIFIED
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED] Taxonomy: UNSPECIFIED
    Lab CLIA #         : UNSPECIFIED
    Mammography Cert # : UNSPECIFIED
[5] Form Locator 19   : UNSPECIFIED [NOT REQUIRED]
[6] Print Main Facility Box 32: UNSPECIFIED [NOT REQUIRED]
    Force To Print?    : NO FORCED PRINT
[7] Provider ID Maint : (Edit Provider ID information)Billing Process Overview

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

### 5.3. UB-04 Claims

The following screens provide a simplified example of a UB-04 claim:

Step	Procedure
1	When processing a UB-04 claim, information on Screens 1 and 2 should be reviewed for correctness. Press the <b>Return</b> key to move from one screen to the next.
2	On Screen 3, the payer information is reviewed for correctness. The patient may have more than one insurance policy. If the correct information is not

displayed, select a section (1, 2, or 3 ) and edit the necessary fields. Press **Return** to continue to Screen 5.

```

IB,PATIENT3  000-00-0000  BILL#: K300XX - Outpat/UB-04 SCREEN <3>
=====
                                PAYER INFORMATION
[1] Rate Type   : REIMBURSABLE INS.           Form Type: UB-04
    Responsible: INSURER                     Payer Sequence: Primary
    Bill Payer  : Blue Cross Fep             Transmit: Yes

    Ins 1: Blue Cross Fep                    Policy #: RXXXXXXXXX
    Grp #: 100                               Whose: VETERAN      Rel to Insd: PATIENT
    Grp Nm: STANDARD FAMILY                 Insd Sex: MALE     Insured: IB,PATIENT3

[2] Primary   : 010100
    Secondary  :
    Tertiary   :

[3] Mailing Address :
    Blue Cross Fep
    P O Box 10401
    Birmingham, AL 352020401
    Electronic ID: 12B54

<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT:

```

Step	Procedure
------	-----------

- |   |   |
|---|---|
| 3 | On Screen 5, enter sections 1-7 to type in the diagnosis information, the services/procedures provided and the date of service. Include the Occurrence and Condition Code when required. Press the <b>Return</b> key to move to Screen 7. |
|---|---|

```

IB,PATIENT3  000-00-0000  BILL#: K300XX - Outpat/UB-04 SCREEN <5>
=====
                                EVENT - OUTPATIENT INFORMATION
[1] Event Date : XXX XX, XXXX
[2] Prin. Diag : ABDOM PAIN, L L QUADR - 789.04
    Other Diag : BENIGN NEOPLASM LG BOWEL - 211.3
    Other Diag : DIVERTICULOSIS OF COLON - 562.10
[3] OP Visits  : XXX XX, XXXX
[4] Cod. Method: HCPCS
    CPT Code   : LESION REMOVE COLONOSCOPY 45384          XXX XX, XXXX
[5] Rx. Refills: UNSPECIFIED [NOT REQUIRED]
[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[7] Occ. Code  : ONSET OF SYMPTOMS/ILLNESS             XXX XX, XXXX
[8] Cond. Code : UNSPECIFIED [NOT REQUIRED]
[9] Value Code : UNSPECIFIED [NOT REQUIRED]

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

```

Step	Procedure
------	-----------

- |   |   |
|---|---|
| 4 | If all information has been entered correctly, Screen 7 will be auto-populated (as shown below) with the necessary information to send the claim electronically. <i>Make sure that the Disch Stat field in Section 1 is populated.</i> Press the <b>Return</b> key to move to Screen 8. |
|---|---|

```

IB,PATIENT3  000-00-0000  BILL#: K300XX - Outpat/UB-04  SCREEN <7>
=====
                        BILLING - GENERAL INFORMATION
[1] Bill Type      : 131                      Loc. of Care: HOSPITAL - INPT OR OPT (INCLU
    Covered Days: UNSPECIFIED                Bill Classif: OUTPATIENT
    Non-Cov Days: UNSPECIFIED                Timeframe: ADMIT THRU DISCHARGE
    Charge Type   : INSTITUTIONAL            Disch Stat: DISCHARGED TO HOME OR SELF CAR
    Form Type     : UB-04                    Division: MONTGOMERY VAMC
                                           Div. Taxonomy: UNSPECIFIED
[2] Sensitive?    : UNSPECIFIED                Assignment: YES
[3] Bill From     : XXX XX, XXXX              Bill To: XXX XX, XXXX
[4] OP Visits     : XXX XX, XXXX
[5] Rev. Code     : 750-GASTR-INST SVS       45384          $2,137.44  OUTPATIENT VISIT
    OFFSET        : $0.00 [NO OFFSET RECORDED]
    BILL TOTAL   : $2,137.44
[6] Rate Sched   : (re-calculate charges)
[7] Prior Claims : UNSPECIFIED

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

```

Step	Procedure
------	-----------

- |   |   |
|---|---|
| 5 | On Screen 8, enter <b>2</b> to enter the name of the Attending Physician. A UB-04 claim can also contain an Operating and/or Other Physician. |
|---|---|

```

IB,PATIENT3  000-00-0000  BILL#: K300XX - Outpat/UB-04  SCREEN<8>
=====
                        BILLING - SPECIFIC INFORMATION
[1] Bill Remark      : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)       : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s) : UNSPECIFIED [NOT REQUIRED]
    Admitting Dx     : UNSPECIFIED [NOT REQUIRED]
    Admission Source  : UNSPECIFIED
[2] Providers        :
    - ATTENDING      : UNSPECIFIED           Taxonomy: UNSPECIFIED
[3] Force To Print? : NO FORCED PRINT
[4] Provider ID Maint : (Edit Provider ID information)
[5] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]           Taxonomy: UNSPECIFIED

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

```



*The Primary ID (SSN) for the Attending, Operating or Other Physician is always transmitted with a claim.*



*The Secondary IDs for the Attending, Operating or Other Physician are determined from what the user enters and from entries in Provider ID Maintenance.*



*If users have set a default ID type and made it required for the current or other payers, the claim can not be authorized if the physician does not have an ID of that type defined.*

When a provider is first added to Screen 8, the user will be shown a screen that contains a list of all the provider's IDs, the ID type and, optionally, the care unit on file for the provider's IDs. This will include the provider's own IDs, the provider's IDs

assigned by the insurance company, the insurance company defaults, if any, and all IDs assigned to the provider by care unit.

The first 2 entries in this list will always be:

- 1 - NO SECONDARY ID NEEDED
- 2 - ADD AN ID FOR THIS CLAIM ONLY



*Any ID entered on screen 8 will automatically override any default provider secondary ID that exists for the same ID Qualifier for this claim ONLY.*

```

**** SECONDARY PERFORMING PROVIDER IDs ****

PRIMARY INSURANCE CO: BLUE CROSS CA (WY)
PROVIDER: IB,PHYSICIAN4 (ATTENDING)

INS. COMPANY'S DEFAULT SECONDARY ID TYPE IS: BLUE CROSS ID

SELECT A SECONDARY ID OR ACTION FROM THE LIST BELOW:

1 - NO SECONDARY ID NEEDED
2 - ADD AN ID FOR THIS CLAIM ONLY
3 - <DEFAULT> XXXXBCROSS BLUE CROSS ID
4 - WYXXXX ST LIC (WY)

Selection: 3//

```

If there is a default secondary ID found, based on the insurance company parameters and the Provider ID is defined in the Provider ID Maintenance, this will be the 3rd entry in the list and will be preceded with the text <DEFAULT>. If this ID exists, the default for the Selection prompt will be **3**.

If no default ID exists, the default for the selection prompt will be **1** – No Secondary ID needed.

Any care units assigned to an ID using Provider ID Maintenance are displayed at the far right of the ID line. You no longer have to enter a care unit on the bill.

You can make a selection from the list by choosing the number preceding the ID you want to assign to the provider for the bill. This will add both the ID Qualifier and the ID number to the claim.



*Note: If the Provider has multiple IDs defined, the one you select or the new one time only ID that you enter, will appear on Screen 8 and will be the first ID sent but the system will still transmit the remaining IDs. The one you select will just be the first one transmitted. The maximum number that will be transmitted is five.*

If none of the IDs are valid for the provider for the claim, you can add a new ID *for this claim only*.

Step	Procedure
6	At the <b>Selection</b> prompt, type <b>2</b> to add an ID for this claim only.
7	At the <b>PRIM INS PERF PROV SECONDARY ID TYPE:</b> prompt, enter the ID Qualifier that the primary payer requires as a secondary ID type. Type two question marks (??) to see the list of possible choices. (For this example, type <b>Location Number</b> as the secondary ID Qualifier).
8	At the <b>PRIM INS PERF PROV SECONDARY ID:</b> prompt, enter the <b>ID</b> number provided by the payer. In this example, type <b>XXXXA</b> .

```

Selection: 3// 2
PRIM INS PERF PROV SECONDARY ID TYPE: ??
Choose from:
BLUE CROSS ID
BLUE SHIELD ID
COMMERCIAL ID
LOCATION NUMBER
MEDICARE PART A
MEDICARE PART B

PRIM INS PERF PROV SECONDARY ID TYPE: LOCATION NUMBER
PRIM INS PERF PROV SECONDARY ID: XXXXA
    
```

After an ID and ID Qualifier are added to the claim for a provider, the provider’s name and the selected ID are displayed on Screen 8. These fields can be edited/deleted.

If a physician/provider is deleted, the next time the provider entry is accessed, the list of valid IDs will be displayed again.

Valid Secondary ID Types for Current Payer	
Attending/Operating/Other (UB-04)	State License; Blue Cross; Blue Shield; Medicare Part A; UPIN; TRICARE; Commercial ID; Location Number; Network ID; SSN; State Industrial and Accident Provider
Rendering/Referring/Supervising (1500)	State License; Blue Shield; Medicare Part B; UPIN; TRICARE; Commercial ID; Location Number; Network ID; SSN; State Industrial and Accident Provider

Valid Secondary ID Types for Other Payer (Not Current)	
Attending/Operating/Other (UB-04)	Blue Cross; Blue Shield; Medicare; Commercial ID; Location Number
Rendering (1500)	Blue Shield; Medicare Part A and Part B; Commercial ID; Location Number; Network ID
Referring (1500)	Blue Shield; Medicare Part A and Part B; Commercial ID; Location Number; Network ID

Supervising (1500)	Blue Shield; Medicare Part A and Part B; Commercial ID; Network ID
--------------------	---

Step	Procedure
------	-----------

- |   |   |
|---|---|
| 9 | At the <RET> to Continue: prompt (any screen), enter ?PRV to see summary information about a particular provider. |
|---|---|

```

IB,PATIENT3  000-00-0000  BILL#: K300XX - Outpat/UB-04  SCREEN<8>
=====
                                BILLING - SPECIFIC INFORMATION
[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]
    Unable To Work To   : UNSPECIFIED [NOT REQUIRED]
[2] Admitting Dx       : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)          : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)    : UNSPECIFIED [NOT REQUIRED]
[3] Providers          :
    - ATTENDING (MD)   : IB,PHYSICIAN4          Taxonomy: UNSPECIFIED
                        [P]XXXXA
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
    Lab CLIA #         : UNSPECIFIED
    Mammography Cert # : UNSPECIFIED
[5] Form Locator 19    : UNSPECIFIED [NOT REQUIRED]
[6] Print Main Facility Box 32: UNSPECIFIED [NOT REQUIRED]
    Force To Print?    : NO FORCED PRINT
[7] Provider ID Maint  : (Edit Provider ID information)

<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT: ?PRV
(V)A or (N)on-VA Provider: V// A PROVIDER

This is a display of provider specific information.
This bill is UB-04/Outpatient

The valid provider functions for this bill are:
2 OPERATING   OPTIONAL - NOT ON BILL
4 ATTENDING   REQUIRED   - ALREADY ON BILL
9 OTHER       OPTIONAL - NOT ON BILL

Select PROVIDER NAME: IB,PHYSICIAN4          PI
-----
Signature Name: PHYSICIAN4 IB
Signature Title: STAFF PSYCHIATRIST
Degree: BA
NPI: 1234567891

License(s): None Active on X/X/XX

Person Class: None Active on X/X/XX

RC Provider Group: None
-----
Select PROVIDER NAME:
    
```

Step	Procedure
------	-----------

- |    |   |
|----|---|
| 10 | At the <RET> to Continue: prompt (any screen), enter ?ID to see what IDs will |
|----|---|

be transmitted with the claim.

```

IB,PATIENT3  000-00-0000  BILL#: K300XX - Outpat/UB-04  SCREEN<8>
=====
                                BILLING - SPECIFIC INFORMATION
[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]
    Unable To Work To   : UNSPECIFIED [NOT REQUIRED]
[2] Admitting Dx       : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)         : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)   : UNSPECIFIED [NOT REQUIRED]
[3] Providers          :
    - ATTENDING (MD)  : IB,PHYSICIAN4          Taxonomy: UNSPECIFIED
                        [P]XXXXA
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
    Lab CLIA #         : UNSPECIFIED
    Mammography Cert # : UNSPECIFIED
[5] Form Locator 19    : UNSPECIFIED [NOT REQUIRED]
[6] Print Main Facility Box 32: UNSPECIFIED [NOT REQUIRED]
    Force To Print?    : NO FORCED PRINT
[7] Provider ID Maint  : (Edit Provider ID information)

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

IF THIS BILL IS TRANSMITTED ELECTRONICALLY, THE FOLLOWING IDS WILL BE SENT:
  PRIMARY INS CO: BLUE CROSS CA (WY) <<<Current Ins
  SECONDARY INS CO: TPM TRUST

PROVIDER IDs: (VISTA RECORDS OP1,OP2,OP4,OP8,OP9,OPR2,OPR3,OPR4,OPR5,OPR8) :
  ATTENDING/RENDERING: IB,PHYSICIAN4
  NPI:                  0000000006
  SSN:                  000000000
  SECONDARY IDS
  (P) LOCATION NUMBER  XXXXA
  (P) BLUE CROSS ID    XXXXBCROSS
  (P) ST LIC (WY)      WYXXXX

```

Step	Procedure
------	-----------

- |    |  |
|----|--|
| 11 | <p>Press the <b>Return</b> key to move through the fields. At the <b>Want To Authorize Bill At This Time?:</b> and <b>Authorize Bill Generation?:</b> prompts, enter <b>Yes</b>. The claim is now complete and will be transmitted to the FSC in Austin at the next regularly scheduled transmission time.</p> |
|----|--|

```

WANT TO EDIT SCREENS? NO// <ENTER>
WANT TO AUTHORIZE BILL AT THIS TIME? No// YES
AUTHORIZE BILL GENERATION?: YES
Adding bill to BILL TRANSMISSION File.

  Bill will be submitted electronically
Passing completed Bill to Accounts Receivable. Bill is no longer editable.
Completed Bill Successfully sent to Accounts Receivable.

This Bill Can Not Be Printed Until Transmit Confirmed

This Outpatient INSTITUTIONAL bill may have corresponding PROFESSIONAL
charges.

```

#### 5.4. CMS-1500 Claims

The following screens provide a simplified example of a CMS-1500 claim.

Step	Procedure
1	When processing a CMS-1500 claim, information on Screens 1 and 2 should be reviewed for correctness. Press the <b>Return</b> key to move from one screen to the next.
2	On Screen 3, the payer information is reviewed for correctness. The patient may have more than one insurance policy. If the correct information is not displayed, select a section (1, 2, or 3) and edit the necessary fields. Press <b>Return</b> to continue to Screen 4.

```

IB,PATIENT3 000-00-0000 BILL#: K300XX - Inpat/1500 SCREEN <3>
=====
                          PAYER INFORMATION
[1] Rate Type : REIMBURSABLE INS.           Form Type: UB-04
    Responsible: INSURER                     Payer Sequence: Primary
    Bill Payer : Blue Cross Fep              Transmit: Yes

    Ins 1: Blue Cross Fep                     Policy #: R00000000
    Grp #: 100                               Whose: VETERAN      Rel to Insd: PATIENT
    Grp Nm: STANDARD FAMILY   Insd Sex: MALE   Insured: IB,PATIENT3

[2] Billing Provider Secondary IDs:
    Primary : 010100
    Secondary:                               Tertiary :

[3] Mailing Address :                       Electronic ID: 12B54
    Blue Cross Fep
    P O Box 10401
    Birmingham, AL 352020401

<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT:

```

Step	Procedure
3	Specify the correct diagnosis and procedure code(s) that must be on this claim. Press the <b>Return</b> key to move to Screen 6.

```

IB,PATIENT3  000-00-0000  BILL#: K300XX - Inpat/1500 SCREEN <4>
=====
EVENT - INPATIENT INFORMATION
[1] Admission : XXX XX, XXXX, 10:56:29 pm          Accident Hour: UNSPECIFIED
    Source : CLINIC REFERRAL                        Type: URGENT
[2] Discharge.: XXX XX, XXXX @14:59
    Status: DISCHARGED TO HOME OR SELF CARE
[3] Prin. Diag.: URIN TRACT INFECTION NOS - 559.0
    Other Diag.: PROTEIN INFECTION NOS - 041.6
    Other Diag.: HYPERTROPHY BENIGN PROSTATE - 600.0
[4] Cod. Method: HCPCS
    CPT Code   : US EXAM, ABDOM, COMPLETE 76700-26      600.0   XXX XX, XXXX
[5] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[6] Occ. Code  : ONSET OF SYMPTOMS/ILLNESS             XXX XX, XXXX
[7] Cond. Code : MEDICAL APPROPRIATENESS
[8] Value Code : UNSPECIFIED [NOT REQUIRED]

```

Step	Procedure
------	-----------

- |   |   |
|---|---|
| 4 | Verify that the Form Type is CMS-1500 and that the date of billing is entered. Make sure the Disch Stat field is populated. If all the data have been entered correctly, section 4 should display the correct revenue codes and costs. Press the <b>Return</b> to move to Screen 8. |
|---|---|

```

IB,PATIENT3  000-00-0000  BILL#: K300XX - Inpat/1500 SCREEN <6>
=====
BILLING - GENERAL INFORMATION
[1] Bill Type   : 131                Loc. of Care: HOSPITAL - INPT OR OPT(INCLU
    Covered Days: UNSPECIFIED         Bill Classif: OUTPATIENT
    Non-Cov Days: UNSPECIFIED         Timeframe: ADMIT THRU DISCHARGE
    Charge Type  : INSTITUTIONAL      Disch Stat:
    Form Type    : CMS-1500           Division: MONTGOMERY VAMC
                                         Div. Taxonomy: UNSPECIFIED
[2] Sensitive? : UNSPECIFIED         Assignment: YES
[3] Bill From   : XXX XX, XXXX       Bill To: XXX XX, XXXX
[4] Bedsection : GENERAL MEDICAL SERVICE
    LOS        : 1
[5] Rev. Code   : 500-OUTPATIENT SVCS  99221      $137.44  GENERAL MEDICAL
    OFFSET      : $0.00 [NO OFFSET RECORDED]
    BILL TOTAL  : $137.44
[6] Rate Sched : (re-calculate charges)
[7] Prior Claims: UNSPECIFIED

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

```

Step	Procedure
------	-----------

- |   |   |
|---|---|
| 5 | From Screen 8, select section 3 to enter the name of the <b>Rendering Provider</b> . Enter a <b>Referring Provider</b> if required by the payer for the procedure codes on the claim. |
|---|---|

```
IB,PATIENT3 000-00-0000 BILL#: K300XX - Inpat/1500 SCREEN <8>
```

```
=====
                                BILLING - SPECIFIC INFORMATION
[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]
    Unable To Work To   : UNSPECIFIED [NOT REQUIRED]
[2] Admitting Dx       : 600.0 - HYPERTROPHY BENIGN PROSTATE
    ICN/DCN(s)          : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)    : UNSPECIFIED [NOT REQUIRED]
[3] Providers          :
    - RENDERING (MD)    : IB,PHYSICIAN4 Taxonomy: 000000000X
                        [P]XXXXBCROSS
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
    Lab CLIA #          : UNSPECIFIED
    Mammography Cert #  : UNSPECIFIED
[5] Form Locator 19    : UNSPECIFIED [NOT REQUIRED]
[6] Print Main Facility Box 32: UNSPECIFIED [NOT REQUIRED]
    Force To Print?     : NO FORCED PRINT
[7] Provider ID Maint  : (Edit Provider ID information)
```

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



*The Primary ID (SSN) for the Attending, Operating or Other Physician is always transmitted with a claim.*



*The Secondary IDs for the Attending, Operating or Other Physician are determined from what the user enters and from entries in Provider ID Maintenance.*



*If users have set a default ID type and made it required for the current or other payer, the claim can not be authorized if the physician does not have an ID of that type defined.*

When a provider is first added to screen 8, the user will be shown a screen that contains a list of all the provider's IDs, the ID type and, optionally, the care unit on file for the provider's IDs. This will include the provider's own IDs, the provider's IDs assigned by the insurance company, the insurance company defaults, if any, and all IDs assigned to the provider by care unit.

The first 2 entries in this list will always be:

- 1 - NO SECONDARY ID NEEDED
- 2 - ADD AN ID FOR THIS CLAIM ONLY



*Any ID entered on screen 8 will automatically override any default provider secondary ID that exists for the same ID Qualifier for this claim ONLY.*

```

**** SECONDARY PERFORMING PROVIDER IDs ****

PRIMARY INSURANCE CO: BLUE CROSS CA (WY)
PROVIDER: IB,PHYSICIAN4 (ATTENDING)

INS. COMPANY'S DEFAULT SECONDARY ID TYPE IS: BLUE SHIELD ID

SELECT A SECONDARY ID OR ACTION FROM THE LIST BELOW:

1 - NO SECONDARY ID NEEDED
2 - ADD AN ID FOR THIS CLAIM ONLY
3 - <DEFAULT> XXXXBSHIELD BLUE SHIELD ID
4 - WYXXXX ST LIC (WY)

Selection: 3//

```

If there is a default secondary ID found, based on the insurance company parameters and the Provider ID is defined in the Provider ID Maintenance, this will be the 3rd entry in the list and will be preceded with the text <DEFAULT>. If this ID exists, the default for the Selection prompt will be **3**.

If no default ID exists, the default for the selection prompt will be **1** – No Secondary ID needed.

Any care units assigned to an ID using Provider ID Maintenance are displayed at the far right of the ID line. You no longer have to enter a care unit on the bill.

You can make a selection from the list by choosing the number preceding the ID you want to assign to the provider for the bill. This will add both the ID Qualifier and the ID number to the claim.



*Note: If the Provider has multiple IDs defined, the one you select or the new one time only ID that you enter, will appear on Screen 8 and will be the first ID sent but the system will still transmit the remaining IDs. The one you select will just be the first one transmitted. The maximum number that will be transmitted is five.*

If none of the IDs are valid for the provider for the claim, you can add a new ID *for this claim only*.

Step	Procedure
6	At the <b>Selection</b> prompt, type <b>2</b> to add an ID for this claim only.
7	At the <b>PRIM INS PERF PROV SECONDARY ID TYPE:</b> prompt, enter the ID Qualifier that the primary payer requires as a secondary ID type. Type two question marks (??) to see the list of possible choices. (For this example, type <b>Location Number</b> as the secondary ID Qualifier).
8	At the <b>PRIM INS PERF PROV SECONDARY ID:</b> prompt, enter the <b>ID</b> number provided by the payer. In this example, type <b>XXXXA</b> .

```

Selection: 3// 2
PRIM INS PERF PROV SECONDARY ID TYPE: ??
Choose from:
BLUE CROSS ID
BLUE SHIELD ID
COMMERCIAL ID
LOCATION NUMBER
MEDICARE PART A
MEDICARE PART B

PRIM INS PERF PROV SECONDARY ID TYPE: LOCATION NUMBER
PRIM INS PERF PROV SECONDARY ID: XXXXA
    
```

After an ID and ID Qualifier are added to the claim for a provider, the provider’s name and the selected ID are displayed on Screen 8. These fields can be edited/deleted.

If a physician/provider is deleted, the next time the provider entry is accessed, the list of valid IDs will be displayed again.

Valid Secondary ID Types for Current Payer	
Attending/Operating/Other (UB-04)	State License; Blue Cross; Blue Shield; Medicare Part A; UPIN; TRICARE; Commercial ID; Location Number; Network ID; SSN; State Industrial and Accident Provider
Rendering/Referring/Supervising (1500)	State License; Blue Shield; Medicare Part B; UPIN; TRICARE; Commercial ID; Location Number; Network ID; SSN; State Industrial and Accident Provider

Valid Secondary ID Types for Other Payer (Not Current)	
Attending/Operating/Other (UB-04)	Blue Cross; Blue Shield; Medicare Part A and Part B; UPIN; TRICARE; Commercial ID; Location Number
Rendering (1500)	Blue Shield; Medicare Part A and Part B; Commercial ID; Location Number; Network ID
Referring (1500)	Blue Shield; Medicare Part A and Part B; Commercial ID; Location Number; Network ID
Supervising (1500)	Blue Shield; Medicare Part A and Part B; Commercial ID; Network ID

Step	Procedure
9	At the <RET> to Continue: prompt (any screen), enter ?PRV to see summary information about a particular provider.

```

IB,PATIENT3  000-00-0000  BILL#: K300XX - Inpat/1500  SCREEN<8>
=====
                                BILLING - SPECIFIC INFORMATION
[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]
    Unable To Work To   : UNSPECIFIED [NOT REQUIRED]
[2] Admitting Dx       : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)          : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)    : UNSPECIFIED [NOT REQUIRED]
[3] Providers         :
    - RENDERING (MD)    : IB,PHYSICIAN4          Taxonomy: 390200000X
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
    Lab CLIA #         : UNSPECIFIED
    Mammography Cert # : UNSPECIFIED
[5] Form Locator 19    : UNSPECIFIED [NOT REQUIRED]
[6] Print Main Facility Box 32: UNSPECIFIED [NOT REQUIRED]
    Force To Print?    : NO FORCED PRINT
[7] Provider ID Maint  : (Edit Provider ID information)

<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT: ?PRV
(V)A or (N)on-VA Provider: V// NON-VA PROVIDER

Select NON-VA PROVIDER NAME: IB,OUTSIDEDOC      OI
-----
Signature Name:  OUTSIDEDOC IB
                  NPI: 1234567892

License(s): None Active on X/X/XX

Person Class: V115500
PROVIDER TYPE: Allopathic and Osteopathic Physicians
CLASSIFICATION: Resident, Allopathic (includes Interns, Residents, Fellows)
SPECIALIZATION:
                  TAXONOMY: 390200000X (144)
-----

Select NON-VA PROVIDER NAME:

```

Step	Procedure
10	At the <RET> to Continue: prompt (any screen), enter ?ID to see what IDs will be transmitted with the claim.

```

IB,PATIENT3  000-00-0000  BILL#: K300XX - Inpat/1500  SCREEN<8>
=====
                                BILLING - SPECIFIC INFORMATION
[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]
    Unable To Work To   : UNSPECIFIED [NOT REQUIRED]
[2] Admitting Dx       : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)         : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)   : UNSPECIFIED [NOT REQUIRED]
[3] Providers         :
    - RENDERING (MD)   : IB,PHYSICIAN4           Taxonomy: 000000000X
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
    Lab CLIA #         : UNSPECIFIED
    Mammography Cert # : UNSPECIFIED
[5] Form Locator 19   : UNSPECIFIED [NOT REQUIRED]
[6] Print Main Facility Box 32: UNSPECIFIED [NOT REQUIRED]
    Force To Print?    : NO FORCED PRINT
[7] Provider ID Maint : (Edit Provider ID information)

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

IF THIS BILL IS TRANSMITTED ELECTRONICALLY, THE FOLLOWING IDS WILL BE SENT:
  PRIMARY INS CO: BLUE CROSS CA (WY) <<<Current Ins
  SECONDARY INS CO: TPM TRUST

PROVIDER IDS: (VISTA RECORDS OP1,OP2,OP4,OP8,OP9,OPR2,OPR3,OPR4,OPR5,OPR8) :
  ATTENDING/RENDERING: IB,PHYSICIAN4
  NPI:                  0000000006
  SSN:                  000000000
  SECONDARY IDS
  (P) LOCATION NUMBER  XXXXA
  (P) BLUE CROSS ID    XXXXBCROSS
  (P) ST LIC (WY)      WYXXXXX

```

**Step****Procedure**

- 11 Press the **Return** key to move through the fields. At the **Want To Authorize Bill At This Time?:** and **Authorize Bill Generation?:** prompts, enter **Yes**. The claim is now complete and will be transmitted to the FSC in Austin at the next regularly scheduled transmission time.

```

Executing A/R edits
No A/R errors found

WANT TO EDIT SCREENS? NO//

THIS BILL WILL BE TRANSMITTED ELECTRONICALLY

WANT TO AUTHORIZE BILL AT THIS TIME? No// YES
AUTHORIZE BILL GENERATION?: YES
  Adding bill to BILL TRANSMISSION File.

  Bill will be submitted electronically
Passing completed Bill to Accounts Receivable. Bill is no longer editable.
Completed Bill Successfully sent to Accounts Receivable.

This Bill Can Not Be Printed Until Transmit Confirmed

```

## 5.5. Lab Claims

EDI Enhanced HIPAA format allows users to enter a CLIA# when billing for certain laboratory procedures. The VA's CLIA # must be entered on Screen 8 when billing a Medicare secondary payer for laboratory and pathology procedures that are not reimbursed in full by Medicare. A list of these CPT codes may be found on the MRA Training page of VistA University: <http://vaww.vistau.med.va.gov/VistaU/e-bp/e-mra.htm>

The following screens provide a simplified example of a lab claim:

Step	Procedure
1	When processing a Laboratory claim, information on Screens 1 and 2 should be reviewed for correctness. Press the <b>Return</b> key to move from one screen to the next.
2	On Screen 3, the payer information is reviewed for correctness. The patient may have more than one insurance policy. If the correct information is not displayed, select a section (1, 2, or 3 ) and edit the necessary fields. Press <b>Return</b> to continue to Screen 5.

```

IB,PATIENT3  000-00-0000  BILL#: K300XX - Outpat/1500 SCREEN <3>
=====
                                PAYER INFORMATION
[1] Rate Type   : REIMBURSABLE INS.           Form Type: 1500
    Responsible: INSURER                       Payer Sequence: Primary
    Bill Payer  : Blue Cross Fep                Transmit: Yes

    Ins 1: Blue Cross Fep                       Policy #: R00000000
    Grp #: 100                                  Whose: VETERAN      Rel to Insd: PATIENT
    Grp Nm: STANDARD FAMILY                     Insd Sex: MALE     Insured: IB,PATIENT3

[2] Billing Provider Secondary IDs:
    Primary   : 010100
    Secondary:
                                Tertiary  :

[3] Mailing Address :                               Electronic ID: 12B54
    Blue Cross Fep
    P O Box 10401
    Birmingham, AL 352020401

<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT:
    
```

- | Step | Procedure  |
|------|--|
| 3    | Specify the correct diagnosis and procedure code(s) that must be on this claim. Press the <b>Return</b> key to move to Screen 7. |

```

IB,PATIENT3  000-00-0000  BILL#: K300XX - Outpat/1500 SCREEN <5>
=====
                                EVENT - OUTPATIENT INFORMATION
[1] Event Date  : XXX XX,XXXX
[2] Prin. Diag. : URINARY FREQUENCY - 788.41
[3] OP Visits   : XXX XX,XXXX
[4] Cod. Method: HCPCS
    CPT Code    : URINALYSIS, AUTO W/SCOPE 81001   XXX XX,XXXX
    CPT Code    : URINE BACTERIA CULTURE 87088    XXX XX,XXXX
[5] Rx. Refills: UNSPECIFIED [NOT REQUIRED]
[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[7] Occ. Code   : UNSPECIFIED [NOT REQUIRED]
[8] Cond. Code  : UNSPECIFIED [NOT REQUIRED]
[9] Value Code  : UNSPECIFIED [NOT REQUIRED]

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

- | Step | Procedure   |
|------|---|
| 4    | Verify that the Form Type is CMS-1500 and that the date of billing is entered. Make sure the Disch Stat field is populated. If all the data have been entered correctly, section 4 should display the correct revenue codes and costs. Press the <b>Return</b> to move to Screen 8. |

```

IB,PATIENT3  000-00-0000  BILL#: K300XX - Outpat/1500  SCREEN <7>
=====
                                BILLING - GENERAL INFORMATION
[1] Bill Type      : 131                      Loc. of Care: HOSPITAL - INPT OR OPT (INCLU
    Covered Days: UNSPECIFIED                Bill Classif: OUTPATIENT
    Non-Cov Days: UNSPECIFIED                Timeframe: ADMIT THRU DISCHARGE
    Charge Type  : INSTITUTIONAL             Disch Stat:
    Form Type    : CMS-1500                  Division: MONTGOMERY VAMC
                                           Div. Taxonomy: UNSPECIFIED
[2] Sensitive?   : UNSPECIFIED                Assignment: YES
[3] Bill From    : XXX XX,XXXX              Bill To: XXX XX,XXXX
[4] OP Visits    : XXX XX,XXXX
[5] Rev. Code    : 306-LAB/BACT-MICRO        87088      $33.20  OUTPATIENT VISIT
    Rev. Code    : 307-GASTR-INST SVS        81001      $12.77  OUTPATIENT VISIT
    OFFSET       : $0.00 [NO OFFSET RECORDED]
    BILL TOTAL   : $45.97
[6] Rate Sched  : (re-calculate charges)
[7] Prior Claims: UNSPECIFIED

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

```

**Step****Procedure**

5 From Screen 8, enter 3 to add a **Rendering** and **Referring** provider.

6 To edit, select Section 4 and enter the **CLIA #** if required by the payer.



*After Patch IB\*2.0\*320, the billing software will automatically populate the CLIA# for the division on the claim when the claim is for the Service Type = 5 (Diagnostic Laboratory) if the CLIA# exists in the VistA Institution file. Users may override this value for the current claim only.*



*For outside laboratory services, the billing software will automatically populate the CLIA# if there is a Laboratory or Facility secondary ID defined for the outside facility with a ID Qualifier of X4 (CLIA #).*



*There will be a Error Message for laboratory claims to Medicare when there is no CLIA# on the claim and a Warning Message for laboratory claims to other payers when there is no CLIA# on the claim.*

```

IB,PATIENT3  000-00-0000  BILL#: K300XX - Outpat/1500  SCREEN<8>
=====
                                BILLING - SPECIFIC INFORMATION
[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]
    Unable To Work To   : UNSPECIFIED [NOT REQUIRED]
[2] Admitting Dx       : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)         : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)   : UNSPECIFIED [NOT REQUIRED]
[3] Providers         :
    - REFERRING (MD)   : IB,PHYSICIAN5      Taxonomy: UNSPECIFIED
                                [P]XX0000
    - RENDERING (MD)   : IB,PHYSICIAN4      Taxonomy: UNSPECIFIED
                                [P]XXX123
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
    Lab CLIA #         : DXXXX000
    Mammography Cert # :
[5] Form Locator 19   : UNSPECIFIED [NOT REQUIRED]
[6] Print Main Facility Box 32: UNSPECIFIED [NOT REQUIRED]
    Force To Print?    : NO FORCED PRINT
[7] Provider ID Maint : (Edit Provider ID information)

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

```



*Note: There is a new field in Section 4 for the Mammography Certification Number where users can enter a certification number on claims for mammography exams. The known Mammography Certification Numbers will be stored in the Institution file, one per site.*

## 5.6. Pharmacy Claims

1500 pharmacy claims can be submitted electronically to Emdeon where they will be printed and mailed.

The following screens give a simplified example of a pharmacy claim.

Step	Procedure
1	When processing a Pharmacy claim, information on Screens 1 and 2 should be reviewed for correctness. Press the <b>Return</b> key to move from one screen to the next.
2	On Screen 3, the payer information is reviewed for correctness. The patient may have more than one insurance policy. If the correct information is not displayed, select a section (1, 2, or 3) and edit the necessary fields. Press <b>Return</b> to continue to Screen 5. <i>For Pharmacy claims, change the form type to a CMS-1500.</i>

```

IB,PATIENT5      000-00-0000  BILL#: K303XX - Outpat/UB-04          SCREEN <3>
=====
                                PAYER INFORMATION
[1] Rate Type   : REIMBURSABLE INS.                Form Type: CMS-1500
    Responsible: INSURER                          Payer Sequence: Primary
    Bill Payer  : UNSPECIFIED                      Transmit: No-Ins. co transmit off

Insurance   COB Subscriber ID   Group   Holder   Effective   Expires   Only
=====
BLUE CROSS   p  PPAXXXXXXXXXX   13000   SPOUSE   01/01/00           IOrM
MEDICARE(W   XXXXXXXXXXXXA   PART A   SELF    11/01/96           *WNR*
MEDICARE(W   XXXXXXXXXXXXA   PART B   SELF    07/01/99           *WNR*

[2] Billing Provider Secondary IDs: UNSPECIFIED [NOT REQUIRED]

[3] Mailing Address :
    NO MAILING ADDRESS HAS BEEN SPECIFIED!   (Patient has Medicare)
    Send Bill to PAYER listed above.

<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT:

```

### Step Procedure

- 4 The highlighted fields are auto-populated. Remember that this is a professional bill that is being transmitting as a CMS-1500, so each HCPCS code will have to be associated with a diagnosis code. To begin this process, type **4** to edit the **Cod. Method** field and press the **Return** key.

```

IB,PATIENT5      000-00-0000  BILL#: K303XX - Outpat/1500          SCREEN <5>
=====
                                EVENT - OUTPATIENT INFORMATION
<1> Event Date : XXX XX,XXXX
[2] Prin. Diag.: ISSUE REPEAT PRESCRIPT - V68.1
[3] OP Visits   : UNSPECIFIED
[4] Cod. Method: HCPCS
    CPT Code    : Oral prescrip drug non chemo J8499      V68.1   XXX XX,XXXX
[5] Rx. Refills: WARFARIN SODIUM 5MG (COUMADIN) TAB     XXX XX,XXXX
[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[7] Occ. Code  : UNSPECIFIED [NOT REQUIRED]
[8] Cond. Code : UNSPECIFIED [NOT REQUIRED]
<9> Value Code : UNSPECIFIED [NOT REQUIRED]

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

```

### Step Procedure

- 5 At the **Select Procedure Date** field, re-type the date.
- 6 At the **Select Procedure** field, type the appropriate code. Once the code auto-populates the data, type **YES** to confirm.
- 7 At the **Provider** field, type the name of the physician. Information related to that provider will auto-populate.
- 8 Type the appropriate data related to the **Place of Service** and the **Type of Service**.
- 9 Press **Return** until Screen 5 appears.

```
<<CURRENT PROCEDURAL TERMINOLOGY CODES>>
LISTING FROM VISIT DATES WITH ASSOCIATED CPT CODES
IN OUTPT ENCOUNTERS FILE

=====
NO.   CODE   SHORT NAME                CLINIC                DATE
=====

NO CPT CODES ON FILE FOR THE VISIT DATES ON THIS BILL

PROCEDURE CODING METHOD: HCPCS (1500 COMMON PROCEDURE CODING SYSTEM)
// CPT CPT-4
Select PROCEDURE DATE (X/XX/XX-XX/XX/XX): XX-XX-XX
* Patient has no Visits for this date...

Select PROCEDURE: J
Searching for a CPT,(pointed-to by PROCEDURES)
J8499 Oral prescrip drug non chemo
...OK? Yes// Yes Oral prescrip drug non chem Rx: 0000000D
PROCEDURES: J8499//
Select CPT MODIFIER SEQUENCE:
PROVIDER: IB,PROVIDER6// ASSOCIATED CLINIC:
DIVISION: MONTGOMERY VAMC// 619
PLACE OF SERVICE: 22 OUTPATIENT HOSPITAL
TYPE OF SERVICE: 1 MEDICAL CARE
EMERGENCY PROCEDURE?: NO// NO
PRINT ORDER:
```

- | Step | Procedure  |
|------|--|
| 10   | Notice the association has been made between the diagnosis code and the required procedure code. Press <b>Return</b> to move to Screen #7. |

```
IB,PATIENT5 000-00-0000 BILL#: K303XX - Outpat/1500 SCREEN <5>
=====
EVENT - OUTPATIENT INFORMATION
<1> Event Date : XXX XX,XXXX
[2] Prin. Diag.: ISSUE REPEAT PRESCRIPT - V68.1
[3] OP Visits : XXX XX,XXXX
[4] Cod. Method: HCPCS
CPT Code : Oral prescrip drug non chemo J8499 V68.1 XXX XX,XXXX
[5] Rx. Refills: RANITIDINE HCL 150MG (ZANTAC) TAB XXX XX,XXXX
[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[7] Occ. Code : UNSPECIFIED [NOT REQUIRED]
[8] Cond. Code : UNSPECIFIED [NOT REQUIRED]
<9> Value Code : UNSPECIFIED [NOT REQUIRED]

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

- | Step | Procedure  |
|------|--|
| 11   | There are no changes to this screen. Ensure the charges pulled up and the procedure code are associated with the diagnosis code. Press <b>Return</b> to move to Screen #8. |

```

IB,PATIENT5      000-00-0000  BILL#: K303XX - Outpat/1500          SCREEN <7>
=====
                                BILLING - GENERAL INFORMATION
[1] Bill Type      : 131                      Loc. of Care: HOSPITAL - INPT OR OPT (INCLU
    Covered Days:  UNSPECIFIED                Bill Classif: OUTPATIENT
    Non-Cov Days:  UNSPECIFIED                Timeframe: ADMIT THRU DISCHARGE
    Charge Type   :  UNSPECIFIED                Disch Stat:
    Form Type    :  CMS-1500                    Division: MONTGOMERY VAMC
                                                Div. Taxonomy: UNSPECIFIED
[2] Sensitive?    :  UNSPECIFIED                Assignment: YES
[3] Bill From     :  XXX XX,XXXX                Bill To: XXX XX,XXXX
[4] OP Visits     :  UNSPECIFIED
[5] Rev. Code     :  253-WARFARIN SODIUM 5 J8499 1      $36.00 PRESCRIPTION
    OFFSET: $0.00 [NO OFFSET RECORDED]
    BILL TOTAL   :      $36.00
[6] Rate Sched   :  (re-calculate charges)
[7] Prior Claims :  UNSPECIFIED

```

Step	Procedure
12	At the <b>Select Function</b> field, type <b>3</b> for <b>Rendering</b> .
13	At the <b>Function Performed By</b> field, type the provider's name. VistA will identify that provider or return a list for selection. Once the proper provider is selected, at <b>OK?</b> prompt, type <b>YES</b> . The correct provider's information will auto-populate.

```

Select FUNCTION: 3 (3 RENDERING)
FUNCTION PERFORMED BY: IB,PROVIDER6

Searching for a VistA identified provider
IB,PROVIDER6      IPB          PHYSICIAN
...OK? Yes// (Yes)
PERFORMED BY: IB,PROVIDER6//
TAXONOMY: Allopathic and Osteopathic Physicians
//
Taxonomy X12 Code: 207RC0000X
Prov Specialty On File: 06
CREDENTIALS: MD//
Select FUNCTION:

```

This claim is now ready for authorization.

## 5.7. Printed Claims

Some claims should not be transmitted electronically and should be printed locally.

These include:

- Claims requiring clinical attachments such as progress notes;
- Claims containing more than the maximum number of diagnosis codes (9 - Institutional and 8 - Professional);
- Claims containing more than the maximum number of diagnosis pointers (4);
- Institutional claims containing more than the maximum number of procedure codes (999);
- Professional claims containing more than the maximum number of procedure codes/line items (50);
- Institutional pharmacy claims; and
- Secondary claims to Medicare WNR (When Medicare WNR is NOT the primary insurance).

## 5.8. View/Resubmit Claims – Live or Test – Synonym: RCB

A new option View/Resubmit Claims – Live or Test has been added to the EDI menu. This option replaces: Resubmit a Bill; Resubmit a Batch of Bills and View/Resubmit Claims as Test. This option will provide the ability to resubmit claims as test claims for testing or production claims for payment.

Step	Procedure
1	At the <b>Select EDI Menu For Electronic Bills Option</b> , type <b>RCB</b> and press the <b>Return</b> key.
2	At the <b>Enter (C)laim, (B)atch or (L)ist:</b> prompt, press the <b>Return</b> key to accept the default of <b>List</b> .
3	At the <b>(A)ll payers or (S)elected Payers?</b> prompt, type <b>A</b> for All Payers.  <i>If you choose Selected payers, after you enter Blue Cross of CA, for example, you will be prompted to included all insurance companies with the same Electronic Billing ID. This will prevent you from having to enter every BC/BS company defined in your Insurance file.</i>
4	At the <b>Run for (U)B-04, (C)MS-1500 or (B)OTH:</b> prompt, press the <b>Return</b> key to accept the default of Both.  <i>The Date Range for the search for claims has been restricted to a <b>maximum of 90 days</b> to minimize the impact of the search on the system.</i>
5	At the <b>Start with Date Last Transmitted:</b> prompt, type <b>T-200</b> for this example.
6	At the <b>Date Last Transmitted:</b> prompt, press the <b>Return</b> key to accept the default of 12/1/04. This will return results for 90 days.
7	At the <b>Select Additional Limiting Criteria (optional):</b> prompt, press the <b>Return</b> key without selecting anything additional.

```
Select EDI Menu For Electronic Bills Option: RCB View/Resubmit Claims-Live or Test

*** NOTE: 2 '^' ARE NEEDED TO ABORT THE OPTION (^ ^)
          1 '^' BRINGS YOU BACK TO THE PREVIOUS SELECTION PROMPT(^)

SELECT BY: (C)LAIM, (B)ATCH OR SEE A (L)IST TO PICK FROM?: LIST//
PAYER SELECTION:
Run for (A)ll Payers or (S)elected Payers?: SELECTED PAYERS// A ALL PAYERS

BILL FORM TYPE SELECTION:
Run for (U)B-04, (C)MS-1500 or (B)OTH: BOTH//

LAST BATCH TRANSMIT DATE RANGE SELECTION:
Start with Date Last Transmitted: t-200 (SEP 02, 2004)
Go to Date Last Transmitted:(9/2/04-12/1/04): 1/1/05// (JAN 01, 2005)

ADDITIONAL SORT SELECTION CRITERIA:

1 - MRA Secondary Only
2 - Primary Claims Only
3 - Secondary Claims Only
4 - Claims Sent to Print at Clearinghouse Only

Select Additional Limiting Criteria (optional):
```

Step	Procedure
8	At the <b>Would you like to include cancelled claims? No//</b> : prompt, enter <b>No</b> .
9	At the <b>Would you like to include claims Forced to Print at the Clearinghouse? No//</b> prompt, enter <b>No</b> .
	<i>Sort by Batch if you want to resubmit batches of claims or Current Payer if you want to resubmit a variety of individual claims.</i>
10	At the <b>Sort By</b> prompt, enter <b>B</b> to override the default of Current Payer.
11	At the <b>DO YOU WANT A (R)EPORT OR A (S)CREEN LIST FORMAT?</b> : prompt, press the <b>Return</b> key to accept the default of Screen List.

```

Would you like to include cancelled claims? No//
Sort By: Current Payer// ??
Enter a code from the list.

Select one of the following:

1 Batch By Last Transmitted Date (Claims within a Batch)
2 Current Payer (Insurance Company)

Sort By: Current Payer// Batch By Last Transmitted Date (Claims within a Batch)

Would you like to include claims Forced to Print at the Clearinghouse? No// No
DO YOU WANT A (R)EPORT OR A (S)CREEN LIST FORMAT?: SCREEN LIST//

```

The following screen is displayed:

```

PREVIOUSLY TRANSMITTED CLAIMS Mar 21, 2005@15:52:10 Page: 1 of 1215
** A claim may appear multiple times if transmitted more than once. **
** T = Test Claim ** R = Batch Rejected
>>># of Claims Selected: 0 (marked with *)

Claim # Form Type Seq Status Current Payer
Batch: 6050011182 Date Last Transmitted: Nov 30, 2004
1 K500XXX UB-04 OUTPT P PRNT/TX UNITED HEALTHCARE
Batch: 6050011183 Date Last Transmitted: Nov 30, 2004
2 K500XXX UB-04 OUTPT P REQUEST MRA MEDICARE (WNR)
Batch: 6050011184 Date Last Transmitted: Nov 30, 2004
3 K500XXX 1500 OUTPT P PRNT/TX UNITED HEALTHCARE
Batch: 6050011185 Date Last Transmitted: Nov 30, 2004
4 K500XXX 1500 OUTPT S PRNT/TX SOUTHWEST ADMINISTRATORS
Batch: 6050011186 Date Last Transmitted: Nov 30, 2004
5 K500XXX UB-04 OUTPT P PRNT/TX AETNA US HEALTHCARE
Batch: 6050011187 Date Last Transmitted: Nov 30, 2004
6 K500XXX 1500 OUTPT P PRNT/TX AETNA US HEALTHCARE
+ Enter ?? for more actions >>>
Claim(s) Select/De select View Claims Selected
Batch Select/De select Print Report
Resubmit Claims Exit
Action: Next Screen//

```

Step	Procedure
12	At the <b>Action</b> prompt, type <b>B</b> to select batches of claims to resubmit as test or

'C' to select claims.

- 13 At the **Select EDI Transmission Batch Number:** prompt, enter the number of the desired batch.



*You may repeat the above, entering as many batch numbers as you want.*

```
PREVIOUSLY TRANSMITTED CLAIMS Mar 21, 2005@16:07:38          Page:    1 of 1215
** A claim may appear multiple times if transmitted more than once. **
>>># of Claims Selected: 1 (marked with *)
```

Claim #	Form	Type	Seq	Status	Current Payer
Batch: 6050011182 Date Last Transmitted: Nov 30, 2004					
1	*K500YRJ	UB-04	OUTPT	P PRNT/TX	UNITED HEALTHCARE
Batch: 6050011183 Date Last Transmitted: Nov 30, 2004					
2	K50092T	UB-04	OUTPT	P REQUEST MRA	MEDICARE (WNR)
Batch: 6050011184 Date Last Transmitted: Nov 30, 2004					
3	K500YSF	1500	OUTPT	P PRNT/TX	UNITED HEALTHCARE
Batch: 6050011185 Date Last Transmitted: Nov 30, 2004					
4	K500YSZ	1500	OUTPT	S PRNT/TX	SOUTHWEST ADMINISTRATORS
Batch: 6050011186 Date Last Transmitted: Nov 30, 2004					
5	K500YUD	UB-04	OUTPT	P PRNT/TX	AETNA US HEALTHCARE
Batch: 6050011187 Date Last Transmitted: Nov 30, 2004					
6	K500YUE	1500	OUTPT	P PRNT/TX	AETNA US HEALTHCARE

+ Enter ?? for more actions >>>

Claim(s) Select/De select View Claims Selected  
 Batch Select/De select Print Report  
 Resubmit Claims as TEST Exit

Action: Next Screen// b Batch Select/De select  
 Select EDI TRANSMISSION BATCH BATCH NUMBER: 6050011183

## Step Procedure

- 14 When you have entered all of the batches you want, at the **ACTION** prompt, type 'R' for **Resubmit Claims**.
- 15 At the **Resubmit Claims:** prompt, press the **Return** key to resubmit the claims for payment.
- The system will inform you of the number of claims that will be resubmitted and whether or not they are being submitted for payment or testing.*
- 16 At the **Are You Sure You Want To Continue?:** prompt, type **YES** to override the default.

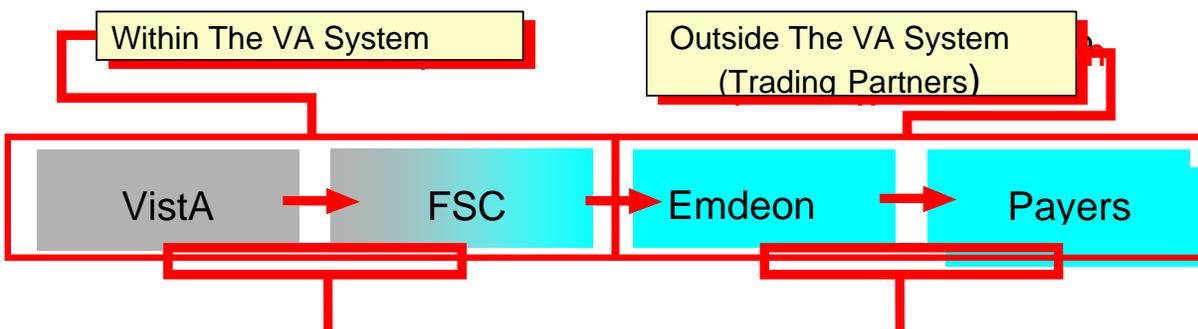
```
You are about to resubmit 2 claims as Production claims.
Are you sure you want to continue?: NO// y YES
Resubmission in process ...
```

## 6. REPORTS

There are a number of reports available to monitor and manage electronic claims. The EDI menu option can be accessed from the Billing Clerk's Menu.

### 6.1. EDI Reports – Overview

TR reports provide the end-user with information to monitor and manage EDI claims still within the VA, that is, between the VAMC and the FSC in Austin, TX. The MM reports provide the end-user with information and feedback from parties external to the VA such as Emdeon™ and the various electronic payers.



#### TR- EDI Transmission Status

BAR	Bills Needing Resubmission Action
ECS	EDI Claim Status Report
MP	EDI Messages Not Yet Filed
PBT	Pending Batch Transmission Status Report
PND	EDI Batches Pending Receipt
REX	Ready for Extract Status Report
VPE	View/Print EDI Bill Extract Data

#### MM-EDI Return Message Management

EDI	Return Message Management Option Menu
CSA	Claim Status Awaiting Resolution
MCS	Multiple CSA Message Management
TCS	Test Claim EDI Transmission Report
	EDI Message Text to Screen Maint
	EDI Message Not Reviewed Report
	Electronic Error Report
	Electronic Report Disposition
	Return Message Filing Exceptions
	Status Message Management

## 6.2. Most Frequently Used Menus/Reports

### 6.2.1 Claims Status Awaiting Resolution – Synonym CSA

#### What is the purpose of this report?

Billing and accounts receivable staff use CSA to review the most current status messages and to perform follow-up actions on the bills. Electronic status messages, which include information and rejection messages from the clearinghouse or the payers, are accessed using this option.

#### When is this option used?

This is an option that must be checked **Daily** to determine which claims have rejection or warning messages that were returned from Emdeon™ or from payers. The cause for rejections must be resolved. This option should be used in conjunction with supporting reports (e.g. R022, R0SS, R0SC).

The CSA report contains a Primary, Secondary and Tertiary sort capability and can be sorted by:

- A Authorizing Biller
- B Bill Number
- C Current Balance
- S Date of Service
- D Division
- E Error Code Text
- N Number of Days Pending
- M Patient Name
- P Payer
- R Review in Process
- L SSN Last 4

Once the CSA screen list is displayed, users can select new sort criteria and **re-sort** the list without exiting the option.

Reports can be run showing rejections only (R) or both informational and rejection messages (B). Users most often run the CSA report to show rejections only so they can focus on those claims that require corrective action.

These messages are automatically assigned a status of **Not Reviewed** and require users to review them and make corrections to update this status in IB. Users select a bill from the list to view the details and the entire message text. Messages are marked as **reviewed** or **review in process**. Users may document comments.



*With Patch IB\*2.0\*320, changes were made to suppress the display of 2Q Claim Status Messages and duplicate claim status messages.*

As messages are reviewed they can be marked as follows:

- Not Reviewed – No action has been taken on a bill that has been returned from the clearinghouse/payer
- Review in Process – While a claim is being reworked, the status can be changed to “Review in Process”
- Review Complete – The error has been resolved and the message from this report will be cleared

Actions such as Cancel Bill, Copy/Cancel Bill, TPJI and Print Bill are available to the user via this option and the user can make needed corrections and re-submit claims from within this option.

Other options available on the CSA include:

- CSA-EDI History Display - The EDI History display option shows all the status messages under the selected bill/message. This information is similar to information that can be viewed under the TPJI menu options.
- CSA-Enter/Edit Comments - The enter/edit comments option gives the user the ability to add a comment onto a bill (status message) in order to inform AR and billing why the issue hasn't been resolved or why the claim was printed to paper.
- CSA-Resubmit by Print - The Resubmit by Print action is used when the user reviews the status message or bill and determines the only way to correct the problem is to submit the claim on hard copy as it cannot pass the electronic edits. The user may “resubmit by print” to the payer instead of retransmitting electronically. If printed from this option, users will be asked if they wish to “review complete” the status message, which will automatically clear it from the report.
- CSA-Retransmit a Bill - Similar to the Resubmit by Print action, the Retransmit Bill is used when the user reviews the status message or bill and determines the reason for the rejection has been corrected elsewhere in the system and the claim just needs to be resent. The user may then retransmit to the payer.
- CSA-Review Status - A bill will continue to show up on the report until it is cancel/cloned, canceled or the status is changed to Review Complete.

Users also have access to the option Multiple CSA Message Management from within the CSA list if they hold the IB Message Management security key.

## **6.2.2 Multiple CSA Message Management – Synonym: MCS**

### **What is the purpose of this option?**

This option is designed to allow users to take action on CSA messages when a problem arises during the processing of electronic claims that causes a large volume of erroneous status messages to be sent to the site. This option performs tasks similar to the CSA option.



*This option is locked by the **IB Message Management** security key.*

### **When is this option used?**

This option is used when there are pages of erroneous messages in CSA that were caused by a processing problem. Use this option to take a similar action (such as retransmission of the associated claims) on multiple claims at the same time.

The initial search for claims and claims status messages is done automatically when the option is selected. The initial search results in the display of all claims that are **Not Cancelled** and for which the review status is **Not Reviewed** or **Review in Process**.



*If someone else is working on a claim in CSA, it will not display in MCS. Only one user can be in MCS at a time. The following message will be displayed: **Sorry, another user is currently using the MCS option. Please try again later.***

Once the initial list has been built, users may further refine their search or work from the default list.



*The purpose of MCS is to select multiple claims and then apply the same action to all the selected claims. For example, users can enter a comment once and then apply the comment to 1-n claims.*

Other actions available on the MCS include:

- Message Search – Allows the user to change the criteria upon which the list of claims will be built
- Change Review Status – Same as CSA
- Cancel Claims – Same as CSA
- Enter Comment – Same as CSA
- Resubmit by Print – Same as CSA
- Retransmit Bill – Same as CSA
- Select/Deselect Claims – Allows users to select the claims to which they want to apply an action



*When using the Resubmit by Print action, the claims selected will not be removed from the list of claims until the claims have actually been printed.*

## **6.2.3 Electronic Report Disposition**

### **What is the purpose of this option?**

This option allows the site to determine which clearinghouse generated electronic messages/reports are to be sent to the EDI mail group and which should be ignored.

### **When is this option used?**

The default setting on this report will contain a disposition of “Mail Report to Mail Group”. It is up to the individual site’s supervisory staff to determine what reports should be ignored.



*Further explanations of these reports are available in documents provided by Emdeon™. They are entitled Claim Submitter Reports – Providers Reference Guide. The guides are available at <http://www.emdeon.com/VendorPartners/vendorpartners.php>*

The following reports should be reviewed when they are received. They contain information that cannot be translated into claim status messages therefore, this information is not available in CSA.

### **R000 NETWORK NEWS**

Provides news on system problems, updates and other pertinent information.

### **RPT-02 FILE STATUS REPORT**

Provides an initial analysis of the file by displaying file status of accepted or rejected and a description of the status. It also indicates the total number of claims and the dollar value if the file contains valid claims.

### **RPT-03 FILE SUMMARY REPORT**

Provides summarized information on the quantity of accepted, rejected, and pending claims, as well as the total number of claims received by Emdeon for each submitted file.

### **RPT-08 PROVIDER MONTHLY SUMMARY**

Displays the number and dollar value of claims accepted and forwarded by Emdeon for the month. Monthly and Y-T-D Totals for both accepted and rejected claims are included as well as the provider’s top 25 errors for the month.

The following reports contain information that is also translated into status messages and displayed on CSA.

### **RPT-04 FILE DETAIL SUMMARY REPORT**

Contains a detail summary of the file submitted for processing. It provides a file roll-up listing of all accepted, rejected, and pending claims contained in each file submitted to Emdeon. It also contains payer name/id and status of claim.

### **RPT-04A AMENDED FILE DETAIL SUMMARY REPORT**

Contains a detailed listing of all claims for which the status was amended during the previous processing day. Claims statuses are amended when a pending claim is processed and/or a claim is reprocessed at Emdeon.

### **RPT-05 BATCH & CLAIM LEVEL REJECTION REPORT**

Contains rejected batches and claims listed with detailed error explanations. In order to prevent "lost" claims, the RPT-05 report must be reviewed and worked after each file transmission.

**RPT-05A AMENDED BATCH & CLAIM LEVEL REJECTION REPORT**

Contains rejected batches and claims listed with detailed error explanations. In order to prevent "lost" claims, the RPT-05A report must be reviewed and worked after each file transmission.

**RPT-10 PROVIDER CLAIM STATUS**

This report contains information provided from payers who are receiving claims for adjudication from Emdeon. Not all payers who process claims through the Emdeon system provide information for this Provider Claim Status Report and the amount/frequency of information produced will vary from payer to payer.

**RPT-11 SPECIAL HANDLING/UNPROCESSED CLAIMS REPORT**

This report contains information provided from payers who are receiving claims for adjudication from Emdeon. Not all payers who process claims through the Emdeon system provide information for this Provider Claim Status Report and the amount/frequency of information produced will vary from payer to payer. The RPT-11 returns Unprocessed, Request for Additional Information, and Rejected statuses only.

## 6.2.4 EDI Claim Status Report- Synonym: ECS

### What is the purpose of this report?

View electronic transmission status to assure claims move through the system in a timely fashion.

### When is this option used?

It is recommended that initially this report be viewed daily as it provides transmission status of all claims that were transmitted to FSC Austin. Once a comfort zone is established and everything is flowing correctly, this report may only need to be run monthly.

Reports can be created based on:

- Specific Claim or Search Criteria
- Division
- Payer
- Transmission Date range
- EDI Status

Reports can be sorted by:

- Transmission Date
- Payer
- EDI Status
- Current Balance
- Division
- Claim Number
- AR Status
- Age

Possible EDI claim statuses include:

- Ready for Extract
- Pending Austin Receipt
- Accepted by Non-Payer
- Accepted Payer
- Error Condition
- Cancelled
- Corrected/Retransmitted
- Closed

## 6.3. Additional Reports and Options

### 6.3.1 Ready for Extract Status Report - Synonym: REX

#### What is the purpose of this report?

This report provides a list of claims held in a Ready for Extract status. These claims are held in a queue until batching occurs.

**When is this option used?**

Initially this option is used to assure claims are being transmitted at the times set in the MCCR Site Parameters. This option should be reviewed daily until there is a comfort level with the transmission timeframes and then less frequently based on local experience.

Claims that are trapped due to the EDI parameters being turned off can also be viewed. It is rare that EDI is turned off during processing. If this occurs, use EXT Extract Status Management to Cancel or Cancel/Clone/Auth the trapped claims.

Choices to view are:

- 1 All bills in Ready for Extract status
- 2 Bills trapped due to EDI parameter being turned off  
(If EDI is on, no bills will be trapped in extract)

**6.3.2 Transmit EDI Bills – Manual - Synonym: SEND****What is the purpose of this option?**

This option is used to by-pass the normal daily/nightly transmissions queues if the need arises to get the claim to the payer quickly.

**When is this option used?**

There are occasions when there is a need to transmit a claim(s) immediately instead of waiting for the batching frequency as scheduled in the MCCR Site Parameter. This option will allow sending individual claim(s) or all claims in a ready for extract status.

Select one of the following:

- A Transmit (A)LL bills in READY FOR EXTRACT status
- S Transmit only (S)ELECTED bills

**6.3.3 EDI Return Message Management Menu – Synonym: MM**

This menu contains the options needed to define the types of electronic reports from the clearinghouse that the site needs to see and defines the text that should/should not allow automatic review and filing for informational status messages. It also contains an option to purge old status messages, reports for maintaining the integrity of the return message subsystem and the option for reviewing electronically returned messages.

**6.3.4 EDI Message Text to Screen Maintenance****What is the purpose of this option?**

This option controls what status and/or error messages users may wish to review using special text words and/or phrases. This will either require the message to be reviewed or it will auto-file the message and flag it as not needing a review.

This option allows for the display of a list of words or phrases that, if found in the text of an informational status message, will either always require the message to be reviewed or will auto-file the message and flag it as not needing a review.

**When is this option used?**

Depending on what types of status messages users wish to review for follow-up on rejected claims and/or monitoring claims status, users may want to add or edit additional text as needed.

The words and phrases for “Requiring Review” and “Not Requiring Review” will initially populate as shown in the screen print below. This option is used to edit or add more words or phrases, as required, to manage and control the status messages.

**6.3.5 EDI Messages Not Reviewed Report****What is the purpose of this report?**

This option allows for the display of all EDI return messages that were filed without needing a review based on the text entries in the message screen text file.

**When is this option used?**

The report can be run for a user-selected date range, based on the date the message was received at the site, and may be sorted by the message text that caused the message to not need a review or by the bill number. Users may want to use this option for analysis or review of all EDI messages that they were not able to view initially.

**6.3.6 Electronic Error Report****What is the purpose of this report?**

This report provides a tool for billing supervisors and staff to identify the “who, what, and where” of errors in the electronic billing process. This is a report that will allow the supervisory staff to review “frequently received” errors. This is an informational management tool requiring no actions on the part of the billing staff.

**When is this option used?**

This option can be used at any time by a supervisor or other management staff when they want to determine the reason for various errors (i.e., the same error being made by one or more of the billing staff). The report can be sorted by:

- A    AUTHORIZING BILLER
- B    BILLED AMOUNT
- E    EPISODE OF CARE
- P    PATIENT NAME
- S    PATIENT SSN
- Y    PAYER NAME
- C    ERROR CODE

### 6.3.7 Return Messages Filing Exceptions

#### What is the purpose of this option?

After users have transmitted claims and they have been received for EDI processing, a message will be sent to the mail groups shown in the set-up section of this manual.

#### When is this option used?

When a message is sent, it is temporarily stored in the "EDI MESSAGES" file. Normally, these messages are in and out of this file in a matter of seconds. If, however, a problem is detected and a message cannot be filed in the appropriate file (s) for its message type, the message will remain in this temporary file.

There are two (2) **statuses** for messages in this file.

- **Pending:** The task to force a message to update the IB files has either not yet been created or has been created, but has not yet begun to run.
- **Updating:** The task to force a message to update the IB files has started. It may or may not still be running. If you try to file a message with this status, a check is made to see if it is currently running. If it is, the message will not be re-tasked.

Any message may be viewed or printed. This does not affect the message in any way, but looking at the message may help to indicate the next course of action needed.

There are two (2) **actions** available to get these messages out of the file.

- **File Message:** This action re-executes the tasked job to update the database with the contents of the message.
- **Delete Message:** This is a drastic action that should only be taken when it has been determined there is no other possible way to process a message. When a message is deleted using this action, a bulletin is sent to the IB EDI Mail Group with the text of the message and the name of the user who deleted the message. Users must hold the IB SUPERVISOR security key to perform this action.

### 6.3.8 Status Message Management

#### What is the purpose of this option?

This option allows users to print/purge electronically returned status messages that have been in a final review status for a user-selected number of days.

#### When is this option used?

There will be an accumulation of status messages in a final review status. This option will delete or purge status messages in one of the Final Review statuses prior to a selected date. Auto purging of messages can also be set in the IB Site Parameters.

This report can be sorted by:

- A ALL STATUS MESSAGES
- S SELECTED STATUS MESSAGES

Selected status message reports can be run showing:

- A Auto Filed/No Review Only
- B Bill Number
- S Message Severity
- T Specific Message Text

### **6.3.9 Bills Awaiting Resubmission – Synonym: BAR**

#### **What is the purpose of this report?**

This report lists all batches that have been resubmitted but which did not include all of the bills from the original batch. These are batches that have at least one bill still not resubmitted or canceled.

#### **When is this option used?**

When a batch is identified to have a claim in error, the batch may be re-submitted with the claim in error removed. This option will track and report specific bills in this category. The report can sort data by:

- B BILL NUMBER
- L LAST SENT DATE
- A BILLED AMOUNT
- N BATCH NUMBER (LAST SENT IN)

The report will also indicate the “Bill Transmission Status”.

### **6.3.10 EDI Messages Not Yet Filed –Synonym: MP**

#### **What is the purpose of this report?**

This report allows you to select receipt, rejection or both message types and a minimum number of days these messages have been in a PENDING or UPDATING status before they will be included on the report. The report will then list all messages in the file that meet these criteria.

#### **When is this option used?**

This is a status report that allows for review of messages not yet filed.

### **6.3.11 Pending Batch Transmission Status Report – Synonym: PBT**

#### **What is the purpose of this report?**

This report shows the current transmission status of a batch's mail message. It also includes the mail message number; the first and last date/time it was sent. Only batches in a pending transmission status will be on this report.

#### **When is this option used?**

This is another option to track the batch(s) of claims after authorizing and transmission to be sure all batches transmitted have been received in Austin. Users can omit both the station number prefix at the front of the batch number and the following zeroes and use only the final digits of the batch number for lookup.

### 6.3.12 EDI Batches Pending Receipt– Synonym: PND

#### What is the purpose of this report?

This report lists all batches by batch number that have been in a PENDING status and have not yet received confirmation of receipt from Austin for more than one (1) day. The report includes individual claims if the users choose to include them.

The report includes:

- Batch Number
- Transmission Date
- Mail Message #

Claims display the following:

- Claim Number
- Payer Sequence
- Balance Due
- EDI Status
- IB Status
- AR Status

EDI Batches Pending Austin Receipt After 1 Day						Page: 2
Run Date: 01/07/2008@14:44:28						
Batch #	Transmission Date			Mail Message #		
-----						
Claim	Seq	Bal Due	EDI Stat	IB Status	AR Status	
K600KQD	P	198.54	P	PRNT/TX	NEW BILL	
K600NEU	P	76.36	P	PRNT/TX	NEW BILL	
K600QR2	P	305.11	P	PRNT/TX	NEW BILL	
K600WS7	P	76.36	P	PRNT/TX	NEW BILL	
K600WSF	P	880.71	P	PRNT/TX	NEW BILL	
4420029590	03/29/2006@21:05:33			1321		
Claim	Seq	Bal Due	EDI Stat	IB Status	AR Status	
K600FN7	P	76.36	P	REQUEST MRA	BILL INCOMPLETE	
K600IPF	P	73.01	P	REQUEST MRA	BILL INCOMPLETE	
K600WSA	P	4390.06	P	REQUEST MRA	BILL INCOMPLETE	
K600WSK	P	73.01	P	REQUEST MRA	BILL INCOMPLETE	
Enter RETURN to continue or '^' to exit:						



*Members of the G.IB EDI mail group will receive an email message when there are batches of claims that have not received a confirmation message from Austin after 1 day.*

```

Subj: EDI BATCHES WAITING AUSTIN RECEIPT FOR OVER 1 DAY [#21387]
06/19/04@19:02 6 lines
From: XXXXXXXXXXXX,XXXX X In 'IN' basket. Page 1 *New*
-----
There are 30 EDI batch(es) still pending Austin receipt
for more than 1 day. Please investigate why they have not yet been confirmed
as being received by Austin.

Since there were more than 10 batches found, please run the
EDI BATCHES WAITING FOR AUSTIN RECEIPT OVER 1-DAY report to get a list of the
se batches.

Enter message action (in IN basket): Delete//

```

### When is this option used?

Users may use this option to obtain Batch or Messages numbers when a problem arises or to monitor the status of batches recently transmitted. Batches should not be in a “Pending Austin Receipt” status for more than a day.



**Contact IRM** for assistance in finding out why a confirmation message has not been received from Austin.



Before contacting IRM, note the **Message Numbers** for the batches that you need investigated. These numbers can be found in the **PND** option.



If IRM needs assistance, log a **REMEDY ticket** or call the **National Help Desk at 1-888-596-4357**.

### 6.3.13 View/Print EDI Bill Extract Data – Synonym: VPE

#### What is the purpose of this option?

This option will display the EDI extract data for a bill.

#### When is this option used?

This option is used only if there is a need to determine what data was transmitted for a specific bill. The detailed extract data will contain all the elements in the flat file that is transmitted to FSC Austin. FSC Austin, in turn, translates the data to a HIPAA-compliant format for transmission to Emdeon™.

### 6.3.14 Insurance Company EDI Parameter Report – Synonym: EPR

#### What is the purpose of this option?

This option will display the EDI Parameters of the Active Insurance Companies defined in Vista.

The contents of the following parameters will be included in this report:

- Insurance Company Name
- Street Address and City of Insurance Company
- Electronic Transmit?
- Institutional Electronic Bill ID

- Professional Electronic Bill ID
- Electronic Type
- Type of Coverage

All Companies Insurance Company EDI Parameter Report							Page: 1
Sorted By Ins Company Name							
Mar 21, 2005@14:03:32							
Only Blank or 'PRNT' Bill ID's = NO							
Insurance Company Name	Street Address	City	Electron Transmit	Inst ID	Prof Electronic ID	Type	Type of Coverage
=====							
AETNA LIFE INSURANCE	741.. STREET	...,CA	YES-LIVE	XXXXX		Commercial	Health Insurance

**When is this option used?**

This option can be used whenever there is a need to confirm that the Insurance Company parameters are correctly defined to support the electronic transmission of claims. This option will be of value when the eClaims Plus patches are loaded and sites gain the ability to transmit secondary claims to the payers (electronic, end-to-end processing). For example, sites can use this option to make sure the payers' Electronic Bill IDs are defined.

**6.3.15 Test Claim EDI Transmission Report - TCS**

**What is the purpose of this option?**

The Claim Status Messages for claim(s) and batch(es) submitted via the RCB option as Test claims will not appear in CSA. No action will be required in response to these messages. For informational purposes, these messages will be available through the Test Claim EDI Transmission Report. This option can be used to investigate the status of test claims to see, for example, whether the transmission was accepted/rejected by FSC or accepted/rejected by Emdeon™.



*The messages in this option will be automatically purged after 60 days.*

**When is this option used?**

This option can be used whenever a user needs to investigate the current status of a claim or batch of claims. The messages in this report will be like the messages in TPJI.

Test Claim EDI Transmission Report							Page: 1
Selected Batches							Mar 22, 2005@12:14:38
=====							
Batch#:	6050011719						
Claim#:	K404XXX	IB,Patient7	(1500, Prof, Outpat)				
-----							
Transmission Information							
	03/17/2005@11:11:25	Bch#11719	IB,Clerk2	CIGNA HEALTHCARE (S)			

**6.3.16 Third Party Joint Inquiry – Synonym: TPJI**

**What is the purpose of this option?**

This option provides a convenient location for both claim, AR, Insurance and EDI data related to a claim.

**When is this option used?**

This option is used by both Integrated Billing and Accounts Receivable personnel who require information about a claim. Both AR and IB users can also add comments to an MRA Request or non-MRA Request claim using this option.

The following actions are available from TPJI

BC	Bill Charges
DX	Bill Diagnosis
PR	Bill Procedures
CB	Change Bill
ED	EDI Status
AR	Account Profile
CM	Comment History
IR	Insurance Reviews
HS	Health Summary
AL	Active List
VI	Insurance Company
VP	Policy
AB	Annual Benefits
EL	Patient Eligibility



*Patch IB\*2\*377 included changes to allow the addition of and the viewing of MRA Request claim comments using TPJI. Comment History now pertains to MRA Request claims as well as regular claims. MRA Request claim comments are not stored as AR comments though.*

**6.3.17 Patient Billing Inquiry – Synonym: INQU****What is the purpose of this option?**

This option provides some basic information about a particular claim. It is a simple inquiry option.

**When is this option used?**

This option can be used to view the following type of information related to a bill:

- Bill Status
- Rate Type
- Form Type
- Visit Date(s)
- Charges
- AR Status
- Statement Dates
- Dates related to actions such as Entered, Cancelled or Printed
- Bill Number copied from or to

- Patient, Mailing and Insurance Company address

The data available varies based upon when the inquiry is made and what actions have been carried out regarding the claim.

## **7. APPENDIX A – BATCH PROCESSING SETUP**

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## BATCH PROCESSING SETUP

The following example shows you how to define batch processing for a payer:

Step	Procedure
1	Under the IB Site Parameters, go to <b>field [15] EDI/MRA Activated</b> .
2	Edit fields as necessary (fields are highlighted in yellow for this example).
	<i>Details on each field follow the screen example.</i>
	<p><i>When the MRA software was loaded (Patch IB*2.0*155), the <b>EDI/MRA Activated</b> field was removed from this screen. Only <b>IRM</b> is able to access this field via <b>Fileman</b>. The reason for this is to prevent MRA from being activated before the FSC is ready to accept MRA transmissions from a particular site.</i></p>

```

IB Site Parameters          Aug 13, 2003@10:22:46          Page:    5 of 6
Only authorized persons may edit this data.
-----
[15] EDI/MRA Activated      : EDI
EDI Contact Phone          :
EDI 837 Live Transmit Queue : MCH
EDI 837 Test Transmit Queue : MCT
Auto-Txmt Bill Frequency   : Every Day
Hours To Auto-Transmit     : 1300;1600
Max # Bills Per Batch      : 50
Only Allow 1 Ins Co/Claim Batch?: NO
Last Auto-Txmt Run Date    : 08/13/03
Days To Wait To Purge Msgs : 120
    
```

**EDI/MRA Activated:** Controls whether EDI is available for the site. Choose from:

- 0 - NOT EDI OR MRA;
- 1 - EDI ONLY;
- 2 - MRA ONLY; or
- 3 - BOTH EDI AND MRA



You will have to reset this to **3** when you want to activate **MRA**.

Following the installation of MRA, there will be additional fields that you must define.

```
IB Site Parameters          May 27, 2004@14:14:24          Page:    5 of    6
Only authorized persons may edit this data.
+
  HMO NUMBER                :
  STATE INDUSTRIAL ACCIDENT PROV:
  LOCATION NUMBER           :

[15] EDI/MRA Activated      : BOTH EDI AND MRA
  EDI Contact Phone         : 217-554-3135
  EDI 837 Live Transmit Queue : MCH
  EDI 837 Test Transmit Queue : MCT
  Auto-Txmt Bill Frequency  : Every Day
  Hours To Auto-Transmit    : 1000;1400;2000
  Max # Bills Per Batch     : 10
  Only Allow 1 Ins Co/Claim Batch?: NO
  Last Auto-Txmt Run Date   : 05/26/04
  Days To Wait To Purge Msgs : 45
  Allow MRA Processing?     : YES
  Enable Automatic MRA Processing?: YES

+          Enter ?? for more actions
EP  Edit Set                               EX  Exit Action
```

**EDI Contact Phone:** The phone number of the person at the site contact to whom EDI inquiries will be directed. It will appear on the UB-04 in box 1 and on the CMS-1500 in box 32.

**EDI 837 Live Transmit Queue:** The name of the Austin data queue that will receive claims to be processed via a live connection to the clearinghouse. These data are populated at the time of installation and would not normally be edited by the site.

**EDI 837 Test Transmit Queue:** The name of the Austin data queue that will receive test claims. These data are populated at the time of installation and would not normally be edited by the site.

**Auto Transmit Bill Frequency:** The desired number of days between each execution of the automated bill transmitter. For example, if the automated bill transmitter should run only once a week, this number would be 7. If the automated bill transmitter should run every night, then the number should be 1. If this is left blank or zero then the automated bill transmitter background job will never run.

**Hours To Transmit Bills:** Contains the times of the day when EDI transmission of bills should occur. A maximum of 4 daily times daily may be entered and the times must be separated by a semi-colon. Times must be entered in 4-digit military format, without punctuation (HHMM;HHMM;HHMM;HHMM). If no times are entered, EDI transmission will take place as a normal part of the nightly job.

**Max # Of Bills In A Batch:** The maximum number of bills allowed in a single batch. With a new payer, it is suggested that you begin with fairly small batches (10-20 claims).

**Only Allow 1 Ins Co/Claim Batch:** Indicates whether or not the site wishes to limit batches to claims for a single insurance company.

**Last Auto-Txmt Run Date:** The last date the auto transmit of bills was run at the site. These data are display only and cannot be edited.

**Days To Wait To Purge Msgs:** This is the number of days after an electronic status message has been marked reviewed, that the purge message option can delete it from the system.

## **8. APPENDIX B – GLOSSARY**

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## GLOSSARY OF TERMS

835	The HIPAA adopted standard for electronic remittance advice to report the processing of all claim types (including retail pharmacy). The 835 is sent from health plans to health care providers and contains detailed information about the processing of the claim. This includes payment information and reduction or rejection reasons. The 835 transactions generally contain information about multiple claims. All health plans are required to use the same explanation of benefit codes (adjustment reason codes) and adhere to very specific reporting requirements. The term "835" is used interchangeably with electronic remittance advice.
837	The HIPAA adopted standard for electronic submission of hospital, professional and dental claims or encounters. The 837 is sent from health care providers to health plans (payers). The 837 transactions are generally multiple claims (batches). The 837 standard includes the information for coordination of benefits and is also used for secondary payer claims submission. The term "837" is used interchangeably with electronic claim.
Billing Provider Secondary ID Number	This is either the facility tax ID # (default) or an ID assigned to the facility by the insurance company.
Care Unit	Specific data related to patient care (pre-defined by an insurance company) that provides the insurance company with a finer breakdown of the care being billed. The data that comprises the breakdown are insurance company specific and are not required by all payers. (For example, Orthopedics, Dermatology, Urology, etc.)
Claim Status Message	Electronic messages returned to the VAMC providing status an information on a claim from the Financial Service Center (FSC), Emdeon™ Envoy Clearinghouse or a payer.
Clearinghouse	A company that provides batch and real-time transaction processing services. Transactions include insurance eligibility verification, claims submission process and electronic remittance information and payment posting for electronic claims.
CSA	Claims Status Awaiting Resolution  Used to reference the option used by billing staff to review the most current status messages received for a bill(s) and do follow-up on the bills. Users will be able to select a bill from the list to view the details and the entire message text as well as to

	mark the message as reviewed or under review and document user comments.
eClaim	A claim that is submitted electronically from the VA.
EDI	Electronic Data Interchange. Electronic Data Interchange (EDI) is the process of transacting business electronically. It includes submitting claims electronically (paperless claims processing), as well as electronic funds transfer and electronic inquiry for claim status and patient eligibility.
Electronic Payer	A payer that has an electronic connection with Emdeon™ Envoy, the clearinghouse.
Emdeon	The clearinghouse that transmits all VA claims to payers, or prints and mails claims to payers that do not have an electronic connection.
Envoy	The previous name of the clearinghouse, currently named Emdeon Envoy.
ePayer	Payer that accepts electronic claim from the clearinghouse pays electronically. See Payer.
EPS (Formerly EVS)	Enterprise Product Support
Express Bill	Emdeon™ Envoy's print house that prints and mails claims to payers who do not have the capability to accept electronic claims or in specific circumstances when a paper claim is required.
Facility Fed Tax ID #	This is the number that will be the default for all providers for the ID type at the facility if the payer does not have specific requirements.
Fiscal Intermediary	A fiscal intermediary performs services on behalf of health care payers. These services include claim adjudication, reimbursement and collections. Trailblazer is an example of a fiscal intermediary that acts on behalf of Medicare. Trailblazer receives claims from the VA in the form of an 837 file and then adjudicates the claims to create a MRA/EOB 835 file.
Form Types	The UB-04 or CMS-1500 billing form on which services will be billed.
FSC	The VA Financial Services Center in Austin. The Financial Service Center translates claims into an industry-standard format (HIPAA 837) and forwards claims to the clearinghouse. The FSC is the single point for the exchange of data between VistA and Emdeon™ Envoy.
Healthcare Company	See Payer.
HIPAA	Health Insurance Portability and Accountability Act. Health

	Insurance Portability and Accountability Act. In 1996 Congress passed into law the Health Insurance Portability and Accountability Act (HIPAA). This Act is comprised of two major legislative actions: Health Insurance Reform and Administrative Simplification. The Administrative Simplification provisions of HIPAA direct the federal government to adopt national electronic standards for automated transfer of certain health care data between health care payers, plans, and providers. This will enable the entire health care industry to communicate electronic data using a single set of standards thus eliminating all non-standard formats currently in use. Once these standards are in place, a health care provider will be able to submit a standard transaction for eligibility, authorization, referrals, claims, or attachments containing the same standard data content to any health plan. This will "simplify" many clinical, billing, and other financial applications and reduce costs.
Insurance Company	See Payer.
Legacy IDs	This term refers to those payer-provided or users own IDs (individual and organizational) which will eventually be made obsolete by the use of National Provider Identifiers.
Non-VA Facility	Any facility that provides services to a VA patient and subsequently bills the VA for those services.
Non-VA Provider	Any individual provider who provides services to a VA patient and subsequently bills the VA for these services
National Provider Identifier	A standard, unique health identifier for health care providers, both individuals and organizations
Parent	The top facility in a hierarchical domain.
Payer	The insured's insurance company. Other terms that are used to denote Payer include, ePayer, insurance company, healthcare company, etc.
Payer Code	A code used for enrollment that uniquely identifies the payer.
Payer List	List of payers that consist of the payer category, claim type, payer code, and payer name.
Provider	Provider of health care services.
Provider ID	A provider ID can represent a facility or an individual physician/provider.
Taxonomy Code	The Health Care Provider Taxonomy code set is a collection of unique alphanumeric codes, ten characters in length. The code set is structured into three distinct "Levels" including Provider Type, Classification, and Area of Specialization.

	The Health Care Provider Taxonomy code set allows a single provider (individual, group, or institution) to identify their specialty category.
UPIN	Unique Provider Identification Number.
URL	Uniform Resource Locator.
VAMC	Veterans Affairs Medical Center.
VISN	Veterans Integrated Service Network.

## **9. APPENDIX C –HIPAA PROVIDER ID –REFERENCE GUIDE**

**APPENDIX C –HIPAA Provider ID –Reference Guide**

This table displays the HIPAA qualifiers and associated ID types. This table can be used to help identify what type of Provider ID type is being used in the electronic format.

Institutional										
Qualifier		Billing Provider	Attending		Operating		Other		Service	
	Definition	2010AA	2310A	2330D	2310B	2330E	2310C	2330F	2310E	2330H
			C	O	C	O	C	O	C	O
		PRV1	OPR2	OP1	OPR3	OP2	OPR4	OP9	SUB2	OP3
OB	State License Number	-	OB		OB		OB		OB	
1A	Blue Cross Provider Number	1A	1A	1A	1A	1A	1A	1A	1A	-
1B	Blue Shield Provider Number	-	1B	1B	1B	1B	1B	1B	1B	1B
1C	Medicare Provider Number	1C	1C	1C	1C	1C	1C	1C	1C	1C
1D	Medicare Provider Number	1D	1D	1D	1D	1D	1D	1D	1D	1D
1G	Provider UPIN Number	1G	1G	1G	1G	1G	1G	1G	1G	-
1H	TRICARE ID Number	1H	1H	1H	1H	1H	1H	1H	1H	-
1J	Facility ID Number	1J	-	-	-	-	-	-	1J	-
B3	PPO Number	B3	-	-	-	-	-	-	-	-
BQ	HMO Code Number	BQ	-	-	-	-	-	-	-	-
EI	Employer's ID Number	EI	EI	EI	EI	EI	EI	EI	EI	EI
FH	Clinic Number	FH	-	-	-	-	-	-	FH	-
G2	Provider Commercial Number	G2	G2	G2	G2	G2	G2	G2	G2	G2
G5	Provider Site Number	G5	-	-	-	-	-	-	G5	-
LU	Location Number	LU	LU	LU	LU	LU	LU	LU	LU	LU
N5	Provider Plan Network ID Number	-	N5	N5	N5	N5	N5	N5	N5	N5
TJ	Federal Taxpayer's ID Number	-	-	-	-	-	-	-	-	-
X4	Clinical Lab Improvement Amendment (CLIA #)	-	-	-	-	-	-	-	-	-
U3	Unique Supplier ID Number (USIN)	-	-	-	-	-	-	-	-	-
SY	Social Security Number	SY	SY	-	SY	-	SY	-	-	-
X5	State Industrial Accident Provider Number	X5	X5	-	X5	-	X5	-	X5	-

C = Current Payer    O = Other Payer

Professional												
Qualifier		Billing Provider	Referring		Rendering		Purchased		Service Facility		Supervising	
	HIPAA Loop	2010AA	2310A	2330 D	2310B	2330 E	2310 C	2330 F	2310 D	2330 G	2310 E	2330 H
			C	O	C	O	C	O	C	O	C	O
	VPE Record	PRV1	OPR5	OP4	OPR2	OP1	SUB1	OP6	SUB2	OP7	OPR8	OP8
OB	State License Number	-	OB	-	OB	-	OB	-	OB	-	OB	-
1A	Blue Cross Provider Number	-	-	-	-	-	1A	-	1A	-	-	-
1B	Blue Shield Provider Number	1B	1B	1B	1B	1B	1B	1B	1B	1B	1B	1B
1C	Medicare Provider Number	1C	1C	1C	1C	1C	1C	1C	1C	1C	1C	1C
1D	Medicare Provider Number	1D	1D	-	1D	-	1D	1D	1D	1D	1D	1D
1G	Provider UPIN Number	1G	1G	-	1G	-	1G	-	1G	-	1G	-
1H	TRICARE ID Number	1H	1H	-	1H	-	1H	-	1H	-	1H	-
1J	Facility ID Number	1J	-	-	-	-	-	-	-	-	-	-
B3	PPO Number	B3	-	-	-	-	-	-	-	-	-	-
BQ	HMO Code Number	BQ	-	-	-	-	-	-	-	-	-	-
EI	Employer's ID Number	EI	EI	EI	EI	EI	EI	EI	-	-	EI	EI
FH	Clinic Number	FH	-	-	-	-	-	-	-	-	-	-
G2	Provider Commercial Number	G2	G2	G2	G2	G2	G2	G2	G2	G2	G2	G2
G5	Provider Site Number	G5	-	-	-	-	-	-	-	-	-	-
LU	Location Number	LU	LU	LU	LU	LU	LU	LU	LU	LU	LU	-
N5	Provider Plan Network ID Number	-	N5	N5	N5	N5	N5	N5	-	N5	N5	N5
TJ	Federal Taxpayer's ID Number	-	-	-	-	-	-	-	TJ	-	-	-
X4	Clinical Lab Improvement Amendment (CLIA #)	-	-	-	-	-	-	-	X4	-	-	-
U3	Unique Supplier ID Number (USIN)	U3	-	-	-	-	U3	-	-	-	-	-
SY	Social Security Number	SY	SY	-	SY	-	SY	-	-	-	SY	-
X5	State Industrial Accident Provider Number	X5	X5	-	X5	-	X5	-	X5	-	X5	-

C = Current Payer    O = Other Payer