Department of Veterans Affairs
Decentralized Hospital Computer Program

INTEGRATED BILLING

USER MANUAL

Version 2.0

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Information Systems Center
Albany, New York

Preface

This is the user manual for the Integrated Billing (IB) software package.

This manual is designed to provide guidance to a broad range of users within VA medical facilities in daily usage of the Integrated Billing software.

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Revision History

Initiated on 12/29/04

Date	Description (Patch # if applic.)	Project Manager	Technical Writer
10/16/07	Updated for patch IB*2*303		Tim Dawson
5/27/05	Re-paged for clarity.		Mary Ellen Gray
12/29/04	Updated to comply with SOP 192-352 Displaying Sensitive Data.		Mary Ellen Gray
12/29/04	Pdf file checked for accessibility to readers with disabilities.		Mary Ellen Gray

Introduction

The release of Integrated Billing (IB) version 2.0 introduces fundamental changes to the way MCCR-related tasks are done. This software introduces three new modules: Claims Tracking, Encounter Form Utilities, and Insurance Data Capture.

There are also significant enhancements to the two previous modules, Patient Billing and Third Party Billing. IB has moved from a package with the singular purpose of identifying billable episodes of care and creating bills, to a package responsible for the whole billing process through to the passing of charges to Accounts Receivable (AR). Functionality has been added to assist in capturing patient data, tracking potentially billable episodes of care, completing utilization review (UR) tasks, and capturing more complete insurance information.

This version of IB has been targeted for a much wider audience than previous versions.

- The Encounter Form Utilities module is used by MAS ADPACs or clinic supervisors to create and print clinic-specific forms. Physicians use the forms and consequently provide input into their creation.

- The Claims Tracking module is used by UR nurses within MCCR and Quality Management (QM) to track episodes of care, do pre-certifications, do continued stay reviews, and complete other UR tasks.

- Insurance verifiers use the Insurance Data Capture module to collect and store patient and insurance carrier-specific data.

- The billing clerks see substantial changes to their jobs with the enhancements provided in the Patient Billing and Third Party Billing modules.

Following is an overview of the major functions of the Integrated Billing software, excluding the Encounter Form functionality. That information can be found in the IB User Manual, Encounter Form Utilities Module.

Patient Billing

- automates billing of pharmacy, inpatient, nursing home care unit (NHCU), and outpatient copayments; inpatient and NHCU per diem charges; and passing charges to Accounts Receivable (AR).

- automatically exempts patients who are eligible for VA Pension, Aid and Attendance, or House Bound benefits from the Medication Copayment requirement.

- provides for manual assignment of hardship exemptions from the copayment requirement and the ability to track those exemptions.

- integrates with the checkout functionality released in the PIMS V. 5.3 package. Patients who claim exposure to Agent Orange and environmental contaminants, and who are treated for conditions not related to this exposure, are billed automatically.

- allows patient charges to be added, edited, or deleted if there is no automated charge or the automated charge is incorrect.

- creates subsistence charges for CHAMPVA patients and passes to Accounts Receivable. This functionality will not be activated until the AR package releases a patch that allows AR to process CHAMPVA receivables.

- allows Means Test billing data to be transmitted between facilities in conjunction with PDX V. 1.5.

- automatically creates Means Test charges when a verified Means Test is electronically received from the Income Verification Match (IVM) Center.

Third Party Billing

- automates the creation of third party billing forms (UB-82, UB-92, HCFA-1500), allowing for the entry, editing, authorizing, printing, and canceling of bills.

- provides the ability to add prescription refills and prosthetic items to bills.

- expands the UB-92 functionality to include ability to add/edit all unlabeled form locators (except 49), additional diagnosis, some occurrence spans, and value codes.

- provides a check-off sheet (can be replaced by the Encounter Form depending on local needs) that can be printed in a variety of site configurable formats to be used in clinics to identify CPT codes.

- allows the transfer of CPT codes between the billing screens and the SCHEDULING VISITS file.

- provides reports to identify billable episodes of care, patient and insurance inquiries, and statistical data.

- provides the ability to create CHAMPVA bills. You will not be able to pass them to Accounts Receivable until the AR package releases a patch that allows AR to process CHAMPVA receivables.

- provides an employer report, which lists uninsured patients who are employed.

- allows printing of all authorized bills in user-specified order.

- provides an Automated Biller which will automatically generate reimbursable insurance bills for inpatient stays, outpatient visits, and prescription refills. Through the use of site parameters, sites can specify what types of events are billed using the Automated Biller.

- provides an expanded HCFA-1500 claim form to include inpatient bills, user-specified charges, and multiple pages.

- provides an addendum sheet to HCFA-1500 claim form to list the bill's prescription refills and prosthetic items.

Insurance Data Capture

- stores multiple addresses (main mailing, outpatient claims, inpatient claims, prescription claims, appeals, inquiries) for each insurance carrier.

- provides insurance company-specific billing parameters so bills can reflect local insurance company requirements.

- provides the ability to establish group plans which will be pointed to by each patient with a policy attached to the plan. This saves re-entry of the same policy data for each patient.

- stores annual benefits associated with group plans.

- provides tools to maintain and/or clean up the INSURANCE COMPANY file.
- allows patient insurance information to be updated and verified.
- stores benefits used by a patient, such as deductibles and lifetime maximums.
- provides an insurance worksheet for use by the insurance verifier.

Claims Tracking

- provides the ability to track billing information concerning inpatient visits, outpatient visits, prescription refills, prosthetics, and fee basis visits from time of event until payment.
- provides a pending review (to do) list.
- introduces an Admission Sheet which can be placed in the front of the inpatient chart and used to document concurrent reviews.
- provides the feeding mechanism for automated bill preparation of third party bills.
- provides tracking of those cases requiring utilization review by VA Central Office (VACO) Quality Management (QM) office based on Interqual criteria.
- provides tracking of those cases where the insurance company requires reviews.
- provides tracking of appeals and denials.
- provides U/R management reports.

Additional Functionality

- purges data from selected IB files.
- provides the medical centers flexibility in implementing the package functionality through site parameters.
- provides the ability to enter new billing rates and VA pension income thresholds.
- produces management reports to provide workload, productivity, statistical, and historical data.

Related materials include the IB User Manual, Encounter Form Utilities Module; IB Technical Manual; Package Security Guide; Installation Guide; and Release Notes. The Technical Manual assists the site manager in maintenance of the software. The Package Security Guide provides information concerning security requirements for the package. The Installation Guide provides assistance in installation of the package while the Release Notes describe modifications and enhancements to the software that are new to this version.

Orientation

How To Use This Manual

This manual is presented in an online format, but it may also be printed; however, because its intent is for online viewing, and it is not anticipated that is will be printed in its entirety, it has not been formatted for double-sided printing.

The best way to navigate through this manual is by using the Table of Contents (for Word format) and Bookmarks (for pdf format).

The Table of Contents and Bookmarks are presented in a format similar to the exported menu structure.

Package Management

Data in the INTEGRATED BILLING ACTION file should not be added to, edited, or deleted. This data is designed to provide an audit trail of transactions. If the charges for a copayment are removed, a separate transaction that is a cancellation type will be created and cause the decrease adjustment to be made. If charges are to be changed, the original (or last) charges are cancelled and the new charges are set-up as an update type transaction. Data in this file is maintained through documented routine calls from the Outpatient Pharmacy and MAS packages to Integrated Billing. Data in other Integrated Billing files should be maintained through package options.

Instructions to enter new billing rates and VA pension income thresholds will be provided by VACO and/or the Albany ISC.

The automated billing of Category C veterans for outpatient copayments, inpatient copayments, and per diems happens automatically through links to the scheduling event driver, the MAS movement event driver, and the nightly background job.

There are numerous parameters in the IB SITE PARAMETERS file that affect the functional and technical operations of the billing software.

There are several options that contain parameters that affect the operation of the IB package. The MCCR Site Parameter Enter/Edit option parameters affect the operation of the Patient and Third Party Billing modules. The Select Default Device for Forms option affects where forms will print. The Claims Tracking Parameter Edit option affects the operation of the Claims Tracking module. The Enter/Edit Automated Billing Parameters option allows the site to determine when and what bills the Automated Biller generates. The Enter/Edit IB Site Parameters option on the System Manager's IB Menu affects many of the technical aspects of the IB package.

Per VHA Directive 10-93-142, many of the IB routines, data dictionaries, and data files are not to be modified. Only the routines for Encounter Form utilities and selected outputs may be modified.

An electronic signature code is required for users of the Manually Change Copay Exemption (Hardships) option under the Medication Copayment Income Exemption Menu and the Purge Update File and Archive Billing Data options under the Purge Menu.

Package Operation

On-line Help

When the format of a response is specific, a Help message is usually provided for that prompt. Help messages provide lists of acceptable responses or format requirements which provide instruction on how to respond.

A Help message can be requested by typing one or two question marks. The Help message will appear under the prompt, then the prompt will be repeated. For example:

```
BILLING LOCATION OF CARE: 1//
```

and you need assistance answering. You enter ?? and the Help message would appear.

```
BILLING LOCATION OF CARE: 1// ??

This identifies the type of facility at which care was administered.
  Choose from:
    1        HOSPITAL (INCLUDES CLINIC) - INPT. OR OPT.
    2        SKILLED NURSING (NHCU)
    3        CLINIC (WHEN INDEPENDENT OR SATELLITE)

BILLING LOCATION OF CARE: 1//
```

For some prompts, the system will list the possible answers from which you can choose. Any time choices appear with numbers, the system will usually accept the number or the name.

A Help message may not be available for every prompt. If you enter question marks at a prompt that does not have a Help message, the system will repeat the prompt.

Note to Users With "QUME" Terminals

It is very important that you set up your Qume terminal properly. After entering your access and verify codes, you will see the following prompt.

```
Select TERMINAL TYPE NAME: {type}//
```

Please make sure that C-QUME is entered here. This entry will become the default and you can then enter `<RET>` for all subsequent log-ins. If any other terminal type configuration is set, options using the List Manager utilities will not display nor function properly on your terminal.

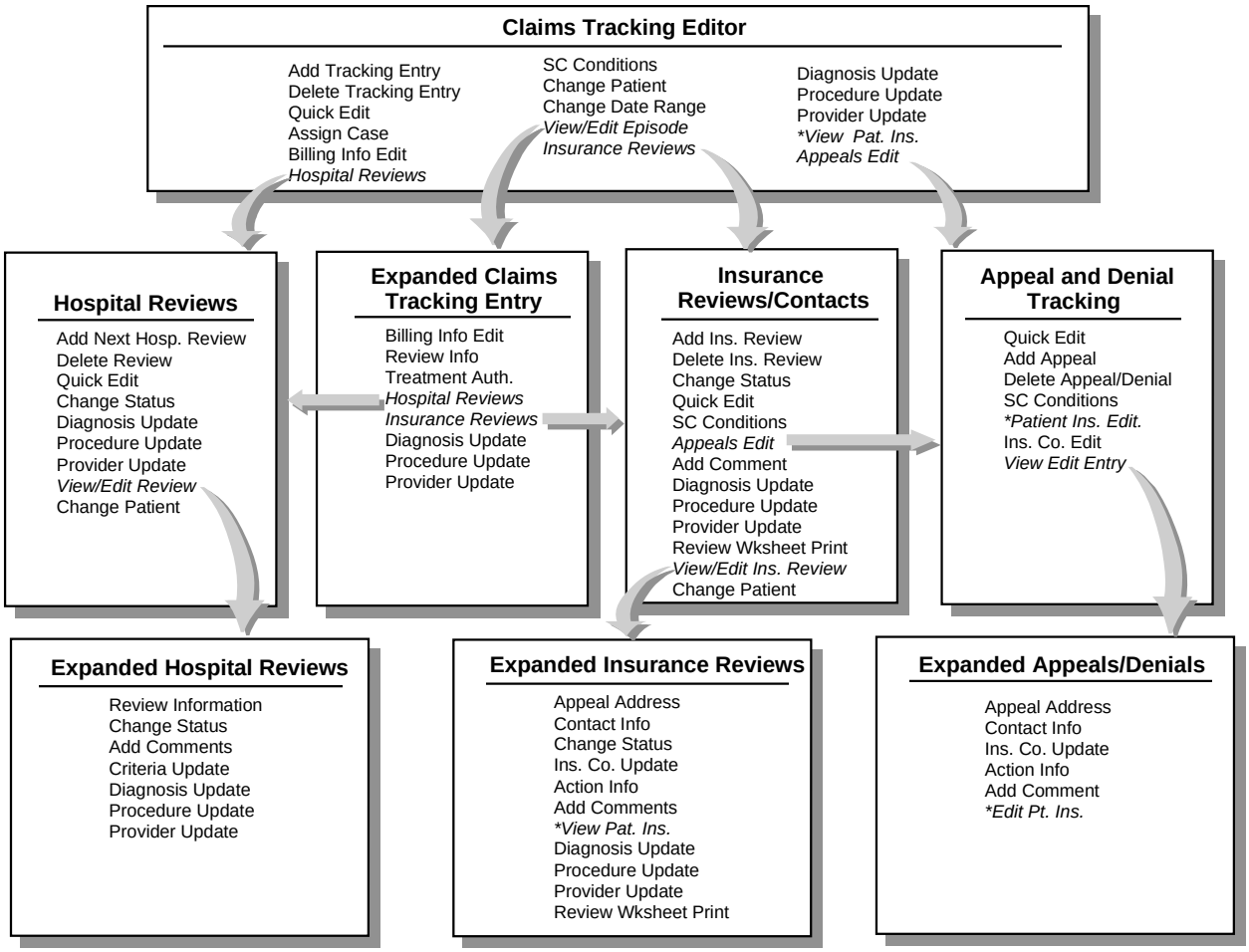
Billing Clerk's Menu

Claims Tracking Menu for Billing

Claims Tracking Edit

This option allows entering/editing of Claims Tracking Entries. Data associated with a CT entry may affect if or how it is billed and the types of reviews that may or must be entered. It is the main gateway to most Claims Tracking functions. Each visit, whether inpatient, outpatient, or prescription refill, has a unique entry where it is tracked to see whether or not it is billable. Normally, only visits of insured patients are tracked; however, all visits may be tracked. You can edit information about anticipated revenues and required reviews with this option, and perform a number of maintenance and clinical update edits. Depending on how your site parameters are set, admissions, outpatient visits, and prescription refills may be added automatically. If you are using the Scheduled Admissions module of the PIMS software, scheduled admissions will also be added.

The following chart shows the Claims Tracking Screens accessed through this option and the actions available on each screen. Actions might not be shown in the order in which they actually appear on the screens.



*These actions bring you to the Patient Insurance Screens. Please refer to the Patient Insurance Menu section of this manual for documentation of these screens.

In the top left corner of each screen is the screen title. A plus sign (+) at the bottom left of the screen indicates there are additional screens. Left or right arrows (<<< >>>) may be displayed to indicate there is additional information to the left or right on the screen. Available actions are displayed below the screen. Two question marks entered at any "Select Action" prompt displays all available actions for that screen. For more information on the use of the screens, please refer to the appendix at the end of this manual.

You may quit from any screen, which will bring you back one level or screen, or you may exit (this exits the option entirely and returns you to the menu).

Common Actions
The following actions are common to more than one screen accessed through this option. They are listed here to avoid duplication of documentation.

Quick Edit - This action allows you to edit most of the fields in Claims Tracking, specify if there should be insurance or hospital reviews, add billing information, and assign the visit to a reviewer.

SC Conditions - This action allows a quick look at the patient's
eligibility, SC status, service-connected conditions, and percent of service connection for service-connected veterans.

Change Patient - This action allows you to change the selected patient without having to leave and reenter the option.

Diagnosis Update - This action allows input of ICD-9 diagnoses for the patient. Whether diagnoses are input on this screen or another screen, they are available across the Claims Tracking module. You may enter an admitting diagnosis, primary (DXLS) diagnosis, secondary diagnosis, and the onset of the diagnosis for this admission. For outpatient visits, this information is stored with the outpatient encounter information.

Procedure Update - This action allows the input of ICD-9 procedures for the patient. You may input the procedure and the date. This is a separate procedure entry from the PTF module and is optional for use.

Provider Update - This action allows you to input the admitting physician, attending physician, and care provider separate from the MAS information. The purpose is to provide a location to document the attending physician and to provide an alternate place to document actual physicians if the administrative record indicates teams or vice versa.

Change Status - This action allows you to quickly change the status of a review. Only completed reviews are used in the report preparation and by the MCCR NDB roll-up or the QM roll-up (which is tentatively scheduled for release in June, 1994).

Reviews have a status of ENTERED when automatically added. A status of PENDING may be used for those you are still working on or when one person does the data entry and another needs to review it.

Add Comment - This action allows you to edit the word processing (comments) field in Hospital or Insurance Reviews without having to edit other fields.

Review Worksheet Print - This action prints a worksheet for use on the wards for writing notes prior to calling the insurance company and entering the review. Basic information about the patient and the visit is included. Please note that the format is slightly different for 80 and 132 column outputs.

Contact Info - This action allows you to enter/edit the review date, person contacted, method of contact, phone and reference numbers.

View Pat. Ins. - This action takes you to the Patient Insurance Screens. Please refer to the Patient Insurance Menu documentation.

Following is a list of the screens, the actions they provide, and a brief description of each action.

Claims Tracking Editor Screen

Add Tracking Entry - This action can be used to add an entry to be tracked if it was not automatically added. This will most commonly be used to add old visits or to add scheduled admissions if you are not using the scheduled admission package. After installation, this action should be used to add past admissions for Quality Management required reviews.

Delete Tracking Entry - This action allows you to delete a tracking entry. If for some reason an entry was mistakenly added, use this action to delete the entry; however, if there is associated data with a review, it is preferable to inactivate the entry rather than delete it. Deleting a tracking entry will automatically delete all associated reviews.

Assign Case - This action allows you to assign a visit to a reviewer. This is useful in sorting pending reviews by the reviewer to whom they are assigned. Insurance and hospital reviews can be assigned separately.

Billing Info Edit - This action allows you to edit the billing information about expected revenues and next auto bill date. This is useful for comparing expected revenues versus what was received.

View/Edit Episode - This action allows you to jump to the Expanded Claims Tracking Screen where you can view data on a specific episode/visit and perform related actions.

Hospital Reviews - This action allows you to jump to the Hospital Reviews Screen. For details please refer to the Hospital Reviews option. This is not available on the Claims Tracking for Insurance Reviewers option.

Insurance Reviews - This action allows you to jump to the Insurance Reviews Screen. For details see the Insurance Reviews option. This is not available on the Claims Tracking for Hospital Reviewers option.

Appeals Edit - This action allows you to jump to the Appeals and Denials Screen. For details see the Appeals and Denials option.. Only denials and penalties may be appealed. This is not available on the Claims Tracking for Hospital Reviews option.

Change Date Range - This action allows you to change the default date range for the list of visits. Normally only the past year's visits are displayed, including any current admission. If you wish to view or take action on a visit outside of the current year, use this action to select the correct date range. Note that for inpatient care, the admission date is used.

Expanded Claims Tracking Entry Screen

Billing Info Edit - This action allows you to edit the billing information about expected revenues and next auto bill date. This is useful for comparing expected revenues versus what was received.

Review Info - This action allows you to review/edit whether or not a special consent release of information form (ROI) for this patient for this episode of care is required, obtained, or not necessary; and whether this review should be tracked as a random sample, insurance claim, special condition, or local addition.

Treatment Auth. - This action allows you to enter whether a second opinion for this patient insurance policy was required and obtained. (If a second opinion was obtained but did not meet the insurance company's criteria, enter NO in the SECOND OPINION OBTAINED field.) This field will be used to help determine the estimated reimbursement from the insurance carrier. If a second opinion was not obtained, certain denials and penalties may be assessed.

Hospital Reviews - This action accesses the Hospital Reviews Screen.

Insurance Reviews - This action accesses the Insurance Reviews/Contacts Screen.

Insurance Reviews/Contacts Screen

Add Ins. Review - This action will add a new review for the visit. Following are the default review types.

- Pre-certification Review (if it is a scheduled admission and no previous review)
- Urgent Admission review (if it is not a scheduled admission and no previous review)
- Continued Stay Review (for follow-up reviews)

Delete Ins. Review - This action allows an insurance review to be deleted. If a review is automatically created, but the visit does not require reviews and follow-up with the insurance company, it can be deleted. Use care in exercising this action. It can be as important to document that no review is required as it is to document the required reviews.

View/Edit Ins. Review - This action allows access to the Expanded Insurance Reviews Screen.

Appeals Edit - This action allows you to jump to the Appeals and Denials Screen. For details see the Appeals and Denials option. Only denials and penalties may be appealed. This action is not available on the Claims Tracking for Hospital Reviews option.

Expanded Insurance Reviews

Appeal Address - This action allows you to edit the appeals address information for the insurance company.

Ins. Co. Update - This action allows you to view/edit the billing, pre-certification, verification, claims, appeals, and inquiry phone numbers for the insurance company.

Action Info - This action allows you to view/edit information pertaining to action taken on a review such as type of contact, care authorization from and to dates, authorization number, and review date and status.

Hospital Reviews Screen

Add Next Hosp. Review - This action will add the next review and automatically set it to either an admission review or continued stay review. The day for review and review date are automatically computed but can be edited. The category of severity of illness and intensity of service that was met can be entered; or if not met, the reason it wasn't met.

Delete Review - This action allows a hospital review to be deleted. If a review is automatically created, but the visit does not require reviews and follow-up with the insurance company, it can be deleted. Use care in exercising this action. It can be as important to document that no review is required as it is to document the required reviews.

View/Edit Review - This action allows access to the Expanded Hospital Reviews Screen.

Expanded Hospital Reviews Screen

Review Information - This action allows you to enter/edit the type of review (admission or continued stay), review date, and the specialty and methodology for the review. There should be only one admission review (pre-certification or urgent/ emergent admission review) for an admission. Normally, reviews are done for UR purposes on days 3, 6, 9, 14, 21, 28, and every 7 days thereafter. (Usually, the INTERQUAL method is used as the methodology for UR required review. Insurance carriers may require other review methodologies.)

Criteria Update - This action allows you to enter or edit data regarding criteria met/not met for an acute admission within 24 hours, such as the review date and methodology; severity of illness and intensity of service; and whether additional reviews are required

Appeal and Denial Tracking Screen

View/Edit Entry - This action allows you to jump to the Expanded Appeal/Denial Screen where you can view much of the data for one visit and perform related actions.

Add Appeal - This action allows adding an appeal to a denial or penalty. The first appeal will be an initial appeal. All other appeals will be subsequent appeals. You may enter an administrative or clinical appeal. There is no limit to the number of appeals that may be entered.

Delete Appeal/Denial - This action allows deletion of appeals and denials. This was designed to be used in cases of erroneous entry.

Patient Ins. Edit - This action allows editing of fields in the Insurance Company file (#36) that pertain to appeals address and phone numbers.

Ins. Co. Edit - This action allows you to edit patient policy information.

Expanded Appeals/Denials Screen

Appeal Address - This action allows you to edit the name and address for a selected appeal.

Ins. Co. Update - This action allows you to view/edit the billing, pre-certification, verification, claims, appeals, and inquiry phone numbers for the insurance company.

Action Info - This action allows you to view/edit information pertaining to action taken on a review such as type of contact, care authorization from and to dates, authorization number, and review date and status.

Edit Pt. Ins. - This action brings you to the Patient Insurance Screen. Please refer to the Patient Insurance Menu section of this manual for documentation.

Sample Screens

```
Claims Tracking Editor        Feb 03, 1994 09:24:20          Page:    1 of    1
Claims Tracking Entries for: IBpatient,one     1111
    for Visits beginning on: 02/03/93 to 02/10/94
    Type      Urgent  Date             Ins.  UR    ROI          Bill  Ward
1   *ADMIT    NO      02/03/94 9:30 am YES   R     OBTAINED     NO    11-B MED




          Service Connected: 20%   Previous Spec. Bills: OWC                >>>
AT  Add Tracking Entry    HR  Hospital Reviews      DU  Diagnosis Update
DT  Delete Tracking Entry IR  Insurance Reviews     PU  Procedure Update
QE  Quick Edit            SC  SC Conditions         PV  Provider Update
AC  Assign Case           AE  Appeals Edit          VP  View Pat. Ins.
BI  Billing Info Edit     CP  Change Patient        EX  Exit
VE  View/Edit Episode     CD  Change Date Range
```

```
Claims Tracking Editor        Feb 03, 1994 09:26:18          Page:    0 of    0
Claims Tracking Entries for: IBpatient,one     1111
    for Visits beginning on: 02/03/93 to 02/10/94
    Type      Urgent  Date             Ins.  UR    ROI           Bill  Ward




          Service Connected: 20%    *=Current Admission                     >>>
AT  Add Tracking Entry    HR  Hospital Reviews      DU  Diagnosis Update
DT  Delete Tracking Entry IR  Insurance Reviews     PU  Procedure Update
QE  Quick Edit            SC  SC Conditions         PV  Provider Update
AC  Assign Case           AE  Appeals Edit          VP  View Pat. Ins.
BI  Billing Info Edit     CP  Change Patient        EX  Exit
VE  View/Edit Episode     CD  Change Date Range
```

```
Claims Tracking Editor        Feb 03, 1994 15:47:40          Page:    1 of    1
Claims Tracking Entries for: IBpatient,one     1111
    for Visits beginning on: 02/03/93 to 02/10/94
    Type      Urgent  Date              Ins.  UR    ROI           Bill  Ward
1   ADMIT     NO      02/03/94 9:30 am YES   R     OBTAINED      YES

          Service Connected: 20%   Previous Spec. Bills: OWC                >>>
AT  Add Tracking Entry    HR  Hospital Reviews      DU  Diagnosis Update
DT  Delete Tracking Entry IR  Insurance Reviews     PU  Procedure Update
QE  Quick Edit            SC  SC Conditions         PV  Provider Update
AC  Assign Case           AE  Appeals Edit          VP  View Pat. Ins.
BI  Billing Info Edit     CP  Change Patient        EX  Exit
VE  View/Edit Episode     CD  Change Date Range
```

```
Claims Tracking Editor        Feb 03, 1994 09:40:29          Page:    1 of    1
Claims Tracking Entries for: IBpatient,one     1111
    for Visits beginning on: 02/03/93 to 02/10/94
    Type      Urgent  Date              Ins.  UR    ROI           Bill  Ward
1   *ADMIT    NO      02/03/94 9:30 am YES   R     OBTAINED      YES   11-B MED

          Service Connected: 20%    *=Current Admission                     >>>
AT  Add Tracking Entry    HR  Hospital Reviews      DU  Diagnosis Update
DT  Delete Tracking Entry IR  Insurance Reviews     PU  Procedure Update
QE  Quick Edit            SC  SC Conditions         PV  Provider Update
AC  Assign Case           AE  Appeals Edit          VP  View Pat. Ins.
BI  Billing Info Edit     CP  Change Patient        EX  Exit
VE  View/Edit Episode     CD  Change Date Range
```

Print CT Summary for Billing

The Bill Preparation Report is designed to provide as much detailed information about a visit as possible for use by billers when entering claims, or answering questions about claims. It may also be of interest to MCCR and UR employees wishing to verify information entered into Claims Tracking.

The following types of summary information may be included.

- visit
- insurance
- billing
- eligibility
- diagnosis
- procedure
- provider
- insurance review
- hospital review

Sample Output

```
Bill Preparation Report                        Page 1  Feb 10, 1994@13:58:52

IBpatient,one                     000-11-1111          DOB: Jan 01, 1940
INPATIENT ADMISSION on Jan 13, 1994@09:30:35
-------------------------------------------------------------------------------
 Visit Information
    Visit Type: INPATIENT ADMISSION          Visit Billable: NO-NOT INSURED
Admission Date: JAN 13,1994@09:30:35         Second Opinion: NOT REQUIRED
          Ward: 11-B MEDICINE XREF           Auto Bill Date:
     Specialty: MEDICINE                    Special Consent: ROI OBTAINED
Discharge Date:                             Special Billing:
    ---------------------------------------------------------------------------

  Insurance Information
     Ins. Co 1: ABC INS                      Pre-Cert Phone: 555-432-4312
             Subsc.: IBpatient,one                     Type: MAJOR MEDICAL EXPE
          Subsc. ID: 000111111                       Group: 4446333
          Coord Ben:                          Billing Phone: 555-678-6568
     Filing Time Fr:                           Claims Phone: 000-444-5656
Group Plan Comments:
                              ----------------------------------
    ---------------------------------------------------------------------------

  Billing Information
  Initial Bill: N10090                 Estimated Recv (Pri): $
   Bill Status: ENTERED/NOT RE         Estimated Recv (Sec): $
 Total Charges: $        0             Estimated Recv (ter): $
   Amount Paid: $        0               Means Test Charges: $
Reason Not Billable: NOT INSURED
Additional Comment:
    ---------------------------------------------------------------------------

  Eligibility Information
```

```
       Primary Eligibility: SC LESS THAN 50%
         Means Test Status:
 Service Connected Percent: 20%

     Service Connected Conditions:
     NONE STATED




    ------------------------------------------------------------------------


Bill Preparation Report                        Page 2  Feb 10, 1994@13:58:52

IBpatient,one                     000-11-1111           DOB: Jan 01, 1940
INPATIENT ADMISSION on Jan 13, 1994@09:30:35
-------------------------------------------------------------------------------
  Diagnosis Information

  1  101.0     VINCENTS ANGINA          01/13/94    ADMITTING
    ------------------------------------------------------------------------

  Procedure Information

  1  89.44     CARDIAC STRESS TEST NEC                      01/13/94
    ------------------------------------------------------------------------

  Provider Information

  1  IBprovider,one                 01/13/94            ADMITTING
    ------------------------------------------------------------------------


Bill Preparation Report                        Page 3  Feb 10, 1994@13:58:52

IBpatient,one                     000-11-1111           DOB: Jan 01, 1940
INPATIENT ADMISSION on Jan 13, 1994@09:30:35
-------------------------------------------------------------------------------
    ------------------------------------------------------------------------

  Insurance Review Information
    Type Review: URGENT/EMERGENT ADMIT       Review Date: 02/03/94
         Action: APPROVED                  Insurance Co.: ABC
Authorized From: 02/03/94               Person Contacted: SPOUSE
  Authorized To: 02/08/94                 Contact Method: VOICE MAIL
Authorized Diag: 101.0 - VINCENTS ANG D Call Ref. Number: 8995444a
   Auth. Number: 8995444a                          Status: COMPLETE
                                         Last Edited By: EMPLOYEE
Comment:
                              -----------------------------------

    Type Review: INITIAL APPEAL              Review Date: 01/17/94
    Appeal Type: CLINICAL                  Insurance Co.: ABC
    Case Status: PENDING                Person Contacted: JOHN
No Days Pending: 10                       Contact Method: MAIL
  Final Outcome:                        Call Ref. Number:
                                                   Status: ENTERED
                                         Last Edited By: EMPLOYEE
Comment:
```

```
                              -----------------------------------

    Type Review: CONTINUED STAY REVIEW       Review Date: 01/15/94
         Action: DENIAL                    Insurance Co.: ABC
    Denied From: 01/21/94               Person Contacted: SPOUSE
      Denied To: 01/31/94                 Contact Method: PHONE
 Denial Reasons: TREATMENT PROVIDED NOT Call Ref. Number:
                                                  Status: PENDING
                                          Last Edited By: EMPLOYEE
Comment:
                              -----------------------------------

  Hospital Review Information
     Review Date: 01/15/94                 Day of Review:  3
     Review Type: CONTINUED STAY REVIEW  Severity of Ill: GENERIC
       Specialty: MEDICINE              Intensity of Svc: GENERIC
     Methodology: INTERQUAL             Dschg Screen Met:
          Status: ENTERED               Acute Care Dschg:
  Last Edited By: EMPLOYEE
Next Review Date: 02/06/94
Comment:


                              -----------------------------------


Bill Preparation Report                        Page 4  Feb 10, 1994@13:58:52

IBpatient,one                     000-11-1111           DOB: Jan 01, 1940
INPATIENT ADMISSION on Jan 13, 1994@09:30:35
-------------------------------------------------------------------------------
    ---------------------------------------------------------------------------

     Review Date: 01/14/94                 Day of Review:  2
     Review Type: CONTINUED STAY REVIEW  Severity of Ill: GENERIC
       Specialty: MEDICINE              Intensity of Svc: GENERIC
     Methodology: INTERQUAL             Dschg Screen Met:
          Status: ENTERED               Acute Care Dschg:
  Last Edited By: EMPLOYEE
Next Review Date:
Comment:

                              -----------------------------------

     Review Date: 01/13/94               Severity of Ill: GENERIC
     Review Type: ADMISSION REVIEW      Intensity of Svc: GENERIC
       Specialty: MEDICINE                  Criteria Met: YES
     Methodology: INTERQUAL              Prov. Intervwed:
          Status: ENTERED                Dec. Influenced:
  Last Edited By: EMPLOYEE
Next Review Date:
Comment:

                              -----------------------------------
```

Assign Reason Not Billable

This option allows you to flag an inpatient or outpatient visit, or Rx refill as billable or non-billable by assigning a Reason Not Billable. If there is no Reason Not Billable assigned, the billing information can be entered into Claims Tracking for the visit.

Third Party Joint Inquiry

This option provides information needed to answer questions from insurance carriers regarding specific bills or episodes of care. This information is presented in List Manager Screens.

Because the same actions are available on most screens, and most screens can be accessed from any other screen; these "Common Actions" are listed first and are not repeated under each screen description. Only actions specific to a screen are included with that screen description.

You may QUIT from any screen, which will bring you back one level or screen. EXIT is also available on most screens. EXIT returns you to the menu. For more information on the use of the List Manager utility, please refer to the appendix at the end of this manual.

Common Actions

BC Bill Charges - Accesses the Bill Charges screen.

DX Bill Diagnoses - Accesses the Bill Diagnoses screen.

PR Bill Procedures - Accesses the Bill Procedures screen.

CI Go to Claim Screen - Returns you to the Claim Information screen. Available on all screens that may be opened from the Claim Information screen.

AR Account Profile - Accesses the AR Account Profile screen.

CM Comment History - Accesses the AR Comment History screen.

IR Insurance Reviews - Accesses the Insurance Reviews/ Contacts screen.

HS Health Summary - Displays a Health Summary report. The information displayed on the Health Summary is site specified through the MCCR Site Parameter Display/Edit option.

AL Go to Active List - Returns you to the Third Party Active Bills screen if that screen was accessed upon entering this option; otherwise, this action returns you to the menu.

VI Insurance Company - Accesses the Insurance Company screen.

VP Policy - Accesses the Patient Policy Information screen.

AB Annual Benefits - Accesses the Annual Benefits screen.

EL Patient Eligibility - Accesses the Patient Eligibility screen.

Third Party Active Bills Screen
This is the first screen displayed if you enter a patient name at the first prompt of this option. It lists all active third party bills for the specified patient in order of date created. All bills created in the Integrated Billing Third Party Billing module can be found on this screen or the Inactive Bills screen.

Actions
IL Inactive Bills - Accesses the Inactive Bills screen.

PI Patient Insurance - Accesses the Patient Insurance screen.

CP Change Patient - Allows you to choose another patient and re-displays the Third Party Active Bills screen for that patient.

Inactive Bills Screen
This screen lists inactive bills for a specified patient. All bills created in the Integrated Billing Third Party Billing module are found on this screen or the Third Party Active Bills screen. Bills are displayed beginning with most recent “statement from” date.

Actions
CD Change Dates - Allows you to change the bills listed by
changing the most recent “statement from” date to be displayed.

Patient Insurance Screen
This screen displays the list of insurance policies for a patient. It is based on the Patient Insurance Management screen of the Patient Insurance Info View/Edit option. It is only available from the Third Party Active Bills screen.

Claim Information Screen
This screen contains bill data and status information to provide an overall status of the bill. This is the primary claim screen for the inquiry, and many actions are provided to expand on the details of the claim.

If a policy has been updated but the bill has not, those changes are not reflected on this screen. Updated or current insurance information may be viewed using the three insurance screens.

Actions
CB Change Bill - Allows you to change the bill being displayed. If you entered a patient name at the first prompt of this option, only bills for that patient may be selected. If you entered a bill number at the first prompt, any bill may be selected.

Bill Charges Screen
This screen displays a bill's charge information as it would print on the bill. For UB-92 bills, this closely corresponds to Form Locators 42-49; therefore, any prosthetic items, Rx refills, or additional diagnoses and procedures are included. For HCFA 1500 bills, this closely corresponds to Block 24.

Bill Diagnosis Screen
This screen displays all diagnoses assigned to the bill, in the order they are printed on the bill.

Bill Procedures Screen
This screen lists all procedures assigned to a bill, in the order they are printed on the bill.

AR Account Profile Screen
This screen provides the financial history of a claim's account. This includes the current status of the bill in both IB and AR, as well as the payment or transaction history of the bill from Accounts Receivable. This screen is loosely based on the Profile of Accounts Receivable option.

Actions
VT Transaction Profile - Accesses the AR Transaction Profile screen for a selected transaction.

AR Transaction Profile Screen
This screen displays detailed account transaction information for individual claim transactions. It is loosely based on the Accounts Receivable Transaction Profile option.

AR Comment History Screen
This screen displays AR comments for the claim's account.

Actions
AD Add AR Comment - Allows you to add an AR Transaction Comment to the bill being displayed. Comment transactions may not be added to a bill that has not been authorized in IB.

Insurance Reviews/Contacts Screen
This screen displays all insurance reviews and contacts for the episodes of care on a bill. It is based on the Insurance Reviews/Contacts screen of the Claims Tracking Insurance Review Edit option. The primary difference between the two screens is that this screen consolidates all contacts for each episode being billed on a claim, while the Claims Tracking screen displays the contacts for a single episode of care.

Actions
VR Reviews/Appeals - Displays expanded information on a selected insurance contact. The screen accessed by this action will depend on the type of contact selected. If the contact is an appeal or denial, the Expanded Appeals/Denials screen is opened; otherwise, the Expanded Insurance Reviews screen is opened.

Expanded Appeals/Denials Screen
This screen displays expanded information on insurance appeals and denials listed on the Insurance Review/Contacts screen. This screen is based on the Expanded Appeals/Denials screen of the Claims Tracking Appeal/Denial Edit option.

Expanded Insurance Reviews Screen
This screen displays expanded information on insurance reviews listed on the Insurance Reviews/Contacts screen. This screen is based on the Expanded Insurance Reviews screen of the Claims Tracking Insurance Review Edit option.

Insurance Company Screen
This screen displays extended information on an Insurance Company. It is based on the Insurance Company Editor screen of the Insurance Company Entry/Edit option. This screen may be entered from the Patient Insurance screen or from any of the bill specific screens. Once a bill is selected, this screen displays only information related to the insurance carriers assigned to that bill.

Patient Policy Information Screen
This screen displays extended information on insurance policies. It is based on the Patient Policy Information screen of the Patient Insurance Info View/Edit option. This screen may be entered from either the Patient Insurance screen or from any of the bill specific screens. Once a bill is selected, this screen will only display information related to the insurance policies assigned to the bill.

Annual Benefits Screen
This screen displays extended information on the annual benefits of insurance policies. It is based on the Annual Benefits Editor screen of the Patient Insurance Info View/Edit option. This screen may be entered from the Patient Insurance screen or from any of the bill specific screens. Once a bill has been chosen, this screen displays information related to the insurance policies assigned to that bill.

Patient Eligibility Screen
This screen displays the current information on the patient's eligibility for care and service connection status. It is loosely based on the Eligibility Inquiry for Patient Billing option. This screen is available from the Third Party Active Bills screen and the bill specific screens.

If this screen is accessed from one of the bill specific screens, such as the Claim Information screen, the standard list of bill screen actions will be available from this screen.

If this screen is accessed from the Patient Insurance screen, no other screens are available as actions from this screen; and you must return to a previous screen to access other screens.

Sample Screens

```
Third Party Active Bills          May 31, 1995 @10:07:11                    Page 1 of 1
IBpatient,one          1111                                                       NSC
Bill #        From       To         Type   Stat Rate        Insurer    Orig Amt Curr Amt
1  T10263     04/20/92   04/20/92   OP     BI   REIM INS      HEALTH       0.00     0.00
2  T10270     04/20/92   04/24/92   OP     PC   REIM INS      HEALTH     698.30   698.30
3  T10072 *   11/16/93   11/17/93   OP     N    REIM INS    + HEALTH     199.00   199.00
4  T10094     02/16/94   02/16/94   OP     PC   REIM INS    + HEALTH     196.00   196.00
5  T10123 *   03/01/94   03/15/94   OP     BI   REIM INS    + HEALTH       0.00     0.00
6  T10150 *   03/14/94   03/15/94   OP     BI   REIM INS    + ABC          0.00     0.00
7  T10173 *   03/02/94   03/03/94   OP     BI   REIM INS      ABC          0.00     0.00
8  T10174 *   03/06/94   03/07/94   OP     N    REIM INS      ABC        356.00   356.00
9  T10222     05/01/94   05/31/94   IP-F   BI   REIM INS      HEALTH       0.00     0.00
10 T10236     06/01/94   06/05/94   IP-L   BI   REIM INS      HEALTH       0.00     0.00
11 T10273 *   03/03/94   03/31/94   IP-F   A    REIM INS    + HEALTH   11221.00   856.45
12 T10275     08/30/94   09/30/94   IP     BI   REIM INS      ABC          0.00     0.00
+         | * Cat C Charges on Hold | + 2nd/3rd Carrier |
CI  Claim Information     IL  Inactive Bills        PI  Patient Insurance
CP  Change Patient        HS  Health Summary        EL  Patient Eligibility
Select Action: Next Screen//
```

```
Inactive Bills                 May 17, 1996 13:30:26                 Page:    1 of    2
IBpatient,one          1111                                  ** All Inactive Bills **  (9)
Bill #       From        To          Type   Stat Rate        Insurer  Orig Amt   Curr Amt
1  T10397    06/01/94    06/05/94    IL-L   CC   REIM INS    + ABC      935.00       0.00
2  T10198    06/01/94    06/05/94    IP-L   CB   REIM INS    + HEALTH     0.00       0.00
3  T10212    05/07/94    05/12/94    IP-C   CB   REIM INS      HEALTH     0.00       0.00
4  T10148 *  03/02/94    03/03/94    OP     CB   REIM INS                 0.00       0.00
5  T10162 *  03/02/94    03/03/94    OP     CB   REIM INS                 0.00       0.00
6  T10095    02/16/94    02/16/94    OP     CB   REIM INS                 0.00       0.00
7  T10260    04/14/92    04/20/92    OP-F   CB   REIM INS      ABC     1026.02    1026.02
8  T00389    02/08/90    02/08/90    OP     CC   REIM INS      BC/BS     26.00       0.00
9  T0036A    02/07/90    02/07/90    OP     CC   REIM INS      BC/BS     26.00       0.00
+         |* Cat C Charges on Hold |+ 2nd/3rd Carrier |
CI  Claim Information     AL  Go to Active List     CD  Change Dates
                                                    EX  Exit Action
Select Action: Next Screen//
```

```
Claim Information              May 17, 1996 13:44:58          Page:    1 of    2
N10072   IBpatient,one      1111            DOB: 5/22/50   Subsc ID: 000111111

      Insurance Demographics                    Subscriber Demographics
  Carrier Name:  HEALTH INS LIMITED          Group Number:  GN 48923222
 Claim Address:  789 3RD STREET                Group Name:
                 ALBANY, NY 44438           Subscriber ID:  000111111
   Claim Phone:  333-444-5676                    Employer:  Snow Movers
                                            Insured's Name:  IBpatient,one
                                             Relationship:  PATIENT

                              Claim Information
     Bill Type:  OUTPATIENT                Service Dates:  11/16/93 - 11/17/93
    Time Frame:  ADMIT THRU DISCHARGE CLAIM Date Entered:  12/23/93
     Rate Type:  REIMBURSABLE INS             Orig Claim:  199.00
     AR Status:  NEW BILL                    Balance Due:  199.00
     Secondary:  ABC

       Entered:  12/23/93  by   John
    Authorized:  01/04/94  by   Jane
 First Printed:  01/04/94  by   Jane
  Last Printed:  04/01/94  by   Deb
+         Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CB  Change Bill           HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Next Screen//
```

```
Patient Insurance              May 31, 1995 @10:07:11        Page 1 of   1
Insurance Management for Patient: IBpatient,one         1111
  Insurance Co.    Type of Policy  Group        Holder   Effect.    Expires
1 HEALTH INS LTD                  GN 48923222  SELF     01/01/87
2 ABC              MAJOR MEDICAL  AE 76899354  SPOUSE   10/1/90    19/30/95
3 XYZ INS          INDEMNITY      T109         OTHER    10/1/94    01/01/95
4 BC/BS            MAJOR MEDICAL  GN 392043    SELF     01/01/90   12/31/92


VI  Insurance Company          VP Policy         AB  Annual Benefits
AL  Go to Active List                            EX  Exit Action
Select Action: Quit//
```

```
Bill Charges                    May 31, 1995 @10:07:11              Page 1 of 1
N10072  IBpatient,one      1111 DOB: 5/22/50            Subsc ID: 000111111
11/16/93 - 11/17/93        ADMIT THRU DISCHARGE         Orig Amt:    199.00
_____________________________________________________________________________

      OUTPATIENT VISIT
500   OUTPATIENT SVS        178.00         1                178.00
      PRESCRIPTION
257   DRGS/NONSCRPT          21.00         1                 21.00

001   TOTAL CHARGE                                          199.00

      OP VISIT DATE(S) BILLED:        NOV 16, 1993

      PRESCRIPTION REFILLS:
      30948          NOV 17, 1993     ABBOCATH-T 18G 1.25 IN
                                      QTY: 20 for 10 days supply

Bill Remark:  This is a demonstration bill created for Joint Billing Inquiry.
_____________________________________________________________________________
          Enter ?? for more actions
_____________________________________________________________________________
DX  Bill Diagnosis        AR  Account Profile       VI  Insurance Company
PR  Bill Procedures       CM  Comment History       VP  Policy
CI  Go to Claim Screen    IR  Insurance Reviews     AB  Annual Benefits
                          HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Bill Charges                    May 31, 1995 @10:07:11              Page 1 of 1
N10273  IBpatient,one      1111 DOB: 5/22/50    Subsc ID:  000111111
03/02/94 - 03/31/94        INTERIM - FIRST CLAIM        Orig Amt: 11221.00
_____________________________________________________________________________

30 DAYS INPATIENT CARE
      INTERMEDIATE CARE
101   ALL INCL R&B          246.00         30              7380.00
240   ALL INCL ANCIL         48.00         30              1440.00
960   PRO FEE                49.00         30              1470.00
274   PROSTH/ORTH DEV       931.00         1                931.00

001   TOTAL CHARGE                                         11221.00

      PROSTHETIC ITEMS:
      Sep 18, 1994  WHEELCHAIR
      Sep 21, 1994  CANE-ALL OTHER
_____________________________________________________________________________
          Enter ?? for more actions
_____________________________________________________________________________
DX  Bill Diagnosis        AR  Account Profile       VI  Insurance Company
PR  Bill Procedures       CM  Comment History       VP  Policy
CI  Go to Claim Screen    IR  Insurance Reviews     AB  Annual Benefits
                          HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Bill Diagnosis                  May 17, 1996 14:07:56          Page:    1 of    1
N10072   IBpatient,one      1111          DOB: 5/22/50      Subsc ID: 000111111
 11/16/93 - 11/17/93        ADMIT THRU DISCHARGE CLAIM   Orig Amt:    199.00

       1)  490.    BRONCHITIS NOS
       2)  030.1   TUBERCULOID LEPROSY
       3)  101.    VINCENT'S ANGINA
       4)  330.1   CEREBRAL LIPIDOSES
       5)  461.0   AC MAXILLARY SINUSITIS
       6)  310.0   FRONTAL LOBE SYNDROME
       7)  200.01  RETICULOSARCOMA HEAD

          Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
PR  Bill Procedures       CM  Comment History       VP  Policy
CI  Go to Claim Screen    IR  Insurance Reviews     AB  Annual Benefits
                          HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Bill Procedures                 May 17, 1996 14:12:58          Page:    1 of    1
N10072   IBpatient,one      1111          DOB: 5/22/50      Subsc ID: 000111111
 11/16/93 - 11/17/93        ADMIT THRU DISCHARGE CLAIM   Orig Amt:    199.00

 11000   SURGICAL CLEANSING OF SKIN      11/16/93
 11001   ADDITIONAL CLEANSING OF SKIN    11/16/93
 12001   REPAIR SUPERFICIAL WOUND(S)     11/16/93

          Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
CI  Go to Claim Screen    IR  Insurance Reviews     AB  Annual Benefits
                          HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
AR Account Profile              May 31, 1995 @10:07:11         Page:    1 of    1
N10273   IBpatient,one      1111          DOB: 5/22/50   Subsc ID:  000111111
AR Status: ACTIVE         Orig Amt:    11221.00       Balance Due:  856.45

            04/01/94      IB Status:  Printed  (Last)      11221.00  11221.00
1   1578    05/07/94      PAYMENT (IN PART)                 7856.21   3364.79
2   1598    07/07/94      PAYMENT (IN PART)                 2508.34    856.45
3   1601    07/08/94      COMMENT                              0.00    856.45

    Total Collected:  10364.55
    Percent Collected:    92.37%
          Enter ?? for more actions
BC  Bill Charges          VT  Transaction Profile   VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
AR Transaction Profile        May 31, 1995 @10:07:11                Page 1 of 1
N10273  IBpatient,one      1111 DOB: 5/22/50             Subsc ID:  000111111
AR Status:  ACTIVE             Orig Amt:    11221.00   Balance Due:  856.45

      TRANS. NO:  1578               TRANS. TYPE:  PAYMENT (IN PART)
    TRANS. DATE:  05/07/94           DATE POSTED:  05/10/94    (ARH)
  TRANS. AMOUNT:  7856.21              RECEIPT #:  D2982398

                                       BALANCE    COLLECTED
                                 ------------- ---------------
                  PRINCIPLE:          3364.79      7856.21
                  INTEREST:              0.00         0.00
                  ADMINISTRATIVE:        0.00         0.00
                  MARSHALL FEE:          0.00         0.00
                  COURT COST:            0.00         0.00
                                     --------    ---------
                  TOTAL:              3364.79      7856.21

       FY:  94            PR AMT: 3364.79            FY TR AMT: 7856.21

COMMENTS:   Date of Deposit: MAY 10, 1994

          Enter ?? for more actions
CI  Go to Claim Screen          AL Go to Active List        EX Exit Action
Select Action: Quit//
```

```
AR Comment History            May 17, 1996 14:21:37         Page:    1 of    1
L10260   IBpatient,one         1111        DOB: 5/22/50    Subsc ID:  AH33334
AR Status:  CANCELLED          Orig Amt: 1026.02       Balance Due: 1026.02

1582  04/21/92  Copy of bill sent.                FOLLOW-UP DT:  05/12/92
                Carrier did not receive initial bill.

1594  05/20/92  Bill canceled, wrong form type.   FOLLOW-UP DT:  06/01/92
                Carrier refuses to process this type of bill on a UB-92.
                They are requiring the HCFA 1500 form.

          Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        AD  Add AR Comment        VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Insurance Reviews/Contacts     May 31, 1995 @10:07:11        Page:    1 of    1
Insurance Review Entries for:  N10072     IBpatient,one         1111
    Date       Ins. Co.           Type Contact       Action    Auth. No.  Days

    OUTPATIENT VISIT of AMBULATORY SURGERY OFFICE on 11/16/93
1   11/30/93   HEALTH INS LIMITED  1st Appeal-Clin    APPROVED  AU 39824
2   11/17/93   HEALTH INS LIMITED  OPT                DENIAL               0

    PRESCRIPTION REFILL of 30948 on 11/17/93
3   11/17/93   HEALTH INS LIMITED  OPT                APPROVED  RN 9384222

         Service Connected: NO   Previous Spec. Bills: TORT                >>>
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       VR  Reviews/Appeals       AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Expanded Appeals/Denials      May 31, 1995 @10:07:11              Page 1 of  2
Insurance Appeal/Denial for: IBpatient,one         1111 ROI: NOT REQUIRED

           Visit Information                Action Information
        Visit Type:  OUTPATIENT VISIT       Type Contact:  INITIAL APPEAL
        Visit Date:  03/09/94 9:00 am        Appeal Type:  CLINICAL
            Clinic:  AMBULATORY SURGERY      Case Status:  OPEN
      Appt. Status:  CHECKED OUT         No Days Pending:
        Appt. Type:  REGULAR               Final Outcome:
      Special Cond:
          Clinical Information            Appeal Address Information
           Provider:                     Ins. Co. Name:  HEALTH INS LIMITED
           Provider:                    Alternate Name:
          Diagnosis:                     Street line 1:  HIL - APPEALS OFFICE
          Diagnosis:                     Street line 2:  1099 THIRD AVE, SUITE
      Special Cond:                      Street line 3:
                                        City/State/Zip:  TROY, NY  12345
                     Insurance Policy Information
    Ins. Co. Name:  HEALTH INS LIMITED   Subscriber Name:  IBpatient,one
     Group Number:  GN 48923222            Subscriber ID:  000111111
  Whose Insurance:  VETERAN               Effective Date:  01/01/87
   Pre-Cert Phone:  444-444-444 E        Expiration Date:

    User Information                     Contact Information
      Entered By:  EMPLOYEE               Contact Date:  04/01/94
      Entered On:  11/16/93 3:30 pm   Person Contacted:  SPOUSE
  Last Edited By:                       Contact Method:  PHONE
  Last Edited On:                     Call Ref. Number:  RN 3320944
                                           Review Date:  06/02/95
 Comments
 Policy should cover treatment.
 Service Connected Conditions:
 Service Connected: NO
 NO SC DISABILITIES LISTED
          Enter ?? for more actions                                          >>>
CI  Go to Claim Screen       AL Go to Active List    EX Exit Action
Select Action: Quit//
```

```
Expanded Insurance Reviews    May 31, 1995 @10:07:11            Page 1 of   2
Insurance Review Entries for:                IBpatient,one     1111     ROI:
NOT REQUIRED

   Contact Information                    Action Information
     Contact Date:  11/17/93          Type Contact:  OUTPATIENT TREATMEN
 Person Contacted:  Steve            Opt Treatment:  RX REFILL
   Contact Method:  PHONE                   Action:  APPROVED
 Call Ref. Number:  RN 9384222        Auth. Number:  RN 9384222
      Review Date:  06/02/95

                       Insurance Policy Information
  Ins. Co. Name:  HEALTH INS LIMITED  Subscriber Name:  IBpatient,one
   Group Number:  GN 48923222           Subscriber ID:  000111111
Whose Insurance:  VETERAN              Effective Date:  01/01/87
 Pre-Cert Phone:  933-3434            Expiration Date:

   Appeal Address Information           User Information
  Ins. Co. Name:  HEALTH INS LIMITED             Entered By: EMPLOYEE
 Alternate Name:                                 Entered On: 11/17/93 12:54 pm
  Street line 1:  HIL - APPEALS OFFICE       Last Edited By: EMPLOYEE
  Street line 2:  1099 THIRD AVE, SUITE 301  Last Edited On: 11/20/93 12:55 pm
  Street line 3:
 City/State/Zip:  TROY, NY 12345

 Comments
 One refill of prescription approved.

 Service Connected Conditions:
 Service Connected: NO
 NO SC DISABILITIES LISTED
          Enter ?? for more actions                                      >>>
CI  Go to Claim Screen        AL Go to Active List          EX Exit Action
Select Action: Quit//
```

```
Insurance Company            May 17, 1996 15:25:42          Page:    1 of    5
Insurance Company Information for: HEALTH INS LIMITED                  Primary
Type of Company: HEALTH INSURANCE                     Currently Active

                          Billing Parameters
 Signature Required?:  YES              Attending Phys. ID:  AT PH ID VAH500000
          Reimburse?:  WILL REIMBURSE   Hosp. Provider No.:
   Mult. Bedsections:  YES               Primary Form Type:
    Diff. Rev. Codes:                        Billing Phone:
      One Opt. Visit:  NO               Verification Phone:
 Amb. Sur. Rev. Code:                   Precert Comp. Name:  ABC INSURANCE
 Rx Refill Rev. Code:                        Precert Phone:  444-444-4444
   Filing Time Frame:

                         Main Mailing Address
             Street:  2345 CENTRAL AVENUE      City/State:  ALBANY, NY 12345
           Street 2:  FREAR BUILDING                Phone:  555-1234
           Street 3:                                  Fax:  555-4884

               Inpatient Claims Office Information
             Street:  2345 CENTRAL AVENUE      City/State:  ALBANY, NY 12345
           Street 2:  FREAR BUILDING                Phone:  555-0392
           Street 3:                                  Fax:  555-4432

              Outpatient Claims Office Information
             Street:  789 3RD STREET           City/State:  ALBANY, NY 12345
           Street 2:                                Phone:  333-444-5676
           Street 3:                                  Fax:  333-444-9245
```

```
               Prescription Claims Office Information
   Company Name:  GHI PROCESSING             Street 3:
         Street:  1933 CORPORATE DRIVE     City/State:  RIVERSIDE, NY 39332
       Street 2:  TANGLEWOOD PARK               Phone:  339-0000
            Fax:

                     Appeals Office Information
         Street:  HIL - APPEALS OFFICE     City/State:  TROY, NY 12345
       Street 2:  1099 THIRD AVE, SUITE 301     Phone:  555-1923
       Street 3:                                  Fax:  555-5464

                     Inquiry Office Information
         Street:  2345 CENTRAL AVENUE      City/State:  ALBANY, NY 12345
       Street 2:  FREAR BUILDING                Phone:  555-1923
       Street 3:                                  Fax:  555-5336

  Remarks

  Synonyms

          Enter ?? for more actions                                      >>>
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Patient Policy Information    May 31, 1995 @10:07:11      Page:     1 of    3
Extended Policy Information for:   IBpatient,one       000-11-1111
Primary
HEALTH INS LIMITED Insurance Company              ** Plan Currently Active **

 Plan Information                                Insurance Company
    Is Group Plan: YES                              Company: HEALTH INS LIMITED
       Group Name:                                   Street: 2345 CENTRAL AVE
     Group Number: GN 48923222                   City/State: ALBANY, NY 12180
     Type of Plan: DUAL COVERAGE                 Billing Ph:
   Plan Filing TF:                               Precert Ph:


  Utilization Review Info                     Effective Dates & Source
          Require UR: YES                         Effective Date: 01/01/94
    Require Amb Cert:                            Expiration Date:
    Require Pre-Cert: YES                         Source of Info: INTERVIEW
    Exclude Pre-Cond: NO                     Policy Not Billable: NO

 Subscriber Information                    Subscriber's Employer Information
  Whose Insurance: VETERAN                Emp Sponsored Plan: No

+         Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Annual Benefits                May 17, 1996 15:39:23        Page:    1 of    3
Annual Benefits for: GHI Ins. Co                                        Primary
             Policy: GN 48923222              Ben Yr:  MAR 01, 1993
                          Policy Information
                Max. Out of Pocket: $  500
             Ambulance Coverage (%):     85 %

                             Inpatient
        Annual Deductible:  $ 500         Drug/Alcohol Lifet. Max: $
    Per Admis. Deductible:  $ 100         Drug/Alcohol Annual Max: $
       Inpt. Lifetime Max:  $                    Nursing Home (%):
         Inpt. Annual Max:  $             Other Inpt. Charges (%):
         Room & Board (%):

                            Outpatient
        Annual Deductible:  $ 50                      Surgery (%):
     Per Visit Deductible:  $ 50                    Emergency (%):        85%
             Lifetime Max:  $                    Prescription (%):        80%
               Annual Max:  $              Adult Day Health Care?: UNK
                Visit (%):                       Dental Cov. Type: PERCENTAGE AMOU
      Max Visits Per Year:                        Dental Cov. (%): 48%

        Mental Health Inpatient                Mental Health Outpatient
    MH Inpt. Max Days/Year:                  MH Opt. Max Days/Year:
     MH Lifetime Inpt. Max:  $                MH Lifetime Opt. Max: $
       MH Annual Inpt. Max:  $                  MH Annual Opt. Max: $
   Mental Health Inpt. (%):                 Mental Health Opt. (%):

         Home Health Care                           Hospice
               Care Level:                     Annual Deductible: $
            Visits Per Year:                 Inpatient Annual Max.: $
        Max. Days Per Year:                          Lifetime Max.: $
        Med. Equipment (%):                     Room and Board (%):
          Visit Definition:                Other Inpt. Charges (%):

           Rehabilitation                         IV Management
           OT Visits/Yr:                     IV Infusion Opt?: UNK
           PT Visits/Yr:                    IV Infusion Inpt?: UNK
           ST Visits/Yr:                  IV Antibiotics Opt?: UNK
    Med Cnslg. Visits/Yr:                IV Antibiotics Inpt?: UNK

           User Information
             Entered By: EMPLOYEE
             Entered On: 02/02/94
         Last Updated By: EMPLOYEE
         Last Updated On: 02/18/94

          Enter ?? for more actions                                        >>>
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Patient Eligibility          May 20, 1996 07:45:44         Page:    1 of    1
N10273   IBpatient,one      1111         DOB: 07/07/50   Subsc ID:

             Means Test: CATEGORY A                      Insured: Yes
           Date of Test: 08/24/94                   A/O Exposure:
  Co-pay Exemption Test:                           Rad. Exposure:
           Date of Test:

     Primary Elig. Code: NSC
    Other Elig. Code(s): EMPLOYEE
                         AID & ATTENDANCE
      Service Connected: No
     Rated Disabilities: BONE DISEASE (0%-NSC)
                         DEGENERATIVE ARTHRITIS (40%-NSC)



          Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EX  Exit Action
                          AL  Go to Active List
Select Action: Quit//
```

Enter/Edit Billing Information

The IB EDIT security key is required to access this option.

The Enter/Edit Billing Information option is used to enter the information required to generate a third party bill and to edit existing billing information. A new bill can be entered or an existing bill can be edited, as long as the existing bill has not been authorized or cancelled. Once a bill has been filed (billing record number established), it cannot be deleted. The bill can be cancelled through the Cancel Bill option.

If the selected patient's eligibility has not been verified and the ASK HINQ IN MCCR parameter is set to YES, the user will have the opportunity to enter a HINQ (Hospital Inquiry) request into the HINQ Suspense File. This request will be transmitted to the Veterans Benefits Administration to obtain the patient's eligibility information. If Means Test data such as category, Means Test last applied, and date Means Test completed is available, it will be displayed after the patient name or bill number has been entered.

When entering a new bill, the system will prompt for EVENT DATE. When billing for multiple outpatient visits, the date of the initial visit is used. For an inpatient bill, the date of the admission is used. If an interim bill is being issued, the EVENT DATE should be the date of admission for that episode of care.

The Medical Care Cost Recovery data is arranged so that it can be viewed and edited through various screens. The data is grouped into sections for editing. Each section is labeled with a number to the left of the data items. Data group numbers enclosed by brackets ([ ]) can be edited while those enclosed by arrows (< >) cannot. The patient's name, social security number, bill number, the bill classification (Inpatient or Outpatient) and the screen number appear at the top of every screen. A <?> entered at the prompt which appears at the bottom of every screen will provide you with a HELP SCREEN for that particular screen. The HELP SCREEN lists the data groups found on that screen, and provides the name and number of each available screen in the option. Please see the Supplement at the end of this section for descriptions and samples of the billing screens.

The bill mailing address appears on this screen. Please see the Supplement at the end of this section for important information on how this is determined.

When insurance companies are entered into the INSURANCE COMPANY file, the system prompts for whether or not this company will reimburse VA for the cost of the patient's care. Entry of an insurance company that has been designated as "will not reimburse" is not allowed at this screen. For bills where the payer is the insurance company and the patient has <u>one</u> insurance company that will reimburse the government, that company will be stored as the primary insurance company. Inactivating the insurance company has no effect on the insurance carriers associated with the bill.

Selection of insurance companies is limited to the primary, secondary, and tertiary insurance companies that are billable for the event date. A provider number can be entered for each of the three possible insurance carriers. This field will be loaded from the Hospital Provider Number if one has been entered for the insurance carrier.

Insurance company addresses can only be edited through the Insurance Company Entry/Edit option.

Any bill with a CHAMPVA rate type requires the primary insurance carrier to have a type of coverage defined as CHAMPVA; otherwise, the bill cannot be authorized.

If the MULTIPLE FORM TYPES site parameter is set to YES, a form type prompt will appear. The UB-82 and UB-92 are considered a single form, so for a site to have multiple forms they would have to use one of the UB forms and the HCFA-1500.

Changing the form type to HCFA-1500 will cause the CODING METHOD field to default to CPT-4 if it has not already been defined. Changing the primary insurance carrier or responsible institution will cause the revenue codes to be rebuilt and charges to be recalculated.

If the MCCR site parameter USE OP CPT SCREEN is set to YES, the Current Procedural Terminology Code Screen will appear when editing procedure codes. The screen will list CPT codes for the dates associated with the bill.

An associated diagnosis (diagnosis responsible for the procedure being performed) must be entered for each procedure for HCFA-1500s. You can enter from 1 to 4 associated diagnoses. The associated diagnosis must match one of the first four diagnoses entered.

Adding a BASC procedure or an OP VISIT DATE will cause the revenue codes to be rebuilt and charges recalculated for both UB-82/92 and HCFA-1500 form types. Only one visit date is allowed on a UB-82/92 that also has BASC procedures. This restriction does not apply to HCFA-1500s.

A print order can be specified for each procedure/diagnosis entered. If no print order is specified, the procedures/diagnoses will print in the order entered. The six procedures and nine diagnoses with the lowest print order will be printed in the boxes on the form and the remainder will print as additional procedures/diagnoses.

If the TRANSFER PROCEDURES TO SCHED? parameter is set to YES, any ambulatory surgery entered on the bill can be transferred to the Scheduling Visits file and stored under a 900 stop code. An associated clinic must be entered for all procedures that are to be transferred to the SCHEDULING VISITS file.

Several site parameters and two security keys affect the prompts that will appear at the end of this option. Please see the Supplement at the end of this section for an explanation of how these site parameters and security keys affect the option.

A mail group can be specified (through the site parameters) so that every time a bill is disapproved during the authorization phase of the billing process, all members of this group are notified via electronic mail. If this group is not specified, only the billing supervisor, the initiator of the billing record and the user who disapproved the bill will be a recipient of the message. An example of this message can be found in the Supplement.

The UB-82, UB-92, and HCFA-1500 billing forms are the output which can be produced from this option. The data elements and design of these forms has been determined by the National Uniform Billing Committee and has been adapted to meet the specific needs of the Department of Veterans Affairs. They must be generated (printed) at 80 characters per line at 10 pitch. Copies of the billing forms are included in the Print Bill option documentation.

The UB-82, UB-92, and HCFA-1500 billing forms are the output which may be produced from this option. The data elements and design of these forms has been determined by the National Uniform Billing Committee and has been adapted to meet the specific needs of the Department of Veterans Affairs. They must be generated (printed) at 80 characters per line at 10 pitch. Copies of the billing forms are included in the Print Bill option documentation.

Automated Means Test Billing Menu

Cancel/Edit/Add Patient Charges

The IB AUTHORIZE security key is required to access this option.

The Cancel/Edit/Add Patient Charges option allows you to manually cancel, edit, or add per diem and copayment patient charges or fee services for a specified patient and date range. When a charge is edited, the original charge is canceled and a new charge is added. Once added or edited, the charges are passed to Accounts Receivable. You may receive Accounts Receivable mail messages when editing/canceling through this option.

You cannot add medication copayment charges for patients determined to be exempt from the medication copayment requirement.

You can choose whether or not to include pharmacy copay charges. Only pharmacy charges which have been added through this option can be edited or deleted through this option.

You can also choose to bill CHAMPVA inpatient subsistence charges for past admissions. (Current and future admissions will be billed automatically at discharge.) The CHAMPVA inpatient subsistence charge may be canceled through this option, but it will be canceled **only** in IB. You **must** go into the AR module to decrease the receivable to zero ($0).

Charges are displayed for the specified patient and date range and several "actions" can be taken against these charges. You can add/edit/cancel a charge, pass a charge to Accounts Receivable, change to another patient or date range, update an event by changing the event status, or change the date used to record the last date for which Means Test charges were billed for the admission.

List Manager actions are also available (i.e., First Screen, Last Screen, Up a Line, Down a Line, etc.). If you need help in using the List Manager functionality, please refer to the Appendix of this user manual.

Once action has been taken on a charge, the screen is redisplayed showing the new data. If you have edited a charge, the status of the original entry is changed to CANCELLED, and two new entries are added. The first entry offsets the original charge (the amount appears in parentheses indicating a credit) and the new charge is shown.

Charges added or edited through this option are added/edited to the INTEGRATED BILLING ACTION file (#350). When adjustments are made through this option which affect the number of inpatient days or inpatient amount, you are prompted to choose whether or not you wish to make the adjustment to the Means Test Billing Clock.

Patient Billing Clock Maintenance

The IB AUTHORIZE security key is required to access this option.

This option allows adding or editing of patient billing clocks. Most often this option will be used to add or edit clocks of patients transferred from other facilities. The following fields are editable: clock begin date, status, 90 day inpatient amounts, and number of inpatient days. A free text field to include a reason for the update is also provided.
The fields contained in this option are used to determine, and directly affect, the copayment charges billed to the patient for care received. These fields can also be affected by other options such as the Cancel/Edit/Add Patient Charges option. For further details, please see that option documentation.
The clock will automatically be closed after 365 days or on the date the patient is no longer Category C, whichever is earlier. Billing clocks which may have been "left open" due to a lack of billable activity will be closed during the nightly compilation job which is run automatically. Billing clocks which must be deleted for any reason will have a status of CANCELLED.

Estimate Category C Charges for an Admission

This option is used to estimate the Means Test/Category C charges for an episode of hospital or nursing home care for a proposed length of stay. It can also be used to estimate charges to be billed to a current inpatient for the remainder of his/her stay.

The report will indicate whether or not the patient has an active billing clock, the start date, and the number of inpatient days of care within that clock.

If a patient has an active clock and has already been charged a copayment for the current 90 days of inpatient care, that amount billed is shown. Also provided is the amount of copay and per diem that would be billed for this proposed episode of care. Following is a description of fields.

Field	**Description**
CLOCK DATE	Date the current billing clock began for this patient.
DAYS OF INPATIENT CARE WITHIN CLOCK	Number of days of inpatient care within the current billing clock.
COPAYMENTS MADE FOR CURRENT 90 DAYS OF INPATIENT CARE	Total amount of copayment made for the current 90 days of inpatient care for the current billing clock.

COPAYMENT CHARGES FOR {type of care}	Amount of the copayment charge for this proposed inpatient stay. The copayment charge differs depending on the type of inpatient care; however, it will not exceed the current Medicaid deductible. Once the deductible is met, the patient is covered for a 90 day period. For the second, third and fourth 90 days of hospital care, the copayment charge is half of the current Medicaid deductible. For other than hospital care (i.e., NHCU), the full deductible applies for each 90 days of care.
BILLING DATES {FROM/TO}	Date(s) the copayment occurred. If the proposed episode of care was for a total of five days (2/1/92 - 2/5/92) but the deductible was met the first day, the billing dates (from and to) would reflect the first day only (2/1/92).
INPATIENT DAYS {1st/Last}	On which days of the current 90 days of inpatient care this copayment occurred. If the patient previously had two days of inpatient care in the current 90 days and the deductible was met the first day of this proposed episode of care, the "inpatient days" would reflect day three as the days (1st and last) this copayment was incurred.
CLOCK DAYS {1st/Last}	On which days of the current billing clock this copayment was incurred. If the current billing clock began on 2/1/92 and the copayment for this proposed episode of care was incurred on 2/15 and 2/16/92, the "clock days" would reflect day 15 for the 1st and day 16 for the last.
CHARGE	Amount of the copayment or per diem charge for this proposed episode of care.
PER DIEM CHARGES FOR {type of care}	A daily charge for the inpatient stay. No charge is incurred for the day of discharge (i.e., if the proposed inpatient stay is 2/1/92 thru 2/5/92 and the per diem rate is $10.00, the total per diem charge would be $40.00).
TOTAL ESTIMATED CHARGES	Total of the copayment and the per diem charges for the proposed inpatient stay.

On Hold Menu

On Hold Charges Released to AR

This report lists all charges identified as once being ON HOLD (after the installation of patch IB*2*70) that currently have a status of BILLED, and the DATE LAST UPDATED is within the specified date range.

Sample Output

```
List of ON HOLD Charges released to AR between  JAN 09, 1998 and MAR 10, 1998
Date Printed: MAR 10,1998                                                Page 1
-----------------------------------------------------------------------------
Name              Pt.ID  Act.ID    Bill #   Type  From      To         Charge
-----------------------------------------------------------------------------
IBpatient,one        1111  500759   K700069  OPT   08/30/94  08/30/94    36.00
IBpatient,two        2222  5001083  K700079  OPT   02/07/96  02/07/96    41.00
IBpatient,three      3333  500852   K700071  OPT   01/25/95  01/25/95    39.00
IBpatient,four       4444  500592   K700068  OPT   05/02/94  05/02/94    36.00
IBpatient,five       5555  5001140  K700077  OPT   05/14/96  05/14/96    41.00
                       5001244  K700078  INPT  01/21/97  01/21/97   736.00
IBpatient,six        6666  500680   K700063  INPT  07/15/94  07/15/94   696.00
                       500773   K700063  INPT  10/13/94  10/13/94   348.00
                       500793   K700064  NHCU  11/09/94  11/10/94   348.00
```

Count/Dollar Amount of Charges On Hold

This option produces the Count and Dollar Amount of Charges On Hold Report. The report provides a subtotal and subcount, by action type, of each patient charge with an ON HOLD status. These charges have not been passed to Accounts Receivable. Accounting is responsible for supplying these figures to FMS on a monthly basis.

Days on Hold Report

This option produces the “Days On Hold Report”. The report lists all Integrated Billing charges that have had a status of ON HOLD for an extended period of time.

Sample Output

```
                                        CHARGES ON HOLD LONGER THAN 60 DAYS                    Mar 10, 1998@11:42:06  PAGE 1
HELD CHARGES                                                                                 CORRESPONDING THIRD PARTY BILLS
==============================================================================================||==============================
                                                                 On Hold    # Days            ||        AR
Name                  Pt.ID  Act.ID    Type   From     To        Date       On Hold     Charge|| Bill#  Status  Charge      Paid
==============================================================================================||==============================
IBpatient,one             1550P  5001254   INPT   04/10/97 04/10/97   08/11/97        88     368.00||
                             5001256   INPT   07/14/97 07/15/97   08/11/97        88     736.00||
```

Held Charges Report

The Held Charges Report provides you with a list of all charges with a status of ON HOLD. Charges for Category C patients with insurance are placed on hold until the patient's insurance company bill is resolved. When payment is received from the insurance carrier, the status of the charge is updated through the Release Charges 'On Hold' option.

This report can be used to insure that there is an insurance bill established for each charge on hold, and to identify charges that should be released when payments are received from insurance carriers.

Sample Output

```
                                        CATEGORY C CHARGES ON HOLD                              MAR 10,1998  PAGE 1
HELD CHARGES                                                                   CORRESPONDING THIRD PARTY BILLS
==============================================================================||=====================================
Name           Pt.ID  Act.ID    Type   Bill#   From       To          Charge || Bill#    AR-Status         Charge       Paid
==============================================================================||=====================================
==============================================================================||=====================================
IBpatient,one      1111   500942    OPT    L10220  03/01/92   03/11/92     30.00 || L10209   NEW BILL   148.00    0.00
                      500948    INPT   L10233  03/11/92   03/14/92    652.00 ||
                      500954    OPT    L10229  03/11/92   03/11/92     30.00 ||
IBpatient,two      2222   5002661   OPT    L10305  05/08/92   05/08/92     30.00 ||
IBpatient,three    3333   5001488   OPT    L10259  04/07/92   04/07/92     30.00 ||
                      5001512   OPT    L10259  04/03/92   04/03/92     30.00 || L10342   NEW BILL   296.00     0.0
IBpatient,four     4444   5002673   INPT   L10304  05/19/92   05/19/92    238.00 ||
IBpatient,five     5555   5001449   INPT   L10178  03/01/92   03/01/92    652.00 || L10235   NEW BILL  5736.00    0.00
IBpatient,six      6666   5001476   INPT   L10261  04/13/92   04/16/92    652.00 ||
IBpatient,seven    7777   5001024   OPT    L10121  03/23/92   03/23/92     30.00 || L10329   NEW BILL   740.00    0.00
                      5001025   OPT    L10121  03/23/92   03/23/92     30.00 ||
                      5001026   OPT    L10121  03/23/92   03/23/92     30.00 ||
                      5001029   OPT    L10121  03/23/92   03/23/92     30.00 ||
                      5001030   OPT    L10121  03/23/92   03/23/92     30.00 ||


                                        CATEGORY C CHARGES ON HOLD                              MAR 10,1998  PAGE 1
HELD CHARGES                                                                   CORRESPONDING THIRD PARTY BILLS
==============================================================================||=========================================
Name                 Pt.ID  Act.ID    Type   Bill#    From       To          Charge || Bill#    AR-Status       Charge       Paid
==============================================================================||=========================================
==============================================================================||=========================================
IBpatient,one        1111         Insurance Co.     Subscriber ID     Group           Eff Dt        Exp Dt
==============================================================================||=========================================
                                  BLUE CROSS/BLUE   GEE302            MAN32           01/00/93
                                      Plan Coverage   Effective Date   Covered?     Limit Comments
                                      -------------   --------------   --------     --------------
                                      INPATIENT                                     BY DEFAULT
                                      OUTPATIENT                                    BY DEFAULT
                                      PHARMACY                                      BY DEFAULT
                                      DENTAL                                        BY DEFAULT
                                      MENTAL HEALTH                                 BY DEFAULT
                                 ---------------------------------------------------------------------------
                            5001261   OPT             03/02/98   03/02/98     45.80 ||
```

History of Held Charges

This option provides a count and dollar amount of charges that have been on hold for a specified date range. This report sorts charges by their current status. You will be able to keep track of how many charges are cancelled, released (billed), or remain on hold. This report only counts charges with an ON HOLD DATE defined.

Release Charges 'On Hold'

The IB AUTHORIZE security key is required to access this option.

The Release Charges 'On Hold' option is used to release Means Test Category C charges, with a status of ON HOLD, to Accounts Receivable. This option is also available on the Agent Cashier's Menu in Accounts Receivable.

If the HOLD MT BILL W/INS parameter is set to YES, inpatient and outpatient copayments for Category C patients with insurance will automatically be placed on hold. These charges will not be passed to Accounts Receivable until they are released through this option. Please note that the $5/$10 hospital/NHCU per diem charges are not placed on hold.

If the original bill number is no longer open when the charge is passed to Accounts Receivable, a new bill number is assigned.

List Charges Awaiting New Copay Rate

The List Charges Awaiting New Copay Rate option is used to generate a list of all Means Test outpatient copayment charges which have been placed on hold because the copay rate is over one year old.

New billing rates are scheduled to be released from VA Central Office at the beginning of each fiscal year (10/1). However, there may be a delay in the release of these new rates. If the rate on file for the Means Test outpatient copayment charge is over one year old at the time the bill is created, these charges will be held until the new copay rate is entered. When the rate is entered, you are given the opportunity to release the charges to Accounts Receivable at that time or they can be released through the Release Charges Awaiting New Copay Rate option.

Sample Output

```
              LIST OF ALL OUTPATIENT COPAYMENT CHARGES 'ON HOLD'
                  AWAITING ENTRY OF THE NEW COPAYMENT RATE
                                                                  Page: 1
                                                             Run Date: 10/18/93
-------------------------------------------------------------------------------
Patient Name (ID)                        Visit Date          Charge
-------------------------------------------------------------------------------

IBpatient,one      (1111)                    10/08/93            $33
IBpatient,two      (2222)                    10/12/93            $33
IBpatient,three    (3333)                    10/05/93            $33
                                             10/04/93            $33
IBpatient,four     (4444)                    10/01/93            $33
IBpatient,five     (5555)                    10/05/93            $33
```

Send Converted Charges to A/R

The IB AUTHORIZE security key is required to access this option.

This option is designed for use after the Integrated Billing conversion is completed. After the conversion, certain inpatient and outpatient charges will have a status of CONVERTED. This option allows you to choose which converted charges are passed to Accounts Receivable.

During the conversion, the BILLS/CLAIMS file (#399) is checked to insure that each outpatient visit has been billed. For each visit without an established bill, one is established and given a status of CONVERTED. The conversion cannot determine whether or not an episode of care has been billed for inpatients; therefore, all billable inpatient episodes are provided a status of CONVERTED and you must determine which ones should be passed.

You can choose to pass the charges by patient or date. If patient is selected, all billing actions with a status of CONVERTED are displayed. You can then select which actions will be passed to accounts receivable. If date is selected, all outpatient copay and fee service billing actions that were created on or before the selected date are passed to accounts receivable.

If the HOLD MT BILL W/INS parameter at your site is set to YES, inpatient and outpatient copayments for Category C patients with insurance will automatically be placed on hold. These charges will not be passed to Accounts Receivable until they are released through the Release Charges 'On Hold' or Cancel/Edit/Add Patient Charges options. You may wish to set this parameter to NO until all charges that should be passed to A/R are passed.

This option is being distributed as "out of order" as it is no longer needed and will probably be deleted in the next release of Integrated Billing.

Release Charges 'Pending Review'

The Release Charges 'Pending Review' option is used to review charges which have been created when an Income Verification Match (IVM) verified Means Test has been received and filed at the medical facility. If such a Means Test results in changing the patient's Means Test status from Category A to Category C, copayment and per diem charges for previous episodes of care will automatically be created. The charges will not be automatically passed to Accounts Receivable but will be held in Billing until a review of the charges is complete. A mail message is sent to the Category C Billing mail group notifying users that the charges have been created and are pending review.

After review, you may pass the charges to Accounts Receivable for billing or cancel the charges. If passed to AR, the billing information will also be passed to the IVM software which will in turn transmit it to the IVM Center in Atlanta.

Since the billing clock was updated when the charge was originally built, you may need to update the billing clock if the charge is cancelled. This can be accomplished through the Patient Billing Clock Maintenance option.

List Current/Past Held Charges by Pt

This option lists all IB Actions for a patient that are currently on hold or were on hold for a specified date range. The report lists IB Action ID, Rate Type, Bill #, AR status, IB Status and information related to corresponding Third Party Claims. Only charges placed on hold since the installation of patch IB*2*70 will appear on this report.

Sample Output

```
List of all HELD bills for IBpatient,one      SSN: 000-11-1111                        NOV 7,1997  PAGE 1
PATIENT CHARGES                                                   CORRESPONDING THIRD PARTY BILLS
==============================================================||================================
Action ID  Type   Bill#  Svc Dt   Dt to AR  Charge  AR-Sts  IB-Sts|| Bill#  AR-Status  Charge  % Paid
==============================================================||================================
5001254    INPT C        08/11/97           368.00          ON HOL||
5001256    INPT C        08/11/97           736.00          ON HOL||
5003424    OPT CO K70025 02/20/97 05/07/97   38.80 ACTIVE   BILLED||
5003423    OPT CO K70007 02/18/97 04/25/97   38.80 COLLEC   BILLED||
5003411    OPT CO K70007 02/06/97 04/25/97   38.80 COLLEC   BILLED|| K70073  ACTIVE    194.00     80%
5003409    OPT CO K70007 02/05/97 04/25/97   38.80 COLLEC   BILLED||
5003398    OPT CO        02/04/97            38.80          CANCEL|| REASON: INSURANCE CO PD IN FULL
5003396    OPT CO K70006 02/03/97 05/19/97   38.80 COLLEC   BILLED|| K70212  NEW BILL  194.00      0%
```

Release Charges Awaiting New Copay Rate

The Release Charges Awaiting New Copay Rate option is used to release charges which have been placed on hold because the outpatient copay rate is over one year old.

New billing rates are scheduled to be released from VA Central Office at the beginning of each fiscal year (10/1). However, there may be a delay in the release of these new rates. If the rate on file for the Means Test outpatient copayment charge is over one year old at the time the bill is created, these charges will be held until the new copay rate is entered. When the rate is entered, you are given the opportunity to release the charges to Accounts Receivable at that time or they can be released through this option. You will be prompted to task off a job which will automatically update the dollar amount and bill all such charges. The user will receive a message when the tasked job has completed.

If the copay rate currently in your Billing Table is too old to use, the following message will appear.

"The current copay rate (effective {date}) is still too old to use. Please be sure that you have entered the most current rate in your Billing Rates table."

Patient Billing Clock Inquiry

This option allows you to display data contained in the patient billing clock. It can be used to view the number of inpatient days and amount billed for inpatient copayments for Category C patients.

When the patient is selected, all billing clocks for that patient are displayed. The reference number, patient name, and the cycle begin date are provided. Once a clock is selected, information such as the clock status, primary eligibility code, cycle begin and end dates, number of inpatient days, and 90 day inpatient amounts are displayed.

Category C Billing Activity List

The Category C Billing Activity List option is used to list all Means Test/Category C charges within a specified date range. The list is alphabetical by patient name.

This output provides the patient name and ID, a brief description, the status and the billing period for the bill, the units (the number of days a charge occurred), and the amount of the charge. For inpatient copay charges, the description includes the treating specialty for the episode of care.

As stated above, the units reflect the number of days a charge occurred. For inpatient copay charges the unit will always be one, even if the patient accrued the charges over a number of days before the Medicaid deductible was met.

Sample Output

```
Category C Billing Activity List            FEB 26, 1992@09:14:28     Page: 1
Charges from 01/01/92 through 02/26/92
PATIENT/ID                DESCRIPTION       STATUS        FROM       TO   UNITS CHARGE
-------------------------------------------------------------------------------------
IBpatient,one     2086    INPT PER DIEM     BILLED      01/02/92  01/03/92  2   $20.00
                          INPT COPAY (ALC)  BILLED      01/02/92  01/03/92  1  $476.00
IBpatient,two     8745    OPT COPAY         PENDING A/R 02/11/92  02/11/92  1    $0.00
IBpatient,three     8761  INPT PER DIEM     BILLED      01/13/92  01/14/92  2   $20.00
                          INPT COPAY (MED)  BILLED      01/13/92  01/14/92  1  $652.00
IBpatient,four     0978   OPT COPAY         PENDING A/R 02/12/92  02/12/92  1    $0.00
IBpatient,five     9065   OPT COPAY         BILLED      02/17/92  02/17/92  1   $30.00
IBpatient,six     1243    OPT COPAY         BILLED      02/13/92  02/13/92  1   $30.00
IBpatient,seven     1122  INPT PER DIEM     BILLED      01/13/91  01/18/92  6   $60.00
                          INPT COPAY (MED)  BILLED      01/13/92  01/18/92  1   $24.00
IBpatient,eight     9467  OPT COPAY         BILLED      02/12/92  02/12/92  1   $30.00
```

Single Patient Category C Billing Profile

The Single Patient Category C Billing Profile option provides a list of all Means Test/Category C charges within a specified date range for a selected patient.

You will be prompted for patient name, date range, and device. The default at the "Start with DATE" prompt is October 1, 1990. This is the earliest date for which charges can be displayed.

This output displays the date the Category C billing clock began, bill date, bill type (including the treating specialty for inpatient copay charges), the bill number, bill to date (for inpatient charges), amount of each charge, and the total charges for the selected date range.

Sample Output

```
Category C Billing Profile for IBpatient,one     000-11-1111
From 02/26/91 through 02/26/92        FEB 10, 1994@13:56              Page: 1
BILL DATE   BILL TYPE                        BILL #   BILL TO   TOT CHARGE
-------------------------------------------------------------------------------

04/28/91    Begin Category C Billing Clock
04/28/91      OPT COPAYMENT                  L10038                  $26.00
09/07/91      INPT PER DIEM                  L10085   09/08/91       $20.00
09/07/91      INPT CO-PAY (NEU)              L10084   09/08/91      $628.00
02/10/92      OPT COPAYMENT                  L10038                  $30.00
02/24/92      OPT COPAYMENT                  L10038                  $30.00
                                                                 ----------
                                                                    $774.00
```

Disposition Special Inpatient Billing Cases

The Disposition Special Inpatient Billing Cases option is used to enter the reason for not billing inpatient billing cases for veterans whose care is related to their exposure to Agent Orange, ionizing radiation, or environmental contaminants. This option can also be used to edit the reason on cases that have already been dispositioned.

Inpatient bills created for veterans who claim exposure to Agent Orange, ionizing radiation, or environmental contaminants are automatically placed on hold. Once the veteran's treatment has been completed and s/he is discharged, a determination needs to be made if in fact the care rendered was related to the claimed exposure. If the case was not related, charges will have to be entered through the Cancel/Edit/Add Patient Charges option and passed to Accounts Receivable for billing. If the care was related, the patient will not be billed and the case will be dispositioned after the reason for not billing is entered through this option.

You will be prompted for the patient name. The following information will be displayed for the case record: patient name, type, admission date, discharge date, care related to exposure (yes/no), case dispositioned (yes/no), date record last edited, and edited by. You will then be prompted for the reason the case was not billed. This is a free text field allowing up to 80 characters.

List Special Inpatient Billing Cases

The List Special Inpatient Billing Cases option is used to provide a listing of all special inpatient billing cases, both dispositioned and un-dispositioned. Special inpatient billing cases are those where the veteran has claimed his need for treatment is related to exposure to Agent Orange, ionizing radiation, or environmental contaminants.

Inpatient care for NSC Category C veterans who claim exposure to Agent Orange, ionizing radiation, or environmental contaminants is not automatically billed. Once the veteran's treatment has been completed and s/he is discharged, a determination needs to be made if in fact the care rendered was related to the claimed exposure. If the care was related, the patient should not be billed and the case should be dispositioned through the Disposition Special Inpatient Billing Cases option. If the case was not related to exposure, charges will have to be entered manually through the Cancel/Edit/Add Patient Charges option and passed to Accounts Receivable for billing. If the case is billed, the system automatically dispositions the special case.

The following information may be displayed for each case record on the output: patient name, type, admission date, discharge date, care related to exposure (yes/no), case dispositioned (yes/no), date record last edited, and edited by.

Sample Output

```
                    LIST ALL SPECIAL INPATIENT BILLING CASES
                                                              Page: 1
                                                         Run Date: 10/20/93
-------------------------------------------------------------------------------
 Pt. Name: IBpatient,one     (1111)    Care related to EC: NO
     Type: ENV CONTAMINANT             Case Dispositioned: YES
 Adm Date: 11/17/93 2:23 pm              Date Last Edited: 11/22/93 10:04 am
Disc Date: 11/22/93 9:52 am                Last Edited By: JOHN
-------------------------------------------------------------------------------
 Charges Billed:
     INPT COPAY (MED) NEW          11/17/93   11/17/93   $676   BILLED
     INPT PER DIEM NEW             11/17/93   11/21/93   $40    BILLED
-------------------------------------------------------------------------------

-------------------------------------------------------------------------------
 Pt. Name: IBpatient,one     (1111)    Care related to AO: YES
     Type: AGENT ORANGE                Case Dispositioned: YES
 Adm Date: 10/03/93 10:10 pm             Date Last Edited: 10/20/93 7:46 am
Disc Date: 10/06/93 2:25 pm                Last Edited By: JANE
-------------------------------------------------------------------------------
 Reason for Non-Billing:
TREATMENT FOR AGENT ORANGE
-------------------------------------------------------------------------------
```

CHAMPUS Billing Menu

Delete Reject Entry

This option allows you to delete individual entries from the CHAMPUS PHARMACY REJECTS (#351.52) file. Entries are automatically deleted from this file when a rejected transmission is re-submitted and subsequently approved. However, there will be instances when rejected transmissions will not be re-submitted. Therefore, this option may be used to purge unwanted reject transactions from the file.

Reject Report

The Reject Report allows you to view all of the entries in the CHAMPUS PHARMACY REJECTS (#351.52) file and determine the reason(s) for the rejected entries. Rejected entries for transactions which will not be re-submitted and continue to be displayed on this report may be deleted using the Delete Reject Entry option.

Sample Output

```
==============================================================================
Date: 05/30/97            IPS Unresolved Reject Report                Page:  1
==============================================================================

RX# 100136, filled on 09/10/96 (IBpatient,one    000111111) rejected because:
    Invalid NDC Number
    Missing/Invalid Insurance data
    NDC not in local AWP file
    Call Failed

RX# 100114, filled on 02/03/94 (IBpatient,one    000111111) rejected because:
    Modem is not Responding
    Bad/Invalid baud Rate Setting
    Call Interrupted by User
    Bad/Invalid Data bits Setting
```

Resubmit a Claim

This option is used to re-submit a transaction that was originally rejected by the FI (Fiscal Intermediary - the company with which a Tricare patient holds their Tricare insurance coverage). The user is allowed to select a prescription that has not been submitted for billing, or was submitted and then rejected. The prescription is then placed in the queue to be processed by the IB background filer, and it is processed in the same manner as prescriptions that are queued by the foreground processor. If the prescription was previously submitted and rejected, the reject entry in file #351.52 will automatically be deleted if the prescription is authorized for billing.

Reverse a Claim

This option may be used to reverse or cancel a claim for a prescription that was submitted in error. The user is allowed to select a prescription that was previously billed. The prescription is then placed in the queue to be processed by the IB background filer. The filer creates a cancellation-type transaction message that is transmitted to the RNA package. When the receipt confirmation has been received by VISTA from the Fiscal Intermediary (FI), through RNA, another job is queued which cancels the patient copayment charge and the claim for the FI.

Transmission Report

The Transmission report allows you to view a list of pharmacy transmissions for prescriptions which were filled during a specified date range.

Sample Output

```
==============================================================================
Date: 05/30/97          IPS Prescription Status Report                Page: 1
                       JAN 1,1996 through MAY 30,1997
RX#            Fill Date   Patient Name                       Patient SSN
NDC            AWP       Copay     Ing Cost  Fee Paid  Total PD
               Auth. #                 Message
Reject Failure Codes
==============================================================================


100136         09/10/96    IBpatient,one                           000111111
  Drug Name: PRESAMINE 50MG TABS
     Status: Rejected
    Invalid NDC Number
    Missing/Invalid Insurance data
    NDC not in local AWP file
    Call Failed
```

Patient Billing Reports Menu

Patient Currently Cont. Hospitalized since 1986

This option allows you to print a list (from the IB CONTINUOUS PATIENT file) of current inpatients continuously hospitalized at the same level of care since 1986. This report can be used to verify that all continuous patients are correctly identified. The margin width for this report is 132 columns.

Patients continuously hospitalized since 7/1/86 are exempt from the Medicare deductible copayments, but may still be subject to per diem charges. Facilities are authorized to charge inpatients a per diem charge of $10.00 a day for each day of inpatient care or $5.00 for each day of NHCU care.

Sample Output

```
APR 28,1992        ***Patients Continuously Hospitalized Since July 1, 1986***         PAGE 1

Patient NAME           Pt-Id         Ward Location    Last Means  Means Test     Eligibility
                                                      Test Date   Status
==========================================================================================
IBpatient,one              000-11-1111   4D(NHCU)                                      NSC
IBpatient,two              000-22-2222   4A(NHCU)         04/02/90    CATEGORY C     NSC
IBpatient,three            000-33-3333   4B(NHCU)         02/18/92    CATEGORY C     NSC
IBpatient,four             000-44-4444   4B(NHCU)         02/18/92    CATEGORY C     NSC
```

Print IB Actions by Date

The Print IB Actions by Date option provides a list of the Integrated Billing actions for a specified date range. Although totals are included, this output should not be used for statistical reporting. The Statistical Report option is provided for that purpose.

This output can be sorted by a specified field. <??> can be entered for a list of appropriate fields for selection and additional commands which may be used to customize your report. If you choose to sort by a certain field, you will be prompted to enter a range for that field. If you accept the default of FIRST, the system will assume you want to include first to last.

Sample Output

```
INTEGRATED BILLING ACTION LIST                                                    APR 19,1991  10:34    PAGE 1
PATIENT        REF. NO  TYPE              STATUS     DATE ADDED   UNITS    CHARGE  BRIEF DESCRIPTION     CHARGE ID
-----------------------------------------------------------------------------------------------------------------

IBpatient,one      500283   SC RX COPAY NEW   BILLED     APR  5,1991      1      2.00  322B-RANITIDINE 15-1  500-M10027
IBpatient,two      500285   SC RX COPAY NEW   BILLED     APR  5,1991      1      2.00  230A-AMPICILLIN 50-1  500-M10033
IBpatient,three    500286   NSC RX COPAY NEW  BILLED     APR  5,1991      1      2.00  193B-BELLADONNA TI-1  500-M10033
IBpatient,four     500287   SC RX COPAY NEW   BILLED     APR  5,1991      3      6.00  357-BENZTROPINE 1M-3  500-M10009
               ---------                                                 -----  --------
SUBTOTAL                                                                   6     12.00
SUBCOUNT       4
IBpatient,one      500263   SC RX COPAY NEW   CANCELLED  APR  4,1991      1      2.00  352-AMPICILLIN 25, 1  500-M10027
IBpatient,two      500264   SC RX COPAY NEW   CANCELLED  APR  4,1991      1      2.00  286A-CIMETIDINE 3, 1  500-M10027
IBpatient,three    500275   SC RX COPAY NEW   CANCELLED  APR  4,1991      3      6.00  167A-ACETAMINOPHE, 3  500-M10009
               ---------                                                 -----  --------
SUBTOTAL                                                                   5     10.00
SUBCOUNT       3
               ---------                                                 -----  --------
TOTAL                                                                     11     22.00
COUNT          7
```

Employer Report

The Employer Report option is used to provide a listing of patients and spouses' employers for patients without active insurance that can be used by billing clerks to confirm insurance coverage with those employers.

The report is sorted by employer name and is run for a selected date range. You can run the report for inpatient admissions or outpatient visits. One, many, or all divisions can be chosen. For outpatients, patients are included on the report if they have an event within the specified date range, do not have active insurance on the event date, and the patient or spouse's employment status is one of the following.

EMPLOYED FULL TIME
EMPLOYED PART TIME
SELF EMPLOYED
RETIRED

Events include admissions for inpatients and scheduled/
unscheduled visits and dispositions that are not Application Without Exam for outpatients.

Deceased veterans do not appear on the report.

The following information may appear on the output: employer name, address, phone number, patient name, SSN, occupation, employment status, home and work phone numbers, primary eligibility, admission date, transaction type, appointment date, and appointment type. This report requires a 132 column margin width.

Sample Output

```
EMPLOYER REPORT FOR INPATIENT ADMISSIONS JUN 1,1993 - OCT 21,1993         OCT 21, 1993  11:15        PAGE 1

-----------------------------------------------------------------------------------------------------------

ACME                                  4444 E KINDER RD, ALBANY, NEW YORK 12443

   Patient: IBpatient,one                     000-11-1111    NSC    JUN 10, 1993   ADMISSION      Home:
   Employed: Spouse:  SPOUSE                      DAY CARE              RETIRED

-----------------------------------------------------------------------------------------------------------

XYZ, INC.            518-5551234          5678 South St, Troy, New York 12345

   Patient: IBpatient,three               000-11-1111    NSC    JUN 10, 1993   ADMISSION      Home: 518-5559393
   Employed: Patient: IBpatient,one       000-22-2222    Hertygertyman         FULL TIME      Work: 518-5558383

-----------------------------------------------------------------------------------------------------------

XXX CORPORATION       000-11-1111         1 XXX LANE, OSSINING, NEW YORK 10045

   Patient: IBpatient, two                000-33-3333    SC 1   JUN 02, 1993   ADMISSION      Home: 345-5552332
   Employed: Patient: IBpatient, two      000-44-4444    Computer Operator     FULL TIME      Work: 345-5551234

-----------------------------------------------------------------------------------------------------------
```

Episode of Care Bill List

The Episode of Care Bill List option is used to list all bills related to an episode of care. The bills are listed by event date in reverse date order. The bill number, rate type, bill classification, event date, statement from and to dates, bill status, and time frame of bill will be displayed for each bill on the list.

You may enter the bill number, event date, or patient name at the bill selection prompt. If the event date or patient name is entered, all bills with that event date or for that patient will be listed for selection. Only patients with bills on file may be entered.

The output produced by this option must be generated at a 132 column margin width.

Sample Output

```
LIST OF ALL BILLS FOR AN EPISODE OF CARE                                    JUL 5,1990@08:16   PAGE 1
FOR PATIENT: IBpatient,one      EVENT DATE: FEB 13,1987
                                                          STATEMENT    STATEMENT
BILL NO.   RATE TYPE           CLASSIFICATION  EVENT DATE   FROM DATE    TO DATE  STATUS      TIMEFRAME OF BILL
-----------------------------------------------------------------------------------------------------------------
900071     MEANS TEST/CAT. C   INPATIENT       02/13/87     02/13/87    03/12/87  PRINTED     INTERIM - CONTINUING
    PAYOR: Patient - IBpatient,one
000491     REIMBURSABLE INS.   INPATIENT       02/13/87     03/13/87    04/12/87  PRINTED     INTERIM - CONTINUING
    PAYOR: Insurance Co. - ABC INSURANCE
000543     REIMBURSABLE INS.   INPATIENT       02/13/87     04/13/87    04/30/87  AUTHORIZED  INTERIM - LAST
    PAYOR: Insurance Co. - ABC INSURANCE
```

Estimate Category C Charges for an Admission

This option is used to estimate the Means Test/Category C charges for an episode of hospital or nursing home care for a proposed length of stay. It may be used to answer patient inquiries pertaining to estimated charges to be billed for an inpatient stay.

The report will indicate whether or not the patient has an active billing clock, the start date, and the number of inpatient days of care within that clock.

If a patient has an active clock and has already been charged a copayment for the current 90 days of inpatient care, the amount billed is shown. Also provided is the amount of copay and per diem that would be billed for this proposed episode of care. A description of fields follows.

DATA ELEMENT	DESCRIPTION
CLOCK DATE	Date the current billing clock began for this patient.
DAYS OF INPATIENT CARE WITHIN CLOCK	Number of days of inpatient or nursing home care within the current billing clock.

DATA ELEMENT	DESCRIPTION
COPAYMENTS MADE FOR CURRENT 90 DAYS OF INPATIENT CARE	Total amount of copayments made for the current 90 days of inpatient care for the current billing clock.
COPAYMENT CHARGES FOR {type of care}	Amount of the copayment charge for this proposed inpatient stay. The copayment charge differs depending on the type of inpatient care; however, it will not exceed the current Medicare deductible. Once the deductible is met, the patient is covered for 90 days of hospital care. For the second, third, and fourth 90 days of hospital care, the copayment charge is half of the current Medicaid deductible. For other than hospital care (i.e., NHCU), the full deductible applies for each 90 days of care.
BILLING DATES	Date(s) the copayment occurred. If the
{FROM/TO}	proposed episode of care was for a total of five days (2/1/92 - 2/5/92), but the deductible was met the first day; the billing dates (from and to) would reflect the first day only (2/1/92).
INPATIENT DAYS {1st/Last}	On which days of the current 90 days of inpatient care this copayment occurred. If the patient previously had two days of inpatient care in the current 90 days and the deductible was met the first day of this proposed episode of care, the "inpatient days" would reflect day three as the days (1st and last) this copayment was incurred.

DATA ELEMENT	DESCRIPTION
CLOCK DAYS {1st/Last}	On which days of the current billing clock this copayment was incurred. If the current billing clock began on 2/1/92 and the copayment for this proposed episode of care was incurred on 2/15/92 and 2/16/92, the "clock days" would reflect day 15 for the 1st and day 16 for the last.
CHARGE	Amount of the copayment or per diem charge for this proposed episode of care.
PER DIEM CHARGES FOR {type of care}	A daily charge for the inpatient stay. No charge is incurred for the day of discharge (i.e., if the proposed inpatient stay is 2/1/92 thru 2/5/92 and the per diem rate is $10.00, the total per diem charge would be $40.00).
TOTAL ESTIMATED CHARGES	Total of the copayment and the per diem charges for the proposed inpatient stay.

Outpatient/Registration Events Report

In Integrated Billing V. 1.5, the Outpatient/Registration Events Report was used primarily to list potentially billable outpatient activity (for Category C veterans) for the purpose of billing charges that were not automatically billable by the system. As IB V. 2.0 completes the automation of Means Test billing for all outpatient activity, this report becomes a validation tool.

This option lists all episodes of outpatient care for Category C veterans within a user specified date range; appointments, stop codes, and registrations. For each visit, the clinic, appointment time, type, and status are provided. Clinics with a default type of "research" are flagged on the report to assist sites in determining if regular appointments are being scheduled in clinics where the primary intent is research. For each patient listed, the report indicates whether the patient has claimed exposure to Agent Orange, ionizing radiation, or environmental contaminants and whether the patient has active insurance. If exposure is claimed, the responses to the Classification questions answered during the checkout process are displayed. Any charges associated with the episode of care are included.

A separate page will print for each date within the date range; therefore, you may wish to limit the date range selected. You may also wish to run this report during off hours, as it may be quite time consuming.

Sample Output

```
          Category C Outpatient and Registration Activity for 09/01/93
                                Printed: 09/13/93                      Page: 1

Patient/Event       Time  Clinic/Stop       Appt.Type          (Status)


IBpatient,one    1111    [AO]    **Insured**
     CLINIC APPT    12:00 PODIATRY          REGULAR            NO ACTION TAKEN


IBpatient,two    2222    [AO]    **Insured**
     CLINIC APPT    09:00 GEN. MEDICAL      REGULAR            CHECKED OUT
      Care related to AO? YES

     STOP CODE      09:00 EKG               REGULAR
                    09:00 LABORATORY        REGULAR





          Category C Outpatient and Registration Activity for 09/02/93
                                Printed: 09/13/93                      Page: 2

Patient/Event       Time  Clinic/Stop       Appt.Type          (Status)


No Outpatient activity recorded for Category C patients on 09/02/93.
```

Held Charges Report

The Held Charges Report provides you with a list of all charges with a status of ON HOLD. Charges for Category C patients with insurance are placed on hold until the patient's insurance company bill is resolved. When payment is received from the insurance carrier, the status of the charge is updated through the Release Charges 'On Hold' option.

This report may be used to insure that there is an insurance bill established for each charge on hold, and to identify charges that should be released when payments are received from insurance carriers.

Sample Output

```
                                        CATEGORY C CHARGES ON HOLD                          MAY 26,1992  PAGE 1
HELD CHARGES                                                                  CORRESPONDING THIRD PARTY BILLS
=====================================================================||=====================================
Name              Pt.ID  ActionID  Type   Bill#   From       To       Charge || Bill#    AR-Status    Charge    Paid
=====================================================================||=====================================
IBpatient,one      1111   500942    OPT   L10220  03/01/92   03/11/92   30.00 || L10209   NEW BILL     148.00   0.00
                          500948    INPT  L10233  03/11/92   03/14/92  652.00 ||
                          500954    OPT   L10229  03/11/92   03/11/92   30.00 ||
IBpatient,two      2222   5002661   OPT   L10305  05/08/92   05/08/92   30.00 ||
IBpatient,three    3333   5001488   OPT   L10259  04/07/92   04/07/92   30.00 ||
                          5001512   OPT   L10259  04/03/92   04/03/92   30.00 || L10342   NEW BILL     296.00   0.00
IBpatient,four     4444   5002673   INPT  L10304  05/19/92   05/19/92  238.00 ||
IBpatient,five     5555   5001449   INPT  L10178  03/01/92   03/01/92  652.00 || L10235   NEW BILL    5736.00   0.00
IBpatient,six      6666   5001476   INPT  L10261  04/13/92   04/16/92  652.00 ||
IBpatient,seven    7777   5001024   OPT   L10121  03/23/92   03/23/92   30.00 || L10329   NEW BILL     740.00   0.00
                          5001025   OPT   L10121  03/23/92   03/23/92   30.00 ||
                          5001026   OPT   L10121  03/23/92   03/23/92   30.00 ||
                          5001029   OPT   L10121  03/23/92   03/23/92   30.00 ||
                          5001030   OPT   L10121  03/23/92   03/23/92   30.00 ||
```

Patient Billing Inquiry

The Patient Billing Inquiry option allows you to display/print information on any reimbursable insurance bill, Pharmacy Copay, or Means Test bill. The information provided differs depending on the bill type.

For reimbursable insurance bills, the information provided includes bill status, rate type, reason cancelled (if applicable), admission date (for inpatients), all outpatient visits (for outpatients), charges, amount paid, statement to and from dates, each action that was taken on that bill, and the user who performed it. If you choose to view the full inquiry, address information from the PATIENT file (#2) and the bill is also provided.

The information provided in a brief inquiry for Pharmacy Copay charges includes date of charge, type of charge (syntax: patient eligibility - action type - status), brief description (syntax: prescription # - drug name - # of units), amount of charge or credit, and an explanation of any charge removed, if applicable. A full inquiry, in addition to the information provided in the brief inquiry, provides information from the PRESCRIPTION file (#52), as well as address information on the patient.

The display/output for Means Test bills is very similar to the brief inquiry for Pharmacy Copay. It includes the date of charge, charge type, brief description, units, and amount of charge. A full inquiry also includes address information on the patient.

The medication copayment exemption status and reason are displayed for medication copayment and Means Test bills.

Sample Output of Brief Inquiry

```
IBpatient,one       000-11-1111       500-000303   FEB 19, 1992@14:17  PAGE: 1
==============================================================================
Bill Status    : PRINTED - RECORD IS UNEDITABLE
Rate Type      : REIMBURSABLE INSURANCE
Form Type      : UB-82

Op Visit dates : APR 14,1992

Charges        :  $148.00
LESS Offset    :   $30.00
Bill Total     :  $118.00

Statement From : APR 14,1992
Statement To   : APR 14,1992

Entered        : APR 15, 1992 by ED
First Reviewed : APR 16, 1992 by SUE
Last Reviewed  : APR 16, 1992 by SUE
Authorized     : APR 16, 1992 by SUE
Last Printed   : APR 16, 1992 by GARY




IBpatient,one       000-11-1111     500-000303  FEB 19, 1992@14:17     PAGE: 2
==============================================================================

*** ADDRESS INFORMATION ***

Patient Address:  117 TEST DRIVE
                  COLONIE, NEW YORK
                  518-555-0990

Mailing Address:  ABC INS
                  1262 MOONBEAM AVENUE
                  LOS ANGELES, CALIFORNIA   12345

Ins Co. Address:  ABC INS
                  1262 MOONBEAM AVENUE
                  LOS ANGELES, CALIFORNIA   12345
                  618-555-5555
```

Sample Output of Full Inquiry

```
IBpatient,one      000-11-1111       500-L10098   FEB 24, 1992@09:09   PAGE: 1
Medication Copayment Exemption Status: NON-EXEMPT
Patient's income is greater than Copay Income Threshold
==============================================================================
FEB 14, 1992   INPT COPAY (MED) NEW  INPT CO-PAY (MED)         1      $200.00
FEB 20, 1992   INPT COPAY (MED) CAN  INPT CO-PAY (MED)         1     ($200.00)
     Charge Removal Reason: MT CHARGE EDITED
                                                                  ------------
                                                                        $0.00



IBpatient,one      000-11-1111       500-L10098   FEB 24, 1992@09:09   PAGE: 2
Medication Copayment Exemption Status: NON-EXEMPT
Patient's income is greater than Copay Income Threshold
==============================================================================

                         *** ADDRESS INFORMATION ***

Patient Address:  28 TEST RD
                  EASTHAM, MASSACHUSETTS
                  508-555-4321
```

Sample Output of Brief Inquiry for a Pharmacy Copay bill.

```
IBpatient,one       000-11-1111      500-M10004   FEB 24, 1992@09:18   PAGE: 1
Medication Copayment Exemption Status: EXEMPT
Patient's income below Copay Income Threshold

DATE           CHARGE TYPE           BRIEF DESCRIPTION        UNITS     CHARGE
==============================================================================
MAR 15, 1991   SC RX COPAY NEW       RX#111128-REF 5-ENDU       3        $6.00
MAR 15, 1991   SC RX COPAY NEW       RX#111199 9999-CLONI       4        $8.00
                                                                  ------------
                                                                       $14.00
```

List all Bills for a Patient

The List all Bills for a Patient option is used to print a list of all bills on file for a selected patient. The patient may be selected by name or social security number.

The bills are listed by date of care in reverse date order. The bill number, date printed, action/rate type, classification, date of care, statement from and to dates, amount collected, status, and time-frame of the bill will be displayed for each bill on the list. Below is a brief explanation of some of these data elements.

Bill Number — If IB action is incomplete, "pending" is displayed. If IB action is converted, this field will be blank.

Date Printed — Date bill generated.

Action/Rate Type — Action for IB actions; rate type for insurance bills.

Date of Care — Admission date for inpatients; opt visit date for outpatients; date medication dispensed for Pharmacy Copay.

Amount Collected — Not applicable to patient bills; amount from Accounts Receivable for insurance bills.

Time frame of Bill — Null if IB action.

You will be prompted for a patient name and whether or not to include Pharmacy Copay charges on the report.

The output produced by this option must be generated at a 132 column margin width.

Sample Output

```
List of all Bills for IBpatient,one                                                                                    MAR 5,1992@08:16   PAGE 1
BILL      DATE                                                DATE OF    STATEMENT   STATEMENT    AMOUNT
NO.       PRINTED    ACTION/RATE TYPE    CLASSIFICATION    CARE      FROM DATE    TO DATE    COLLECTED   STATUS    TIMEFRAME OF BILL
-----------------------------------------------------------------------------------------------------------------------------------------
M10053   02/20/92   NSC RX COPAY        PHARMACY COPAY   02/20/92   02/20/92    02/20/92      N/A       BILLED
L10157   02/07/92   NSC RX COPAY        PHARMACY COPAY   02/07/92   02/07/92    02/07/92      N/A       UPDATED
L10063   02/11/92   REIMBURSABLE INS.   OUTPATIENT       01/30/92   01/01/92    01/31/92      0.00      PRINTED   ADMIT-DISCHARGE
```

Category C Billing Activity List

The Category C Billing Activity List option is used to list all Means Test/Category C charges within a specified date range. The list is alphabetical by patient name.

This output provides the patient name and ID, a brief description, the status and the billing period for the bill, the units (the number of days a charge occurred), and the amount of the charge. For inpatient copay charges, the description includes the treating specialty for the episode of care.

As stated above, the units reflect the number of days a charge occurred. For inpatient copay charges the unit will always be one, even if the patient accrued the charges over a number of days before the Medicare deductible was met.

Sample Output

```
Category C Billing Activity List                  FEB 26, 1992@09:14:28     Page: 1
Charges from 01/01/92 through 02/26/92
PATIENT/ID            DESCRIPTION       STATUS        FROM       TO   UNITS CHARGE
-------------------------------------------------------------------------------------
IBpatient,one    1111 INPT PER DIEM     BILLED      01/02/92  01/03/92  2    $20.00
                  INPT COPAY (ALC)      BILLED      01/02/92  01/03/92  1   $476.00
IBpatient,two    2222 OPT COPAY         PENDING A/R 02/11/92  02/11/92  1     $0.00
IBpatient,three   3333 INPT PER DIEM   BILLED      01/13/92  01/14/92  2    $20.00
                  INPT COPAY (MED)      BILLED      01/13/92  01/14/92  1   $652.00
IBpatient,four    4444 OPT COPAY        PENDING A/R 02/12/92  02/12/92  1     $0.00
```

Veterans w/Insurance and Discharges

The Veterans w/Insurance and Discharges option is used to produce a list of all patients who have reimbursable insurance and who were discharged from the medical center during a selected date range. For dates of care prior to 10/1/90, service-connected veterans with insurance who were treated for a non service-connected condition (from the PTF record) will be included on the list. This list may be used to help insure that a bill exists for all billable inpatient episodes of care for that date range.

You may include unbilled patients, previously billed patients, or both on the report. If you choose to print ALL (both unbilled and previously billed), the report is sorted by these two categories. The unbilled patients portion displays the patient ID#, patient name, SSN, eligibility status, date of care (event date), and the patient's insurance companies. The previously billed list displays the same data plus every bill within the selected date range for each patient showing the bill number, bill rate type, statement from and to dates, and the debtor.

The lists are printed in alphabetical order by patient name or numerically by terminal digit (8th and 9th digit of the SSN, then 6th and 7th, etc.). For multidivisional sites, you may print a list for each division.

It is recommended the report be queued to print during non-peak user hours.

Sample Output

```
*Veterans with Reimbursable Insurance and INPATIENT Discharges for the period covering FEB 01,1992 through FEB 29,1992
UNBILLED PATIENTS for Division ALBANY                    Printed: MAR 01,1992@06:00               Page: 1
PT ID PATIENT                SSN           ELIGIBILITY       DATE OF DISCHARGE     INSURANCE COMPANIES
=================================================================================================================

1111  IBpatient,one          000-11-1111   NON-SERVICE CONN  FEB 20,1992@15:51:15  ABC

2222  IBpatient,two          000-22-2222   NON-SERVICE CONN  FEB 19,1992@12:52:51  ALLSTATE

3333  IBpatient,three        000-33-3333   NON-SERVICE CONN  FEB 19,1992@14:40:18  NORTHWEST




*Veterans with Reimbursable Insurance and INPATIENT Discharges for the period covering FEB 01,1992 through FEB 29,1992
PREVIOUSLY BILLED PATIENTS for Division ALBANY           Printed: MAR 01,1992@06:00               Page: 1
PT ID PATIENT             SSN           ELIGIBILITY       DATE OF DISCHARGE     INSURANCE COMPANIES
=================================================================================================================
1111  IBpatient,one       000-11-1111   NON-SERVICE CONN  FEB 7,1992@13:48:23   ABC
          L10042    REIM INS-INPT      From: 02/07/92    To: 02/07/92       Debtor: ABC

2222  IBpatient,two       000-22-2222   NON-SERVICE CONN  FEB 14,1992@13:00     ABC
          L10030    REIM INS-INPT      From: 02/14/92    To: 02/19/92       Debtor: ABC

3333  IBpatient,three     000-33-3333   NON-SERVICE CONN  FEB 7,1992@13:48:23   ABC
          L10042    REIM INS-INPT      From: 02/07/92    To: 02/10/92       Debtor: ABC
```

Veteran Patient Insurance Information

The Veteran Patient Insurance Information option provides insurance information on veteran inpatients. This includes such information as insurance company, insurance number, group number, and insurance expiration date. Medical information is also shown. Dates of admission and discharge and status of the PTF records are provided. The report is broken down by patient, with information on length of stay for each bedsection, diagnoses, and diagnostic codes. The total length of stay is shown with the primary diagnosis.

The form indicates whether or not the policy shown will reimburse VA for the cost of medical care. If the REIMBURSE field of the INSURANCE COMPANY file is set to NO for any of the companies that cover the applicant, an asterisk (*) will be shown next to the insurance company name and the following message will appear.

```
* -  Insurer may not reimburse!!
```

All of this information is used in billing the insurance companies for the cost of the veteran's care.

The report may be sorted sequentially by discharge or admission date. You will be prompted for a date range and device. Depending on the number of applicable admissions and the size of the date range specified, generation of this report could be time-consuming. You may choose to queue the report to print during non-peak user hours.

Sample Output

```
THIRD PARTY REIMBURSEMENT                                PRINTED:  JAN 11,1991@0915

IBpatient,one                                EMPLOYMENT STATUS:  EMPLOYED
(PT ID: 000111111)                                    EMPLOYER:  ABC LUMBER
307 TEST BLVD                                       OCCUPATION:  CARPENTER
TOLEDO, OHIO   55555

INSURANCE TYPE            INSURANCE #            GROUP #       EXPIRES        HOLDER
--------- ----            --------- -            ----- -       -------        ------

ABC INS                   123                    887           01/01/93      VETERAN
*XYZ INS                  64098                  21            12/31/91      VETERAN
                    * - Insurer may not reimburse!!

Admitted:  APR 9,1990@14:00                Discharged:  APR 19,1990@13:39
PTF Record not closed


DATE                LOS BEDSECTION      LOS     DIAGNOSES
----                ---------------     ----    ---------
APR 10,1990@11:29   OPHTHALMOLOGY          1    334.4 (CORNEAL ABRASION)
APR 11,1990@10:10   UROLOGY                1    778.0 (URINARY TRACT INFECTION,
                                                       UNSPEC.)
APR 19,1990@13:39   CARDIOLOGY             8    654.00 (MYOCARDIAL INFARCTION)
                                         ----    -----------

                    TOTAL LOS:             10    DXLS: 654.00 (MYOCARDIAL INFARCTION)
```

Veterans w/Insurance and Inpatient Admissions

The Veterans w/Insurance and Inpatient Admissions option is used to produce a list of all patients who have reimbursable insurance and who had admissions to the medical center during a selected date range. For dates of care prior to 10/1/90, service-connected veterans with insurance who were treated for a non service-connected condition (from the PTF record) will be included on the list. This list may be used to help insure that a bill exists for all inpatient billable episodes of care for the selected date range.

You may include unbilled patients, previously billed patients, or both on the report. If you choose to print ALL (both unbilled and previously billed), the report is sorted by these two categories. The unbilled patients portion displays the patient ID#, patient name, SSN, eligibility status, date of care (event date), and the patient's insurance companies. The previously billed list displays the same data plus every bill within the selected date range for each patient showing the bill number, bill rate type, statement from and to dates, and the debtor.

The lists are printed in alphabetical order by patient name or numerically by terminal digit (8th and 9th digit of the SSN, then 6th and 7th, etc.). For multidivisional sites, you may print a list for each division.

Depending on the size of your database and the date range selected, this report could be quite lengthy. It is recommended the report be queued to print during non-peak user hours.

Sample Output

```
Veterans with Reimbursable Insurance and INPATIENT Admissions for period covering FEB 1,1992 through FEB 29,
1992
UNBILLED PATIENTS for Division ALBANY                          Printed: MAR 01,1992@06:00    Page: 1
PT ID  PATIENT            SSN           ELIGIBILITY       DATE OF CARE          INSURANCE COMPANIES
==========================================================================================================
1111   IBpatient,one      000-11-1111   NON-SERVICE CONN  FEB 05,1992@15:51:15  ABC

2222   IBpatient,two      000-22-2222   NON-SERVICE CONN  FEB 13,1992@13:40     NATIONWIDE


Veterans with Reimbursable Insurance and INPATIENT Admissions for period covering FEB 1,1992 through FEB 29,
1992
PREVIOUSLY BILLED PATIENTS for Division ALBANY                    Printed: MAR 01,1992@06:00    Page: 1
PT ID  PATIENT            SSN            ELIGIBILITY        DATE OF CARE          INSURANCE COMPANIES
==========================================================================================================

1111   IBpatient,one       000-11-1111    NON-SERVICE CONN   FEB 1,1992@11:10      XYZ INS
          000272    REIM INS-INPT     From: 02/01/92    To: 02/10/92        Debtor: XYZ INS

2222   IBpatient,two       000-22-2222    NON-SERVICE CONN   FEB 24,1992@08:09     UNITED WORKERS
          000312    REIM INS-INPT     From: 02/24/92    To: 02/28/92        Debtor: UNITED WORKERS
          000346    REIM INS-INPT     From: 02/28/92    To: 02/29/92        Debtor: UNITED WORKERS
3333   IBpatient,three     000-33-3333    NON-SERVICE CONN   FEB 10,1992@13:34     INTERNATIONAL
          000287    REIM INS-INPT     From: 02/10/92    To: 02/14/92        Debtor: INTERNATIONAL
```

Veterans w/Insurance and Opt. Visits

The Veterans w/Insurance and Opt. Visits option is used to produce a list of all patients who have reimbursable insurance and who had outpatient visits to the medical center during a selected date range. For dates of care prior to 10/1/90, service-connected veterans with insurance will be included on the list.

Non-count clinics and unbillable appointment types are excluded from the list. This list may be used to help insure that a bill exists for all outpatient billable episodes of care for that time frame.

This report includes patients who have either add/edit stop codes, 10-10 registrations, or scheduled appointments during the selected date range. The stop code, registration type, or clinic is included on the output for each entry. This information may be used to aid in determining how a charge should be billed.

You may include unbilled patients, previously billed patients, or both on the report. If you choose to print ALL (both unbilled and previously billed), the report is sorted by these two categories. The unbilled patients portion displays the patient ID#, patient name, SSN, eligibility status, date of care (event date), and the patient's insurance companies. The previously billed list displays the same data plus every bill within the selected date range for each patient showing the bill number, bill rate type, statement from and to dates, and the debtor.

The lists are printed in alphabetical order by patient name or numerically by terminal digit (8th and 9th digit of the SSN, then 6th and 7th, etc.). For multidivisional sites, you may print a list for each division.

It is recommended the report be queued to print during non-peak user hours.

Sample Output

```
Veterans with Reimbursable Insurance and OUTPATIENT Appointments for period covering FEB 1,1992 through FEB 29, 1992
UNBILLED PATIENTS for Division ALBANY                          Printed: MAR 01,1992@06:00    Page: 1
PT ID  PATIENT             SSN          ELIGIBILITY        DATE OF CARE          INSURANCE COMPANIES
=============================================================================================================
1111   IBpatient,one       000-11-1111  NON-SERVICE CONN   FEB 12,1992@09:45     XYZ INS
           Add/Edit Stop Code with 900,

2222   IBpatient,two       000-22-2222  NON-SERVICE CONN   FEB 23,1992@13:40     ABC
           Clinic: DERMATOLOGY
3333   IBpatient,three     000-33-3333  NON-SERVICE CONN   FEB 29,1992@09:44     ABC
           Clinic: DERMATOLOGY


4444   IBpatient,four      000-44-4444  NON-SERVICE CONN   FEB 18,1992@23:45     BLUE SHIELD
           Registration: HOSPITAL ADMISSION

Veterans with Reimbursable Insurance and OUTPATIENT Appointments for period covering FEB 1,1992 through FEB 29, 1992
PREVIOUSLY BILLED PATIENTS for Division ALBANY                    Printed: MAR 01,1992@06:00    Page: 1
PT ID  PATIENT               SSN           ELIGIBILITY       DATE OF CARE          INSURANCE COMPANIES
=============================================================================================================

1111   IBpatient,one         000-11-1111   NON-SERVICE CONN  FEB 11,1992@14:34     BLUE CROSS
           Add/Edit Stop Code with 102, 301, 706
           00024A    REIM INS-OUTP    From: 02/11/92    To: 02/11/92          Debtor: BLUE CROSS

2222   IBpatient,two         000-22-2222   NON-SERVICE CONN  FEB 12,1992@07:09     ABC   INSURANCE
           Clinic: MEDICAL
           00089A    REIM INS-OUTP    From: 02/12/92    To: 02/12/92          Debtor: ABC   INSURANCE
3333   IBpatient,three       000-33-3333   NON-SERVICE CONN  FEB 26,1992@09:45     ABC   INSURANCE
           Clinic: MEDICAL
           00096A    REIM INS-OUTP    From: 02/26/92    To: 02/29/92          Debtor: ABC   INSURANCE
```

Patient Review Document

The Patient Review Document option is used to print the Third Party Review Form by patient name and admission date specifications. This form is used in connection with veteran patients admitted to the hospital who have private medical insurance. The form provides patient's name, patient ID#, admission date, diagnoses, and ward location. Insurance information provided includes insurance company name, address and phone number, policy number, and group number. The insurance data is not displayed if the insurance has expired.

The form is then divided into four sections. Section one concerns pre-admission certification. It shows whether or not pre-admission certification is required. If required, it provides information concerning the decision made by the insurance company regarding the admission. Information includes number of days certified, whether medical information is insufficient, and whether outpatient care is more appropriate. Section two concerns the need for a second surgical opinion, if required, and results of the second opinion. Section three provides information concerning the length of stay review; if further stay was approved or if disapproved, the reasons for denial. Section four shows bill status - denied in full, denied in part, or paid in full. If denied, the reasons for denial are given. The bill number is also shown.

Sample Output

```
NAME:  IBpatient,one                                                    DATE PRINTED:  DEC 12, 1990
                                                                             PT ID:  000111111

INSURANCE CARRIER:  ABC Insurance Company
          ADDRESS:  234 Test St., Loma Linda, California  15436
            PHONE:  555-4789                   POLICY #:  6740879BB          GROUP #:  10
   PRE-CERT PHONE:                        BILLING PHONE:

INSURANCE CARRIER:
          ADDRESS:
            PHONE:                             POLICY #:                     GROUP #:
   PRE-CERT PHONE:                        BILLING PHONE:

INSURANCE CARRIER:
          ADDRESS:
            PHONE:                             POLICY #:                     GROUP #:
   PRE-CERT PHONE:                        BILLING PHONE:

ADMITTING DX:  Pneumonia                                        WARD:  8A
SCHEDULED ADMISSION DATE:                                       ADMISSION DATE:  JUN 26, 1986
-----------------------------------------------------------------------------------------------
PRE-ADMISSION CERTIFICATION:
___NUMBER DAYS CERTIFIED                                 _________________________AUTHORIZATION NUMBER
___NOT REQUIRED
___FAILURE TO MEET ESTABLISHED ADMISSION CRITERIA
___MEDICAL INFORMATION IS INSUFFICIENT
___OPT CARE IS MORE APPROPRIATE
___OTHER LEVELS OF SERVICE ARE MORE APPROPRIATE (NURSING HOME VS HOSPITAL)
___POLICY DOES NOT COVER MEDICAL CARE REQUIRED
___COVERAGE EXHAUSTED
___OTHER                                                                 PREPARED BY _______________________
-----------------------------------------------------------------------------------------------
SECOND SURGICAL OPINION NEEDED:    _______YES    _______NO
SECOND SURGICAL OPINION OBTAINED:  _______YES             ________OUTSIDE MD RECOMMENDED AGAINST SURGERY
                                   _______NOT APPLICABLE  ________OTHER
                                   _______NOT RECEIVED                   PREPARED BY _______________________
-----------------------------------------------------------------------------------------------
LOS REVIEW DATE:   ___________                      DATE APPROVED:   ________________
NUMBER OF DAYS EXTENDED:   ___________                               ________________AUTHORIZATION NUMBER
___PRE-OP DAYS DENIED                                ___APPROPRIATE ALTERNATIVE TREATMENT OPTIONS EXIST
___MORE MEDICAL INFORMATION NEEDED                   ___ALTERNATIVE TREATMENT NOT COVERED BY POLICY
___FAILURE TO MEET CONTINUED STAY CRITERIA           ___AVAILABILITY OF ALTERNATIVE TREATMENT
___APPROPRIATE ALTERNATIVE TREATMENT OPTIONS EXIST   ___COVERAGE EXHAUSTED
___OTHER                                                                 PREPARED BY _______________________
-----------------------------------------------------------------------------------------------
BILLS DENIED IN FULL:                                BILL DENIED IN PART:
__________EXCLUSIONARY CLAUSE STILL IN EFFECT        __________DEDUCTIBLE/COPAYMENT APPLIES
__________DEDUCTIBLE/COPAYMENT APPLIES               __________PORTION OF CARE NOT COVERED BY POLICY
__________TYPE OF CARE NOT COVERED BY POLICY         __________EXCEEDS USUAL AND CUSTOMARY CHARGES
__________PATIENT DOES NOT HAVE CURRENT COVERAGE     __________PAYMENT LIMITED TO PREAUTHORIZED DAYS
__________INSURER WILL NOT PAY PER DIEM RATES        __________OTHER
__________TREATMENT/ADMISSION NOT AUTHORIZED BY INSURANCE CARRIER
__________OTHER                                      __________BILL PAID IN FULL
                                                     PREPARED BY ___________________________
-----------------------------------------------------------------------------------------------
REMARKS:

BILL # _______________
```

Inpatients w/Unknown or Expired Insurance

This option allows you to print a list of veteran inpatients with no insurance, expiring insurance (expired or will expire within 30 days), or unknown insurance. You may include any or all of these categories. The output may then be used to obtain insurance information from veterans while they are current inpatients.

If your site is multidivisional, one, many, or all divisions may be included. A subtotal is provided for each division.

The report may be printed for the current date or a specified date range. When you select a date range, all patients who were admitted during that date range are included. If you choose to display for the current date, all patients who are currently inpatients are included. The report may be further sorted by ward.

Producing this output may be very time consuming. It is recommended you queue this option to run during off hours. The required margin width is 132 columns.

Sample Output

```
                                                
```

```
                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                
JUN 1,1993  PAGE 3
VETERANS WHOSE INSURANCE IS UNKNOWN THAT WERE ADMITTED BETWEEN MAY 22,1993 AND JUN 1,1993

   PATIENT/WARD            PT ID           ADMISSION DATE         AGE     %SC   MARITAL STATUS   EMPLOYMENT STATUS
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------


      Division:            NORTHSIDE

=============================================================================================================================================================================================================

      Ward:                11C

   IBpatient,one           000-11-1111      MAY 22,1993@16:37      82      10   WIDOW/WIDOWER    RETIRED
     11C                   Address:         55 TEST AVE                         Tele:            518-555-9090
                                            TROY,NY 12180

   IBpatient,two           000-22-2222      MAY 25,1993@07:00      60       0   MARRIED          EMPLOYED FULL TIME
     11C                   Address:         256 HOLLAND AVE.                    Tele:            518-555-0786
                                            ALBANY,NY 12208
                           Employer:        ABC SECURITY                        Tele:            518-555-7485
                                            519 4TH ST
                                            TROY,NY 12208


-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------
----------------
   Subtotal: 2
----------------
   Total: 2
```

Outpatients w/Unknown or Expired Insurance

This option allows you to print a list of veteran outpatients with no insurance, expiring insurance (expired or will expire within 30 days), or unknown insurance for a specified date range. You may include any or all of these categories.

One, many, or all divisions (if your site is multidivisional) and clinics may be included. A subtotal is provided for each division/clinic.

This option may be used to identify those patients who should be interviewed for insurance information while visiting a specified clinic. This report may be printed for a specified date or range of dates and sent to the appropriate clinic for follow-up.

This output may be very time consuming and should be queued. The margin width is 132 columns.

Sample Output

```
OUTPATIENT VISITS FOR VETERANS WITH NO INSURANCE                                                    JUN 1,1992  PAGE 1
FOR APPOINTMENTS FROM MAY 22,1992 TO JUN 1,1992

   PATIENT NAME           PT ID               APPT DATE/TIME     AGE     %SC   MARITAL STATUS   EMPLOYMENT STATUS
-------------------------------------------------------------------------------------------------------------------

      Division:           ALBANY


      Clinic:             DERMATOLOGY

   IBpatient,one          000-11-1111         MAY 22,1992@16:37   55      40   WIDOW/WIDOWER    EMPLOYED FULL TIME
                          Address:            555 TEST                         Tele:            518-555-9292
                                              TROY,NY 12180
                          Employer:           ACME CONSTRUCTION                Tele:            518-555-0926
                                              MAPLE AVE
                                              ALBANY,NY 12208

   ______________________
   Clinic Subtotal  : 1

      Clinic:             ORTHOPEDIC

   IBpatient,two          000-22-2222         JUN 1,1992@11:32    42       0   MARRIED          EMPLOYED FULL TIME
                          Address:            121 TEST AVE                     Tele:            518-555-0097
                                              COHOES,NY 12184
                          Employer:           VAMC ALBANY                      Tele:            518-555-3311
                                              113 HOLLAND AVE.
                                              ALBANY,NY 12208

   ______________________
   Clinic Subtotal  : 1

   ______________________
   Division Subtotal: 2

   ______________________
   Total            : 2
```

```
OUTPATIENT VISITS FOR VETERANS WHOSE INSURANCE IS EXPIRED OR WILL EXPIRE WITHIN 30 DAYS         JUN 1,1992  PAGE 1
FOR APPOINTMENTS FROM MAY 22,1992 TO JUN 1,1992

   PATIENT NAME             PT ID              APPT DATE/TIME      AGE    %SC   MARITAL STATUS   EMPLOYMENT STATUS
-------------------------------------------------------------------------------------------------------------------

       Division:            ALBANY


       Clinic:              OPHTHALMOLOGY

   IBpatient,one            000-11-1111        MAY 25,1992@16:37   35       0   WIDOW/WIDOWER    NOT EMPLOYED
                            Address:           49 TEST AVE                      Tele:            518-555-8374
                                               TROY,NY 12180
                            Insurance:         XYZ INS                          Expiration:      JUN 15,1992

   ______________________
   Clinic Subtotal  : 1

   ______________________
   Division Subtotal: 1

   ______________________
   Total            : 1


OUTPATIENT VISITS FOR VETERANS WHOSE INSURANCE IS UNKNOWN                                         JUN 1,1992  PAGE 1
FOR APPOINTMENTS FROM MAY 22,1992 TO JUN 1,1992

   PATIENT NAME           PT ID              APPT DATE/TIME       AGE    %SC   MARITAL STATUS   EMPLOYMENT STATUS
-------------------------------------------------------------------------------------------------------------------

      Division:           ALBANY

      Clinic:             MEDICAL

   IBpatient,two          000-22-2222        MAY 22,1992@16:37   82      10   WIDOW/WIDOWER    RETIRED
                          Address:           55 TEST AVE                    Tele:            518-555-9090
                                             TROY,NY 12180

   ______________________
   Clinic Subtotal  : 1

      Clinic:             SURGICAL

   IBpatient,three        000-33-3333        MAY 25,1990@07:00   60       0   MARRIED          EMPLOYED FULL TIME
                          Address:           256 TESTING AVE.                 Tele:            518-555-0786
                                             ALBANY,NY 12208
                          Employer:          GAVIN'S SECURITY                 Tele:            518-555-7485
                                             519 4TH ST
                                             TROY,NY 12208

   ______________________
   Clinic Subtotal  : 1

   ______________________
   Division Subtotal: 2

   ______________________
   Total            : 2
```

Single Patient Category C Billing Profile

The Single Patient Category C Billing Profile option provides a list of all Means Test/Category C charges within a specified date range for a selected patient.

You will be prompted for patient name, date range, and device. The default at the "Start with DATE" prompt is October 1, 1990. This is the earliest date for which charges may be displayed.

This output displays the date the Category C billing clock began, bill date, bill type (including the treating specialty for inpatient copay charges), the bill number, bill to date (for inpatient charges), amount of each charge, and the total charges for the selected date range.

Sample Output

```
Category C Billing Profile for IBpatient,one     000-11-1111
From 02/26/91 through 02/26/92        FEB 10, 1994@13:56              Page: 1
BILL DATE   BILL TYPE                       BILL #   BILL TO   TOT CHARGE
-------------------------------------------------------------------------------

04/28/91    Begin Category C Billing Clock
04/28/91      OPT COPAYMENT                 L10038                  $26.00
09/07/91      INPT PER DIEM                 L10085   09/08/91       $20.00
09/07/91      INPT CO-PAY (NEU)             L10084   09/08/91      $628.00
02/10/92      OPT COPAYMENT                 L10038                  $30.00
02/24/92      OPT COPAYMENT                 L10038                  $30.00
                                                                -----------
                                                                   $774.00
```

Third Party Billing Menu

Print Bill Addendum Sheet

This option is used to print the addendum sheets that may accompany HCFA-1500 prescription refill or prosthetic bills. The addendum contains information that could not fit on the bill form.

Prescription refill data provided on the addendum sheet may include prescription number, refill date, drug, quantity, # of days supply, and the National Drug Code (NDC) #. Prosthetic data will include the date delivered to the patient and the item.

In order for the bill addendums to automatically print for every HCFA-1500 bill with prescription refills or prosthetic items, the billing default printer for the BILL ADDENDUM form type must be set through the Select Default Device for Forms option found on the System Manager's Integrated Billing Menu.

Sample Output

```
BILL ADDENDUM FOR IBpatient,one    - T10088      JAN 28, 1994  11:00   PAGE 1
-------------------------------------------------------------------------------


PRESCRIPTION REFILLS:

481  Jan 03, 1994  DIGOXIN 0.25MG      QTY: 60   DAYS SUPPLY: 30  NDC #: 19-929-922
432  Jan 10, 1994  NAPROXEX 250MG S.T. QTY: 10   DAYS SUPPLY: 10  NDC #: 22-834-871




PROSTHETIC ITEMS:

JAN 02, 1994     WALKER-FOLDING-WHEELED
JAN 02, 1994     CANE-ALL OTHER
```

Authorize Bill Generation

The Authorize Bill Generation option is used to authorize the printing of third party bills and the release of the information to Fiscal Service.

When a billing record is selected, the system performs a check to determine if another user is currently processing the same record. If not, the system will lock the record. If the lock is unsuccessful, it means another user already has that record locked and the following message will be displayed.

"No further processing of this record permitted at this time. Record locked by another user. Try again later."

A final review/edit of the information in the billing record may be performed through this option. The data is arranged so that it may be viewed and edited through various screens. The data is grouped into sections for editing. Each section is labeled with a number to the left of the data items. Data group numbers enclosed by brackets ([ ]) may be edited while those enclosed by arrows (< >) may not. The patient's name, social security number, bill number, the bill classification (Inpatient or Outpatient), and the screen number appear at the top of every screen. A <?> entered at the prompt which appears at the bottom of every screen will provide you with a HELP SCREEN for that particular screen. The HELP SCREEN lists the data groups found on that screen, and also provides the name and number of each available screen in the option. For more detailed documentation on editing a bill, please see the Enter/Edit Billing Information option documentation.

For a detailed explanation of all screens, please see the Supplement at the end of this section.

The CAN INITIATOR AUTHORIZE? site parameter and the IB AUTHORIZE security key affect the prompts which appear at the end of this option.

CAN INITIATOR AUTHORIZE?
If set to YES, the user who initiated the bill can authorize generation of billing form (if required security key held). If this parameter is set to NO, the initiator of the bill will not be allowed to authorize its generation.

IB AUTHORIZE
Allows the holder to authorize generation of bills. You must hold this key to access this option.

The UB-82, UB-92, and HCFA-1500 billing forms are the output which may be produced from this option. The data elements and design of these forms has been determined by the National Uniform Billing Committee and has been adapted to meet the specific needs of the Department of Veterans Affairs. They must be generated (printed) at 80 characters per line at 10 pitch. Copies of the billing forms are included in the Print Bill option documentation.

Enter/Edit Billing Information

The IB EDIT security key is required to access this option.

The Enter/Edit Billing Information option is used to enter the information required to generate a third party bill and to edit existing billing information. A new bill may be entered or an existing bill can be edited. Only existing bills that have not been authorized or cancelled may be edited. Once a bill has been filed (billing record number established), it cannot be deleted. The bill may be cancelled through the Cancel Bill option.

If the selected patient's eligibility has not been verified and the ASK HINQ IN MCCR parameter is set to YES, the user will have the opportunity to enter a HINQ (Hospital Inquiry) request into the HINQ Suspense File. This request will be transmitted to the Veterans Benefits Administration to obtain the patient's eligibility information. If Means Test data such as category, Means Test last applied, and date Means Test completed is available, it will be displayed after the patient name or bill number has been entered.

When entering a new bill, the system will prompt for EVENT DATE. When billing for multiple outpatient visits, the date of the initial visit is used. For an inpatient bill, the date of the admission is used. If an interim bill is being issued, the EVENT DATE should be the date of admission for that episode of care.

The Medical Care Cost Recovery data is arranged so that it may be viewed and edited through various screens. The data is grouped into sections for editing. Each section is labeled with a number to the left of the data items. Data group numbers enclosed by brackets ([ ]) may be edited while those enclosed by arrows (< >) may not. The patient's name, social security number, bill number, the bill classification (Inpatient or Outpatient) and the screen number appear at the top of every screen. A <?> entered at the prompt which appears at the bottom of every screen will provide you with a HELP SCREEN for that particular screen. The HELP SCREEN lists the data groups found on that screen and also provides the name and number of each available screen in the option.

Cancel Bill

The IB AUTHORIZE security key is required to access this option.

The Cancel Bill option allows the user to cancel a bill at any point in the billing process. Once the bill is cancelled, there is no way to view the data contained in that bill.

If you select a bill which has been previously cancelled, certain prompts will appear with defaults.

A mail group may be specified (through the site parameters) so that every time a bill is cancelled, all members of this group are notified through electronic mail. If this group is not specified, only the billing supervisor and the user who cancelled the bill will be recipients of the message. An example of this message may be found in the Example Section of this option.

When a bill is cancelled, it is removed as a Prior Bill Number from previous bills in the Primary/Secondary/Tertiary Series.

Sample Mail Message

```
Subj: MAS UB-92 BILL CANCELLATION BULLETIN  [#120774] 22 Mar 95 13:22  11 Lines
From: EMPLOYEE (ALBANY ISC)  in 'IN' basket.   Page 1
-------------------------------------------------------------------------------

The following UB-92 bill has been cancelled:

Bill Number: N10276

Patient Name: IBpatient,one            PT ID: 000-11-1111

Event Date: MAR 12,1995@08:00

Reason for cancellation: Patient is service connected.

Status when cancelled: CANCELLED  -  Not passed to AR


Select MESSAGE Action: IGNORE (in IN basket)//
```

Copy and Cancel

The IB AUTHORIZE security key is required to access this option.

The CAN INITIATOR AUTHORIZE? site parameter affects this option.

This option is used to cancel a bill, copy all the information into a new bill, and edit the new bill where necessary. The status of the new bill is ENTERED/NOT REVIEWED. This process prevents having to use the Enter/Edit Billing Information option to create a new bill which would require re-entry of ALL data. Bills returned from Accounts Receivable with minor inconsistencies can quickly and easily be corrected through this option.

The Medical Care Cost Recovery data is arranged so that it may be viewed and edited through various screens. The data is grouped into sections for editing. Each section is labeled with a number to the left of the data items. Data group numbers enclosed by brackets ([ ]) may be edited while those enclosed by arrows (< >) may not. The patient's name, social security number, bill number, the bill classification (Inpatient or Outpatient), and the screen number appear at the top of every screen. A <?> entered at the prompt which appears at the bottom of every screen will provide you with a HELP SCREEN for that particular screen. The HELP SCREEN lists the data groups found on that screen and also provides the name and number of each available screen in the option.

A mail group may be specified (through the site parameters) so that every time a bill is disapproved during the authorization phase of the billing process, or suspended during the generation phase, all members of this group are notified via electronic mail. If this group is not specified, only the billing supervisor, the initiator of the billing record, and the user who disapproved or generated the bill will be recipients of the message. Examples of messages may be found in the Enter/Edit Billing Information documentation. An explana-tion of how the bill mailing address field is determined is provided in the Supplement at the end of this option documentation.

The UB-82, UB-92, and HCFA-1500 billing forms are the output which may be produced from this option. The data elements and design of both forms has been determined by the National Uniform Billing Committee and has been adapted to meet the specific needs of the Department of Veterans Affairs. Both must be generated (printed) at 80 characters per line at 10 pitch. Copies of the billing forms are included in the Print Bill option documentation.

Please see the Supplement found at the end of this section for descriptions of the parameter and security key as well as a description of most fields included on the billing screens.

Delete Auto Biller Results

This option is used to delete entries from the Automated Biller Errors/Comments report prior to a user-selected date for any entry not associated with a bill.

The auto biller checks a variety of data elements concerning an event before a bill is created. The auto biller will only create reimbursable insurance bills, so the patient must be a veteran with active insurance. The disposition prior to the event date is checked and if the need for care was related to an accident or the veteran's occupation, the auto biller will not create a bill. Since dental is usually billed separately, any event with a dental clinic stop will also be excluded. The auto biller also checks to ensure that the event has not already been billed.

Entries are removed from the Automated Biller Errors/ Comments report in two ways. If a bill was created for the event, the bill's entry is removed from the report when the bill is either printed or cancelled. If a bill was not created, this option must be used to delete the entry.

You will be prompted for a date. The default value provided is three days previous to the current date.

Print Bill

The Print Bill option is used to print third party bills on the appropriate form (UB-82/92 or HCFA-1500) after all required information has been input and the billing record has been authorized. You may also reprint a previously printed bill.

A final review of the information in the billing record may be performed through this option. The data is arranged so that it may be viewed through various screens. The patient's name, social security number, bill number, the bill classification (Inpatient or Outpatient), and the screen number appear at the top of every screen. A <?> entered at the prompt which appears at the bottom of each screen will provide you with a HELP SCREEN for that particular screen. The HELP SCREEN lists the name and number of each available screen for the bill you are working on and the data groups for that particular screen.

No editing of the data is allowed in this option. Data can be edited through the Enter/Edit Billing Information option, if necessary.

The UB-82, UB-92, and HCFA-1500 billing forms are the output which may be produced from this option. The data elements and design of these forms has been determined by the National Uniform Billing Committee and has been adapted to meet the specific needs of the Department of Veterans Affairs. They must be generated (printed) at 80 characters per line at 10 pitch.

Patient Billing Inquiry

The Patient Billing Inquiry option allows you to display/print information on any reimbursable insurance bill, pharmacy copay, or Means Test bill. The information provided differs depending on the bill type.

For reimbursable insurance bills, the information provided includes bill status, rate type, reason cancelled (if applicable), admission date (for inpatients), all outpatient visits (for outpatients), charges, amount paid, statement to and from dates, each action that was taken on that bill, and the user who performed it. If you choose to view the full inquiry, address information from the PATIENT file and the bill is also provided.

The information provided in a brief inquiry for Pharmacy Copay charges includes date of charge, type of charge (syntax: patient eligibility - action type - status), brief description (syntax: prescription # - drug name - # of units), amount of charge or credit, and an explanation of any charge removed, if applicable. A full inquiry, in addition to the information provided in the brief inquiry, provides information from the PRESCRIPTION file, as well as address information on the patient.

The display/output for Means Test bills is very similar to the brief inquiry for Pharmacy Copay. It includes the date of charge, charge type, brief description, units, and amount of charge. A full inquiry also includes address information on the patient.

Sample Outputs

Full inquiry for a reimbursable insurance bill.

```
IBpatient,one       000-11-1111     500-000303    FEB 19, 1992@14:17   PAGE: 1
==============================================================================
Bill Status    : PRINTED - RECORD IS UNEDITABLE
Rate Type      : REIMBURSABLE INSURANCE

Op Visit dates : APR 14,1992

Charges        :  $148.00
LESS Offset    :   $30.00
Bill Total     :  $118.00

Statement From : APR 14,1992
Statement To   : APR 14,1992

Entered        : APR 15, 1992 by ED
First Reviewed : APR 16, 1992 by SUE
Last Reviewed  : APR 16, 1992 by SUE
Authorized     : APR 16, 1992 by SUE
Last Printed   : APR 16, 1992 by GARY
```

```
IBpatient,one       000-11-1111     500-000303   FEB 19, 1992@14:17   PAGE: 2
================================================================================

*** ADDRESS INFORMATION ***

Patient Address:  117 TEST DRIVE
                  COLONIE, NEW YORK
                  518-786-0990

Mailing Address:  ABC
                  1262 TEST AVENUE
                  LOS ANGELES, CALIFORNIA   12345

Ins Co. Address:  ABC
                  1262 TEST AVENUE
                  LOS ANGELES, CALIFORNIA   12345
                  618-567-5555
```

Full inquiry for a Means Test bill.

```
IBpatient,one      000-11-1111          500-L10098   FEB 24, 1992@09:09   PAGE: 1
=========================================================================
FEB 14, 1992   INPT COPAY (MED) NEW  INPT CO-PAY (MED)         1      $200.00
FEB 20, 1992   INPT COPAY (MED) CAN  INPT CO-PAY (MED)         1     ($200.00)
     Charge Removal Reason: MT CHARGE EDITED
                                                                  ------------
                                                                         $0.00



IBpatient,one      000-11-1111          500-L10098   FEB 24, 1992@09:09   PAGE: 2
=========================================================================

                        *** ADDRESS INFORMATION ***

Patient Address:  28 TEST RD
                  EASTHAM, MASSACHUSETTS
                  508-321-4321
```

Brief inquiry for a Pharmacy Copay bill.

```
IBpatient,one       000-11-1111      500-M10004   FEB 24, 1992@09:18   PAGE: 1
DATE           CHARGE TYPE          BRIEF DESCRIPTION        UNITS      CHARGE
================================================================================
MAR 15, 1991   SC RX COPAY NEW       RX#111128-REF 5-ENDU       3        $6.00
MAR 15, 1991   SC RX COPAY NEW       RX#111199 9999-CLONI       4        $8.00
                                                                  ------------
                                                                        $14.00
```

Print Auto Biller Results

This option is used to print the Automated Biller Errors/Comments report. The results of the execution of the auto biller are listed on this report. For Claims Tracking events for which the auto biller attempted to create a bill, this report will list either the reason a bill was not created or the bill number and any comments on the bill.

The auto biller checks a variety of data elements concerning an event before a bill is created. The auto biller will only create reimbursable insurance bills, so the patient must be a veteran with active insurance. The disposition prior to the event date is checked and if the need for care was related to an accident or the veteran's occupation, the auto biller will not create a bill. Since dental is usually billed separately, any event with a dental clinic stop will also be excluded. The auto biller also checks to ensure that the event has not already been billed.

Entries are removed from the Automated Biller Errors/ Comments report in two ways. If a bill was created for the event, the bill's entry is removed from the report when the bill is either printed or cancelled. If a bill was not created, the Delete Auto Biller Results option must be used to delete the entry.

The bills will be grouped on the output by the date entered. The following information may appear on the report: patient name, event type, episode date, bill number, bill status, timeframe of bill, and statement covers from and to dates. Comments relating to individual bills may also be provided.

You will be prompted for a date range, a patient range, and a device.

Sample Output

```
AUTOMATED BILLER ERRORS/COMMENTS FOR Nov 1, 1993 - Nov 10, 1993                        DEC 10,1993  13:19    PAGE 1
                                EVENT                          BILL                  TIMEFRAME OF        STATEMENT     STATEMENT
PATIENT                         TYPE   EPISODE DATE            NUMBER    STATUS      BILL                COVERS FROM   COVERS TO
-------------------------------------------------------------------------------------------------------------------------------------

        DATE ENTERED: NOV  1,1993

IBpatient, one        B6711   INPA   SEP  1,1993  17:07     N10003    ENTERED     INTERIM - FIRST     SEP  1,1993   SEP 30,1993
IBpatient, two        C4949   INPA   SEP  1,1993  01:00     N10005    ENTERED     INTERIM - FIRST     SEP  1,1993   SEP 30,1993
IBpatient, three      K2123   INPA   SEP 14,1993  11:42     N10002    ENTERED     ADMIT THRU DISC     SEP 14,1993   SEP 14,1993
                                     No billable Days.

        DATE ENTERED: NOV  3,1993

IBpatient,one         B6711   INPA   SEP  1,1993  17:07     N10023    ENTERED     INTERIM - CONTI     OCT  1,1993   OCT 31,1993
IBpatient,one         C4949   INPA   SEP  1,1993  01:00     N10025    ENTERED     INTERIM - CONTI     OCT  1,1993   OCT 31,1993

        DATE ENTERED: NOV  8,1993

IBpatient,one         D3333   INPA   SEP 15,1993  12:30     N10027    ENTERED     INTERIM - CONTI     OCT  1,1993   OCT 31,1993
```

Print Authorized Bills

The Print Authorized Bills option will print all bills with a status of AUTHORIZED in a user-specified order. The bills may be sorted by zip code, insurance company name, and patient name.

You may enter <??> at the "Begin printing bills?" prompt to see a list of all the bills which will print when this option is utilized. The list will show bill number, patient name, event date, inpatient or outpatient bill, bill type, bill status (AUTHORIZED), and bill form type. If this list is quite lengthy, you may wish to queue the output to print during off hours.

You are not prompted for a device in this option. Each bill form type will print on the billing default printer specified through the Select Default Device for Forms option on the System Manager's Integrated Billing Menu. Any form type not set up there, will not print when utilizing this option.

Return Bill Menu

Edit Returned Bill

The IB EDIT security key is required to access this option.

The Edit Returned Bill option is used to correct bills with a
status of RETURNED FROM AR (NEW) which have been returned to MAS from Accounts Receivable. You should generate the returned bill report through the Returned Bill List option before utilizing this option. That report contains a listing of all bills which have been returned to MAS providing the reason returned for each. This information is required to make the appropriate corrections to each bill. The bill number appears on that report preceded by the station number. The station number should not be entered when selecting the bill for editing.

After editing, the option allows you to return the bill to Accounts Receivable and print the bill if the required security key is held. It should be noted that returned bills with a status of RETURNED FOR AMENDMENT cannot be edited through this option and must be corrected through the Copy and Cancel option.

Supplemental information such as sample billing screens is provided in the Supplement at the end of this section.

Note: It is possible to edit a returned bill if it is not an "electronically transmittable" bill. For returned electronically transmittable bills/claims, the IB COPY AND CANCEL option will need to be used.

Returned Bill List

The Returned Bill List option prints a listing of all bills that have been returned to MAS from Accounts Receivable. When you log on the Billing System, you may see the following message.

"You have {#} bill(s) returned from Fiscal (New Bill)."

When this occurs, you need to generate the output produced by this option to obtain a listing of the returned bills.

The following data items may be provided for each bill on the list: bill number, payer, previous and current status of bill, original bill amount, service which approved bill and when, returned by, reason returned, and date returned. The bill number appears on this report preceded by the station number. The station number should not be entered when selecting the bill for editing.

You will need this report when using the Edit Returned Bill option to determine why the bill was returned and what needs to be corrected. Once the bills have been corrected and sent back to Accounts Receivable, they no longer will appear on the Returned Bill List.

Sample Output

```
<< BILL RETURNED FROM AR >>
==============================================================================
BILL NO.:  500-90032A                  PAYER: ABC
PREV. STATUS: NEW BILL                 CURR. STATUS:  RETURNED FROM AR (NEW)
ORIGINAL AMOUNT: $70                   SERVICE: MEDICAL ADMINISTRATION

                                  << SERVICE >>
APPROV. BY: JAMES                      DATE: JUL 2,1990

                                  << FISCAL >>
RETN'D BY:  ALAN                       DATE:  JUL  5,1990
RETN'D REASON:
   RETURNED FOR CORRECT RATES
==============================================================================
<< BILL RETURNED FROM AR >>
==============================================================================
BILL NO.: 500-T00006                   PAYER: ABC
PREV. STATUS: NEW BILL                 CURR. STATUS:  RETURNED FROM AR (NEW)
ORIGINAL AMOUNT: $673                  SERVICE: MEDICAL ADMINISTRATION

                                  << SERVICE >>
APPROV. BY: JAMES                      DATE: JUL 2,1990

                                  << FISCAL >>
RETN'D BY: ALAN                        DATE:  JUL  5,1990
RETN'D REASON:
   RETURNED FOR CORRECT INS ADDRESS
```

Return Bill to A/R

The IB AUTHORIZE security key is required to access this option.

The Return Bill to A/R option is used to send bills that have been returned to MAS back to Accounts Receivable after they have been corrected. Editing is not allowed in this option. All editing is done through the Edit Returned Bill option; however, all billing screens associated with the bill may be displayed for viewing.

UB-82 Test Pattern Print

The UB-82 Test Pattern Print option is used to print a test pattern on the UB-82 billing form so that the form alignment in the printer may be checked. This will insure that each data item prints in the correct block on the form.

The test pattern displays what data element should appear in the different blocks of the billing form. For example, in Block 3 - Patient Control Number, "BILL NUMBER" will be printed in that block when this option is utilized.

Sample Output

```
                  *** UB-82 TEST PATTERN ***
AGENT CASHIER
AGENT CASHIER STREET     F. L. 2                        BILL NUMBER      XXX
CITY STATE  ZIP
PHONE #                 BC/BS #       FED TAX #                        F. L. 9

PATIENT NAME                      PATIENT ADDRESS

PT DOB  X X   ADM DT HR  X  X AH DH XX  FROM    TO                    F. L. 27

OC DATE    OC DATE    OC DATE      OC DATE    OC DATE
MAILING ADDRESS NAME
STREET ADDRESS 1              CC CC CC CC CC                 F. L. 45
STREET ADDRESS 2
STREET ADDRESS 3
CITY  STATE  ZIP


000 DAYS MEDICAL CARE

REV CODE 1              000.00 000 00    0000.00
REV CODE 2              000.00 000 00    0000.00
REV CODE 3              000.00 000 00    0000.00

SUBTOTAL                                 00000.00



TOTAL                                    00000.00
```

```
PAYER 1                 X  X
PAYER 2                 X  X
PAYER 3                 X  X


INSURED NAME 1         X  XX POLICY # 1       GROUP NAME 1   GROUP # 1
INSURED NAME 2         X  XX POLICY # 2       GROUP NAME 2   GROUP # 2
INSURED NAME 3         X  XX POLICY # 3       GROUP NAME 3   GROUP # 3

X X EMPLOYER NAME                        CITY  STATE  ZIP


PRINCIPAL DIAGNOSIS                        CODE   CODE   CODE   CODE   CODE

X  PRINCIPAL PROCEDURE                     CODE   DATE  CODE  DATE CODE  DATE

                      TX. AUTH.  Dept. Veterans Affairs F. L. 93

Patient ID: XXXXXXXXX
Bill Type: XXXX XXXXXXX
UB-82 TEST PATTERN
**TEST PATTERN**                           UB-82 SIGNER NAME
                                           UB-82 SIGNER TITLE     DATE
```

UB-92 Test Pattern Print

The UB-92 Test Pattern Print option is used to print a test pattern on the UB-92 billing form so that the form alignment in the printer may be checked. This will insure that each data item prints in the correct block on the form.

Sample Output

```
##SR                              *** UB-92 TEST PATTERN ***
AGENT CASHIER
AGENT CASHIER STREET                                        BN XXX            XXX
CITY  STATE  ZIP
PHONE #                   TAX# XXXX  5/1/93 5/4/93

PATIENT NAME                   PT SHORT ADDRESS

DOB      X  X DATE   HR  X  X DR ST 000-00-0000       CC CC CC CC CC CC CC

OC DATE   OC DATE   OC DATE   OC DATE   OC DATE

RESPONSIBLE PARTY'S NAME
STREET ADDRESS 1
STREET ADDRESS 2
STREET ADDRESS 3
CITY  STATE  ZIP

CD1  REV CODE description                       xx       xxxx.xx
CD2  REV CODE description                       xx       xxxx.xx
CD3  REV CODE description                       xx       xxxx.xx
     Subtotal                                            xxxx.xx

     Total                                               xxxx.xx
```

```
For your information, even though the patient may be otherwise eligible
for Medicare, no payment may be made under Medicare to any Federal provider
of medical care or services and may not be used as a reason for non-payment.
Please make your check payable to the Department of Veterans Affairs and
send to the address listed above.

The undersigned certifies that treatment rendered is not for a
service connected disability.

Name of Payer 1           Provider #    x  x
Name of Payer 2           Provider #    x  x
Name of Payer 3           Provider #    x  x


Insured's Name 1          x  Insurance #         Group Name     Group #
Insured's Name 2          x  Insurance #         Group Name     Group #
Insured's Name 3          x  Insurance #         Group Name     Group #

Treatment Auth. Cd x Employer Name             Employer Location
                   x Employer Name             Employer Location
                   x Employer Name             Employer Location

PDX    Dx Cd  Dx Cd  Dx Cd  Dx Cd  Dx Cd  Dx Cd  Dx Cd  Dx Cd   ADMT DX

   P-code  mmddyy P-code  mmddyy P-code  mmddyy     Attending Phys. ID#

   P-code  mmddyy P-code  mmddyy P-code  mmddyy     Other Phys. ID#
       Patient ID#: xxx-xx-xxxx
Bill Type: xxx xxxxxx
UB 92 TEST PATTERN                                Provider Representative DATE
*** comment ***
```

HCFA-1500 Test Pattern Print

This option allows you to print a test pattern on the HCFA-1500 form in order for the form alignment in the printer to be checked. The test pattern displays what data element should appear in the different blocks of the billing form. This insures that each data item prints in the correct block on the form.

Sample Output

```
INSURANCE CARRIER NAME
CARRIER ADDRESS LINE 1
CARRIER ADDRESS LINE 2
CARRIER ADDRESS LINE 3
CARRIER CITY, STATE ZIP

                                                SUBSCRIBER ID#

PATIENT NAME                  MM DD YY          INSURED'S NAME

PATIENT ADDRESS STREET                          INSURED'S ADDRESS STREET

PATIENT ADDRESS CITY     ST                     INSURED'S ADDRESS CITY  ST

PT ZIP CODE   999 999-9999                      INS ZIP CODE   999 999-9999

OTHER INSURED'S NAME                            INSURED'S POLICY GROUP

OTHER POLICY NUMBER                                 MM DD YY

 MM DD YY                                   ST   INSURED'S EMPLOYER

OTHER'S EMPLOYER                                INSURANCE PLAN NAME

OTHER'S INSURANCE PLAN

 MM DD YY                           MM DD YY         MM DD YY      MM DD YY

REFERRING PHYSICIAN        PHYSICIAN ID             MM DD YY      MM DD YY

                                                            9999.99  9999.99

  X99.99                     X99.99

  X99.99                     X99.99

MM DD YY MM DD YY        CPT    MODIF    DIAG     9999.99            BC/BS#

MM DD YY MM DD YY        CPT    MODIF    DIAG     9999.99            BC/BS#


FEDERAL TAX ID        PAT ACCT#                    9999.99   9999.99  9999.99

                      VAMC                      AGENT CASHIER  (999) 999-9999
                      STREET ADDRESS            STREET ADDRESS
                      CITY, STATE ZIP           CITY, STATE ZIP
```

Outpatient Visit Date Inquiry

The Outpatient Visit Date Inquiry option allows you to display information on any outpatient insurance bill for a selected patient. You will be prompted for a patient name and an outpatient visit date. You may select any patient with billed outpatient visits. <??> may be entered at the second prompt for a list of billed visits for the selected patient.

The information provided includes bill status, rate type, reason cancelled (if applicable), outpatient visit date, charges, amount paid, statement from and to dates, each action that was taken on that bill, the date, and the user who performed it.

Sample Output

```
IBpatient,one       000-11-1111      500-L10171    MAR 19, 1992@14:17
PAGE: 1
==============================================================================
Bill Status    : CANCELLED - RECORD IS UNEDITABLE
Rate Type      : REIMBURSABLE INS.
Reason Canceled: WRITE OFF

Op Visit dates : JAN 25,1992

Charges        :  $148.00
LESS Offset    :   $30.00
Bill Total     :  $118.00

Statement From : JAN 25,1991
Statement To   : JAN 25,1991

Entered        : FEB 15, 1991 by EDWARD
First Reviewed : FEB 16, 1991 by SUE
Last Reviewed  : FEB 16, 1991 by SUE
Authorized     : FEB 16, 1991 by SUE
Last Printed   : FEB 16, 1991 by GARY
Cancelled      : MAR  6, 1992 by EMPLOYEE
```

Claims Tracking Master Menu

Task Chart

The following chart was taken from questions most commonly asked during testing of the Claims Tracking software.

To accomplish this...	Do this...
Print a screen when you don't have a slave printer	Type PL (Print List) from any screen to print the entire list region including headers.
Let the computer remind you when a case should be reviewed again	Go into either the Hospital Reviews or Insurance Reviews screen, at the NEXT REVIEW DATE field enter the date you would like to review this case again. It will appear on the Pending Work Report for that day.
Remove pending items from the Pending Work Report ***(Especially after installation of this software, you might have items appearing on the list that do not actually require follow-up.)***	Print the list (Pending Work Report); mark the cases you wish to follow; go into the Pending Reviews option; at the "Select Action:" prompt enter "RL" (Remove From List); enter the corresponding number(s) from the list of the cases you wish to delete. This removes the entry from the list, but not from Claims Tracking. HINT: You can use abbreviations such as RL=3-8 to remove items 3 thru 8; however, on a list screen you can only select items that are shown. Taking an action such as RL=3-99 won't work.
Print a list of random sample patients	Go into the List Visits Requiring Reviews option; include only Hospital Reviews and answer YES to "List Admissions Only?". Accept the default at the "START WITH PATIENT:" prompt, and enter the date range you want.

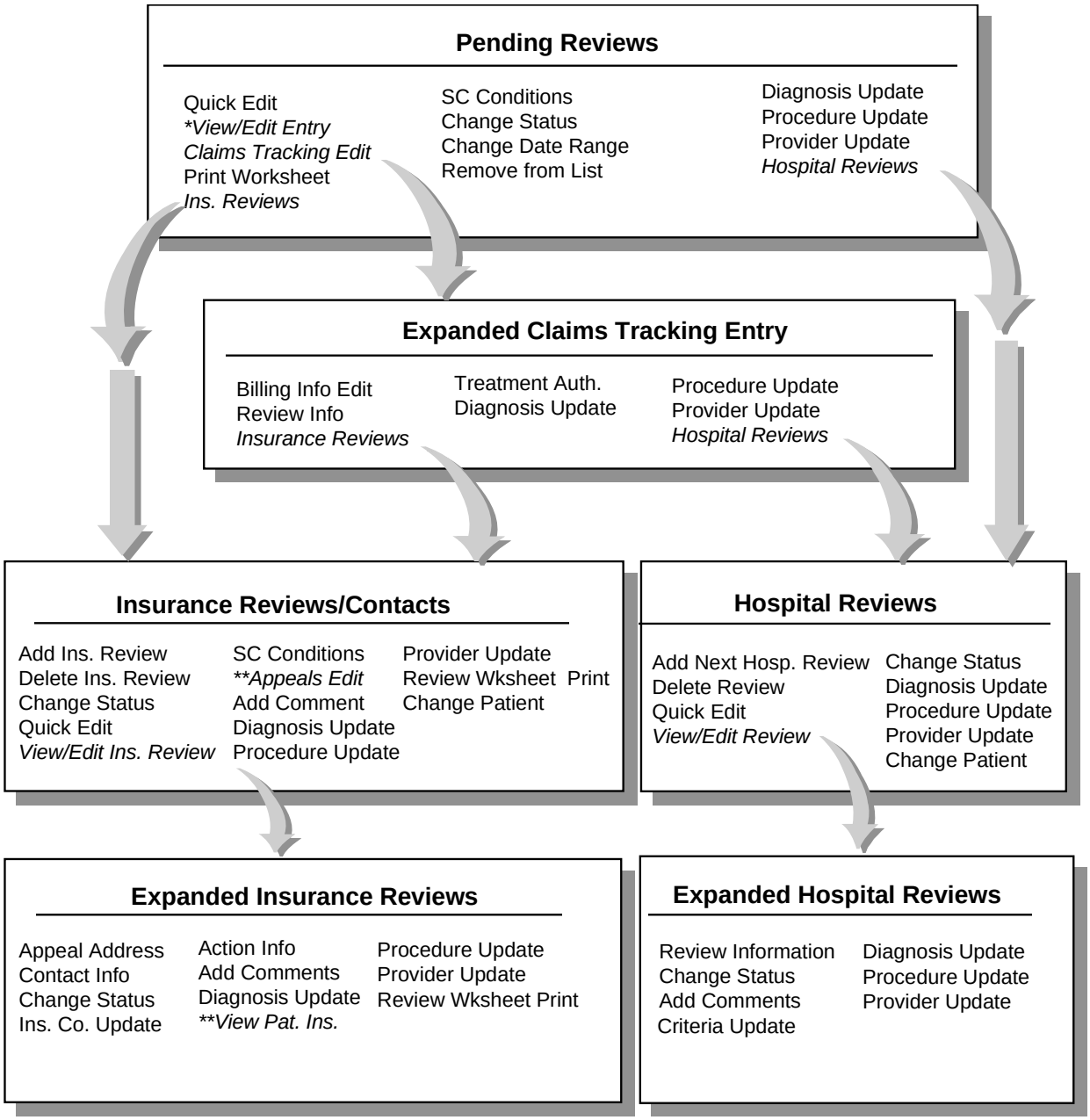
To accomplish this...	Do this...
Print a summary of Hospital Reviews	UR Activity Report - prints cases reviewed and the results Inquire to Claims Tracking - prints visit, billing, and insurance information for a single visit, and lists all reviews performed Print CT Summary for Billing - visit, insurance, billing, eligibility
Have one person enter data, and another review and "complete" it.	The person entering the data should give the review a status of PENDING. The person reviewing/approving should then use the Inquire to Claims Tracking or Print CT Summary for Billing option to print the reviews. Then go into the Insurance Reviews Edit or Hospital Reviews option to edit, if necessary, then use the CS (Change Status) action on these screens to update the status to COMPLETE.

Pending Reviews

This option uses a series of screens to display all pending reviews that have a pending review date within the last seven days. Each day, a Pending Review List should be printed sorted by ward, patient, assignment or date and used on the ward to perform reviews. The Pending Reviews option may then be used to perform all necessary actions on the reviews. This option is available to individuals who do Insurance Reviews, Hospital Reviews or both. If the user performs both types of reviews, a plus sign (+) will appear by the names of patients needing both types of review. On admission, appropriate reviews are automatically made pending for the day they are added. Please refer to the Insurance Reviews and Hospital Reviews option documentation for information on when reviews are automatically created.

For examples of screens accessed while using this option, please refer to the example section of the appropriate option documentation (i.e., Claims Tracking Edit option for the Claims Tracking Entry Screen, Hospital Reviews option for the Hospital Review Screens, etc.).

The chart on the following page shows the Claims Tracking Screens accessed through this option and the actions available on each screen. Actions may not be shown in the order in which they actually appear on the screens.



*The View Edit Entry action will take you directly to the Expanded Insurance or Expanded Hospital Reviews Screens depending on the type of review.

**The View Pat. Ins action brings you to the Patient Insurance Screens. The Appeals Edit action brings you to the Appeal and Denial Tracking screen. Please refer to the Patient Insurance Menu and the Appeal/Denial Edit option for details.

About the Screens
In the top left corner of each screen is the screen title. A plus sign (+) at the bottom left of the screen indicates there are additional screens. Left or right arrows (<<< >>>) may be displayed to indicate there is additional information to the left or right on the screen. Available actions are displayed below the screen. Two question marks entered at any "Select Action" prompt displays all available actions for that screen. For more information on the use of the screens, please refer to the appendix at the end of this manual.

You may quit from any screen, which will bring you back one level or screen, or you may exit (this exits the option entirely and returns you to the menu).

Common Actions
The following actions are common to more than one screen accessed through this option. They are listed here to avoid duplication of documentation.

Quick Edit - This action allows you to quickly edit all information about the review without leaving the Pending Review option.

SC Conditions - This action allows a quick look at the patient's eligibility, SC status, service-connected conditions, and percent of service connection for service-connected veterans.

Change Status - This action allows you to quickly change the status of a review. Only completed reviews are used in the report preparation and by the MCCR NDB roll-up or the QM roll-up (which is tentatively scheduled for release in June 1994).

Reviews have a status of ENTERED when automatically added. A status of PENDING may be used for those you are still working on or when one person does the data entry and another needs to review it.

Add Comment - This action allows you to edit the word processing (comments) field in Hospital or Insurance Reviews without having to edit other fields.

Diagnosis Update - This action allows input of ICD-9 diagnoses for the patient. Whether diagnoses are input on this screen or another screen, they are available across the Claims Tracking module. You may enter an admitting diagnosis, primary (DXLS) diagnosis, secondary diagnosis and the onset date of the diagnosis for this admission. For outpatient visits this information is stored with the outpatient encounter information.

Procedure Update - This action allows the input of ICD-9 procedures for the patient. You may input the procedure and the date. This is a separate procedure entry from the PTF module and is optional for use.

Provider Update - This action allows you to input the admitting physician, attending physician, and care provider separate from the MAS information. The purpose is to provide a location to document the attending physician and to provide an alternate place to document individual physicians if the administrative record indicates teams, or vice versa.

Change Patient - This action allows you to change the selected patient without having to leave and reenter the option.

Review Worksheet Print - This action prints a worksheet for use on the wards for writing notes prior to calling the insurance company and entering the review. Basic information about the patient and the visit is included. Please note that the format is slightly different for 80 and 132 column outputs.

Pending Reviews Screen

View/Edit Entry - This action allows you to jump to either the expanded Insurance Review screen or the expanded Hospital Review screen, depending on the type of review.

Claims Tracking Edit - This action allows you to jump to the expanded Claims Tracking screen and perform all necessary edits to the entry in that file. This may include the input of billing information.

Print Worksheet - This action allows you to print a generic worksheet for selected entries. The latest administrative data is printed on the worksheet including patient name, ward, physicians, room-bed, etc.

Insurance Reviews - This action allows you to jump to the Insurance Reviews Screen. For details see the Insurance Reviews option documentation. Please note that if you try to perform an Insurance Review on a pending Hospital Review, the software will automatically take you to the Hospital Review screen. This action is not available on the Claims Tracking Menu (Hospital Reviews).

Hospital Reviews - This action allows you to jump to the Hospital Reviews screen. For details see the Hospital Reviews option documentation. Please note that if you try to perform a Hospital Review on a pending Insurance Review, the software will automatically take you to the Insurance Review screen. This action is not available on the Claims Tracking Menu (Insurance Reviews).

Change Date Range - This action allows you to change the beginning and ending date of the search for pending reviews. You can search into the past or future for pending reviews. Reviews for the past 7 days is the default.

Remove From List - This action allows you to quickly remove the review from the Pending Review List by automatically deleting the Next Review Date. For Insurance Reviews, the TRACK AS INSURANCE CLAIM field is also asked. If this is set to NO, no further reviews are automatically created for this visit.

On installation of IB V. 2.0, current inpatients with insurance are loaded. This action can be used to remove those you are not following.

Expanded Claims Tracking Entry Screen

Billing Info Edit - This action allows you to edit the billing information about expected revenues and next auto bill date. This is useful for comparing expected revenues versus what was received.

Review Info - This action allows you to review/edit whether or not a special consent release of information form (ROI) for this patient for this episode of care is required, obtained, or not necessary; and whether this review should be tracked as a random sample, insurance claim, special condition, or local addition.

Treatment Auth. - This action allows you to enter whether a second opinion for this patient insurance policy was required and obtained. (If a second opinion was obtained but did not meet the insurance company's criteria, enter NO in the SECOND OPINION OBTAINED field.) This field will be used to help determine the estimated reimbursement from the insurance carrier. If a second opinion was not obtained, certain denials and penalties may be assessed.

Hospital Reviews - This action accesses the Hospital Reviews Screen.

Insurance Reviews - This action accesses the Insurance Reviews/Contacts Screen.

Insurance Reviews/Contacts Screen

Add Ins. Review - This action will add a new review for the visit. Following are the default review types.

- Pre-certification Review (if it is a scheduled admission and no previous review)
- Urgent Admission review (if it is not a scheduled admission and no previous review)
- Continued Stay Review (for follow-up reviews)

Delete Ins. Review - This action allows an insurance review to be deleted. If a review is automatically created, but the visit does not require reviews and follow-up with the insurance company, it can be deleted. Use care in exercising this action. It can be as important to document that no review is required as it is to document the required reviews.

View/Edit Ins. Review - This action allows access to the Expanded Insurance Reviews Screen.

Appeals Edit - This action allows you to jump to the Appeals and Denials Screen. For details see the Appeals and Denials option. Only denials and penalties may be appealed. This action is not available on the Claims Tracking for Hospital Reviews option.

Expanded Insurance Reviews

Appeal Address - This action allows you to edit the appeals address information for the insurance company.

Contact Info - This action allows you to enter/edit the review date, person contacted, method of contact, phone and reference numbers.

Ins. Co. Update - This action allows you to view/edit the billing, pre-certification, verification, claims, appeals, and inquiry phone numbers for the insurance company.

Action Info - This action allows you to view/edit information pertaining to action taken on a review such as type of contact, care authorization from and to dates, authorization number, and review date and status.

View Pat. Ins. - This action takes you to the Patient Insurance Screens. Please refer to the Patient Insurance Menu documentation.

Hospital Reviews Screen

Add Next Hosp. Review - This action will add the next review and automatically set it to either an admission review or continued stay review. The day for review and review date are automatically computed but can be edited. The category of severity of illness and intensity of service that was met can be entered; or if not met, the reason it wasn't met.

Delete Review - This action allows a hospital review to be deleted. If a review is automatically created, but the visit does not require reviews and follow-up with the insurance company, it can be deleted. Use care in exercising this action. It can be as important to document that no review is required as it is to document the required reviews.

View/Edit Review - This action allows access to the Expanded Hospital Reviews Screen.

Expanded Hospital Reviews Screen

Review Information - This action allows you to enter/edit the type of review (admission or continued stay), review date, and the specialty and methodology for the review. There should be only one admission review for an admission. Normally, reviews are done for UR purposes on days 3, 6, 9, 14, 21, 28, and every 7 days thereafter. (Usually, the INTERQUAL method is used as the methodology for UR required review. Insurance carriers may require other review methodologies.)

Criteria Update - This action allows you to enter or edit data regarding criteria met/not met for an acute admission within 24 hours, such as the review date and methodology; severity of illness and intensity of service; and whether additional reviews are required

Single Patient Admission Sheet

This option allows you to print an admission sheet for a single visit (either the current admission or a selected admission). The admission sheet serves as a temporary cover sheet in the inpatient chart where reviewers and coders can make notes about the visit in summary form. If the facility chooses to have physicians sign the admission sheet, it can then be used as documentation to prepare inpatient bills prior to the signing of the discharge summary.

Insurance Review Edit

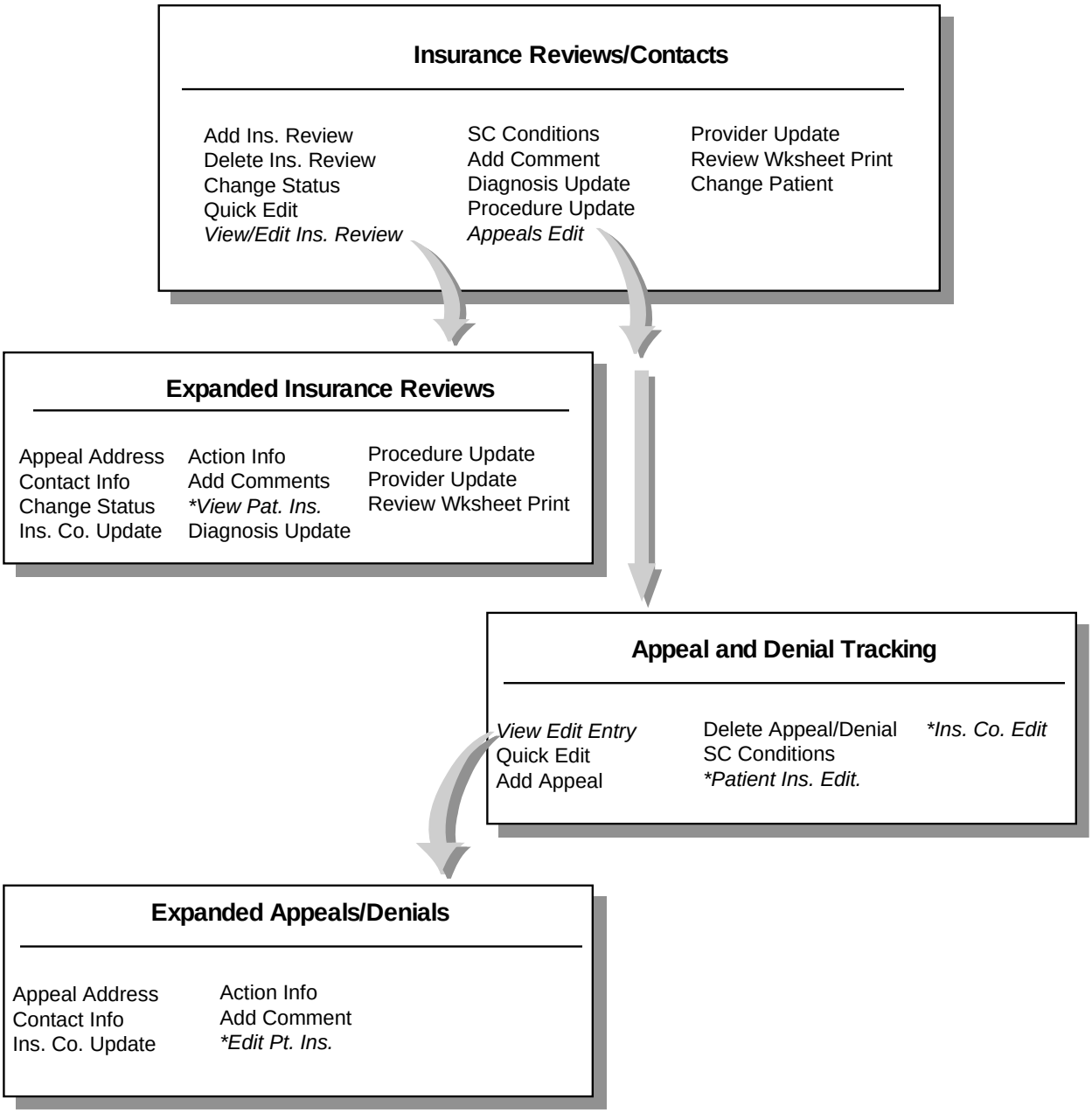
This option uses a series of screens to allow you to enter and edit MCCR/UR related contacts associated with a claims tracking entry.

An initial review is automatically created upon admission for all insured patients. If UR is not required for the patient, the review can be deleted, inactivated, or left in an Entered status. If reviews are performed, and contact with the insurance company is made, the following information can be documented through this option.

- Contact with the insurance company
- Action taken by the insurance company
- Relevant clinical information
- The need for further reviews

Once a review or entry is complete, its status should be updated to COMPLETE in order to be used in reporting. If further reviews are required, the NEXT REVIEW DATE should contain the date the next review is required. It will then appear in the Pending Reviews option or the Pending Reviews List.

The following chart shows the Claims Tracking Screens accessed through this option and the actions available on each screen. Actions may not be shown in the order in which they actually appear on the screens.



*These actions bring you to the Patient Insurance Screens. Please refer to the Patient Insurance Menu section of this manual for documentation of these screens.

About the Screens...

In the top left corner of each screen is the screen title. A plus sign (+) at the bottom left of the screen indicates there are additional screens. Left or right arrows (<<< >>>) may be displayed to indicate there is additional information to the left or right on the screen. Available actions are displayed below the screen. Two question marks entered at any "Select Action" prompt displays all available actions for that screen. For more information on the use of the screens, please refer to the appendix at the end of this manual.

You may quit from any screen, which will bring you back one level or screen, or you may exit (this exits the option entirely and returns you to the menu).

Common Actions

The following actions are common to more than one screen accessed through this option. They are listed here to avoid duplication of documentation.

Quick Edit - This action allows you to edit most of the fields in Claims Tracking, specify if there should be insurance or hospital reviews, add billing information, and assign the visit to a reviewer.

SC Conditions - This action allows a quick look at the patient's eligibility, SC status, service-connected conditions, and percent of service connection for service-connected veterans.

Diagnosis Update - This action allows input of ICD-9 diagnoses for the patient. Whether diagnoses are input on this screen or another screen, they are available across the Claims Tracking module. You may enter an admitting diagnosis, primary (DXLS) diagnosis, secondary diagnosis, and the onset of the diagnosis for this admission. For outpatient visits, this information is stored with the outpatient encounter information.

Procedure Update - This action allows the input of ICD-9 procedures for the patient. You may input the procedure and the date. This is a separate procedure entry from the PTF module and is optional for use.

Provider Update - This action allows you to input the admitting physician, attending physician, and care provider separate from the MAS information. The purpose is to provide a location to document the attending physician and to provide an alternate place to document actual physicians if the administrative record indicates teams or vice versa.

Change Status - This action allows you to quickly change the status of a review. Only completed reviews are used in the report preparation and by the MCCR NDB roll-up or the QM roll-up (which is tentatively scheduled for release in June, 1994).

Reviews have a status of ENTERED when automatically added. A status of PENDING may be used for those you are still working on or when one person does the data entry and another needs to review it.

Add Comment - This action allows you to edit the word processing (comments) field in Hospital or Insurance Reviews without having to edit other fields.

Review Worksheet Print - This action prints a worksheet for use on the wards for writing notes prior to calling the insurance company and entering the review. Basic information about the patient and the visit is included. Please note that the format is slightly different for 80 and 132 column outputs.

Following is a list of the screens, the actions they provide, and a brief description of each action.

Insurance Reviews/Contacts

Add Ins. Review - This action will add a new review for the visit. Following are the default review types.

- Pre-certification Review (if it is a scheduled admission and no previous review)
- Urgent Admission review (if it is not a scheduled admission and no previous review)
- Continued Stay Review (for follow-up reviews)

Delete Ins. Review - This action allows an insurance review to be deleted. If a review is automatically created, but the visit does not require reviews and follow-up with the insurance company, it can be deleted. Use care in exercising this action. It may be just as important to document that no review is required as it is to document the required reviews.

View/Edit Ins. Review - This action allows access to the Expanded Insurance Reviews Screen.

Appeals Edit - This action allows you to jump to the Appeals and Denials Screen to add/edit appeals. Only reviews where the action is either a denial or a penalty can be appealed. The denials and penalties can be edited on either the appeals screen or the insurance reviews screen. Appeals can only be edited on the appeals screen.

Change Patient - This action allows you to change to another patient without going back to the beginning of the option.

Expanded Insurance Reviews

Appeal Address - This action allows you to edit the appeals address information for the insurance company.

Contact Info - This action allows you to enter/edit the review date, person contacted, method of contact, phone and reference numbers.

Ins. Co. Update - This action allows you to view/edit the billing, pre-certification, verification, claims, appeals, and inquiry phone numbers for the insurance company.

Action Info - This action allows you to view/edit information pertaining to action taken on a review such as type of contact, care authorization from and to dates, authorization number, and review date and status.

View Pat. Ins. - This action takes you to the Patient Insurance Screens. Please refer to the Patient Insurance Menu documentation.

Appeal and Denial Tracking Screen

View/Edit Entry - This action allows you to jump to the Expanded Appeal/Denial Screen where you can view much of the data for one visit and perform related actions.

Add Appeal - This action allows adding an appeal to a denial or penalty. The first appeal will be an initial appeal. All other appeals will be subsequent appeals. You may enter an administrative or clinical appeal. There is no limit to the number of appeals that may be entered.

Delete Appeal/Denial - This action allows deletion of appeals and denials. This was designed for use in cases of erroneous entry.

Patient Ins. Edit - This action allows editing of fields in the Insurance Company file (#36) that pertain to appeals address and phone numbers.

Ins. Co. Edit - This action allows you to edit patient policy information.

With the exception of the Edit Pt. Ins. action, all other actions available on this screen are also available on the Expanded Insurance Reviews Screen documented on the previous page.

Edit Pt. Ins. - This action brings you to the Patient Insurance Screen. Please refer to the Patient Insurance Menu section of this manual for documentation.

Sample Screens

```
Insurance Reviews/Contacts    Feb 04, 1994 10:37:09          Page:    1 of    1
Insurance Review Entries for: IBpatient,one     1111   ROI: OBTAINED
                          for: INPATIENT ADMISSION on 01/13/94 9:30 am
    Date       Ins. Co.            Type Contact       Action    Auth. No.  Days
1   01/14/94   ABC INS             URG ADM

          Service Connected: 20%   Previous Spec. Bills: OWC                >>>
AI  Add Ins. Review       SC  SC Conditions         PV  Provider Update
DI  Delete Ins. Review    AE  Appeals Edit          RW  Review Wksheet Print
CS  Change Status         AC  Add Comment           CP  Change Patient
QE  Quick Edit            DU  Diagnosis Update      EX  Exit
VE  View/Edit Ins. Review PU  Procedure Update
```

```
Insurance Reviews/Contacts    Feb 07, 1994 15:45:07          Page:    1 of    1
Insurance Review Entries for: IBpatient,one     1111   ROI: OBTAINED
                          for: INPATIENT ADMISSION on 01/13/94 9:30 am
    Date       Ins. Co.            Type Contact       Action    Auth. No.  Days
1   01/14/94   ABC INS             URG ADM            APPROVED  88889354A    5

          Service Connected: 20%   Previous Spec. Bills: OWC                >>>
AI  Add Ins. Review       SC  SC Conditions         PV  Provider Update
DI  Delete Ins. Review    AE  Appeals Edit          RW  Review Wksheet Print
CS  Change Status         AC  Add Comment           CP  Change Patient
QE  Quick Edit            DU  Diagnosis Update      EX  Exit
VE  View/Edit Ins. Review PU  Procedure Update
```

```
Insurance Reviews/Contacts    Feb 07, 1994 15:53:12          Page:    1 of    1
Insurance Review Entries for: IBpatient,one     1111   ROI: OBTAINED
                          for: INPATIENT ADMISSION on 01/13/94 9:30 am
    Date       Ins. Co.            Type Contact       Action    Auth. No.  Days
1   01/16/94   ABC INS             CONT. STAY         DENIAL                 3
2   01/14/94   ABC INS             URG ADM            APPROVED  88889354A    5 ‌‌‌
```

```
Expanded Insurance Reviews    Feb 07, 1994 15:54:38          Page:    2 of    2
Expanded Insurance Reviews for: IBpatient,one     1111   ROI: OBTAINED
                           for: INPATIENT ADMISSION on 01/13/94 9:30 am

  Appeal Address Information                    User Information
   Ins. Co. Name: ABC INS                        Entered By: ALAN
  Alternate Name: ABC INS                        Entered On: 01/14/94 3:01 pm
   Street line 1: 122 MAIN STREET            Last Edited By: ALAN
   Street line 2: APPEALS OFFICE             Last Edited On: 01/14/94 3:04 pm
   Street line 3: BOX 13 SUITE 305
  City/State/Zip: TROY, NY  12180

  Comments
   Per June, policy does not cover provided care.  File administrative
   Appeal if not convinced.

  Service Connected Conditions:
 Service Connected: 20%

          Enter ?? for more actions
AA  Appeal Address        AI  Action Info           PU  Procedure Update
CI  Contact Info          AC  Add Comments          PV  Provider Update
CS  Change Status         VP  View Pat. Ins.        RW  Review Wksheet Print
IU  Ins. Co. Update       DU  Diagnosis Update      EX  Exit
```

```
Expanded Insurance Reviews    Feb 07, 1994 15:54:38          Page:    1 of    2
Expanded Insurance Reviews for: IBpatient,one     1111   ROI: OBTAINED
                           for: INPATIENT ADMISSION on 01/13/94 9:30 am

  Contact Information                       Action Information
     Contact Date: 01/16/94                   Type Contact: CONTINUED STAY REVI
 Person Contacted: SPOUSE                       Action: DENIAL
   Contact Method: PHONE                      Denied From: 01/17/94
 Call Ref. Number: 88888SS                      Denied To: 01/20/94
      Review Date:                          Denial Reasons: NOT MEDICALLY NECES
                                            Denial Reasons: TREATMENT PROVIDED

                           Insurance Policy Information
    Ins. Co. Name: ABC INS                  Subscriber Name: IBpatient,one
     Group Number: 4446333                    Subscriber ID: 000111111
  Whose Insurance: VETERAN                  Effective Date: 01/01/88
   Pre-Cert Phone: 555-555-4312             Expiration Date:

+         Enter ?? for more actions
AA  Appeal Address        AI  Action Info           PU  Procedure Update
CI  Contact Info          AC  Add Comments          PV  Provider Update
CS  Change Status         VP  View Pat. Ins.        RW  Review Wksheet Print
IU  Ins. Co. Update       DU  Diagnosis Update      EX  Exit
```

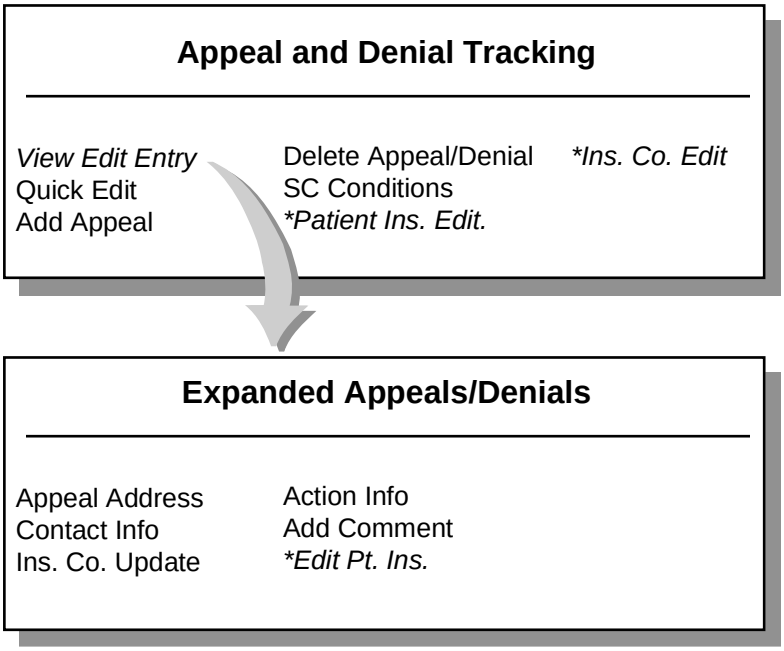
```
Insurance Reviews/Contacts    Feb 07, 1994 15:53:12          Page:    1 of    1
Insurance Review Entries for: IBpatient,one     1111   ROI: OBTAINED
                          for: INPATIENT ADMISSION on 01/13/94 9:30 am
    Date       Ins. Co.            Type Contact       Action    Auth. No.  Days
1   01/16/94   ABC INS             CONT. STAY         DENIAL                  3
2   01/14/94   ABC INS             URG ADM            APPROVED  88889354A     5



          Service Connected: 20%   Previous Spec. Bills: OWC                >>>
AI  Add Ins. Review       SC  SC Conditions         PV  Provider Update
DI  Delete Ins. Review    AE  Appeals Edit          RW  Review Wksheet Print
CS  Change Status         AC  Add Comment           CP  Change Patient
QE  Quick Edit            DU  Diagnosis Update      EX  Exit
VE  View/Edit Ins. Review PU  Procedure Update
```

Appeal/Denial Edit

This option allows you to enter, edit, and track the appeals for either a patient or an insurance company. You can speed processing by using the following syntax: 2.<entry name> (i.e., 2.John) to enter a patient name or 36.<entry name> (i.e., 36.GHI) to select an insurance company. If you simply enter a name, the system searches both files for the name you have entered.

This option uses a series of screens to display denials and penalties with all associated appeals. It is very similar to the Insurance Review option; however, if an appeal is approved or partially approved, the amount won on appeal is tracked.

The following chart shows the Claims Tracking Screens accessed through this option and the actions available on each screen. Actions may not be shown in the order in which they actually appear on the screens.



*These actions bring you to the Patient Insurance Screens. Please refer to the Patient Insurance Menu section of this manual for documentation of these screens.

About the Screens...
In the top left corner of each screen is the screen title. A plus sign (+) at the bottom left of the screen indicates there are additional screens. Left or right arrows (<<< >>>) may be displayed to indicate there is additional information to the left or right on the screen. Available actions are displayed below the screen. Two question marks entered at any "Select Action" prompt displays all available actions for that screen. For more information on the use of the screens, please refer to the appendix at the end of this manual.

You may quit from any screen, which will bring you back one level or screen, or you may exit (this exits the option entirely and returns you to the menu).

Following is a list of the screens accessed through this option, the actions they provide, and a brief description of each action.

Appeal and Denial Tracking Screen

View/Edit Entry - This action allows you to jump to the Expanded Appeal/Denial Screen where you can view much of the data for one visit and perform related actions.

Quick Edit - This action allows you to edit nearly all of the fields in the appeal or denial, add comments, maintain its status, and assign follow-up dates.

Add Appeal - This action allows adding an appeal to a denial or penalty. The first appeal will be an initial appeal. All other appeals will be subsequent appeals. You may enter an administrative or clinical appeal. There is no limit to the number of appeals that may be entered.

Delete Appeal/Denial - This action allows deletion of appeals and denials. This was designed to be used in cases of erroneous entry.

SC Conditions - This action allows a quick look at the patient's eligibility, SC status, service-connected conditions, and percent of service connection for service-connected veterans.

Ins. Co. Edit - This action allows editing of fields in the Insurance Company file (#36) that pertain to appeals address and phone numbers.

Patient Ins. Edit - This action allows you to edit patient policy information.

Expanded Appeals/Denials Screen

Appeal Address - This action allows you to edit the name and address for a selected appeal.

Contact Info - This action allows you to enter/edit the review date, person contacted, method of contact, phone and reference numbers.

Ins. Co. Update - This action allows you to view/edit the billing, pre-certification, verification, claims, appeals, and inquiry phone numbers for the insurance company.

Action Info - This action allows you to view/edit information pertaining to action taken on a review such as type of contact, care authorization from and to dates, authorization number, and review date and status.

Add Comment - This action allows you to edit the word processing (comments) field in Hospital or Insurance Reviews without having to edit other fields.

Edit Pt. Ins. - This action brings you to the Patient Insurance Screen. Please refer to the Patient Insurance Menu section of this manual for documentation.

Sample Screens

```
Appeal and Denial Tracking    Feb 08, 1994 09:59:09          Page:    1 of    1
Denials and Appeals for: IBpatient,one     1111

    Ins. Co.          Group        Date      Action     Visit    Visit Date
1   ABC INS           4446333      01/16/94  DENIAL     ADMIT    01/13/94 9:30 a









          Service Connected: 20%   Previous Spec. Bills: OWC                >>>
VE  View Edit Entry       DA  Delete Appeal/Denial  IC  Ins. Co. Edit
QE  Quick Edit            SC  SC Conditions         EX  Exit
AA  Add Appeal            PI  Patient Ins. Edit.
```

```
Appeal and Denial Tracking    Feb 08, 1994 09:59:09          Page:    1 of    1
Denials and Appeals for: IBpatient,one     1111

    Ins. Co.          Group        Date      Action     Visit    Visit Date
1   ABC INS           4446333      01/16/94  DENIAL     ADMIT    01/13/94 9:30 a
2   ABC INS           4446333      01/17/94  1st Appeal ADMIT    01/13/94 9:30 a



          Service Connected: 20%   Previous Spec. Bills: OWC                >>>
AI  Add Ins. Review       SC  SC Conditions         PV  Provider Update
DI  Delete Ins. Review    AE  Appeals Edit          RW  Review Wksheet Print
CS  Change Status         AC  Add Comment           CP  Change Patient
QE  Quick Edit            DU  Diagnosis Update      EX  Exit
VE  View/Edit Ins. Review PU  Procedure Update
```

Inquire to Claims Tracking

This option will display or print stored information about a single visit. You are prompted to select a patient and the Claims Tracking entry you wish to view/print. Visit, billing, and insurance information is provided, as well as all reviews performed. This output is less detailed than the Claims Tracking Summary for Billing option, and does not contain the word processing fields from the reviews.

```
Claim Tracking Inquiry                          Page 1  Jan 14, 1994@15:55:54
IBpatient,one                     000-11-1111           DOB: Jan 01, 1940
INPATIENT ADMISSION on Jan 13, 1994@09:30:35
-------------------------------------------------------------------------------
 Visit Information
    Visit Type: INPATIENT ADMISSION          Visit Billable: YES
Admission Date: JAN 13,1994@09:30:35         Second Opinion: NOT REQUIRED
          Ward: 11-B MEDICINE XREF           Auto Bill Date:
     Specialty: MEDICINE                    Special Consent: ROI OBTAINED
Discharge Date:                             Special Billing: FEDERAL OWCP

  Billing Information
  Initial Bill:                        Estimated Recv (Pri): $
   Bill Status:                        Estimated Recv (Sec): $
 Total Charges: $        0             Estimated Recv (ter): $
   Amount Paid: $        0               Means Test Charges: $
```

```
Claim Tracking Inquiry                          Page 2  Jan 14, 1994@15:55:54
IBpatient,one                     000-11-1111           DOB: Jan 01, 1940
INPATIENT ADMISSION on Jan 13, 1994@09:30:35
-------------------------------------------------------------------------------

  Insurance Review Information
    Type Review: INITIAL APPEAL              Review Date: 01/17/94
    Appeal Type: ADMINISTRATIVE            Insurance Co.: ABC
    Case Status: OPEN                   Person Contacted: Mary
No Days Pending: 3                        Contact Method: Letter
  Final Outcome:                        Call Ref. Number:
                                                  Status: COMPLETE
                                          Last Edited By:

    Type Review: CONTINUED STAY REVIEW       Review Date: 01/16/94
         Action: DENIAL                    Insurance Co.: ABC
    Denied From: 01/17/94               Person Contacted: SPOUSE
      Denied To: 01/20/94                 Contact Method: PHONE
 Denial Reasons: NOT MEDICALLY NECESSAR Call Ref. Number: 88888SS
 Denial Reasons: TREATMENT PROVIDED NOT           Status: COMPLETE
                                          Last Edited By: ALAN
```

```
Claim Tracking Inquiry                          Page 3  Jan 14, 1994@15:55:54
IBpatient,one                     000-11-1111           DOB: Jan 01, 1940
INPATIENT ADMISSION on Jan 13, 1994@09:30:35
-------------------------------------------------------------------------------
    Type Review: URGENT/EMERGENT ADMIT       Review Date: 01/14/94
         Action: APPROVED                  Insurance Co.: ABC
Authorized From: 01/13/94               Person Contacted: Mary
  Authorized To: 01/18/94                 Contact Method: VOICE MAIL
Authorized Diag: 259.0 - DELAY SEXUAL D Call Ref. Number: 88889354A
   Auth. Number: 88889354A                        Status: COMPLETE
                                         Last Edited By: ALAN

  Hospital Review Information
     Review Date: 01/15/94                 Day of Review:  3
     Review Type: CONTINUED STAY REVIEW  Severity of Ill: Generic
       Specialty: MEDICINE              Intensity of Svc: Generic
     Methodology: INTERQUAL             Non-Acute Reason:
          Status: ENTERED
  Last Edited By: ALAN
```

Manually Add Opt. Encounters to Claims Tracking

Outpatient encounters that have been checked out through the Scheduling module are normally added during the IB nightly background job. Only primary outpatient encounters that have been checked out will be added in the first twenty days after the date of the encounter. This option allows you to search for outpatient encounters that were not checked out within twenty days and automatically add them to Claims Tracking. If you choose to run the automated bill preparation portion of IB V. 2.0, you should periodically run this report to insure that all outpatient care is billed. This option is automatically queued and a mail message is sent upon completion.

You may queue this option into the future; however, only outpatient encounters checked out at least one day prior to the actual running will be added automatically. A message indicating any change will be added to the completion mail message.

Sample Mail Message

```
Subj: Outpatient Encounters added to Claims Tracking Complete  [#114893]
02 Feb 94 08:52  12 Lines
From: INTEGRATED BILLING PACKAGE  in 'IN' basket.   Page 1  **NEW**
-------------------------------------------------------------------------------

The process to automatically add Opt Encounters has successfully completed.

              Start Date: 01/22/94
                End Date: 01/31/94
(Selected end date of 02/1/94 automatically changed to 01/31/94.

            Total Encounters Checked: 0
              Total Encounters Added: 0
 Total Non-billable Encounters Added: 0

*The SC, Agent Orange, Environmental Contaminate, and Ionizing
Radiation visits have been added for insured patients but
automatically indicated as not billable


Select MESSAGE Action: IGNORE (in IN basket)//
```

Claims Tracking Parameter Edit

This option allows you to edit MCCR site parameters that affect the Claims Tracking module.

Following is a list of each parameter with a brief description.

INSURANCE EXTENDED HELP
Should the extended help display always be on in the Insurance Management options.

ON - if you always want it to display automatically
OFF - if you do not want to see it

It is recommended that the extended help be turned on initially after V. 2 is installed. As users become more familiar with the new functionality, the parameter can be turned off.

CLAIMS TRACKING START DATE
If you choose to run the Claims Tracking module and populate the files with past episodes of care, (If the year is omitted, the computer uses the CURRENT YEAR.) this is the earliest visit date that the Claims Tracking software will add visits. (Earlier visit dates may be added manually.)

INPATIENT CLAIMS TRACKING
This field determines what inpatients will automatically be added to the Claims Tracking module. It is recommended that it is set to INSURED AND UR ONLY.

OFF - no new patients will be added
INSURED AND UR ONLY - only the insured patients and random sample patients will be added
ALL PATIENTS -a record of all admissions will be created

If a patient is not insured, each record will be so annotated automatically on creation and no follow-up will be required. The advantage of tracking all patients is that you can determine the percentage of billable cases and make necessary adjustments if the patients are later found to have insurance. The disadvantage is that additional capacity is used.

OUTPATIENT CLAIMS TRACKING
This field determines whether outpatient visit dates will automatically be entered into the Claims Tracking module.

OFF - no entries will be entered
INSURED ONLY - only outpatient encounters for insured patients will be added
ALL PATIENTS - an entry for all outpatient encounters will be added

PRESCRIPTION CLAIMS TRACKING
This field determines whether prescriptions will automatically be entered into the Claims Tracking module.

If a prescription or refill does not appear to be billable, that is it may be for SC care, or there is a visit date associated with that prescription or refill, this will be so noted in the reason not billable.

It is recommended that this field is set to INSURED ONLY.

OFF - no prescriptions or refills will be entered
INSURED ONLY - only prescriptions and refills will be added if the patient is insured
ALL PATIENTS - an entry for all prescriptions will be entered

PROSTHETICS CLAIMS TRACKING
This field will be used to determine if prosthetics should be tracked in the Claims Tracking module.

OFF - no prosthetic items should be tracked
INSURED ONLY - only prosthetic items for patients with insurance will be tracked
ALL PATIENTS - prosthetic items for all patients will be tracked

REPORTS ADD TO CLAIMS TRACKING
This field determines whether or not you wish to allow the Veterans with Insurance reports to add entries to Claims tracking. Enter YES for admissions and outpatient visits found as billable but not found in claims tracking to be added to claims tracking for billing information purposes only. No review will be set up. This is to allow flagging of these visits as unbillable so that they can be removed from these reports.

Answering 'YES' does not guarantee that the entry will be added. The related parameters about whether Claims Tracking is turned on and the Claims Tracking Start Date will over ride this parameter.

USE ADMISSION SHEETS
Indicate whether your facility is using Admission Sheets as part of the MCCR/UR functionality. If this parameter is answered YES, users will be asked for the device to print admissions sheets to. The default device will be from the BILL FORM TYPE file.

In the future, it may be possible to print an admission sheet upon admission if this field is set to YES.

ADMISSION SHEET HEADER LINE 1
Enter the text that your facility would like to have printed as the first line of the header on the admission sheet. This is usually the name of your medical center.

ADMISSION SHEET HEADER LINE 2
Enter the text that your facility would like to have printed as the second line of the header on the admission sheet. This is usually the street address of your medical center.

ADMISSION SHEET HEADER LINE 3
Enter the text that your facility would like to have printed as the third line of the header on the admission sheet. This is usually the city, state, and zip code of your medical center.

MEDICINE SAMPLE SIZE
This is the number of required Utilization Reviews that you wish to have done each week for Medicine admissions. The minimum recommended by the QA office is one per week.

MEDICINE WEEKLY ADMISSIONS
This is the minimum number of admissions that your facility usually averages for Medicine. This is used along with the Medicine Sample Size to compute a random number. Changing this number to a lower value will cause the random sample case to be selected earlier in the week. A higher number provides a more even distribution of cases during the week. If the number exceeds the admissions for the week, the possibility exists that a random sample case may not be generated for this service.

SURGERY SAMPLE SIZE
This is the number of required Utilization Reviews that you wish to have done each week for Surgery admissions. The minimum recommended by the QA office is one per week.

SURGERY WEEKLY ADMISSIONS
This is the minimum number of admissions that your medical center usually averages for Surgery. This is used along with the Surgery Sample Size to compute a random number. Changing this number to a lower value will cause the random sample case to be selected earlier in the week. A higher number provides a more even distribution of cases during the week. If the number exceeds the admissions for the week, the possibility exists that a random sample case may not be generated for this service.

PSYCH SAMPLE SIZE
This is the number of required Utilization Reviews that you wish to have done each week for Psychiatry admissions. The minimum recommended by the QA office is one per week.

PSYCH WEEKLY ADMISSIONS
This is the minimum number of admissions that your medical center usually averages for Psychiatry. This is used along with the Psychiatry Sample Size to compute a random number. Changing this number to a lower value will cause the random sample case to be selected earlier in the week. A higher number provides a more even distribution of cases during the week. If the number exceeds the admissions for the week, the possibility exists that a random sample case may not be generated for this service.

Manually Add Rx Refills to Claims Tracking

Prescription refills that have been released within ten days of the fill date are automatically added during the IB nightly background job. This option allows you to search for refills that were not released within ten days and automatically add them to Claims Tracking. If you choose to run the automated bill preparation portion of IB V. 2.0, you should run this report periodically to insure that all outpatient care is billed. This option is automatically queued and a mail message is sent upon completion.

You may queue this option into the future; however, only outpatient encounters checked out at least one day prior to the actual running will be added automatically. A message indicating any change will be added to the completion mail message.

Sample Mail Message

```
Subj: Rx Refills added to Claims Tracking Complete  [#114894] 02 Feb 94 08:52
  10 Lines
From: INTEGRATED BILLING PACKAGE  in 'IN' basket.   Page 1  **NEW**
-------------------------------------------------------------------------------

The process to automatically add Rx Refills has successfully completed.

              Start Date: 01/22/94
                End Date: 01/29/94
(Selected end date of 02/01/94 automatically changed to 01/29/94.)

  Total Rx fills checked: 0
Total NSC Rx fills Added: 0
 Total SC Rx fills Added: 0

*The fills added as SC require determination and editing to be billed


Select MESSAGE Action: IGNORE (in IN basket)//
```

UR Activity Report

The UR Activity Report includes the **total** activity during the date range. It provides a detailed listing of the Insurance Reviews, Hospital Reviews, or both for the selected dates; a summary report by admission; and a summary report by specialty. All completed Insurance Reviews are included. For Hospital Reviews, it lists each case reviewed indicating whether it met admission criteria, and the number of days that met/did not meet the criteria for acute care. The detailed report can be sorted by reviewer, specialty, or patient. If sorted by reviewer, it sorts within reviewer by type of review.

These reports could be shared with hospital management and clinical staff to communicate trends in care.

This report is formatted to print at 132 columns.

Sample Outputs

```
UR Insurance Review Activity Report                                                    Page 1  Feb 15, 1994@10:17:10
For Insurance Reviews Dated 01/01/94 to 02/15/94

                                Dates of                  Review
Patient              Pt. ID       Care        Review Type   Date        Ins. Co.              Action    Last
Reviewer
-------------------------------------------------------------------------------------------------------------------
IBpatient,one        000-11-1111  02/07/94    URG ADM       02/07/94    ABC INS               APPROVED  MARY

IBpatient, two       000-22-2222 12/24/93 to  PRE-ADM       01/07/94    CDPHP                 APPROVED  JOHN
                                 12/29/93
IBpatient, three  000-33-3333 02/01/94 to  URG ADM       02/11/94    BLUE SHIELD           APPROVED  MARY
                                 02/09/94
```

```
                                    UR ACTIVITY SUMMARY REPORT
                                      for Insurance Reviews
                                         ALBANY (500)

                                      From: JAN  1, 1994
                                       To: FEB 15, 1994

                                  Date Printed: Feb 15, 1994@10:17:10
                                          Page: 2
                                  --------------------------


                                       Total Admissions:         15
                                 Total Admissions to NHCU:        4
                           Total Admissions to Domiciliary:       1
                       Total Admissions Requiring Reviews:        0
                        Number of Scheduled Adm. Reviewed:        0

                           Total Admissions with Insurance:       4
                                 Total Billable Admissions:       3

                        Cases with Pre-Cert and Follow-up:        0
                         Cases with Pre-Cert no Follow-up:        0

                                   Number of Closed Cases:        0
                           Number of Billable Closed Cases:       0
                         Number of Unbillable Closed Cases:       0

                              Number of New Case Still Open:      0

                                 Number of Previous Cases:        0
             Number of Previous Cases Closed and Billable:        9
```

```
Number of Previous Cases Closed, not Billable:          0
          Number of Previous Cases still Open:          0

          Number of Outpatient Cases Reviewed:          0


                    Reason Not Billable Report:  Reason              Count
                    ---------------------------  ------------------------
                                                 NOT INSURED             1
```

```
INSURANCE REVIEW SPECIALTY SUMMARY REPORT            Feb 15, 1994@10:17:10   Page 3
For Insurance Reviews Dated 01/01/94 to 02/15/94

                         Days             Days          Amount           Amount
Specialty                Approved         Denied        Approved         Denied
-------------------------------------------------------------------------------------
GENERAL MEDICINE              0              0             $0               $0
MEDICINE                      5             10         $4,135           $8,270
ORTHOPEDIC SURGERY            0              0             $0               $0
UROLOGY                       0              1             $0           $1,164
Unknown                       0              0             $0               $0
-------------------------------------------------------------------------------
                              5             11         $4,135           $9,434
```

```
UR Hospital Review Activity Report                                          Page 4  Feb 15, 1994@10:17:10
For Hospital Reviews Dated 01/01/94 to 02/15/94

                                Dates of                    Admission      Days Met    Days Not Met
Patient              Pt. ID       Care         Review Type    Met Criteria   Criteria    Criteria      Assigned Reviewer
-------------------------------------------------------------------------------------------------------------------------
IBpatient,one        000-11-1111  02/07/94     RANDOM          YES                 1           0      JOHN

IBpatient, two       000-22-2222 12/23/93      RANDOM          YES                 1           0      ED

IBpatient, three   000-33-3333 02/01/94 to     COPD            YES                 1           0      STEVE
                                 02/09/94
IBpatient, four    000-44-4444  12/29/93       LOCAL                               1           0      SEAN
```

```
                                   UR ACTIVITY SUMMARY REPORT
                                     for Hospital Reviews
                                        ALBANY (500)

                                     From: JAN  1, 1994
                                      To: FEB 15, 1994

                                 Date Printed: Feb 15, 1994@10:17:10
                                          Page: 5
                                 --------------------------


                                    Total Admissions:         15

                                Total Cases Reviewed:         14
                       Number of New Case Still Open:          0
                            Number of Previous Cases:          3
                  Number of Previous Cases still Open:          0

                      Total Random Sample Cases:         12
                 Total Special Condition Cases:          1
                                          COPD:          1
                                           CVD:          0
                                          TURP:          0
                      Total Locally Added Cases:          1

               Total Cases Meeting Criteria on Adm.:         13
             Total Cases Not Meeting Crit. on Adm.:          1

                               Total Days Reviewed:         20
                         Total Days Meeting Criteria:         14
                     Total Days Not Meeting Criteria:          6
```

```
HOSPITAL REVIEW SPECIALTY SUMMARY REPORT              Feb 15, 1994@10:17:10   Page 6

For Hospital Reviews Dated 01/01/94 to 02/15/94
                      Admissions       Admissions      Days            Days
Specialty             Met Criteria     Not Met Crit.   Met Criteria    Not Met Crit.
-------------------------------------------------------------------------------------
GENERAL MEDICINE           5                0               0               5
MEDICINE                   1                0               2               1
NEUROLOGY                  0                0               1               0
ORTHOPEDIC SURGERY         3                0               0               3
PSYCHIATRY                 1                0               0               1
SURGERY                    2                0               1               2
UROLOGY                    1                1               2               1
-------------------------------------------------------------------------------
                          13                1               6              14
```

Days Denied Report

This report can print a summary or detailed listing of denials. It can be sorted by patient, attending physician, or bed service (i.e., surgery, psychiatry, medicine). The summary report shows the number of denials, the total days denied, the dollar amount of the denials, and the days won on appeal by service.

This report is formatted to print at 132 columns.

Sample Output

```
MCCR/UR DENIED DAYS Report for Reviews Dated Dec 12, 1993 to Feb 10, 1994           Page 1  Feb 10, 1994@14:55:10

                                Dates of                    Dates                                          Days Approved
Patient             Pt. ID       Care         Attending     Denied        Denial Reason             Appealed  on Appeal
-----------------------------------------------------------------------------------------------------------------------
IBpatient,one       000-11-1111  01/13/94       12114      01/21/94 to   TREATMENT PROVIDED NOT CO      YES          0
                                                           01/31/94 (11)

IBpatient, two      000-22-2222  01/13/94           1      01/14/94 to   NOT MEDICALLY NECESSARY        NO           0
                                                           01/14/94 (1)

                                                        ------
                                                            12
```

```
MCCR/UR DENIED DAYS Summary Report for Reviews Dated Dec 12, 1993 to Feb 10, 1994         Page 2  Feb 10, 1994@14:55:10

                                 Number         Days          Amount         Days won            Maximum
Service                          Denials        Denied        Denied         on Appeal           Billing Rate
-----------------------------------------------------------------------------------------------------------------
MEDICINE                             1            11          $9,097              0                $827
SURGERY                              1             1          $1,164              0              $1,164
                                                --------
                                                    12
```

Inquire to Claims Tracking

This option will display or print stored information about a single visit. You are prompted to select a patient and the Claims Tracking entry you wish to view/print. Visit, billing, and insurance information is provided, as well as all reviews performed. This output is less detailed than the Claims Tracking Summary for Billing option, and does not contain the word processing fields from the reviews.

Sample Output

```
Claim Tracking Inquiry                          Page 1  Jan 14, 1994@15:55:54
IBpatient,one                     000-11-1111           DOB: Jan 01, 1940
INPATIENT ADMISSION on Jan 13, 1994@09:30:35
-------------------------------------------------------------------------------
 Visit Information
    Visit Type: INPATIENT ADMISSION          Visit Billable: YES
Admission Date: JAN 13,1994@09:30:35         Second Opinion: NOT REQUIRED
          Ward: 11-B MEDICINE XREF           Auto Bill Date:
     Specialty: MEDICINE                    Special Consent: ROI OBTAINED
Discharge Date:                             Special Billing: FEDERAL OWCP

  Billing Information
  Initial Bill:                        Estimated Recv (Pri): $
   Bill Status:                        Estimated Recv (Sec): $
 Total Charges: $        0             Estimated Recv (ter): $
   Amount Paid: $        0               Means Test Charges: $

Press RETURN to continue or '^' to exit: <RET>
```

```
Claim Tracking Inquiry                          Page 2  Jan 14, 1994@15:55:54
IBpatient, two                    000-22-2222           DOB: Jan 01, 1940
INPATIENT ADMISSION on Jan 13, 1994@09:30:35
-------------------------------------------------------------------------------

  Insurance Review Information
    Type Review: INITIAL APPEAL              Review Date: 01/17/94
    Appeal Type: ADMINISTRATIVE            Insurance Co.: ABC
    Case Status: OPEN                   Person Contacted: Mary
No Days Pending: 3                        Contact Method: Letter
  Final Outcome:                        Call Ref. Number:
                                                  Status: COMPLETE
                                          Last Edited By:

    Type Review: CONTINUED STAY REVIEW       Review Date: 01/16/94
         Action: DENIAL                    Insurance Co.: ABC
    Denied From: 01/17/94               Person Contacted: SPOUSE
      Denied To: 01/20/94                 Contact Method: PHONE
 Denial Reasons: NOT MEDICALLY NECESSAR Call Ref. Number: 88888SS
 Denial Reasons: TREATMENT PROVIDED NOT           Status: COMPLETE
                                          Last Edited By: ALAN
```

```
Claim Tracking Inquiry                          Page 3  Jan 14, 1994@15:55:54
IBpatient, three                  000-33-3333           DOB: Jan 01, 1940
INPATIENT ADMISSION on Jan 13, 1994@09:30:35
-------------------------------------------------------------------------------
    Type Review: URGENT/EMERGENT ADMIT       Review Date: 01/14/94
         Action: APPROVED                    Insurance Co.: ABC
Authorized From: 01/13/94               Person Contacted: Mary
  Authorized To: 01/18/94                 Contact Method: VOICE MAIL
Authorized Diag: 259.0 - DELAY SEXUAL D Call Ref. Number: 88889354A
   Auth. Number: 88889354A                        Status: COMPLETE
                                          Last Edited By: ALAN

  Hospital Review Information
     Review Date: 01/15/94                 Day of Review:  3
     Review Type: CONTINUED STAY REVIEW  Severity of Ill: Generic
       Specialty: MEDICINE              Intensity of Svc: Generic
     Methodology: INTERQUAL             Non-Acute Reason:
          Status: ENTERED
  Last Edited By: ALAN
```

MCCR/UR Summary Report

This report prints a summary of hospital activity by either admission or discharge for a specified date range including the number of reviews. If sorted by discharge, only reviews for discharges for the date range are counted. Included is a Penalty Report and, if appropriate, a Days Approved Report, and a Days Denied Report, all sorted by specialty.

Sample Output

```
                              MCCR/UR SUMMARY REPORT
                                        for
                                   ALBANY (500)

                                  for Discharges
                                From: AUG 18, 1993
                                  To: FEB 14, 1994

                            Date Printed: FEB 14, 1994
                                     Page: 1
                            --------------------------

                        Total Discharges:          29
         Total Discharges with Insurance:           5
               Total Billable Discharges:           4
      Total Discharges Requiring Reviews:           4
               Total Discharges Reviewed:           4
Total Discharges Reviewed, Multi Carrier:           0

                      Total Reviews Done:           5
                 Number of Days Approved:          10
 Amount Collectible Approved for Billing:      $3,370

                   Number of Days Denied:           4
               Amount Denied for Billing:      $1,348

                     Total Cases Appealed:           0
               Number of Initial Appeals:           0
            Number of Subsequent Appeals:           0

                           Penalty Report:  Number of cases              Dollars
                           ---------------  -----------------------------------
          No Pre Admission Certification:          0                          $0
    Untimely Pre Admission Certification:          0                          $0
                       VA a Non-Provider:          0                          $0

              Reason Not Billable Report:  Reason                          Count
              ---------------------------  -----------------------------------
                                           OTHER                               1

              Days Approved by Specialty:  Specialty         No. Days   Dollars
              ---------------------------  -----------------------------------
                                           ALCOHOL               10      $3,370

                Days Denied by Specialty:  Specialty         No. Days   Dollars
                -------------------------  -----------------------------------
                                           ALCOHOL                4      $1,348
```

List Visits Requiring Reviews

This option prints a list of visits that require either an insurance review, hospital review or both. Only visits that are admissions are included. It can be used to list the random sample cases being tracked for hospital reviews by selecting only hospital reviews for admissions to be included.

Sample Output

```
LIST OF VISITS FROM: 01/01/94 TO: 02/18/94 REQUIRING REVIEWS                                   FEB 18,1994  14:40    PAGE 1
                                           VISIT                      INS.  RANDOM  SPECIAL  LOCAL  HOSP
PATIENT              PT. ID       WARD        TYPE      DATE          CASE  CASE    COND.    CASE   REVIEWER       INS REVIEWER
-----------------------------------------------------------------------------------------------------------------------------------

IBpatient,one        000-11-1111  8C ORTHO S  ADMIT     FEB  7,1994  YES   YES                                    DAVID
IBpatient,two        000-22-2222              SCH ADM.  FEB  4,1994  YES   NO      COPD     NO                    GAVIN
IBpatient,three      000-33-3333              OUTPT     FEB 11,1994  YES                                            DAVID
IBpatient,four       000-44-4444  7A(NHCU)    ADMIT     FEB  7,1994  NO    YES                      JANE
IBpatient,five       000-55-5555  11-B MEDIC  ADMIT     JAN 13,1994  YES   YES     NONE     NO                    JOHN
                                                                      ----  ---     ----     ---
COUNT                                                                 4     3       1        0
```

Review Worksheet Print

This option is similar to the Review Worksheet action on the Insurance Review screen. A worksheet for a current inpatient can be printed containing demographic data and information about current room/bed, ward, and provider.

Sample Output

```
                          INSURANCE REVIEW WORKSHEET
                                                          Feb 10, 1994@15:33:37

     Specialty: MEDICINE                          Ward: 11-B MEDICINE XREF

          Name: IBpatient,one                   Insurance Co: ABC
        Pt ID: 000-11-1111
          DOB: Jan 01, 1940

Admission Date: JAN 13,1994@09:30:35          DC Date: ________  LOS: _____

  Attending MD: SMITH                       Primary MD: RICHARD

Complaint/Hist: ____________________________________________________________

                ____________________________________________________________

     Treatment: ____________________________________________________________

                ____________________________________________________________

==============================================================================
|Date    |Diagnosis                |Procedure                  |DRG   |LOS   |
|        |                         |                           |      |      |
|________|_________________________|___________________________|______|______|
|        |                         |                           |      |      |
|________|_________________________|___________________________|______|______|
|        |                         |                           |      |      |
|________|_________________________|___________________________|______|______|
|        |                         |                           |      |      |
|________|_________________________|___________________________|______|______|
|        |                         |                           |      |      |
|________|_________________________|___________________________|______|______|
|        |                         |                           |      |      |
|________|_________________________|___________________________|______|______|
|        |                         |                           |      |      |
|________|_________________________|___________________________|______|______|
|        |                         |                           |      |      |
|________|_________________________|___________________________|______|______|
|        |                         |                           |      |      |
|________|_________________________|___________________________|______|______|
==============================================================================
|Insurance Contact: ___________________________  Phone: ____________________|
|_____________________________________________________________________________|
|Date    |Comments (#day approved, next review date, etc.)                   |
|        |                                                                   |
|________|___________________________________________________________________|
|        |                                                                   |
|________|___________________________________________________________________|
|________|___________________________________________________________________|
|________|___________________________________________________________________|
|        |                                                                   |
|________|___________________________________________________________________|
==============================================================================

Reviewer: ______________________________________  Date: ____________________
```

Scheduled Admissions w/Insurance

This option prints a list of scheduled admissions in Claims Tracking for insured patients. Included are patients with past scheduled admissions and scheduled admissions up to three days into the future. This differs from the Scheduled Admission List from MAS, as it does not contain all scheduled admissions from MAS. Scheduled admissions are normally moved to Claims Tracking four days prior to the scheduled admission date so that reviews can be completed prior to admission. Included are the number and type of reviews performed and the insurance company actions.

This report is formatted to print at 132 columns.

Sample Output

```
Scheduled Admissions with Insurance                                          Page 1  Feb 11, 1994@09:05:48
For Period beginning on 12/13/93 to 02/11/94
Patient                    Pt. ID         Adm. Date            Billable                    Ward           Type
-------------------------------------------------------------------------------------------------------------
IBpatient,one              000-11-1111    12/23/93  1:00 pm     YES                         5D SURG        SCHEDULED
IBpatient,two              000-22-2222    12/24/93  2:40 pm     YES                         9D MED         SCHEDULED
IBpatient,three            000-33-3333    01/31/94 11:40 pm     YES                         2D CARD        SCHEDULED
IBpatient,four             000-44-4444    02/04/94 10:11 am     NO                          4a nurs        SCHEDULED
IBpatient,five             000-55-5555    12/09/93  9:00 am     YES                         9D MED         SCHEDULED
IBpatient,six              000-66-6666    02/01/94  2:52 pm     YES                         2B ICU         SCHEDULED

------------------
TOTAL = 6
```

Single Patient Admission Sheet

This option allows you to print an admission sheet for a single visit (either the current admission or a selected admission). The admission sheet serves as a temporary cover sheet in the inpatient chart where reviewers and coders can make notes about the visit in summary form. If the facility chooses to have physicians sign the admission sheet, it can then be used as documentation to prepare inpatient bills prior to the signing of the discharge summary.

Sample Output

```
                                ADMISSION SHEET
                                   ALBANY VAMC
                                 113 HOLLAND AVE
                                    ALBANY,NY

      Patient: IBpatient,one                        Address: 123 SECOND ST.
        Pt ID: 000-11-1111
          Dob: JAN 1,1940
           SC: YES - 20%                                   TROY, NY  12180
          Sex: MALE                                Phone:
-------------------------------------------------------------------------------
    Adm. Date: JAN 13,1994@09:30:35          Adm. Type: URGENT
     Provider: IBprovider,one                Specialty: MEDICINE
         Ward: 11-B MEDICINE XREF             Room/Bed:
    Adm. Diag: 259.0 - DELAY SEXUAL DEVELOP NEC
-------------------------------------------------------------------------------
     Employer:                                  E-Cont.:


        Phone:                                  Phone:
-------------------------------------------------------------------------------
    Ins. Co 1: ABC INS                          Phone: 555-555-4312
       Subsc.: IBpatient,one                     Type: MAJOR MEDICAL EXPENS
    Subsc. ID: 000111111                        Group: 4446333
-------------------------------------------------------------------------------
    Date    Diagnosis                Procedure              Final   DRG  LOS
         |                        |                      |        |     |
    _____|________________________|______________________|________|_____|_____
         |                        |                      |        |     |
    _____|________________________|______________________|________|_____|_____
         |                        |                      |        |     |
    _____|________________________|______________________|________|_____|_____
         |                        |                      |        |     |
    _____|________________________|______________________|________|_____|_____
         |                        |                      |        |     |
    _____|________________________|______________________|________|_____|_____

    Service Connected Conditions:                      Treated
    NONE STATED


I attest that these are the diagnoses and procedures for which the
Patient was treated during this episode of care.

MD: ___________________________________    Date: ___________________

Patient: IBpatient,one      000-11-1111               Printed: MAR 18, 1994@13:18
```

Pending Work Report

This option will print a Pending Work List similar to the Pending Reviews option. The list can be sorted by who the review is assigned to, due date, patient, type of review, or by current ward of the patient, for either Insurance Reviews, Hospital Reviews, or both. This option will limit the list to those reviews that meet the sort criteria you have selected. A plus sign (+) before the patient's name indicates there is both a hospital and insurance review on the list for that patient.

This report is formatted to print at 132 columns.

Sample Output

```
Pending Reviews Report for Division ALBANY                                          Page 1  Feb 11, 1994@09:44:52
For Period Feb 01, 1994 to Feb 11, 1994
Patient               Pt. ID  Ward        Review Type            Due Date  Status    Assigned to   Visit   Date
-----------------------------------------------------------------------------------------------------------------------
+IBpatient,one         1111    8C ORTHO SU Hosp Review-Admission  02/07/94  ENTERED   JOHN          ADMIT   02/07/94 2:42 pm
 IBpatient, two        2222    2B ICU      Hosp Review-Admission  02/11/94  ENTERED   Unassigned    ADMIT   02/01/94 2:01 am
 IBpatient, three      3333    11-B MEDICI Hosp Review-CONT. STAY 02/06/94  ENTERED   JANE          ADMIT   01/13/94 9:30 am
 IBpatient, four       4444    2D ICU      Ins. Review-URG ADM    02/11/94  ENTERED   Unassigned    ADMIT   02/01/94 2:01 am
 IBpatient, five       5555    11-B MEDICI Ins. Review-URG ADM    02/09/94  COMPLETE  MARK          ADMIT   01/13/94 9:30 am
+IBpatient,one         4554    8C ORTHO SU Hosp Review-Admission  02/07/94  ENTERED   JOHN          ADMIT   02/07/94 2:42 pm
```

Unscheduled Admissions w/Insurance

This option prints a list of patients who were insured on their admission date and were unscheduled admissions. In addition, it prints information about the number of reviews completed and the insurance company actions.

This report is formatted to print at 132 columns.

Sample Output

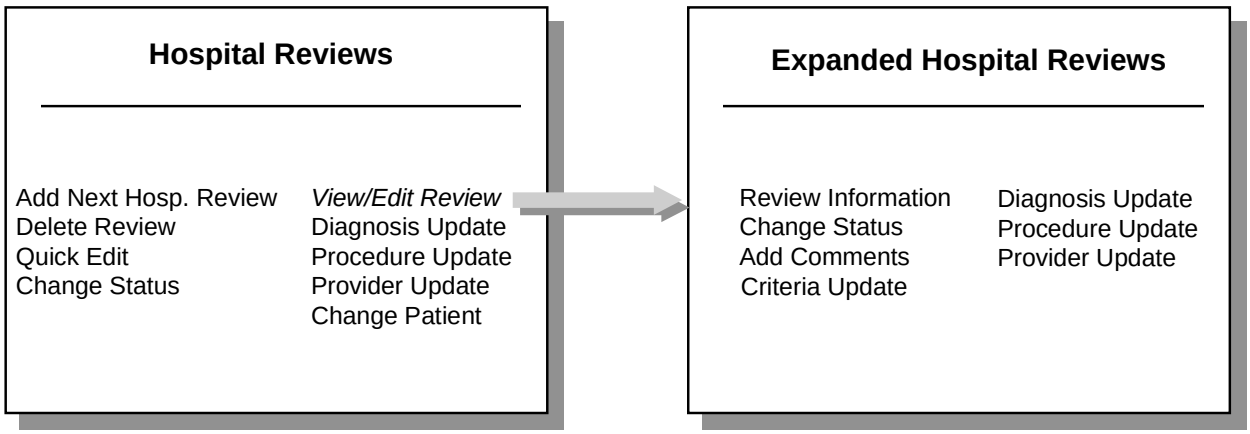
```
Unscheduled Admissions with Insurance                                          Page 1  Feb 11, 1994@10:05:06
For Period beginning on 02/01/94 to 02/11/94
Patient                    Pt. ID         Adm. Date            Billable                    Ward           Type
-----------------------------------------------------------------------------------------------------------------
IBpatient,one              000-11-1111    09/01/93 5:07 pm     YES                         9D MED
IBpatient, two             000-22-2222    05/01/93 11:00 am    YES                         13B PSYCH
IBpatient, three           000-33-3333    02/07/94 2:42 pm     YES                         8C ORTHO SUR   URGENT
IBpatient, four            000-44-4444    02/07/94 11:38 a     YES                         2D ICU         URGENT
IBpatient, five            000-55-5555    02/01/94 2:01 am     YES                         5D SURGICAL    URGENT
------------------
TOTAL = 5
```

Hospital Reviews

This option is designed to allow the entry of the utilization management information required by the Quality Management office. The Claims Tracking module will automatically identify a random sample of admissions (see the Claim Tracking Parameter Edit option) that require review. Hospital reviews are the application of Interqual criteria to determine if the admission or continued stay meets specific criteria. This module will allow entry of the category of criteria that was met for Severity of Illness and Intensity of Service or the reasons that criteria was not met. An entry for every day being reviewed is required. This can easily be accomplished by using the Add Next Review action which is designed to reduce the data entry time by duplicating the entries for days where the information is identical.

A national rollup of this data is scheduled to be released in early summer of 1994. Only reviews with a status of complete will be extracted.

The following chart shows the Claims Tracking Screens accessed through this option and the actions available on each screen. Actions may not be shown in the order in which they actually appear on the screens.



About the Screens...
In the top left corner of each screen is the screen title. A plus sign (+) at the bottom left of the screen indicates there are additional screens. Left or right arrows (<<< >>>) may be displayed to indicate there is additional information to the left or right on the screen. Available actions are displayed below the screen. Two question marks entered at any "Select Action" prompt displays all available actions for that screen. For more information on the use of the screens, please refer to the appendix at the end of this manual.

You may quit from any screen, which will bring you back one level or screen, or you may exit (this exits the option entirely and returns you to the menu).

Common Actions
The following are actions common to both screens accessed through this option. They are listed here to avoid duplication of documentation.

Change Status - This action allows you to quickly change the status of a review. Only completed reviews are used in the report preparation and by the MCCR NDB roll-up or the QM roll-up (which is tentatively scheduled for release in June, 1994).

Reviews have a status of ENTERED when automatically added. A status of PENDING may be used for those you are still working on or when one person does the data entry and another needs to review it.

Diagnosis Update - This action allows input of ICD-9 diagnoses for the patient. Whether diagnoses are input on this screen or another screen, they are available across the Claims Tracking module. You may enter an admitting diagnosis, primary (DXLS) diagnosis, secondary diagnosis and the onset date of the diagnosis for this admission. For outpatient visits this information is stored with the outpatient encounter information.

Procedure Update - This action allows the input of ICD-9 procedures for the patient. You may input the procedure and the date. This is a separate procedure entry from the PTF module and is optional for use.

Provider Update - This action allows you to input the admitting physician, attending physician, and care provider separate from the MAS information. The purpose is to provide a location to document the attending physician and to provide an alternate place to document individual physicians if the administrative record indicates teams, or vice versa.

Following is a list of the screens, the actions they provide, and a brief description of each action.

Hospital Reviews Screen

Add Next Hosp. Review - This action will add the next review and automatically set it to either an admission review or continued stay review. The day for review and review date are automatically computed but can be edited. The category of severity of illness and intensity of service that was met can be entered; or if not met, the reason it wasn't met.

Delete Review - This action allows a hospital review to be deleted. If a review is automatically created, but the visit does not require reviews and follow-up with the insurance company, it can be deleted. Use care in exercising this action. It can be as important to document that no review is required as it is to document the required reviews.

Quick Edit - This action allows you to quickly edit all information about the review without leaving the Pending Review option.

View/Edit Review - This action allows access to the Expanded Hospital Reviews Screen.

Change Patient - This action allows you to change the selected patient without leaving the option.

Expanded Hospital Reviews Screen

Review Information - This action allows you to enter/edit the type of review (admission or continued stay), review date, and the specialty and methodology for the review. There should be only one admission review (pre-certification or urgent/ emergent admission review) for an admission. Normally, reviews are done for UR purposes on days 3, 6, 9, 14, 21, 28, and every 7 days thereafter. (Usually, the INTERQUAL method is used as the methodology for UR required review. Insurance carriers may require other review methodologies.)

Add Comment - This action allows you to edit the word processing (comments) field in Hospital or Insurance Reviews without having to edit other fields.

Criteria Update - This action allows you to enter or edit data regarding criteria met/not met for an acute admission within 24 hours, such as the review date and methodology; severity of illness and intensity of service; and whether additional reviews are required

Sample Screens

```
Hospital Reviews              Feb 03, 1994 13:49:45          Page:    1 of    1
 Hospital Review Entries for: IBpatient,one     1111   ROI: OBTAINED
                         for: INPATIENT ADMISSION on 01/13/94 9:30 am
    Review Date    Type        Ward       Status     Specialty   Day  Next Review
1   01/15/94       CONT. STA   11-B ME    COMPLETE   MEDICINE     3   01/17/94
2   01/14/94       CONT. STA   11-B ME    COMPLETE   MEDICINE     2
3   01/13/94       Admission   11-B ME    COMPLETE   MEDICINE     1

          Random Sample                                                   >>>
AN  Add Next Hosp. Review VE  View/Edit Review      CP  Change Patient
DR  Delete Review         DU  Diagnosis Update      EX  Exit
QE  Quick Edit            PU  Procedure Update
CS  Change Status         PV  Provider Update
```

```
Expanded Hospital Reviews     Feb 03, 1994 13:55:38          Page:    1 of    3
Expanded Review for: IBpatient,one     1111   ROI:OBTAINED
                 for: CONTINUED STAY REVIEW on 01/15/94

  Visit Information                          Review Information
    Visit Type: INPATIENT ADMISSION             Review Type: CONTINUED STAY REVI
Admission Date: JAN 13,1994@09:30:35            Review Date: 01/15/94
          Ward: 11-B MEDICINE XREF                Specialty: MEDICINE
     Specialty: MEDICINE                         Methodology: INTERQUAL
                                                  Ins. Action:

  Criteria Information
    Day of Review:  3
  Severity of Ill: CARDIOVASCULAR
 Intensity of Svc: CARDIOVASCULAR
   Apply all Days:
 Non-Acute Reason:
   No. Acute Days:
   Non-Acute Days:

+         Enter ?? for more actions
RI  Review Information    CU  Criteria Update       PV  Provider Update
CS  Change Status         DU  Diagnosis Update      EX  Exit
AC  Add Comments          PU  Procedure Update
```

```
Expanded Hospital Reviews     Feb 03, 1994 13:58:13          Page:    2 of    3
Expanded Review for: IBpatient,one     1111   ROI:OBTAINED
                for: CONTINUED STAY REVIEW on 01/15/94
+
  Status Information                          Clinical Information
    Review Status: ENTERED                         Provider: IBprovider,one
       Entered by: ALAN                      Admitting Diag: 101.0 - VINCENTS ANG
       Entered on: 01/14/94 2:51 pm            Primary Diag:
     Completed by: ALAN                       1st Procedure: 89.44 - CARDIAC STRE
     Completed on: 01/14/94 2:53 pm           2nd Procedure:
 Next Review Date: 01/17/94                     Interim DRG: 0 -  on
                                               Estimate ALOS:    0.0
                                              Days Remaining:    0.0

  Review Comments
   Patient not doing well, consult to psych is recommended.
+         Enter ?? for more actions
RI  Review Information    CU  Criteria Update       PV  Provider Update
CS  Change Status         DU  Diagnosis Update      EX  Exit
AC  Add Comments          PU  Procedure Update
```

```
Expanded Hospital Reviews     Feb 03, 1994 14:09:46          Page:    3 of    3
Expanded Review for: IBpatient,one     1111   ROI:OBTAINED
                for: CONTINUED STAY REVIEW on 01/15/94
+

  Visit Information                          Review Information
     Visit Type: INPATIENT ADMISSION            Review Type: CONTINUED STAY REVI
 Admission Date: JAN 13,1994@09:30:35           Review Date: 01/15/94
           Ward: 11-B MEDICINE XREF               Specialty: MEDICINE
      Specialty: MEDICINE                        Methodology: INTERQUAL
                                                 Ins. Action:

  Criteria Information
    Day of Review:  3
  Severity of Ill: CARDIOVASCULAR
 Intensity of Svc: CARDIOVASCULAR
   Apply all Days:
 Non-Acute Reason:
   No. Acute Days:
+         Enter ?? for more actions
RI  Review Information    CU  Criteria Update       PV  Provider Update
CS  Change Status         DU  Diagnosis Update      EX  Exit
AC  Add Comments          PU  Procedure Update
```

Third Party Joint Inquiry

This option provides information needed to answer questions from insurance carriers regarding specific bills or episodes of care. This information is presented in List Manager Screens.

Because the same actions are available on most screens, and most screens can be accessed from any other screen; these "Common Actions" are listed first and are not repeated under each screen description. Only actions specific to a screen are included with that screen description.

You may QUIT from any screen, which will bring you back one level or screen. EXIT is also available on most screens, and returns you to the menu. For more information on the use of the List Manager utility, please refer to the appendix at the end of this manual.

Common Actions

BC Bill Charges - Accesses the Bill Charges screen.

DX Bill Diagnoses - Accesses the Bill Diagnoses screen.

PR Bill Procedures - Accesses the Bill Procedures screen.

CI Go to Claim Screen - Returns you to the Claim Information screen. Available on all screens that may be opened from the Claim Information screen.

AR Account Profile - Accesses the AR Account Profile screen.

CM Comment History - Accesses the AR Comment History screen.

IR Insurance Reviews - Accesses the Insurance Reviews/ Contacts screen.

HS Health Summary - Displays a Health Summary report. The information displayed on the Health Summary is site specified through the MCCR Site Parameter Display/Edit option.

AL Go to Active List - Returns you to the Third Party Active Bills screen if that screen was accessed upon entering this option; otherwise, this action returns you to the menu.

VI Insurance Company - Accesses the Insurance Company screen.

VP Policy - Accesses the Patient Policy Information screen.

AB Annual Benefits - Accesses the Annual Benefits screen.

EL Patient Eligibility - Accesses the Patient Eligibility screen.

EX Exit Action - Exits the option.

Third Party Active Bills Screen
This is the first screen displayed if you enter a patient name at the first prompt of this option. It lists all active third party bills for the specified patient in order of date created. All bills created in the Integrated Billing Third Party Billing module can be found on this screen or the Inactive Bills screen.

Actions
IL Inactive Bills - Accesses the Inactive Bills screen.

PI Patient Insurance - Accesses the Patient Insurance screen.

CP Change Patient - Allows you to choose another patient and re-displays the Third Party Active Bills screen for that patient.

Inactive Bills Screen
This screen lists inactive bills for a specified patient. All bills created in the Integrated Billing Third Party Billing module are found on this screen or the Third Party Active Bills screen. Bills are displayed beginning with most recent "statement from" date.

Actions
CD Change Dates - Allows you to change the bills listed by changing the most recent "statement from" date to be displayed.

Patient Insurance Screen
This screen displays the list of insurance policies for a patient. It is based on the Patient Insurance Management screen of the Patient Insurance Info View/Edit option. It is only available from the Third Party Active Bills screen.

Claim Information Screen
This screen contains bill data and status information to provide an overall status of the bill. This is the primary claim screen for the inquiry, and many actions are provided to expand on the details of the claim.

If a policy has been updated but the bill has not, those changes are not reflected on this screen. Updated or current insurance information may be viewed using the three insurance screens.

Actions
CB Change Bill - Allows you to change the bill being displayed. If you entered a patient name at the first prompt of this option, only bills for that patient may be selected. If you entered a bill number at the first prompt, any bill may be selected.

Bill Charges Screen
This screen displays a bill's charge information as it would print on the bill. For UB-92 bills, this closely corresponds to Form Locators 42-49; therefore, any prosthetic items, Rx refills, or additional diagnoses and procedures are included. For HCFA 1500 bills, this closely corresponds to Block 24.

Bill Diagnosis Screen
This screen displays all diagnoses assigned to the bill, in the order they are printed on the bill.

Bill Procedures Screen
This screen lists all procedures assigned to a bill, in the order they are printed on the bill.

AR Account Profile Screen
This screen provides the financial history of a claim's account. This includes the current status of the bill in both IB and AR, as well as the payment or transaction history of the bill from Accounts Receivable. This screen is loosely based on the Profile of Accounts Receivable option.

Actions
VT Transaction Profile - Accesses the AR Transaction Profile screen for a selected transaction.

AR Transaction Profile Screen
This screen displays detailed account transaction information for individual claim transactions. It is is loosely based on the Accounts Receivable Transaction Profile option.

AR Comment History Screen
This screen displays AR comments for the claim's account.

Actions
AD Add AR Comment - Allows you to add an AR Transaction Comment to the bill being displayed. Comment transactions may not be added to a bill that has not been authorized in IB.

Insurance Reviews/Contacts Screen
This screen displays all insurance reviews and contacts for the episodes of care on a bill. It is based on the Insurance Reviews/Contacts screen of the Claims Tracking Insurance Review Edit option. The primary difference between the two screens is that this screen consolidates all contacts for each episode being billed on a claim, while the Claims Tracking screen displays the contacts for a single episode of care.

Actions
VR Reviews/Appeals - Displays expanded information on a selected insurance contact. The screen accessed by this action will depend on the type of contact selected. If the contact is an appeal or denial, the Expanded Appeals/Denials screen is opened; otherwise, the Expanded Insurance Reviews screen is opened.

Expanded Appeals/Denials Screen
This screen displays expanded information on insurance appeals and denials listed on the Insurance Review/Contacts screen. This screen is based on the Expanded Appeals/Denials screen of the Claims Tracking Appeal/Denial Edit option.

Expanded Insurance Reviews Screen
This screen displays expanded information on insurance reviews listed on the Insurance Reviews/Contacts screen. This screen is based on the Expanded Insurance Reviews screen of the Claims Tracking Insurance Review Edit option.

Insurance Company Screen
This screen displays extended information on an Insurance Company. It is based on the Insurance Company Editor screen of the Insurance Company Entry/Edit option. This screen may be entered from the Patient Insurance screen or from any of the bill specific screens. Once a bill is selected, this screen displays only information related to the insurance carriers assigned to that bill.

Patient Policy Information Screen
This screen displays extended information on insurance policies. It is based on the Patient Policy Information screen of the Patient Insurance Info View/Edit option. This screen may be entered from either the Patient Insurance screen or from any of the bill specific screens. Once a bill is selected, this screen will only display information related to the insurance policies assigned to the bill.

Annual Benefits Screen
This screen displays extended information on the annual benefits of insurance policies. It is based on the Annual Benefits Editor screen of the Patient Insurance Info View/Edit option. This screen may be entered from the Patient Insurance screen or from any of the bill specific screens. Once a bill has been chosen, this screen displays information related to the insurance policies assigned to that bill.

Patient Eligibility Screen

This screen displays the current information on the patient's eligibility for care and service connection status. It is loosely based on the Eligibility Inquiry for Patient Billing option. This screen is available from the Third Party Active Bills screen and the bill specific screens.

If this screen is accessed from one of the bill specific screens, such as the Claim Information screen, the standard list of bill screen actions will be available from this screen.

If this screen is accessed from the Patient Insurance screen, no other screens are available as actions from this screen; and you must return to a previous screen to access other screens.

Sample Screens

```
Third Party Active Bills          May 31, 1995 @10:07:11                    Page 1 of 1
IBpatient,one          1111                                                      NSC
Bill #        From       To         Type   Stat Rate        Insurer    Orig Amt Curr Amt
1  L10263     04/20/92   04/20/92   OP     BI   REIM INS      HEALTH       0.00     0.00
2  L10270     04/20/92   04/24/92   OP     PC   REIM INS      HEALTH     698.30   698.30
3  N10072 *   11/16/93   11/17/93   OP     N    REIM INS    + HEALTH     199.00   199.00
4  N10094     02/16/94   02/16/94   OP     PC   REIM INS    + HEALTH     196.00   196.00
5  N10123 *   03/01/94   03/15/94   OP     BI   REIM INS    + HEALTH       0.00     0.00
6  N10150 *   03/14/94   03/15/94   OP     BI   REIM INS    + ABC          0.00     0.00
7  N10173 *   03/02/94   03/03/94   OP     BI   REIM INS      ABC          0.00     0.00
8  N10174 *   03/06/94   03/07/94   OP     N    REIM INS      ABC        356.00   356.00
9  N10222     05/01/94   05/31/94   IP-F   BI   REIM INS      HEALTH       0.00     0.00
10 N10236     06/01/94   06/05/94   IP-L   BI   REIM INS      HEALTH       0.00     0.00
11 N10273 *   03/03/94   03/31/94   IP-F   A    REIM INS    + HEALTH   11221.00   856.45
12 N10275     08/30/94   09/30/94   IP     BI   REIM INS      ABC          0.00     0.00
+         | * Cat C Charges on Hold | + 2nd/3rd Carrier |
CI  Claim Information     IL  Inactive Bills        PI  Patient Insurance
CP  Change Patient        HS  Health Summary        EL  Patient Eligibility
Select Action: Next Screen//
```

```
Inactive Bills                May 17, 1996 13:30:26                Page:    1 of    2
IBpatient,one          1111                                 ** All Inactive Bills **  (9)
Bill #        From       To         Type   Stat Rate       Insurer  Orig Amt   Curr Amt
1  N10397     06/01/94   06/05/94   IL-L   CC   REIM INS   + ABC      935.00       0.00
2  N10198     06/01/94   06/05/94   IP-L   CB   REIM INS   + HEALTH     0.00       0.00
3  N10212     05/07/94   05/12/94   IP-C   CB   REIM INS     HEALTH     0.00       0.00
4  N10148 *   03/02/94   03/03/94   OP     CB   REIM INS                0.00       0.00
5  N10162 *   03/02/94   03/03/94   OP     CB   REIM INS                0.00       0.00
6  N10095     02/16/94   02/16/94   OP     CB   REIM INS                0.00       0.00
7  L10260     04/14/92   04/20/92   OP-F   CB   REIM INS     ABC     1026.02    1026.02
8  L00389     02/08/90   02/08/90   OP     CC   REIM INS     BC/BS     26.00       0.00
9  00036A     02/07/90   02/07/90   OP     CC   REIM INS     BC/BS     26.00       0.00
+         |* Cat C Charges on Hold |+ 2nd/3rd Carrier |
CI  Claim Information     AL  Go to Active List     CD  Change Dates
                                                    EX  Exit Action
Select Action: Next Screen//
```

```
Claim Information              May 17, 1996 13:44:58          Page:    1 of    2
N10072   IBpatient,one      1111           DOB: 5/22/50   Subsc ID: 000111111

      Insurance Demographics                  Subscriber Demographics
  Carrier Name:  HEALTH INS LIMITED         Group Number:  GN 48923222
 Claim Address:  789 3RD STREET               Group Name:
                 ALBANY, NY 44438          Subscriber ID:  000111111
   Claim Phone:  333-444-5676                   Employer:  Snow Movers
                                          Insured's Name:  IBpatient,one
                                            Relationship:  PATIENT

                                Claim Information
     Bill Type:  OUTPATIENT                Service Dates:  11/16/93 - 11/17/93
    Time Frame:  ADMIT THRU DISCHARGE CLAIM Date Entered:  12/23/93
     Rate Type:  REIMBURSABLE INS             Orig Claim:  199.00
     AR Status:  NEW BILL                    Balance Due:  199.00
     Secondary:  ABC

       Entered:  12/23/93  by   JOHN
    Authorized:  01/04/94  by   Jane
 First Printed:  01/04/94  by   Jane
  Last Printed:  04/01/94  by   Deb
+         Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CB  Change Bill           HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Next Screen//
```

```
Patient Insurance              May 31, 1995 @10:07:11         Page 1 of   1
Insurance Management for Patient: IBpatient,one         1111
 Insurance Co.    Type of Policy  Group        Holder   Effect.     Expires
1 HEALTH INS LTD                  GN 48923222  SELF     01/01/87
2 ABC             MAJOR MEDICAL   AE 76899354  SPOUSE   10/1/90     19/30/95
3 XYZ INS         INDEMNITY       T109         OTHER    10/1/94     01/01/95
4 BC/BS           MAJOR MEDICAL   GN 392043    SELF     01/01/90    12/31/92



VI  Insurance Company          VP Policy         AB  Annual Benefits
AL  Go to Active List                            EX  Exit Action
Select Action: Quit//
```

```
Bill Charges                    May 31, 1995 @10:07:11              Page 1 of 1
N10072  IBpatient,one      1111 DOB: 5/22/50            Subsc ID: 000111111
11/16/93 - 11/17/93        ADMIT THRU DISCHARGE         Orig Amt:    199.00
_____________________________________________________________________________

      OUTPATIENT VISIT
500   OUTPATIENT SVS        178.00         1                178.00
      PRESCRIPTION
257   DRGS/NONSCRPT          21.00         1                 21.00

001   TOTAL CHARGE                                          199.00

      OP VISIT DATE(S) BILLED:        NOV 16, 1993

      PRESCRIPTION REFILLS:
      30948          NOV 17, 1993     ABBOCATH-T 18G 1.25 IN
                                      QTY: 20 for 10 days supply


Bill Remark:  This is a demonstration bill created for Joint Billing Inquiry.
_____________________________________________________________________________
          Enter ?? for more actions
_____________________________________________________________________________
DX  Bill Diagnosis        AR  Account Profile       VI  Insurance Company
PR  Bill Procedures       CM  Comment History       VP  Policy
CI  Go to Claim Screen    IR  Insurance Reviews     AB  Annual Benefits
                          HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Bill Charges                    May 31, 1995 @10:07:11              Page 1 of 1
N10273  IBpatient,one      1111 DOB: 5/22/50            Subsc ID:  000111111
03/02/94 - 03/31/94        INTERIM - FIRST CLAIM        Orig Amt: 11221.00
_____________________________________________________________________________

30 DAYS INPATIENT CARE
      INTERMEDIATE CARE
101   ALL INCL R&B          246.00         30              7380.00
240   ALL INCL ANCIL         48.00         30              1440.00
960   PRO FEE                49.00         30              1470.00
274   PROSTH/ORTH DEV       931.00         1                931.00

001   TOTAL CHARGE                                         11221.00

      PROSTHETIC ITEMS:
      Sep 18, 1994  WHEELCHAIR
      Sep 21, 1994  CANE-ALL OTHER
_____________________________________________________________________________
          Enter ?? for more actions
_____________________________________________________________________________
DX  Bill Diagnosis        AR  Account Profile       VI  Insurance Company
PR  Bill Procedures       CM  Comment History       VP  Policy
CI  Go to Claim Screen    IR  Insurance Reviews     AB  Annual Benefits
                          HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Bill Diagnosis                  May 17, 1996 14:07:56          Page:    1 of    1
N10072   IBpatient,one      1111        DOB: 5/22/50      Subsc ID: 000111111
 11/16/93 - 11/17/93        ADMIT THRU DISCHARGE CLAIM   Orig Amt:    199.00

       1)  490.    BRONCHITIS NOS
       2)  030.1   TUBERCULOID LEPROSY
       3)  101.    VINCENT'S ANGINA
       4)  330.1   CEREBRAL LIPIDOSES
       5)  461.0   AC MAXILLARY SINUSITIS
       6)  310.0   FRONTAL LOBE SYNDROME
       7)  200.01  RETICULOSARCOMA HEAD

          Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
PR  Bill Procedures       CM  Comment History       VP  Policy
CI  Go to Claim Screen    IR  Insurance Reviews     AB  Annual Benefits
                          HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Bill Procedures                 May 17, 1996 14:12:58          Page:    1 of    1
N10072   IBpatient,one      1111        DOB: 5/22/50      Subsc ID: 000111111
 11/16/93 - 11/17/93        ADMIT THRU DISCHARGE CLAIM   Orig Amt:    199.00

 11000   SURGICAL CLEANSING OF SKIN      11/16/93
 11001   ADDITIONAL CLEANSING OF SKIN    11/16/93
 12001   REPAIR SUPERFICIAL WOUND(S)     11/16/93

          Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
CI  Go to Claim Screen    IR  Insurance Reviews     AB  Annual Benefits
                          HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
AR Account Profile            May 31, 1995 @10:07:11        Page:    1 of    1
N10273   IBpatient,one         1111        DOB: 5/22/50   Subsc ID:  000111111
AR Status: ACTIVE         Orig Amt:    11221.00       Balance Due:  856.45

            04/01/94      IB Status:  Printed  (Last)      11221.00  11221.00
1   1578    05/07/94      PAYMENT (IN PART)                 7856.21   3364.79
2   1598    07/07/94      PAYMENT (IN PART)                 2508.34    856.45
3   1601    07/08/94      COMMENT                              0.00    856.45

    Total Collected:  10364.55
    Percent Collected:    92.37%
          Enter ?? for more actions
BC  Bill Charges          VT  Transaction Profile   VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
AR Transaction Profile        May 31, 1995 @10:07:11              Page 1 of 1
N10273  IBpatient,one      1111 DOB: 5/22/50            Subsc ID:  000111111
AR Status:  ACTIVE             Orig Amt:    11221.00   Balance Due:  856.45

       TRANS. NO:  1578              TRANS. TYPE:  PAYMENT (IN PART)
     TRANS. DATE:  05/07/94          DATE POSTED:  05/10/94    (ARH)
   TRANS. AMOUNT:  7856.21             RECEIPT #:  D2982398

                                     BALANCE    COLLECTED
                                 ------------- ---------------
                  PRINCIPLE:          3364.79      7856.21
                  INTEREST:              0.00         0.00
                  ADMINISTRATIVE:        0.00         0.00
                  MARSHALL FEE:          0.00         0.00
                  COURT COST:            0.00         0.00
                                     --------    ---------
                  TOTAL:              3364.79      7856.21

        FY:  94            PR AMT: 3364.79            FY TR AMT: 7856.21

COMMENTS:   Date of Deposit: MAY 10, 1994

          Enter ?? for more actions
CI  Go to Claim Screen          AL Go to Active List        EX Exit Action
Select Action: Quit//
```

```
AR Comment History              May 17, 1996 14:21:37          Page:    1 of    1
L10260   IBpatient,one          1111        DOB: 5/22/50    Subsc ID:  AH33334
AR Status:  CANCELLED           Orig Amt: 1026.02       Balance Due: 1026.02

1582  04/21/92   Copy of bill sent.                 FOLLOW-UP DT:  05/12/92
                 Carrier did not receive initial bill.

1594  05/20/92   Bill canceled, wrong form type.    FOLLOW-UP DT:  06/01/92
                 Carrier refuses to process this type of bill on a UB-92.
                 They are requiring the HCFA 1500 form.

          Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        AD  Add AR Comment        VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Insurance Reviews/Contacts    May 31, 1995 @10:07:11        Page:    1 of    1
Insurance Review Entries for:  N10072     IBpatient,one         1111
    Date       Ins. Co.           Type Contact       Action    Auth. No.  Days

    OUTPATIENT VISIT of AMBULATORY SURGERY OFFICE on 11/16/93
1   11/30/93   HEALTH INS LIMITED  1st Appeal-Clin    APPROVED  AU 39824
2   11/17/93   HEALTH INS LIMITED  OPT                DENIAL               0

    PRESCRIPTION REFILL of 30948 on 11/17/93
3   11/17/93   HEALTH INS LIMITED  OPT                APPROVED  RN 9384222

         Service Connected: NO   Previous Spec. Bills: TORT                >>>
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       VR  Reviews/Appeals       AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Expanded Appeals/Denials      May 31, 1995 @10:07:11              Page 1 of  2
Insurance Appeal/Denial for: IBpatient,one         1111 ROI: NOT REQUIRED

            Visit Information                 Action Information
         Visit Type:  OUTPATIENT VISIT       Type Contact:  INITIAL APPEAL
         Visit Date:  03/09/94 9:00 am        Appeal Type:  CLINICAL
             Clinic:  AMBULATORY SURGERY      Case Status:  OPEN
       Appt. Status:  CHECKED OUT         No Days Pending:
         Appt. Type:  REGULAR               Final Outcome:
       Special Cond:

          Clinical Information            Appeal Address Information
           Provider:                     Ins. Co. Name:  HEALTH INS LIMITED
           Provider:                    Alternate Name:
          Diagnosis:                     Street line 1:  HIL - APPEALS OFFICE
          Diagnosis:                     Street line 2:  1099 THIRD AVE, SUITE
       Special Cond:                     Street line 3:
                                        City/State/Zip:  TROY, NY  12345

                     Insurance Policy Information
    Ins. Co. Name:  HEALTH INS LIMITED   Subscriber Name:  IBpatient,one
     Group Number:  GN 48923222            Subscriber ID:  000111111
  Whose Insurance:  VETERAN               Effective Date:  01/01/87
   Pre-Cert Phone:  000-444-444 E         Expiration Date:

    User Information                     Contact Information
      Entered By:  EMPLOYEE               Contact Date:  04/01/94
      Entered On:  11/16/93 3:30 pm   Person Contacted:  SPOUSE
  Last Edited By:                       Contact Method:  PHONE
  Last Edited On:                     Call Ref. Number:  RN 3320944
                                           Review Date:  06/02/95
 Comments
 Policy should cover treatment.
 Service Connected Conditions:
 Service Connected: NO
 NO SC DISABILITIES LISTED
          Enter ?? for more actions                                        >>>
CI  Go to Claim Screen       AL Go to Active List    EX Exit Action
Select Action: Quit//
```

```
Expanded Insurance Reviews    May 31, 1995 @10:07:11            Page 1 of   2
Insurance Review Entries for:             IBpatient,one         1111    ROI:
NOT REQUIRED

   Contact Information                    Action Information
     Contact Date:  11/17/93          Type Contact:  OUTPATIENT TREATMEN
 Person Contacted:  Steve            Opt Treatment:  RX REFILL
   Contact Method:  PHONE                   Action:  APPROVED
 Call Ref. Number:  RN 9384222        Auth. Number:  RN 9384222
      Review Date:  06/02/95

                       Insurance Policy Information
   Ins. Co. Name:  HEALTH INS LIMITED  Subscriber Name:  IBpatient,one
    Group Number:  GN 48923222           Subscriber ID:  000111111
 Whose Insurance:  VETERAN              Effective Date:  01/01/87
  Pre-Cert Phone:  933-3434            Expiration Date:

   Appeal Address Information           User Information
   Ins. Co. Name:  HEALTH INS LIMITED             Entered By: EMPLOYEE
  Alternate Name:                                 Entered On: 11/17/93 12:54 pm
   Street line 1:  HIL - APPEALS OFFICE       Last Edited By: EMPLOYEE
   Street line 2:  1099 THIRD AVE, SUITE 301  Last Edited On: 11/20/93 12:55 pm
   Street line 3:
  City/State/Zip:  TROY, NY 12345

 Comments
 One refill of prescription approved.

 Service Connected Conditions:
 Service Connected: NO
 NO SC DISABILITIES LISTED
          Enter ?? for more actions                                        >>>
CI  Go to Claim Screen        AL Go to Active List          EX Exit Action
Select Action: Quit//
```

```
Insurance Company            May 17, 1996 15:25:42          Page:    1 of    5
Insurance Company Information for: HEALTH INS LIMITED                   Primary
Type of Company: HEALTH INSURANCE                      Currently Active

                          Billing Parameters
 Signature Required?:  YES              Attending Phys. ID:  AT PH ID VAH500000
          Reimburse?:  WILL REIMBURSE   Hosp. Provider No.:
   Mult. Bedsections:  YES               Primary Form Type:
    Diff. Rev. Codes:                        Billing Phone:
      One Opt. Visit:  NO               Verification Phone:
 Amb. Sur. Rev. Code:                   Precert Comp. Name:  ABC INSURANCE
 Rx Refill Rev. Code:                        Precert Phone:  444-444-4444 E
   Filing Time Frame:

                        Main Mailing Address
             Street:  2345 CENTRAL AVENUE      City/State:  ALBANY, NY 12345
           Street 2:  FREAR BUILDING                Phone:  456-1234
           Street 3:                                  Fax:  848-4884

               Inpatient Claims Office Information
             Street:  2345 CENTRAL AVENUE      City/State:  ALBANY, NY 12345
           Street 2:  FREAR BUILDING                Phone:  456-0392
           Street 3:                                  Fax:  848-4432

              Outpatient Claims Office Information
             Street:  789 3RD STREET           City/State:  ALBANY, NY 12345
           Street 2:                                Phone:  333-444-5676
           Street 3:                                  Fax:  333-444-9245

             Prescription Claims Office Information
   Company Name:  GHI PROCESSING             Street 3:
         Street:  1933 CORPORATE DRIVE     City/State:  RIVERSIDE, NY 39332
       Street 2:  TANGLEWOOD PARK               Phone:  339-0000
            Fax:

                      Appeals Office Information
         Street:  HIL - APPEALS OFFICE     City/State:  TROY, NY 12345
       Street 2:  1099 THIRD AVE, SUITE 301     Phone:  436-1923
       Street 3:                                  Fax:  436-5464

                      Inquiry Office Information
         Street:  2345 CENTRAL AVENUE      City/State:  ALBANY, NY 12345
       Street 2:  FREAR BUILDING                Phone:  456-1923
       Street 3:                                  Fax:  848-5336


  Remarks

  Synonyms

          Enter ?? for more actions                                        >>>
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Patient Policy Information    May 31, 1995 @10:07:11       Page:     1 of    3
Extended Policy Information for:   IBpatient,one       000-11-1111    Primary
HEALTH INS LIMITED Insurance Company               ** Plan Currently Active **

      Plan Information                      Insurance Company
  Is Group Plan:  YES                      Company:  HEALTH INS LIMITED
     Group Name:                            Street:  2345 CENTRAL AVENUE
   Group Number:  GN 48923222             Street 2:  FREAR BUILDING
   Type of Plan:                          Street 3:
                                        City/State:  ALBANY, NY 12345

    Utilization Review Info            Effective Dates & Source
          Require UR:               Effective Date:  01/01/87
    Require Pre-Cert:              Expiration Date:
    Exclude Pre-Cond:               Source of Info:  INTERVIEW
 Benefits Assignable:  YES

     Subscriber Information         Subscriber's Employer Information
   Whose Insurance:  VETERAN   Claims to Employer:  No, Send to Insurance
   Subscriber Name:  IBpatient,one        Company:
      Relationship:  PATIENT               Street:
  Insurance Number:  000111111         City/State:
  Coord.  Benefits:  PRIMARY                Phone:

         User Information              Insurance Contact (last)
        Entered By:  EMPLOYEE         Person Contacted:
        Entered On:  09/07/93        Method of Contact:
  Last Verified By:  EMPLOYEE          Contact's Phone:
  Last Verified On:  01/03/95             Contact Date:
   Last Updated By:  EMPLOYEE
   Last Updated On:  04/06/94

 Comment -- Patient Policy
 None

 Comment -- Group Plan

 Personal Riders
    Rider #1:     EXTEND COVERAGE TO 365 DAYS
    Rider #2:     AMBULANCE COVERAGE

+         Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Annual Benefits                May 17, 1996 15:39:23         Page:    1 of    3
Annual Benefits for: GHI Ins. Co                                        Primary
             Policy: GN 48923222                Ben Yr:  MAR 01, 1993

                              Policy Information
                      Max. Out of Pocket: $   500
                  Ambulance Coverage (%):      85 %

                                 Inpatient
            Annual Deductible:  $ 500              Drug/Alcohol Lifet. Max: $
         Per Admis. Deductible:  $ 100             Drug/Alcohol Annual Max: $
            Inpt. Lifetime Max:  $                        Nursing Home (%):
              Inpt. Annual Max:  $                 Other Inpt. Charges (%):
              Room & Board (%):

                                Outpatient
            Annual Deductible:  $ 50                          Surgery (%):
         Per Visit Deductible:  $ 50                       Emergency (%):         85%
                  Lifetime Max:  $                       Prescription (%):         80%
                    Annual Max:  $                  Adult Day Health Care?: UNK
                     Visit (%):                           Dental Cov. Type: PERCENTAGE AMOU
           Max Visits Per Year:                            Dental Cov. (%): 48%

           Mental Health Inpatient                     Mental Health Outpatient
       MH Inpt. Max Days/Year:                      MH Opt. Max Days/Year:
        MH Lifetime Inpt. Max:  $                    MH Lifetime Opt. Max: $
          MH Annual Inpt. Max:  $                      MH Annual Opt. Max: $
      Mental Health Inpt. (%):                     Mental Health Opt. (%):

          Home Health Care                                  Hospice
                   Care Level:                        Annual Deductible: $
              Visits Per Year:                     Inpatient Annual Max.: $
            Max. Days Per Year:                            Lifetime Max.: $
            Med. Equipment (%):                        Room and Board (%):
              Visit Definition:                  Other Inpt. Charges (%):

             Rehabilitation                             IV Management
              OT Visits/Yr:                       IV Infusion Opt?: UNK
              PT Visits/Yr:                      IV Infusion Inpt?: UNK
              ST Visits/Yr:                    IV Antibiotics Opt?: UNK
      Med Cnslg. Visits/Yr:                   IV Antibiotics Inpt?: UNK

             User Information
                Entered By: EMPLOYEE
                Entered On: 02/02/94
           Last Updated By: EMPLOYEE
           Last Updated On: 02/18/94

          Enter ?? for more actions                                          >>>
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Patient Eligibility          May 20, 1996 07:45:44         Page:    1 of    1
N10273   IBpatient,one      1111            DOB: 07/07/50   Subsc ID:

             Means Test: CATEGORY A                      Insured: Yes
           Date of Test: 08/24/94                   A/O Exposure:
  Co-pay Exemption Test:                           Rad. Exposure:
           Date of Test:

     Primary Elig. Code: NSC
    Other Elig. Code(s): EMPLOYEE
                         AID & ATTENDANCE
      Service Connected: No
     Rated Disabilities: BONE DISEASE (0%-NSC)
                         DEGENERATIVE ARTHRITIS (40%-NSC)

          Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EX  Exit Action
                          AL  Go to Active List
Select Action: Quit//
```

Patient Insurance Menu

Patient Insurance Info View/Edit

The Patient Insurance Info View/Edit option is used to look at a patient's insurance information and edit that data, if necessary. The system groups information that is specific to the insurance company, specific to the patient, specific to the group plan, specific to the annual benefits available, and the annual benefits already used. Inactive policies will be listed as long as the patient has not been repointed from that inactive policy to an active policy.

About the Screens...

In the top left corner of each screen is the screen title. On some screens, the following line is a description of the information displayed. A plus sign (+) at the bottom of the screen indicates there are additional screens. Left or right arrows (<<< >>>) may be displayed to indicate there is additional information to the left or right of the screen. Available actions are displayed below the screen. <??> entered at any "Select Action" prompt displays all available actions for that screen.

You may QUIT from any screen which will bring you back one level or screen. EXIT is also available on most screens. When EXIT is entered, you are asked if you wish to "Exit option entirely?". A YES response returns you to the menu. A NO response has the same result as the QUIT action. For more information on the use of the List Manager utility, please refer to the appendix at the end of this manual.

Following is a listing of the screens found in this option and a brief description of the actions they allow. Once an action has been selected, <??> may be entered at most of the prompts that appear for lists of acceptable responses or instruction on how to respond.

Patient Insurance Management Screen

Once a patient is selected, this screen is displayed listing all the patient's insurance policies. Information provided for each policy may include type of policy, group name, holder, effective date, and expiration date.

Actions

AP Add Policy - Allows you to add an insurance policy for the selected patient.

VP Policy Edit/View (accesses Patient Policy Information screen) - Allows you to view and edit extensive insurance policy data.

DP Delete Policy - Allows you to delete an insurance policy for the selected patient. IB INSURANCE SUPERVISOR security key is required.

AB Annual Benefits - (accesses Annual Benefits Editor screen) - Used to enter annual benefits data for the selected policy.

EA Fast Edit All - A quick way to enter portions of the patient insurance information.

BU Benefits Used (accesses the Benefits Used By Date Editor screen) - Used to enter policy benefits already used.

VC Verify Coverage - Allows the user to enter into the system verification that the insurance coverage exists and the information is correct.

RI Personal Riders - Displays current riders and allows addition of new riders.

CP Change Patient - Allows you to change to another patient without returning to the beginning of the option.

WP Worksheet Print - Used to print the standard worksheet showing the data for the benefit year within the past 12 months. If no benefit year on file, will print the standard form without the data. Must be printed at 132 column margin width.

PC Print Insurance Cov. - Similar to worksheet. Used when bulk of information is already in the computer. Will show two most recent benefit years. If no benefit years on file, will offer WP action (see above).

Patient Policy Information Screen
This screen is displayed listing expanded policy information for the selected company. Categories include utilization review data, subscriber data, subscriber's employer information, effective dates, plan coverage limitations, last contact, and comments on the patient policy or insurance group plan. The sections on user informa-tion and insurance company information are not editable.

Actions

PI Change Plan Info - Allows entry/edit of group plan information.

UI UR Info - Allows entry/edit of utilization review information.

ED Effective Dates - Allows you to edit the effective date and expiration date of the insurance policy.

SU Subscriber Update - Allows you to edit the subscriber (person who holds the insurance coverage) information.

IP Inactive Plan - Allows you to inactivate an insurance plan, or move subscribers from multiple insurance plans into one master plan.

IC Insur. Contact Inf. - Allows you to add/edit the last insurance contact.

EM Employer Info - Allows you to edit the subscriber's employer information.

AC Add Comment - Allows the user to add a comment regarding the patient's policy or the insurance group plan.

EA Fast Edit All - A quick way to enter portions of the patient insurance information.

CP Change Policy Plan - Allows you to change the plan to which a veteran is subscribing.

VC Verify Coverage - Allows the user to enter into the system verification that the insurance coverage exists and the information is correct.

AB Annual Benefits (accesses Annual Benefits Editor screen) - Used to enter annual benefits data for the selected policy.

CV Add/Edit Coverage - Allows you to add or edit coverage limitations for a specific plan.

BU Benefits Used - (accesses the Benefits Used By Date Editor screen) - Used to enter policy benefits already used.

Annual Benefits Editor Screen
Once the benefit year is selected, this screen is displayed listing all the benefits for the selected insurance policy and benefit year. Benefit categories may include inpatient benefits, outpatient benefits, mental health, home health care, hospice, rehabilitation, and IV management.

Actions

PI Policy Information - Allows entry/edit of maximum out of pocket and ambulance coverage.

IP Inpatient - Allows entry/edit of inpatient benefits data.

OP Outpatient - Allows entry/edit of outpatient benefits data.

MH Mental Health - Allows entry/edit of mental health inpatient and outpatient benefits data.

HH Home Health - Allows entry/edit of home health care benefits data.

HS Hospice - Allows entry/edit of hospice benefits data.

RH Rehab - Allows entry/edit of rehabilitation benefits data.

IV IV Mgmt. - Allows entry/edit of intravenous management benefits data.

EA Edit All - Lists editable fields line by line for quick data entry.

CY Change Year - Allows you to change to another benefit year.

Benefits Used By Date Editor Screen
Once the benefit year is selected, this screen is displayed
listing all the benefits used for the selected insurance policy and benefit year. Benefit categories may include inpatient and outpatient deductibles.

PI Policy Info - Allows entry/edit of policy information such as deductible met and pre-existing conditions.

OD Opt Deduct - Allows entry/edit of the outpatient deductible insurance information.

ID Inpt Deduct - Allows entry/edit of the inpatient deductible insurance information.

AC Add Comment - Allows the user to add a comment regarding claims filed.

EA Edit All - A quick way to enter portions of the patient insurance information.

CY Change Year - Allows you to change to another benefit year.

Sample Screens

```
Patient Insurance Management  Nov 22, 1993 13:51:09         Page:  1 of    1
Insurance Management for Patient: IBpatient,one    1111
*** Patient has Insurance Buffer Records
    Insurance Co.    Type of Policy   Group       Holder   Effect.    Expires
1   RIGHA                             1546         UNKNOWN
2   XYZ INS          SURGICAL EXPENS  123          SELF     04/01/93

          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=2   Policy Edit/View  ..........
```

```
Patient Policy Information    Nov 22, 1993 13:51:39       Page:    1 of    3
Expanded Policy Information for: IBpatient,one        000-11-1111
XYZ INS    Insurance Company                       ** Plan Currently Active **

  Plan Information                          Insurance Company
    Is Group Plan: YES                          Company: XYZ INS
       Group Name: PACKERS                       Street: 123 MAIN STREET
     Group Number: 123                       City/State: YORKVILLE, NY 33343
     Type of Plan: SURGICAL EXPENSE INSURANCE
   Plan Filing TF: 1 year


  Utilization Review Info                     Effective Dates & Source
          Require UR: YES                     Effective Date: 04/01/93
    Require Amb Cert: YES                    Expiration Date:
    Require Pre-Cert: YES                     Source of Info:
    Exclude Pre-Cond: NO                 Policy Not Billable:

+         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 Item(s): Quit// AB=2   Annual Benefits
```

```
Annual Benefits Editor        Nov 22, 1993 14:17:36        Page:    1 of    4
Annual Benefits for: XYZ INS    Ins. Co
             Policy: 123                            Ben Yr: DEC  1, 1992

                           Policy Information
                       Max. Out of Pocket: $  300
                   Ambulance Coverage (%):    80%




                                   Inpatient
      Annual Deductible: $  200         Drug/Alcohol Lifet. Max: $ 8888
  Per Admis. Deductible: $   40         Drug/Alcohol Annual Max: $  888
     Inpt. Lifetime Max: $ 9999                Nursing Home (%):    80%
       Inpt. Annual Max: $  999         Other Inpt. Charges (%):    80%
       Room & Board (%):    80%

+         Enter ?? for more actions                                    >>>
PI  Policy Info           HH  Home Health           EA  Edit All
IP  Inpatient             HS  Hospice               CY  Change Year
OP  Outpatient            RH  Rehab                 EX  Exit
MH  Mental Health         IV  IV Mgmt.
Select Action: Next Screen// OP   Outpatient
```

```
Annual Benefits Editor        Nov 22, 1993 14:18:25         Page:   2 of    4
Annual Benefits for: XYZ INS    Ins. Co
             Policy: 123                            Ben Yr: DEC  1, 1992
+
                                   Outpatient
      Annual Deductible: $  225                  Surgery (%):    80%
   Per Visit Deductible: $   25                Emergency (%):    80%
           Lifetime Max: $ 9999             Prescription (%):    40%
             Annual Max: $  666       Adult Day Health Care?:    80
              Visit (%):    80%             Dental Cov. Type: PER VISIT AMOUNT
    Max Visits Per Year:    32                  Dental Cov.:   80

    Mental Health Inpatient                Mental Health Outpatient
 MH Inpt. Max Days/Year:    75             MH Opt. Max Days/Year:    30
  MH Lifetime Inpt. Max: $  400              MH Lifetime Opt. Max: $  300
    MH Annual Inpt. Max: $  500                MH Annual Opt. Max: $  400
Mental Health Inpt. (%):    80%           Mental Health Opt. (%):    80%

+         Enter ?? for more actions                                      >>>
PI  Policy Info           HH  Home Health           EA  Edit All
IP  Inpatient             HS  Hospice               CY  Change Year
OP  Outpatient            RH  Rehab                 EX  Exit
MH  Mental Health         IV  IV Mgmt.
Select Action: Next Screen//
```

View Patient Insurance

The View Patient Insurance option is used to look at a patient's insurance information. The system groups information that is specific to the insurance company, specific to the patient, specific to the group plan, specific to the annual benefits available, and the annual benefits already used. Editing of the data is not allowed through this option.

About the Screens...

In the top left corner of each screen is the screen title. On some screens, the following line is a description of the information displayed. A plus sign (+) at the bottom of the screen indicates there are additional screens. Left or right arrows (<<< >>>) may be displayed to indicate there is additional information to the left or right of the screen. Available actions are displayed below the screen. <??> entered at any "Select Action" prompt displays all available actions for that screen.

You may QUIT from any screen which will bring you back one level or screen. EXIT is also available on most screens. When EXIT is entered, you are asked if you wish to "Exit option entirely?". A YES response returns you to the menu. A NO response has the same result as the QUIT action. For more information on the use of the List Manager utility, please refer to the appendix at the end of this manual.

Following is a listing of the screens found in this option and a brief description of the actions they allow.

Patient Insurance Management Screen

Once a patient is selected, this screen is displayed listing all the patient's insurance policies. Information provided for each policy may include type of policy, group name or individual, holder, effective date, and expiration date.

VP View Policy Info (accesses Patient Policy Information screen) - Allows you to view extensive insurance policy data.

Actions

AB Annual Benefits - (accesses Annual Benefits Editor screen) - Used to view annual benefits data for the selected policy.

BU Benefits Used - (accesses Benefits Used By Date Editor screen) - Used to view policy benefits already used.

CP Change Patient - Allows you to change to another patient without returning to the beginning of the option.

Patient Policy Information Screen
This screen is displayed listing expanded policy information for the selected company. Categories include utilization review data, subscriber data, subscriber's employer information, policy information, effective dates, plan coverage limitations,
last contact, comments on the patient policy or insurance
group plan, and personal riders. The only action allowed from this screen is EXIT.

Annual Benefits Editor Screen
Once the benefit year is selected, this screen is displayed listing all the benefits for the selected insurance policy and benefit year. Benefit categories may include inpatient benefits, outpatient benefits, mental health, home health care, hospice, rehabilitation, and IV management. The only actions allowed from this screen are CY to change the benefit year and EXIT.

Benefits Used By Date Editor Screen
Once the benefit year is selected, this screen is displayed listing all the benefits used for the selected insurance policy and benefit year. Benefit categories may include inpatient and outpatient deductibles. The only actions allowed from this screen are CY to change the benefit year and EXIT.

Sample Screens

```
Select PATIENT NAME: IBpatient,one            11-28-31     000111111     YES
SC VETERAN  ..


Patient Insurance Management  Nov 22, 1993 13:51:09         Page:  1 of    1
Insurance Management for Patient: IBpatient,one    1111

    Insurance Co.    Type of Policy   Group       Holder   Effect.    Expires
1   RIGHA                             1546        UNKNOWN
2   XYZ INS          MAJOR MEDICAL    123         SELF     04/01/93

          Enter ?? for more actions                                      >>>
VP  Policy Edit/View      BU  Benefits Used         EX  Exit
AB  Annual Benefits       CP  Change Patient
Select Item(s): Quit// VP=2   View Policy Info
```

```
Patient Policy Information    Nov 22, 1993 13:51:39         Page:  1 of    3
Expanded Policy Information for: IBpatient,one        000-11-1111
XYZ INS    Insurance Company                       **Plan Currently Active**
+

 Plan Information                              Insurance Company
    Is Group Plan: YES                            Company: XYZ INS
       Group Name: GE LIGHT PRUD                   Street: 123MAIN ST
     Group Number: PRUD GRP # GE L             City/State: ALBANY, NY 39239
     Type of Plan: MEDICAL EXPENSE (OPT/PR     Billing Ph:
   Plan Filing TF: 1 year                      Precert Ph:


  Utilization Review Info                   Effective Dates & Source
          Require UR: YES                       Effective Date: 01/01/97
    Require Amb Cert: YES                      Expiration Date:
    Require Pre-Cert: YES                       Source of Info: INTERVIEW
    Exclude Pre-Cond: NO                   Policy Not Billable: NO
 Benefits Assignable: YES

+         Enter ?? for more actions
EX  Exit
Select Item(s): Next Screen//
```

```
Patient Policy Information    Nov 22, 1993 15:27:55         Page:   2 of    3
Expanded Policy Information for: IBpatient,one
XYZ INS    Insurance Company
+
Subscriber Information              Subscriber's Employer Information
 Whose Insurance: VETERAN           Emp Sponsored Plan: Yes
 Subscriber Name: IBpatient,one               Employer: GE LIGHT
    Relationship: PATIENT            Employment Status: RETIRED
Insurance Number: 5948333              Retirement Date: 01/01/96
Coord.  Benefits: PRIMARY           Claims to Employer: Yes, Send to Employer
Primary Provider: IBprovider,one               Street: 1865 TEST ST
 Prim Prov Phone:                           City/State: SCHENECTADY, NY 29292
                                                 Phone: 555-5233


    Insured Person's Information (use Subscriber Update action)
       Insured's DOB:                       Str 1:
+         Enter ?? for more actions
EX  Exit
Select Action:Next Screen//
```

```
Patient Policy Information    Nov 22, 1993 15:30:06          Page:   3 of    3
Expanded Policy Information for: IBpatient,one
XYZ INS    Insurance Company
+
    Insured's Branch:                        Str 2:
      Insured's Rank:                         City:
       Insured's SSN:                       St/Zip:
                                             Phone:

  Plan Coverage Limitations
   Coverage            Effective Date   Covered?       Limit Comments
   --------            --------------   --------       --------------
   INPATIENT           10/01/91         NO
   OUTPATIENT          10/01/91         CONDITIONAL    Cond cov comment opt
                                                       2nd opt cond cov comm
   PHARMACY            10/01/91         YES
   DENTAL              10/01/91         NO
   MENTAL HEALTH       10/01/91         NO
           Enter ?? for more actions
EX  Exit
Select Action:Quit//
```

Insurance Company Entry/Edit

The Insurance Company Entry/Edit option is used to enter new insurance companies into the INSURANCE COMPANY file and edit data on existing companies. An insurance company must be in the INSURANCE COMPANY file before it can be entered into a patient's record.

When entering new insurance companies, you will be prompted for the company street address, city, and whether or not the company will reimburse for treatment.

Following is a listing of the actions found on the screen in this option and a brief description of each. Once an action has been selected, <??> may be entered at most of the prompts that appear for lists of acceptable responses or instruction on how to respond.

Insurance Company Editor Screen

Once the insurance company is selected, this screen is displayed listing the following groups of information for that company: billing parameters, main mailing address, inpatient claims office data, outpatient claims office data, prescription claims office data, appeals office data, inquiry office data, remarks, and synonyms.

BP Billing Parameters - Allows you to add/edit the billing parameters for the selected insurance company.

MM Main Mailing Address - Allows you to add/edit the company's main mailing address. The address entered here will automatically be entered for the other office addresses.

IC Inpt Claims Office - Allows you to add/edit the company's inpatient claims office name, address, phone and fax numbers.

OC Opt Claims Office - Allows you to add/edit the company's outpatient claims office name, address, phone and fax numbers.

PC Prescr Claims Of - Allows you to add/edit the company's prescription claims office name, address, phone and fax numbers.

AO Appeals Office - Allows you to add/edit the company's appeals office name, address, phone and fax numbers.

IO Inquiry Office - Allows you to add/edit the company's inquiry office name, address, phone and fax numbers.

RE Remarks - Allows the user to enter comments concerning the selected insurance company.

SY Synonyms - Allows you to add/edit any synonyms for the selected company.

EA Edit All - Lists editable fields line by line for quick data entry.

AI (In)Activate Company - Allows you to activate/inactivate the selected insurance company. This may be used to inactivate duplicate companies in the system. When an insurance company is no longer valid, it is important to inactivate the company rather than delete it from the system. The IB INSURANCE SUPERVISOR security key is required. Once a company has been inactivated, it may not be selected when entering billing information.

You may also obtain a report of patients insured by a given company through this action.

CC Change Insurance Co. - Allows you to change to another company without returning to the beginning of the option.

DC Delete Company - Allows you to delete an entry from the INSURANCE COMPANY (#36) file. If claims have been submitted to the company, another company must be selected in which to point all claims and receivables information.

PL Plans (accesses Insurance Plan List screen) - Allows you to display and change plan attributes associated with the insurance company.

Insurance Plan List Screen
This screen lists all plans (active and inactive, group and individual) for the selected insurance company.

Actions

VP View/Edit Plan (accessesView/Edit Plan screen) - Allows you to display /change plan detailed information.

IP Inactive Plan - Allows you to inactivate an insurance plan, or move subscribers from multiple insurance plans into one master plan.

AB Annual Benefits - (accesses Annual Benefits Editor screen) - Used to enter annual benefits data for the selected policy.

Annual Benefits Editor Screen
Once the benefit year is selected, this screen is displayed listing all the benefits for the selected insurance policy and benefit year. Benefit categories may include inpatient benefits, outpatient benefits, mental health, home health care, hospice, rehabilitation, and IV management.

Actions

PI Policy Information - Allows entry/edit of maximum out of pocket and ambulance coverage.

IP Inpatient - Allows entry/edit of inpatient benefits data.

OP Outpatient - Allows entry/edit of outpatient benefits data.

MH Mental Health - Allows entry/edit of mental health inpatient and outpatient benefits data.

HH Home Health - Allows entry/edit of home health care benefits data.

HS Hospice - Allows entry/edit of hospice benefits data.

RH Rehab - Allows entry/edit of rehabilitation benefits data.

IV IV Mgmt. - Allows entry/edit of intravenous management benefits data.

EA Edit All - Lists editable fields line by line for quick data entry.

CY Change Year - Allows you to change to another benefit year.

View/Edit Plan Screen
This screen displays plan information for viewing/editing including utilization review info, plan coverage limitations, annual benefit dates, user information, and plan comments.

Actions

PI Policy Information - Allows entry/edit of maximum out of pocket and ambulance coverage.

UI UR Info - Allows entry/edit of utilization review information.

CV Add/Edit Coverage - Allows you to add or edit coverage limitations for a specific plan.

PC Plan Comments - Allows editing of comments for the plan.

IP Inpatient - Allows entry/edit of inpatient benefits data.

AB Annual Benefits - (accesses Annual Benefits Editor screen) - Used to enter annual benefits data for the selected policy.

CP Change Plan - Allows you to select another plan for this insurance company without having to exit back to the previous screen.

Although this option is not locked, the MCCR System Definition Menu is locked with the IB SUPERVISOR security key.

Sample Screens

```
Insurance Company Editor    May 30, 1997 10:32:43     Page:    1 of    5
Insurance Company Information for: FOUNDATION HEALTH
Type of Company: CHAMPUS                      Currently Active

                             Billing Parameters
  Signature Required?: NO                     Attending Phys. ID:
           Reimburse?: WILL REIMBURSE         Hosp. Provider No.:
    Mult. Bedsections:                         Primary Form Type:
     Diff. Rev. Codes:                             Billing Phone:
       One Opt. Visit: NO                      Verification Phone:
  Amb. Sur. Rev. Code:                        Precert Comp. Name:
  Rx Refill Rev. Code:                             Precert Phone:
    Filing Time Frame:                                Bin Number:


+         Enter ?? for more actions                                >>>
BP  Billing Parameters    AO  Appeals Office        AI  (In)Activate Company
MM  Main Mailing Address  IO  Inquiry Office        CC  Change Insurance Co.
IC  Inpt Claims Office    RE  Remarks               DC  Delete Company
OC  Opt Claims Office     SY  Synonyms              PL  Plans
PC  Prescr Claims Of      EA  Edit All              EX  Exit
Select Action: Next Screen// BP   Billing Parameters
```

View Insurance Company

The View Insurance Company option is used to look at datarelated to a selected insurance company. Editing of the data is not allowed through this option.

About the Screen...

In the top left corner of each screen is the screen title. The following line is a description of the information displayed. A plus sign (+) at the bottom of the screen indicates there are additional screens. Left or right arrows (<<< >>>) may be displayed to indicate there is additional information to the left or right of the screen. Available actions are displayed below the screen. <??> entered at any "Select Action" prompt displays all available actions for that screen.

You may QUIT from any screen which will bring you back one level or screen. EXIT is also available on most screens. When EXIT is entered, you are asked if you wish to "Exit option entirely?". A YES response returns you to the menu. A NO response has the same result as the QUIT action. For more information on the use of the List Manager utility, please refer to the appendix at the end of this manual.

Insurance Company Editor Screen

Once the insurance company is selected, this screen is displayed listing the following groups of information for that company: billing parameters, main mailing address, inpatient claims office data, outpatient claims office data, prescription claims office data, appeals office data, inquiry office data, remarks, and synonyms.

The two actions available through this option are CC Change Insurance Co. which allows you to change to another company without returning to the beginning of the option, and EXIT.

```
Insurance Company Editor      Nov 23, 1993 07:35:58         Page:   1 of    5
Insurance Company Information for: XYZ INS
Type of Company: HEALTH INSURANCE                     Currently Inactive
____________________________________________________________________________
                              Billing Parameters
  Signature Required?: YES                     Attending Phys. ID: VAMV001
           Reimburse?: DEPENDS ON POLICY, CH   Hosp. Provider No.: 000
    Mult. Bedsections: YES                      Primary Form Type: UB-92
     Diff. Rev. Codes: 444,555                      Billing Phone: 555-5343
       One Opt. Visit: NO                      Verification Phone: 555-3422
  Amb. Sur. Rev. Code: 960                     Precert Comp. Name:
  Rx Refill Rev. Code:                              Precert Phone: 555-2698
    Filing Time Frame: 18 MONTHS

+         Enter ?? for more actions                                        >>>
CC  Change Insurance Co.            EX  Exit
Select Action: Next Screen// <RET>
```

```
Insurance Company Editor      Nov 23, 1993 07:38:09        Page:    2 of    5
Insurance Company Information for: XYZ INS
Type of Company: HEALTH INSURANCE                     Currently Inactive
+
                          Main Mailing Address
        Street: 222 FIRST ST                   City/State: TROY, NY 12180
      Street 2:                                     Phone: 271-4533
      Street 3:                                       Fax: 271-4500

                       Inpatient Claims Office Information
  Company Name: XYZ INS                            Street 3:
        Street: 222 FIRST ST                   City/State: TROY, NY 12180
      Street 2:                                     Phone: 555-4533
                                                      Fax: 555-4500

+         Enter ?? for more actions                                      >>>
CC  Change Insurance Co.            EX  Exit
Select Action: Next Screen// <RET>
```

```
Insurance Company Editor      Nov 23, 1993 07:40:34        Page:    3 of    5
Insurance Company Information for: XYZ INS
Type of Company: HEALTH INSURANCE                     Currently Inactive
+
                       Outpatient Claims Office Information
  Company Name: ABC INS                            Street 3:
        Street: 789 UBIQUITOUS STREET          City/State: SALT LAKE CITY, UT
      Street 2:                                     Phone: 333 4445676
                                                      Fax:

                      Prescription Claims Office Information
  Company Name: ABC INS                            Street 3:
        Street: 789 UBIQUITOUS STREET          City/State: SALT LAKE CITY, UT
      Street 2:                                     Phone: 333 4445676
                                                      Fax:

+         Enter ?? for more actions                                      >>>
CC  Change Insurance Co.            EX  Exit
Select Action: Next Screen// <RET>
```

```
Insurance Company Editor      Nov 23, 1993 07:40:34        Page:    4 of    5
Insurance Company Information for: XYZ INS
Type of Company: HEALTH INSURANCE                     Currently Inactive
+
                            Appeals Office Information
  Company Name: XYZ INS                            Street 3:
        Street: 123 MAIN STREET                City/State: YORKVILLE, NY 33343
      Street 2:                                     Phone: 222-7544
                                                      Fax:

                            Inquiry Office Information
  Company Name: XYZ INS                            Street 3:
        Street: 123 MAIN STREET                City/State: YORKVILLE, NY 33343
      Street 2:                                     Phone: 222-7544
                                                      Fax:

+         Enter ?? for more actions                                      >>>
CC  Change Insurance Co.            EX  Exit
Select Action: Next Screen// <RET>
```

```
Insurance Company Editor      Nov 23, 1993 07:40:34        Page:    5 of    5
Insurance Company Information for: XYZ INS
Type of Company: HEALTH INSURANCE                     Currently Inactive
+
  Remarks
   Yorkville location is not main address of company.



  Synonyms
   XYZ INS    HEALTH

          Enter ?? for more actions                                      >>>
CC  Change Insurance Co.            EX  Exit
Select Action: Quit// <RET>
```

Process Insurance Buffer

The IB INSURANCE SUPERVISOR security key is required to use the Reject Entry and Accept Entry actions. Adding new insurance companies requires the IB INSURANCE COMPANY ADD security key.

This option is used to process and manage the Insurance Buffer through the use of the following screens and actions.

Insurance Buffer List Screen

This screen contains the list of all Insurance Buffer file entries that have not yet been processed by authorized insurance personnel.

Actions

Process Entry Action

Opens the Insurance Buffer Process screen for a selected buffer entry. The buffer entry can then be compared against existing insurance records, viewed, edited, rejected or accepted.

Reject Entry Action

Allows you to reject a selected buffer entry without any changes to the existing permanent insurance records. This also results in the buffer entries insurance and patient data being deleted, leaving a stub record in the Buffer file for tracking and reporting purposes. The permanent Insurance files are not modified by this action. If the patient has no active insurance then any bills on hold will be released.

Expand Entry Action

Opens the Insurance Buffer Entry screen for a selected buffer entry. This screen displays the complete buffer entry and allows the data to be edited.

Add Action

Allows you to create then edit a new Insurance Buffer entry.

Sort List

Re-sorts the list of unprocessed buffer entries on the Insurance Buffer List screen by a selected data element.

Insurance Buffer Process Screen

This screen contains the information and actions needed to process a buffer entry. The screen display includes data to assist in matching the buffer entry with any existing insurance records. There are two versions of this screen, Patient (list is broken into 2 sections) and Insurance Company.

Accept Entry Action
Allows you to accept the buffer data and transfer the insurance information from the buffer entry into the permanent insurance records. New insurance records can be created, or existing Insurance records can be updated with the buffer data. The new/updated Insurance record is flagged as verified. The insurance and patient data is deleted from the buffer entry leaving only a stub record for tracking and reporting purposes. If a new policy is added for the patient, the on hold date of any patient bills is updated to the current date.

Reject Entry Action
Allows you to reject the buffer entry without any changes to the existing permanent insurance records. This also results in the buffer entries insurance and patient data being deleted, leaving a stub record in the Buffer file for tracking and reporting purposes. The permanent insurance files are not modified by this action. If the patient has no active insurance, any bills on hold are released.

Compare Entry Action
Displays the buffer entry and a user selected Insurance Policy side by side so they can be compared to determine if they match. It is also possible to edit the buffer entry data within this action. The display and editing is broken into 3 parts: Insurance Company data, Group/Plan data, and Patient Policy data.

Expand Entry Action
Opens the Insurance Buffer Entry screen for the buffer entry. It displays the complete buffer entry and allows the data to be edited.

Insurance Co/Patient Action
Toggles between the two versions of the Insurance Buffer Process screen: Patient or Insurance Company. If an Insurance Company is selected the Insurance Company version of the screen is displayed, if no company is selected the Patient version of the screen is displayed.

Insurance Buffer Entry Screen
This screen displays all data defined for a buffer entry and allows that data to be edited.

Insurance Co Edit Action
Edits the Insurance Company specific data in the buffer entry.

Group/Plan Edit Action
Edits the Insurance Group/Plan specific data in the buffer entry.

Patient Policy Edit Action
Edits the Patient Policy specific data in the buffer entry.

All Edit Action
Edits all three types of data in the buffer entry: Insurance Company, Group/Plan, and Patient Policy.

Verify Entry Action

Option to flag the buffer entry as verified before it is accepted. If the buffer entry is later accepted, the person that uses this action is added as the verifier in the permanent insurance policy.

Sample Screens

```
Insurance Buffer List         Nov 05, 1998 09:44:09        Page:    1 of    1
Buffer File entries not yet processed.   (sorted by Patient Name)
   Patient Name              Insurance Company  Subscr Id   Sourc  Entered   iIECH
1   IBpatient,one      2343  GEHA               123         INTVW  10/09/98   I
2  *IBpatient,two      6666  HARTFORD           006066666   INTVW  09/15/98  i  C
3   IBpatient,three    0111  BLUE CROSS/BLUE S  12345       INTVW  09/29/98  i
4   IBpatient,four     0111  GHI                            PreRg  09/30/98  i
5   IBpatient,five     0111  HARTFORD                       INTVW  09/30/98  i



          Enter ?? for more actions
    Process Entry         EE  Expand Entry              Sort List
    Reject Entry              Add Entry             X   Exit
Select Action: Quit//
```

```
Insurance Buffer Process      Nov 05, 1998 11:01:21          Page:    1 of    1
IBpatient,one                       000-11-1111    DOB: JUN 2,1926    AGE: 72

                  HARTFORD   (2222 SOUTH STREET, SAN DIEGO, CA)
   -HARTFORD            000-CHAMPUS    006066666      PATIEN

                          Patient's Existing Insurance
   Insurance Company    Group #        Subscriber Id  Holder  Effective Expires
1   HARTFORD            000            000111111      SPOUSE  01/01/97
2   BC/BS OF ALBANY     415            000111111      PATIEN

            Any Group/Plan that may match Group Name or Group Number
     Insurance Company                  Group Name            Group Number
3    HARTFORD            2222 South St  CHAMPUS PRIM          000



          Enter ?? for more actions
    Accept Entry              Compare Entry             Insurance Co/Patient
    Reject Entry          EE  Expand Entry          X   Exit
Select Action: Quit//
```

```
Insurance Buffer Entry        Nov 05, 1998 11:02:01          Page:    1 of    2
IBpatient,one                       000-11-1111    DOB: JUN 2,1926    AGE: 72
          Buffer entry created on 09/15/98 by ELLEN (INTERVIEW)
                Buffer entry verified on 09/16/98 by CATHI


                         Insurance Company Information
    Name: HARTFORD                           Reimburse?:
   Phone: 1-800-555-1212                  Billing Phone: 1-800-555-1212
                                          Precert Phone: 1-800-555-1212
 Address: 2222 SOUTH STREET, SAN DIEGO, CA  92025

                            Group/Plan Information
   Group Plan?:                                   Require UR:
    Group Name: CHAMPUS                      Require Amb Cert:
  Group Number: 000-CHAMPUS                  Require Pre-Cert:
  Type of Plan: CHAMPUS                      Exclude Pre-Cond:
                                          Benefits Assignable:

                         Policy/Subscriber Information
+         Enter ?? for more actions
    Insurance Co Edit         Group/Plan Edit           Patient Policy Edit
    All Edit                  Verify Entry          X   Exit
Select Action: Next Screen//
```

List Inactive Ins. Co. Covering Patients

The List Inactive Ins. Co. Covering Patients option is used to provide a listing of inactive insurance companies that are listed in the system as providing patient coverage.

Occasionally, an insurance company may be in the system twice under slightly different names (i.e., Blue Cross and Blue Cross of New York) when in fact they are the same company. Once the correct name is established, it would be necessary to inactivate the incorrect name and "repoint" those patients to the correct name. This option provides the number of patients which should be repointed to another company.

Information provided on the output includes insurance company name and address and the number of patients the system shows as having coverage by that company.

Sample Output

```
INACTIVE INSURANCE COMPANIES WITH PATIENTS     NOV 16,1993  08:46    PAGE 1
                                                                       NUMBER
INSURANCE COMPANY       STREET                CITY             STATE  PATIENTS
-------------------------------------------------------------------------------

ABC INSURANCE COMPANY   2123 MAIN STREET      NEW YORK         NY            1
ABC INS                 235 PENN AVE          COHOES           NY           19
NATIONWIDE              77 PARKER BLVD        ROCHESTER        MN            1
XYZ INS                 345 SECOND AVE        ALBANY           NY            2
```

List Plans by Insurance Company

This report provides insurance information from both a plan and subscriber perspective. It is designed to generate lists of plans by insurance company, and lists of subscribers (policies) by insurance plan. It can be used to generate plan and subscriber lists to be used for your database clean-up efforts. Once your database integrity has been restored, the report can be used to generate a list of subscribers to particular plans or companies.

This report is formatted to print at 132 columns.

Sample Screen

```
Insurance Plan Lookup          Sep 19, 1995 13:29:50       Page:    1 of    1
All Plans for: ABC INS                                      Phone: 618-567-987
               123 MAIN Ave.                              Precerts: 987-965-8754
               LOS ANGELES, CA  00098
#  + => Indiv. Plan    * => Inactive Plan                    Pre-  Pre-  Ben
    Group Name          Group Number       Type of Plan   UR?  Ct?   ExC?  As?
1   AE                  93932              MEDICAL EXPEN  NO   YES   YES   YES
2   NYS                 12343221           MEDI-CAL       YES  YES   YES   YES
3   KROGER              112222             MAJOR MEDICAL  NO   YES   NO    YES
4   RETIRED             4321               MAJOR MEDICAL  YES  YES   NO    YES





          Enter ?? for more actions
SP  Select Plan
Select Action: Quit// sp=1 4   Select Plan
Would you like to select any other plans? NO// <RET>
```

Sample Output

```
LIST OF PLANS BY INSURANCE COMPANY                                  SEP 19, 1995@13:34      Page: 1
-------------------------------------------------------------------------------------------------------
 Ins. Co.: ABC INS                        Phone: 618-555-987                      ACTIVE COMPANY
           123 Ave  Of The MOONS          Precert Phone: 987-555-8754             PLAN TOTAL= 4
           LOS ANGELES, CA  00098                                               SUBSCRIBER TOTAL= 11

     GROUP NUMBER         GROUP NAME      GROUP OR IND   ACTIVE/INACTIVE    SUBSCRIBERS   ANN. BEN?  BEN. USED?

     93932                AE              GRP            ACTIVE                 5            NO         NO

     4321                 RETIRED         GRP            ACTIVE                 2            YES        NO

                                                                   Number of Plans Selected = 2
                                                     Total Subscribers Under Selected Plans = 7



Enter RETURN to continue or '^' to exit:
```

List New not Verified Policies

The List New not Verified Policies option is used to produce a list by patient of new insurance entries that have not been verified. After running this report, you would use the Verify Coverage action of the Patient Insurance Info View/Edit option to verify coverage for individual patients.

You may specify a date range and patient name range to limit the parameters of the report.

Information provided on the output includes patient name and ID#, insurance company name, subscriber ID, person who made the entry, and date entered. A total count is also provided.

```
REPORT OF NEW, NOT VERIFIED INSURANCE ENTRIES FROM: 8/01/93 TO: 12/01/93                        DEC 16,1993  15:05    PAGE 1
PATIENT                    PATIENT ID  INSURANCE CO                SUBSCRIBER ID        WHO ENTERED                DATE ENTERED
-------------------------------------------------------------------------------------------------------------------------------------


IBpatient,one              000111111   XYZ INS                     3483920              NANCY                      AUG 17,1993

IBpatient,two              000222222   BLUE CROSS BLUE SHIELD      123456               BETH                       SEP 17,1993

IBpatient,three            000333333   XYZ INS                     2587                 ELLEN                      OCT 12,1993

-------------------------
COUNT 3
```

Billing Supervisor Menu

*Documentation for the Unbilled Amounts Menu, which was released to the field as patch IB*2*19, has been included in this section of the manual as a matter of convenience. The Unbilled Amounts Menu [IBT UNBILLED MENU] need not be assigned to the Billing Supervisor Menu. It may be assigned to any menu in Integrated Billing, or to a user's secondary menu, as deemed appropriate by IRMS.

Insurance Buffer Activity

This report provides a summary of the activity within the Insurance Buffer for a specified date range. Counts, percentages, and average processing times are included for both processed and unprocessed entries. The report can be printed with totals only or by month within the selected date range.

Sample Output

```
INSURANCE BUFFER ACTIVITY REPORT   Apr 17, 1998 - Nov 05, 1998 11/5/98 11:06 PAGE 1
-------------------------------------------------------------------------------

                                        TOTALS

                                           AVERAGE      LONGEST     SHORTEST
STATUS                 COUNT   PERCENT     # DAYS       # DAYS      # DAYS
-----------------------------------------------------------------------------
ENTERED                   24     58.5%       39.0        146.0         0.0
VERIFIED                   4      9.8%       26.7        105.0         0.0
ACCEPTED (&V)              5     12.2%       22.6        108.9         0.2
REJECTED                   7     17.1%       62.6        146.0         3.0
REJECTED (V)               1      2.4%        4.8          4.8         4.8
-----------------------------------------------------------------------------
NOT PROCESSED             28     68.3%       37.3        146.0         0.0
PROCESSED                 13     31.7%       42.8        146.0         0.2
TOTAL                     41    100.0%       39.0        146.0         0.0

  0 New Companies (0%), 0 New Group/Plans (0%), 1 New Patient Policy (20%)
```

Management Reports (Billing) Menu

Statistical Report (IB)

This report lists the total number of Integrated Billing actions by action type along with the total charge by type for a date range. Integrated Billing actions include inpatient copayments by treating specialty, inpatient and NHCU per diems; and NHCU, outpatient, and pharmacy copayments.

Net statistics compute the current status for each new entry in the selected date range to calculate the net totals. Net totals are derived from the last update for a parent (even when the update is not within the date range) using the following formula: new entries (+) updates within the date range (-) cancellations.

The gross statistics count only the entries in the date range. It is possible that the net and gross statistics may not match. For example, if a charge was cancelled after the selected date range of the report but before the report actually ran, the net figures would reflect this but the gross figures would not.

```
INTEGRATED BILLING STATISTICAL REPORT
ALBANY (500)

From: JUN 10, 1992
To: JUN 10, 1992

Date Printed: JUN 10, 1992
Page: 1
--------------------------

NET TOTALS BY ACTION TYPE

FEE SERVICE (OPT) NEW
NUMBER ENTRIES: 1
DOLLAR AMOUNT: $30

INPT COPAY (ALC) NEW
NUMBER ENTRIES: 0
DOLLAR AMOUNT: $0

INPT COPAY (PSY) NEW
NUMBER ENTRIES: 1
DOLLAR AMOUNT: $162

INPT PER DIEM NEW
NUMBER ENTRIES: 1
DOLLAR AMOUNT: $10

OPT COPAY NEW
NUMBER ENTRIES: 13
DOLLAR AMOUNT: $390

SC RX COPAY NEW
NUMBER ENTRIES: 5
DOLLAR AMOUNT: $24

NSC RX COPAY UPDATE
NUMBER ENTRIES: 1
DOLLAR AMOUNT: $2

GROSS TOTALS BY ACTION TYPE

FEE SERVICE (OPT) NEW
NUMBER ENTRIES: 1
DOLLAR AMOUNT: $30

INPT COPAY (ALC) NEW
NUMBER ENTRIES: 1
DOLLAR AMOUNT: $238
```

```
INTEGRATED BILLING STATISTICAL REPORT
ALBANY (500)

From: JUN 10, 1992
To: JUN 10, 1992

Date Printed: JUN 10, 1992
Page: 2
--------------------------

INPT COPAY (PSY) NEW
NUMBER ENTRIES: 1
DOLLAR AMOUNT: $162

INPT PER DIEM NEW
NUMBER ENTRIES: 1
DOLLAR AMOUNT: $10

OPT COPAY NEW
NUMBER ENTRIES: 16
DOLLAR AMOUNT: $480

NSC RX COPAY NEW
NUMBER ENTRIES: 1
DOLLAR AMOUNT: $2

SC RX COPAY NEW
NUMBER ENTRIES: 5
DOLLAR AMOUNT: $28

INPT COPAY (ALC) CANCEL
NUMBER ENTRIES: 1
DOLLAR AMOUNT: $238

OPT COPAY CANCEL
NUMBER ENTRIES: 3
DOLLAR AMOUNT: $90

NSC RX COPAY CANCEL
NUMBER ENTRIES: 2
DOLLAR AMOUNT: $44

SC RX COPAY UPDATE
NUMBER ENTRIES: 1
DOLLAR AMOUNT: $4
```

Most Commonly used Outpatient CPT Codes

This option will list the most common ambulatory procedures and ambulatory surgeries performed within a date range for selected clinic(s). This list may be used to help select which codes to include when building CPT check-off sheets through the Build CPT Check-off Sheet option under the Ambulatory Surgery Maintenance Menu.

You may sort by clinic or procedure. When sorting by procedure, you may also include full procedure descriptions.

All reports provide the CPT code and procedure, a count of each procedure that has been entered for a clinic visit, number billed, the OPC status, and charge amount. The status and charge amount given are as of the current date. If no charge amount is shown, the procedure is not a billable procedure.

This output requires 132 column margin width.

Depending on the date range chosen, this report could be quite lengthy. You may wish to queue this to print during non-work hours.

Sample Output

```
CLINIC CPT USAGE FOR JAN 1,1991 - JAN 1,1992                              APR 16, 1992  11:22   PAGE 1

ALL DIVISIONS AND CLINICS
AMBULATORY PROCEDURE                                  COUNT  #BILLED  OPC STATUS                     CHARGE
-----------------------------------------------------------------------------------------------------------

10121  REMOVE FOREIGN BODY                             38      38   NATIONALLY ACTIVE              256.50
       INCISION AND REMOVAL OF FOREIGN BODY, SUBCUTANEOUS TISSUES;
       COMPLICATED

11000  SURGICAL CLEANSING OF SKIN                      56           NATIONALLY ACTIVE
       DEBRIDEMENT OF EXTENSIVE ECZEMATOUS OR INFECTED SKIN; UP TO 10% OF
       BODY SURFACE

13152  REPAIR OF WOUND OR LESION                       89      34   NATIONALLY ACTIVE              394.20
       REPAIR, COMPLEX, EYELIDS, NOSE, EARS AND/OR LIPS; 2.6 CM TO 7.5 CM

24925  AMPUTATION FOLLOW-UP SURGERY                    29                                          394.20
       AMPUTATION, ARM THROUGH HUMERUS; SECONDARY CLOSURE OR SCAR REVISION

40654  REPAIR LIP                                       1       1   NATIONALLY ACTIVE              394.20
       REPAIR LIP, FULL THICKNESS; OVER ONE HALF VERTICAL HEIGHT, OR
       COMPLEX

65235  REMOVE FOREIGN BODY FROM EYE                    18      15   INACTIVE                       343.80
       REMOVAL OF FOREIGN BODY, INTRAOCULAR; FROM ANTERIOR CHAMBER OR LENS

66820  INCISION, SECONDARY CATARACT                    36           NATIONALLY ACTIVE
       DISCISSION OF SECONDARY MEMBRANEOUS CATARACT (OPACIFIED POSTERIOR
       LENS CAPSULE AND/OR ANTERIOR HYALOID; STAB INCISION TECHNIQUE
       (ZIEGLER OR WHEELER KNIFE)

85102  BONE MARROW BIOPSY                              12           NATIONALLY ACTIVE
       BONE MARROW BIOPSY, NEEDLE OR TROCAR;
```

Insurance Buffer Employee

This report provides a summary of entries and actions in the Insurance Buffer by employee for a specified date range. It can be printed for those employees who create buffer entries (primarily non-insurance personnel) or for those employees who verify and process (accept/reject) buffer entries (primarily insurance personnel). The report can also be printed for one specific employee or all employees. Counts, percentages, and average processing times are included and can be printed with totals only or by month.

Sample Output

```
INSURANCE BUFFER EMPLOYEE REPORT   Apr 17, 1998 - Nov 05, 1998 11/5/98 11:13 PAGE 1
-------------------------------------------------------------------------------

                              ELLEN         TOTALS

                                           AVERAGE      LONGEST     SHORTEST
STATUS                COUNT   PERCENT      # DAYS       # DAYS      # DAYS
-----------------------------------------------------------------------------
ACCEPTED (&V)             1     12.5%         0.2          0.2         0.2
REJECTED                  6     75.0%        72.5        146.0        21.7
REJECTED (V)              1     12.5%         4.8          4.8         4.8
TOTAL                     8    100.0%        55.0        146.0         0.2

  0 New Companies (0%), 0 New Group/Plans (0%), 1 New Patient Policy (100%)
```

```
INSURANCE BUFFER EMPLOYEE REPORT   Apr 17, 1998 - Nov 05, 1998 11/5/98 11:13 PAGE 2
-------------------------------------------------------------------------------

                                HARPER,A  TOTALS

                                           AVERAGE      LONGEST     SHORTEST
STATUS                COUNT   PERCENT      # DAYS       # DAYS      # DAYS
-----------------------------------------------------------------------------
VERIFIED                  1     20.0%       105.0        105.0       105.0
ACCEPTED (&V)             3     60.0%        37.3        108.9         1.0
REJECTED                  1     20.0%         3.0          3.0         3.0
TOTAL                     5    100.0%        44.0        108.9         1.0

  0 New Companies (0%), 0 New Group/Plans (0%), 0 New Patient Policies (0%)
```

```
INSURANCE BUFFER EMPLOYEE REPORT   Apr 17, 1998 - Nov 05, 1998 11/5/98 11:13 PAGE 3
-------------------------------------------------------------------------------
                              GRAVES,CATHI  TOTALS

                                           AVERAGE      LONGEST     SHORTEST
STATUS                COUNT   PERCENT      # DAYS       # DAYS      # DAYS
-----------------------------------------------------------------------------
VERIFIED                  3     75.0%         0.6          1.0         0.0
ACCEPTED (&V)             1     25.0%         0.8          0.8         0.8
TOTAL                     4    100.0%         0.7          1.0         0.0

  0 New Companies (0%), 0 New Group/Plans (0%), 0 New Patient Policies (0%)
```

```
INSURANCE BUFFER EMPLOYEE REPORT   Apr 17, 1998 - Nov 05, 1998 11/5/98 11:13 PAGE 4
-------------------------------------------------------------------------------

                                        TOTALS

                                             AVERAGE      LONGEST     SHORTEST
STATUS                COUNT   PERCENT        # DAYS       # DAYS      # DAYS
-----------------------------------------------------------------------------
VERIFIED                  4     23.5%         26.7        105.0         0.0
ACCEPTED (&V)             5     29.4%         22.6        108.9         0.2
REJECTED                  7     41.2%         62.6        146.0         3.0
REJECTED (V)              1      5.9%          4.8          4.8         4.8
TOTAL                    17    100.0%         39.0        146.0         0.0

  0 New Companies (0%), 0 New Group/Plans (0%), 1 New Patient Policy (20%)
```

Clerk Productivity

The Clerk Productivity option allows you to print a report for bills entered, authorized, or printed within a selected date range. The report is sorted alphabetically by the clerk who first entered, authorized, or printed the bill.

You may print either a full or summary report. If you print a full report, you may select specific clerk(s) and rate type(s) you wish to include.

A summary report will list the clerk, rate type, and the count and dollar amount of bills entered for each rate type for each clerk. A subtotal is provided for each clerk. The total amount for the report is also displayed.

The full report will list the clerk, rate type, date entered, current status, bill number, total charges, patient name, and patient ID for each bill included on the report. The full report should be printed at 132 column margin width.

Depending on the date range and other specifications you choose, this report could be quite lengthy. You may wish to queue the report to print during off hours.

Sample Output

```
CLERK PRODUCTIVITY REPORT FOR JUN 1,1995 - NOV 26,1995                                                  NOV 26,1995  13:02    PAGE 1
                                                                                BILL         TOTAL
ENTERED/EDITED BY     RATE TYPE             DATE ENTERED  CURRENT STATUS   NUMBER      AMOUNT  NAME                   PATIENT ID
-----------------------------------------------------------------------------------------------------------------------------------

JOHN                  REIMBURSABLE INS.     NOV 10,1995   ENTERED/NOT REV  N10026              IBpatient,one          000-11-1111
                      REIMBURSABLE INS.     NOV 17,1995   ENTERED/NOT REV  N10032              IBpatient,two          000-22-2222
                      REIMBURSABLE INS.     NOV 17,1995   ENTERED/NOT REV  N10033              IBpatient,three        000-33-3333
                                                                           -------  ---------
SUBTOTAL                                                                                   0.00
SUBCOUNT                                                                   3

ANDREW                REIMBURSABLE INS.     SEP  7,1995   ENTERED/NOT REV  L10562              IBpatient,one          000-11-1111
                      REIMBURSABLE INS.     SEP  7,1995   AUTHORIZED       L10563     5000.00  IBpatient,two          000-22-2222
                      REIMBURSABLE INS.     SEP  7,1995   ENTERED/NOT REV  L10564              IBpatient,three        000-33-3333
                      REIMBURSABLE INS.     SEP  7,1995   ENTERED/NOT REV  L10565              IBpatient,four         000-44-4444
                      REIMBURSABLE INS.     SEP  7,1995   ENTERED/NOT REV  L10566              IBpatient,five         000-55-5555
                      REIMBURSABLE INS.     SEP  7,1995   ENTERED/NOT REV  L10567              IBpatient,six          000-66-6666
                      REIMBURSABLE INS.     SEP  7,1995   ENTERED/NOT REV  L10568              IBpatient,seven        000-77-7777
                      REIMBURSABLE INS.     SEP  7,1995   ENTERED/NOT REV  L10569              IBpatient,eight        000-88-8888
                      REIMBURSABLE INS.     SEP  7,1995   ENTERED/NOT REV  L10570              IBpatient,nine         000-99-9999
                      REIMBURSABLE INS.     SEP  7,1995   ENTERED/NOT REV  L10571              IBpatient,ten          000-00-0000
                      REIMBURSABLE INS.     NOV 23,1995   ENTERED/NOT REV  N10073              IBpatient,one          000-11-1111
                      REIMBURSABLE INS.     NOV 25,1995   ENTERED/NOT REV  N10074              IBpatient,two          000-22-2222
                                                                           -------  ---------
SUBTOTAL                                                                                5000.00
SUBCOUNT                                                                   12

CHARLES               REIMBURSABLE INS.     SEP 28,1995   ENTERED/NOT REV  L10681              IBpatient,one          000-11-1111
                                                                           -------  ---------
SUBTOTAL                                                                                   0.00
SUBCOUNT                                                                   1

PAUL                  REIMBURSABLE INS.     SEP 10,1995   AUTHORIZED       L10676      163.00  IBpatient,two          000-22-2222
                                                                           -------  ---------
SUBTOTAL                                                                                 163.00
SUBCOUNT                                                                   1

LINDA                 REIMBURSABLE INS.     JUN 10,1995   ENTERED/NOT REV  L10549              IBpatient,three        000-33-3333
                      REIMBURSABLE INS.     JUN 10,1995   ENTERED/NOT REV  L10550      163.00  IBpatient,four         000-44-4444
                                                                           -------  ---------
SUBTOTAL                                                                                 163.00
SUBCOUNT                                                                   2

BETH                  REIMBURSABLE INS.     SEP 15,1995   CANCELLED        L10677      163.00  IBpatient,five          000-55-5555
                                                                           -------  ---------
SUBTOTAL                                                                                 163.00
SUBCOUNT                                                                   1
                                                                           -------  ---------
TOTAL                                                                                   5489.00
COUNT                                                                      20
```

Rank Insurance Carriers By Amount Billed

The Rank Insurance Carriers By Amount Billed option is used to generate a listing of insurance carriers ranked by the total amount billed. You will be prompted for a date range from which bills should be selected and the number of carriers to be ranked.

Please note that insurance carriers which have been inactivated will be flagged as such on this report. If an inactivated company is associated with an active company to which all patients' policies have been recorded, the amount billed to the inactive company is credited to the active company.

This option no longer allows you to transmit the report to the MCCR Program Office. Now, your IRM Service has the capability to transmit the report electronically to the Program Office. A patch will be issued with specific instructions should this report be required to be transmitted.

Sample Output

```
        Ranking Of The Top 9 Insurance Carriers By Total Amount Billed

  Facility: ALBANY (633)                                  Run Date: 05/24/95
Date Range: 10/01/93 thru 05/24/95                            Page: 1
                                                  ** - denotes an inactive company
================================================================================
  Rank              Insurance Carrier                   Total Amt Billed
================================================================================

   1.               HEALTH INSURANCE LTD.                 $215,868.78
                    23 3RD ST
                    Suite 450
                    TROY, NEW YORK   12181

   2.               ABC INS                                $35,843.63
                    123 Ave Of The Moons
                    LOS ANGELES, CALIFORNIA   00098

   3.           **  GHI                                     $4,902.00
                    675 THIRD AVE
                    TROY, NEW YORK   12345

   4.               ABC INS                                 $4,048.06
                    789 UBIQUITOUS STREET
                    SALT LAKE CITY, UTAH   44432

   5.               ABC INS                                 $3,153.24
                    567 RAIN AVE.
                    SIOUX CITY, IOWA   33321

   6.               XYZ INS                                 $2,862.43
                    123 MAIN STREET
                    YORKVILLE, NEW YORK   33343

   7.               ABC INS                                 $1,576.00
                    123 MASON STREET
                    NEW YORK, NEW YORK   11234

   8.               STRAIT INSURANCE                          $950.00
                    98 PARK AVE
                    SAN ANTONIO, TEXAS   43222

   9.               TRAVELERS-RICHMOND                        $482.69
                    1234 THOMAS ST.
                    RICHMOND, VIRGINIA   12345

Total Amount Billed to all Ranked Carriers:              $269,686.83
```

Billing Rates List

The Billing Rates List option will print a list of billing rates for a selected date range. It is an efficient way to verify that all billing rate entries have been entered correctly.

The output generated by this option displays the CHAMPVA, Health Care Finance Administration (HCFA) ambulatory surgery rates, Medicare deductible, and copayments. The effective date, amount (basic rate), and additional amount will be shown for each rate, if applicable. Certain ambulatory surgeries may be billed at the HCFA rate. The amount shown (if any) in the "Additional Amount" column is an extra amount which may be charged for all procedures within that rate group. The amount shown under "Inpatient Per Diem" and "NHCU Per Diem" is the daily charge for Category C patients.

Any billing rate that is effective for any date within the selected range is displayed. If more than one rate was effective within the date range, both rates are displayed.

Sample Output

```
JUN 11,1997       ***Billing Rates Listing***                    PAGE 1
                            Rates in effect from: JAN 01, 1997
                                                 to: JUN 11, 1997
==============================================================================

CHAMPVA LIMIT
  Effective Date      Amount    Additional Amount
  OCT 01, 1991        $25

CHAMPVA SUBSISTENCE
  Effective Date      Amount    Additional Amount
  OCT 01, 1994        $9.50
HCFA AMB. SURG. RATE 1
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $285

HCFA AMB. SURG. RATE 2
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $382
```

Sample Output

```
JUN 11,1997       ***Billing Rates Listing***                    PAGE 2
                            Rates in effect from: JAN 01, 1997
                                                 to: JUN 11, 1997
==============================================================================

HCFA AMB. SURG. RATE 3
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $438

HCFA AMB. SURG. RATE 4
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $539

HCFA AMB. SURG. RATE 5
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $615

HCFA AMB. SURG. RATE 6
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $580      $200
```

```
JUN 11,1997       ***Billing Rates Listing***                    PAGE 3
                            Rates in effect from: JAN 01, 1997
                                                 to: JUN 11, 1997
==============================================================================

HCFA AMB. SURG. RATE 7
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $853

HCFA AMB. SURG. RATE 8
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $705      $200

HCFA AMB. SURG. RATE 9
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $0

INPATIENT PER DIEM
  Effective Date      Amount    Additional Amount
  OCT 01, 1990        $10
```

Sample Output

```
JUN 11,1997       ***Billing Rates Listing***                    PAGE 4
                            Rates in effect from: JAN 01, 1997
                                                to: JUN 11, 1997
==============================================================================

MEDICARE DEDUCTIBLE
  Effective Date      Amount    Additional Amount
  JAN 01, 1996        $736

NHCU PER DIEM
  Effective Date      Amount    Additional Amount
  OCT 01, 1990        $5

NSC PHARMACY COPAY
  Effective Date      Amount    Additional Amount
  OCT 01, 1992        $2
  JUN 09, 1997        $5.00     $2.00

SC PHARMACY COPAY
  Effective Date      Amount    Additional Amount
  OCT 01, 1990        $2
```

Revenue Code Totals by Rate Type

The Revenue Code Totals by Rate Type option prints the total amount billed by revenue code for a selected rate type and date range.

Circular 10-91-012 requires that revenue code 100 be used for the $10.00 hospital per diem and revenue code 550 be used for the $5.00 nursing home per diem. The purpose of this report is to allow sites to calculate the total amount billed for $5 (revenue code 550) and $10 (revenue code 100) Means Test per diems for input to AMIS segments 295 and 296.

You may print a list of all revenue codes (for the date range) with the associated patient name, patient ID, bill #, and individual amount or a summary list which provides the total amount and total number of bills for each code. It should be noted that because more than one revenue code may appear on a bill, the total number of bills does not equal the sum of the number of bills containing a specific revenue code.

```
Revenue Code Totals for MEANS TEST/CAT. C        JUN  3, 1992@15:34:31  PAGE 1
For Bills First Printed JUN  1, 1992  to  JUN  3, 1992
Patient                Pt. ID.        Bill No.          Rev. Code       Amount
-----------------------------------------------------------------------------
IBpatient,one          000-11-1111    L10068               510          $30.00

IBpatient,two          000-22-2222    L10069               100          $50.00

IBpatient,three        000-33-3333    L10174               001         $652.00

IBpatient,four         000-44-4444    L10203               550         $155.00

IBpatient,five         000-55-5555    L10239               100         $150.00

IBpatient,six          000-66-6666    L10489               550          $90.00

---------------------------------------------
REVENUE CODE TOTALS

Revenue Code: 001 ..........         $652.00             1 Bills
Revenue Code: 100 ..........         $200.00             2 Bills
Revenue Code: 510                     $30.00             1 Bills
Revenue Code: 550                    $245.00             2 Bills
                                 --------------
                                   $1,127.00             6 Bills
```

Bill Status Report

The Bill Status Report option is used to print a listing of bills and their status for a specified date range. You may choose to include all statuses or a single status. The report may be sorted by the event date (date beginning the bill's episode of care), bill date (date the bill was initially printed) or entered date (date the bill was first entered).

The following data items will be provided in the first portion of the report for each bill listed: bill number, patient name and patient ID#, event date, initials of the person who entered the bill, rate type, Means Test category, charges, and bill status with date of that status. If you choose to sort by bill date or entered date, the bills are grouped for each date (billed or entered) of the selected range. The second portion of the report provides summary totals. The dollar amount and total number of bills for each bill type and for each status are included. Grand totals are also provided.

For bills which have been disapproved during the authorization process, the report will show *REVIEWED/DISAPP (will appear only for bills prior to this version of the IB software) or *AUTHORIZED/DISAPP after the status. The bill status will be followed by the initials of the user responsible for that status and his/her DUZ number. This is a number which uniquely identifies the user to the system. If a bill is pending (i.e., not printed or cancelled), the bill status will be preceded by an asterisk (*) on the report.

```
Date/Time Printed: DEC 16,1993@09:14
Medical Care Cost Recovery Bill Status Report for period covering JUN 1, 1993 through JUN 16, 1993                        Page 1
-------------------------------------------------------------------------------------------------------------------------------


                                        EVENT     ENTRD                    MT
BILL NO.  PATIENT NAME         PT.ID    DATE       BY     RATE TYPE    CATEGORY   CHARGES      BILL STATUS
===============================================================================================================================
L10574    IBpatient,one        1111    06/01/93   ARH    REIM INS-OPT   N/A      $936.40    * AUTHORIZED 09/07/93 (ARH/10869)
L10651    IBpatient,two        2222    06/02/93   ARH    REIM INS-OPT   A        $442.20    * AUTHORIZED 09/07/93 (ARH/10869)
L10647    IBpatient,three      3333    06/03/93   ARH    MT/CAT C-OPT   N/A      $30.00       PRINTED 09/07/93 (ARH/10869)
N10046    IBpatient,four       1111    06/03/93   ARH    REIM INS-OPT   R        $633.10      PRINTED 11/19/93 (ARH/10869)
L10660    IBpatient,five       5555    06/04/93   ARH    REIM INS-OPT   N/A      $623.60    * AUTHORIZED 09/07/93 (ARH/10869)
L10620    IBpatient,six        6666    06/07/93   ARH    REIM INS-OPT   N/A      $0.00      * ENTERED 09/07/93 (ARH/10869)
L10648    IBpatient,seven      7777    06/07/93   ARH    CRIME-OPT      N/A      $0.00      * AUTHORIZED 09/07/93 (ARH/10869)
L10601    IBpatient,eight      8888    06/09/93   ARH    REIM INS-OPT   N        $150.00    * ENTERED 09/07/93 (ARH/10869)
L10632    IBpatient,nine       9999    06/09/93   ARH    REIM INS-OPT   A        $128.00    * ENTERED 09/07/93 (ARH/10869)
L10549    IBpatient,ten        0000    06/10/93   LR     REIM INS-OPT   N/A      $491.80    * ENTERED 06/10/93 (LR/700)

* Denotes that the bill status is not Printed or Cancelled
```

```
Date/Time Printed: DEC 16,1993@09:14
Medical Care Cost Recovery Bill Status Report for period covering JUN 1, 1993 through JUN 16, 1993                        Page 2
-------------------------------------------------------------------------------------------------------------------------------


                                                    REPORT STATISTICS
===============================================================================================================================

CRIME-OPT         ...................            $0.00         1  BILLS

MT/CAT C-OPT      ...................           $30.00         1  BILLS

REIM INS-OPT      ...................        $3,405.10         8  BILLS

                                        -----------------   -------------
                                             $3,435.10        10  BILLS


AUTHORIZED        ...................        $2,002.20         4  BILLS

ENTERED           ...................          $769.80         4  BILLS

PRINTED           ...................          $663.10         2  BILLS

                                        -----------------   -------------
                                             $3,435.10        10  BILLS
```

Rate Type Billing Totals Report

The Rate Type Billing Totals Report option is used to obtain a listing of all billing totals for each rate type for a specified date range. The date range is selected by event date (the date beginning the bill's episode of care) or bill date (the date the bill was initially printed).

The report is generated in two sections. The first section divides all the bills for each rate type (Category C, Workman's Compensation, Tort Feasor, etc.) into the following categories: initiated, pending, printed, and cancelled. The exact number of bills and dollar amount for each category is provided. The total amounts (sum of all rate types) are also given for each category.

The second section of the report is a breakdown of all the pending billing records (the "pending" category in the first section). All the pending bills for each rate type are divided into the following categories: no action, reviewed, and authorized. The exact number of bills and the dollar amount for each category is provided. The total amounts (sum of all rate types) are also given for each category.

The margin width of this output is 132.

Sample Output

Date/Time Printed: JUL 14,1988@07:46

Billing Summary Report for period covering JAN 3,1988 through MAR 1,1988 (by Event Date)

	INITIATED		PENDING		PRINTED		CANCELLED	
BILL TYPE	Number	Dollars	Number	Dollars	Number	Dollars	Number	Dollars
CRIME VICTIM	0	$0.00	0	$0.00	0	$0.00	0	$0.00
DENTAL	1	$127.00	0	$0.00	0	$0.00	1	$127.00
HUMANITARIAN	1	$0.00	1	$0.00	0	$0.00	0	$0.00
INTERAGENCY	1	$7,200.00	0	$0.00	1	$7,200.00	0	$0.00
MEANS TEST/CAT. C	13	$11,964.00	8	$11,284.00	4	$160.00	1	$520.00
MEDICARE ESRD	1	$124,900.00	1	$124,900.00	0	$0.00	0	$0.00
NO FAULT INS.	0	$0.00	0	$0.00	0	$0.00	0	$0.00
REIMBURSABLE INS.	20	$138,852.00	6	$12,190.00	8	$102,985.00	6	$23,677.00
SHARING AGREEMENT	0	$0.00	0	$0.00	0	$0.00	0	$0.00
TORT FEASOR	0	$0.00	0	$0.00	0	$0.00	0	$0.00
UNKNOWN	0	$0.00	0	$0.00	0	$0.00	0	$0.00
WORKERS' COMP.	1	$2,250.00	0	$0.00	1	$2,250.00	0	$0.00
TOTALS	38	$285,293.00	16	$148,374.00	14	$112,595.00	8	$24,324.00

Date/Time Printed: JUL 14,1988@07:46

Summary of Pending Bill Authorizations for period covering JAN 3,1988 through MAR 1,1988 (by Event Date)

	TOTAL PENDING		NO ACTION		REVIEWED		AUTHORIZED	
BILL TYPE	Number	Dollars	Number	Dollars	Number	Dollars	Number	Dollars
CRIME VICTIM	0	$0.00	0	$0.00	0	$0.00	0	$0.00
DENTAL	0	$0.00	0	$0.00	0	$0.00	0	$0.00
HUMANITARIAN	1	$0.00	1	$0.00	0	$0.00	0	$0.00
INTERAGENCY	0	$0.00	0	$0.00	0	$0.00	0	$0.00
MEANS TEST/CAT. C	8	$11,284.00	3	$0.00	0	$0.00	5	$11,284.00
MEDICARE ESRD	1	$124,900.00	1	$124,900.00	0	$0.00	0	$0.00
NO FAULT INS.	0	$0.00	0	$0.00	0	$0.00	0	$0.00
REIMBURSABLE INS.	6	$12,190.00	2	$0.00	3	$12,140.00	1	$50.00
SHARING AGREEMENT	0	$0.00	0	$0.00	0	$0.00	0	$0.00
TORT FEASOR	0	$0.00	0	$0.00	0	$0.00	0	$0.00
UNKNOWN	0	$0.00	0	$0.00	0	$0.00	0	$0.00
WORKERS' COMP.	0	$0.00	0	$0.00	0	$0.00	0	$0.00
PENDING TOTALS	16	$148,374.00	7	$124,900.00	3	$12,140.00	6	$11,334.00

Insurance Payment Trend Report

This option allows you to analyze payment trends among insurance companies and track receivables which are due your facility. Many different criteria may be specified to limit the selection of bills such as rate type, inpatient or outpatient bills, open or closed bills, treatment dates, bill printed dates, and insurance companies.

The report may be run for a single insurance company or a range of companies. In addition, the user may analyze any specialized subset of bills by selecting an additional field from the BILL/CLAIMS file (#399) and specifying a range of values for that field.

You have the option to run a detailed report for all claims which meet the report criteria, or to print summary statistics only. The detailed report includes the bill number, patient name and age (as of the bill event date), bill from and to dates, date the bill was printed (authorized), date the bill closed, the number of days the bill has been open (the difference between the DATE PRINTED and the DATE BILL CLOSED fields), the amounts billed, collected, unpaid, remaining open, and percentage collected. The AMOUNT PENDING column has been added to differentiate the number of unpaid dollars and the number of dollars which are still pending collection. If the bill is not closed, the amount pending is the same as the amount unpaid. If the bill is closed (signified by an asterisk next to the bill number), the amount pending is zero.

The report is sorted alphabetically by insurance company name and a subtotal for number of bills, amount billed, amount collected, amount unpaid, amount pending, and percentage collected is given for each company. If you choose only to print summary statistics, only these subtotals are printed. Also included, for either the detailed or summary report, are the grand totals for these categories. A margin width of 132 cols. is required for this output.

The DATE BILL CLOSED field will always have an entry. If the bill is not actually closed, the Accounts Receivable status of the bill will appear on the report in the DATE BILL CLOSED column. If a bill is closed, an asterisk (*) will appear after the bill number.

Sample Output for a Range of Insurance Companies

```
REIMBURSABLE INS. PAYMENT TREND REPORT  --  COMBINED INPATIENT AND OUTPATIENT BILLING            NOV 26, 1993   PAGE: 1
      DATE BILL PRINTED:  01/01/92  -  03/04/92          Note: '*' after the Bill Number denotes a CLOSED bill
      DISCHARGE STATUS:  ALL VALUES
BILL      PATIENT                                   DATE     DATE BILL   #     AMOUNT   AMOUNT      AMOUNT   AMOUNT    PERCENT
NUMBER    NAME/ (AGE)            BILL FROM  -  TO    PRINTED    CLOSED    DAYS   BILLED  COLLECTED    UNPAID   PENDING   COLLECTED
-------------------------------------------------------------------------------------------------------------------------------------

        PRIMARY INSURANCE CARRIER:  ABC
                                    123 AVE OF THE MOONS
                                    LOS ANGELES, CALIFORNIA   00098               Phone: 618-567-9871

L10042  IBpatient,one    (49)      02/07/92  02/07/92  02/07/92  NEW BILL    658    200.00    100.00     100.00    100.00    50.00
                                                                                   --------- ---------  --------- ---------  --------
TOTAL NUMBER OF BILLS:  1                                                            200.00    100.00     100.00    100.00    50.00


        PRIMARY INSURANCE CARRIER:  ABC
                                    789 UBIQUITOUS STREET
                                    SALT LAKE CITY, UTAH   44432

L10030  IBpatient,two    (33)    04/09/91  04/14/91  02/06/92  NEW BILL    659   2770.00      0.00    2770.00   2770.00     0.00
                                                                                   --------- ---------  --------- ---------  --------
TOTAL NUMBER OF BILLS:  1                                                           2770.00      0.00    2770.00   2770.00     0.00


        PRIMARY INSURANCE CARRIER:  STRAIT INSURANCE
                                    98 PARK AVE
                                    SAN ANTONIO, TEXAS   43222

L10029  IBpatient,three     (45)  02/05/91  02/05/91  02/18/92  11/26/93    647    950.00    702.50     247.50      0.00    75.00
                                                                                   --------- ---------  --------- ---------  --------
TOTAL NUMBER OF BILLS:  1                                                            950.00    702.50     247.50      0.00    75.00


      GRAND TOTAL NUMBER OF BILLS:             3
      GRAND TOTAL AMOUNT BILLED:         3920.00
      GRAND TOTAL AMOUNT COLLECTED:       802.50
      GRAND TOTAL AMOUNT UNPAID:         3117.50
      GRAND TOTAL AMOUNT PENDING:        2870.00
      PERCENTAGE COLLECTED:                20.47
```

Sample Output for a Single Insurance Company

```
REIMBURSABLE INS. PAYMENT TREND REPORT  --  COMBINED INPATIENT AND OUTPATIENT BILLING            SEP 27, 1995   PAGE: 1
      DATE BILL PRINTED:  01/01/95  -  09/27/95          Note: '*' after the Bill Number denotes a CLOSED bill
BILL      PATIENT                                   DATE     DATE BILL  #       AMOUNT    AMOUNT      AMOUNT    AMOUNT    PERC
NUMBER    NAME/ (AGE)            BILL FROM  -  TO    PRINTED    CLOSED   DAYS     BILLED   COLLECTED    UNPAID    PENDING   COLL
-------------------------------------------------------------------------------------------------------------------------------------


      PRIMARY INSURANCE CARRIER:  ABC
                                  123 AVE OF THE MOONS
                                  LOS ANGELES, CALIFORNIA  00098         Phone: 618-555-9871

L01226    IBpatient,one    (70)    06/22/95  07/10/95  09/20/95   NEW BILL    1      194.00       0.00    194.00     194.00   0.00
L01227    IBpatient,two    (70)    07/17/95  07/31/95  09/20/95   NEW BILL    1      194.00       0.00    194.00     194.00   0.00
L00381    IBpatient,three    (46)  01/01/92  07/02/92  03/28/95   NEW BILL  177     4460.00       0.00   4460.00    4460.00   0.00
L00823    IBpatient,four    (68)   10/22/93  10/22/93  03/15/95   NEW BILL  190      178.00       0.00    178.00     178.00   0.00
                                                                                  ----------  ---------  --------  ---------  -----
TOTAL NUMBER OF BILLS:  4                                                            5026.00       0.00   5026.00    5026.00   0.00


      GRAND TOTAL NUMBER OF BILLS:             4
      GRAND TOTAL AMOUNT BILLED:         5026.00
      GRAND TOTAL AMOUNT COLLECTED:         0.00
      GRAND TOTAL AMOUNT UNPAID:         5026.00
      GRAND TOTAL AMOUNT PENDING:        5026.00
      PERCENTAGE COLLECTED:                 0.00
```

Unbilled BASC for Insured Patient Appointments

The Unbilled BASC for Insured Patient Appointments report lists all BASC (billable ambulatory surgical code) procedures for scheduled appointments of insured patients that could not be matched with BASC procedures entered on a bill for the patient for a selected date range. The match is based on the appointment date in Scheduling and the procedure date in Billing. The purpose of this report is to find all CPTs that were entered in Scheduling but never brought into Billing.

The list is printed in alphabetical order by patient name and provides the patient ID, appointment date, CPT code, and procedure.

Sample Output

```
   PATIENT NAME            PATIENT ID     APPOINTMENT DATE    BILLABLE AMBULATORY PROCEDURE
-----------------------------------------------------------------------------------------------

   IBpatient,one           000-11-1111      MAR 27,1992       15950  REMOVE THIGH PRESSURE SORE
                                                              15951  REMOVE THIGH PRESSURE SORE

   IBpatient,two           000-22-2222      MAR 3,1992        85102  BONE MARROW BIOPSY

   IBpatient,three         000-33-3333      MAR 7,1992        11042  CLEANSING OF SKIN/TISSUE
   IBpatient,four          000-44-4444      MAR 13,1992       24925  AMPUTATION FOLLOW-UP SURGERY
```

Medication Copayment Income Exemption Menu

Print Charges Canceled Due to Income Exemption

This option enables you to print a report which lists patients and medication copayment charges that are cancelled due to the income exemption (charges to patients determined to be exempt from the medication copayment requirement).

You are prompted for a date range. The "start date" defaults to the effective date of the medication copayment legislation (Public Law 102-568), October 30, 1992, and the "to date" defaults to the date of the conversion completion.

This report should be reconciled periodically with the Accounts Receivable Medication Co-Pay Exemption Report (Medication Co-Pay Exemption Report option) to insure accuracy of patients' accounts.

Initially, this report will print a list of charges cancelled during the installation/conversion process. Later, this report may be used to list charges automatically cancelled. This occurs when a patient with a status of NON-EXEMPT due to no income data becomes EXEMPT due to income below the threshold level.

This report includes the patient name and ID, prescription date and number, cancel date and IB number, bill number and amount, a patient count, and dollar total. You may also print a Conversion Quick Status Report with the listing which includes data such as the dates the conversion started and completed, total number of patients checked, number of patients exempt and non-exempt, the number of bills checked, dollar amount checked, total bills cancelled, and amount cancelled.

You may wish to queue this report to print during non-work hours as it may be very lengthy. The output for this option requires 132 columns.

Sample Output

```
Medication Copayment Exemption Conversion Status

Conversion was started on:   FEB  4, 1993@11:18:28
The conversion completed on: FEB  4, 1993@18:19:01
Elapse time for Conversion was: 7 Hours,  0 Minutes,  33 Seconds

            Last Patient DFN Checked  ==        91

  1.          Total Patients Checked  ==        7455
                     Exempt Patients  ==        2069
                 Non-Exempt Patients  ==        5386

  2. Total Number of Bills checked    ==       36568
               Dollar Amount Checked  == $     86252
         No. of Exempt Bills Checked  ==       14218
                Exempt Dollar amount  == $     33426
     No. of Non-Exempt Bills Checked  ==       22350
            Non-exempt Dollar amount  == $     52826

  3.   Total Bills Actually canceled  ==       14113
            Amount Actually canceled  == $     33158
```

```
Rx Copay Income Exemption Report                                   MAR  4, 1993 11:18:43  Page 1
                                                   Cancel     Cancel       Original
Name               Pt. ID        Rx Date   Rx/Refill  Date       IB Number   Bill No.      Amount
-----------------------------------------------------------------------------------------------------
IBpatient,one      000-11-1111  02/01/93    100146    02/02/93   500210       500-P30048      $2
                                02/01/93    100147    02/02/93   500211       500-P30048      $2
                                                                                --------------
                                                                                Count  =     2
                                                                                Amount = $   4

IBpatient,two      000-22-2222  01/26/93    100037/1  01/27/93   500157       500-P30014     $4
                                01/26/93    1003      01/27/93   500158       500-P30014     $2
                                                                                --------------
                                                                               Count  =     2
                                                                               Amount = $   6

IBpatient,three     000-33-3333  01/26/93    100045    01/27/93   500155       500-P30016     $2
                                 01/26/93    100045/1  01/27/93   500156       500-P30016     $2
                                                                                --------------
                                                                               Count  =     2
                                                                               Amount = $   4


                                 ======================================
                                     Total Patient Count =       3
                                     Total Rx Count      =       6
                                     Total Dollar amount = $    14
```

Edit Copay Exemption Letter

This option allows you to edit IB form letters. You are first prompted to edit the HEADER field. This text is automatically centered at the top of the letter (it is not necessary for you to center them), and must be edited to your facility's name and address. You are limited to six lines of text.

The second field, the MAIN BODY, contains the text of the letter including the signer's title. Because the person signing this letter may be site specific, it might be necessary to edit the signer's title.

The default for the starting address line (patient address) is 15. This may be edited to any number between 10 and 25. This feature is provided to account for slight differences in printers and automated letter folders at each site.

When editing the IB Income Test Reminder letter you are also prompted for a reprint date, whether or not to exclude domiciliary patients, and to schedule the days on which you want the letters to print. The days you select to print the letters actually represent the mornings you want to pick up the letters from the printer. For example, if you choose Monday the letters actually print Sunday evening and are ready to be picked up on Monday morning. You can also prevent the letters from being printed by answering YES to the “Do you wish to stop this job from running?” prompt.

After editing is completed, you can test print one letter. If you choose to test print, you are prompted to select a patient and device. The letter is queueable to any printer.

Sample Letter

```
Department of Veterans Affairs Medical Center
113 Holland Avenue
Albany, New York   12208



DEC 14, 1995
                                                    In Reply Reference To:
                                                    000-11-1111 ‡‡‡
```

Inquire to Medication Copay Income Exemptions

This option allows you to print a brief or full inquiry of exemptions for a patient. The brief inquiry is used to view past and/or present exemptions, and the full inquiry is used to view the entire audit history of all changes to a patient's exemption status.

Both inquiries provide the patient name and current status. The brief inquiry provides the following information on all active exemptions for the selected patient: effective date, type, status, reason, how the entry was added, and when. The full inquiry provides the following information for each exemption for the patient: effective date, status, whether active or inactive, how the entry was added, by whom and when, type, and reason for exemption.

NOTE TO PROGRAMMERS
For users whose FileMan Access ="@" (DUZ(0)="@"), the full inquiry feature will display the patient internal entry number and the billing exemption internal entry number to aid in problem resolution.

Sample Output

```
Billing Exemption Inquiry                MAR  5, 1993 13:10:46  Page 1
IBpatient,one           1111   Currently: NON-EXEMPT-INCOME>PENSION   02/10/93
-------------------------------------------------------------------------------
  Effective Date: FEB 10, 1993            Type: COPAY INCOME EXEMPTION
          Status: NON-EXEMPT            Reason: NO INCOME DATA
          Active: NO, INACTIVE            User: ALAN
       How Added: SYSTEM            When Added: FEB 10, 1993@15:14:12

  Effective Date: FEB 10, 1993            Type: COPAY INCOME EXEMPTION
          Status: EXEMPT                Reason: HARDSHIP
          Active: NO, INACTIVE            User: MICHAEL
       How Added: MANUAL            When Added: FEB 11, 1993@09:17:06
Charges Canceled: FEB 10, 1993              To: FEB 11, 1993

  Effective Date: FEB 10, 1993            Type: COPAY INCOME EXEMPTION
          Status: NON-EXEMPT            Reason: INCOME>PENSION
          Active: NO, INACTIVE            User: MICHAEL
       How Added: SYSTEM            When Added: FEB 11, 1993@09:55:38

  Effective Date: FEB 10, 1993            Type: COPAY INCOME EXEMPTION
          Status: EXEMPT                Reason: HARDSHIP
          Active: NO, INACTIVE            User: PETER
       How Added: MANUAL            When Added: FEB 11, 1993@09:56:22
Charges Canceled: FEB 10, 1993              To: FEB 11, 1993

  Effective Date: FEB 10, 1993            Type: COPAY INCOME EXEMPTION
          Status: NON-EXEMPT            Reason: INCOME>PENSION
          Active: NO, INACTIVE            User: STEPHEN
       How Added: SYSTEM            When Added: FEB 11, 1993@10:00:37

  Effective Date: FEB 10, 1993            Type: COPAY INCOME EXEMPTION
          Status: EXEMPT                Reason: HARDSHIP
          Active: NO, INACTIVE            User: PETER
       How Added: MANUAL            When Added: FEB 11, 1993@10:00:49
Charges Canceled: FEB 10, 1993              To: FEB 11, 1993

  Effective Date: FEB 10, 1993            Type: COPAY INCOME EXEMPTION
          Status: NON-EXEMPT            Reason: INCOME>PENSION
          Active: NO, INACTIVE            User: PETER
       How Added: SYSTEM            When Added: FEB 17, 1993@15:28:39
```

Manually Change Copay Exemption (Hardships)

This option is designed to grant and/or remove hardship waivers for patients who request the new copay income test. It may also be used to grant exemptions to Means Test patients; however, if MAS grants a hardship waiver to the Means Test by changing a patient's Means Test status from Category C to Category A, a hardship exemption is automatically generated.

A message or alert is generated anytime a hardship exemption is granted or removed. If the USE ALERTS site parameter is set to NO (or the field is left unanswered), a mail bulletin is generated; if set to YES, an alert is generated. A sample mail bulletin is provided in the example.

The system attempts to keep the effective date of the exemption the same as the effective date of the income test by defaulting to the effective date of the last exemption at the "Select Effective Date" prompt. Only the date of previous exemptions or the current date may be entered at this prompt.

Occasionally, the creation of a patient's exemption may be interrupted unexpectedly. In such cases, this option may be used to detect copay exemption discrepancies and correct/ update the patient's exemption status.

Once a waiver is granted, the exemption is good for one year from the date it is granted. An electronic signature code is required to grant a hardship waiver.

Sample Output

```
Subj: Medication Copayment Exemption Status Change  [#547] 20 Apr 93 14:53
  11 Lines
From: INTEGRATED BILLING PACKAGE  in 'IN' basket.   Page 1  **NEW**
-------------------------------------------------------------------------

The following Patient's Medication Copayment Exemption Status has changed:
    Patient: IBpatient,one              PT. ID: 000-11-1111

 Old Status: NON-EXEMPT - NO INCOME DATA  Dated 03/09/93
 New Status: EXEMPT     - HARDSHIP  Dated 03/10/93



Patient has been given a Hardship Exemption.
    by: MARK/(Manual)
    on: MAR 10, 1993 @ 14:53:40


Select MESSAGE Action: DELETE (from IN basket)//
```

Letters to Exempt Patients

This option is used to print the letters to be sent to patients who have been determined to be exempt from the medication copay. A range of patients and exemption effective dates may be specified. No letters will print for deceased patients, non-veterans, and patients who are SC>50%.

When this option is initially run, you are asked if you would like to store the results of the search in a template. If you answer YES, a search template, IB EXEMPTION LETTER, is created. This data may be accessed through the Print File Entries option in FileMan. For each subsequent search, you are asked if you wish to delete the results of the previous search. If you answer YES, the previous search template is deleted, and you again have the option of storing the results of your search. Only one IB EXEMPTION LETTER search template may exist at a time.

Medication copayment exemptions based on annual income must be re-evaluated yearly on the anniversary of a patient's means or copayment test. If a patient is exempt due to income below the threshold, a renewal date is shown below the "in reply" heading of the letter. The patient must complete a new copay income test by the renewal date or he/she will no longer be considered exempt from the pharmacy copayment requirement.

This letter is designed to be one page and to print to a pin fed printer, on plain paper, in either 10 or 12 pitch. The default is set to start the address on line 15; however, this may be edited through the Edit Copay Exemption Letter option. If address line three contains data, that data prints at the end of address line two. If defined, temporary addresses are used.

Sample Letter

Department of Veterans Affairs Medical Center
113 Holland Avenue
Albany, NY 12208

MAY 5, 1993

In Reply Refer To:
000-11-1111
Renewal Date: MAY 3, 1994

ONE IBPATIENT
77 MAIN ST
CABOT COVE, ME 09876

Public Law 102-568 enacted on October 29, 1992, provided for an exemption to the prescription copayment for those veterans who had income levels less than the maximum rate of VA pension. Charges established before October 29, 1992, were not exempted by the legislation.

We have reviewed your income and eligibility information contained in our records and determined that you are eligible for the exemption. We are currently reviewing your account and will make the appropriate adjustments to it in the near future. If you are eligible for a refund for payments made on charges established since October 29, 1992, we will forward you a check. While we are reviewing your account we will not be sending out a statement.

Medication copayment exemptions based upon annual income must be re-evaluated yearly on the anniversary of your means test or copayment test. If a renewal date is shown below the 'in reply' heading you must complete a new copay income test by that date or you will no longer be considered exempt from the pharmacy copayment requirement.

Please do not send in any more payments until we have completed this review and forwarded a statement to you.

FINANCE OFFICER

List Income Thresholds

This option allows you to print an output which lists the income thresholds used in the medication copayment income exemption process sorted by type of threshold and effective date.

If you accept the default of FIRST at the start date prompt, first to last is assumed.

This output requires 132 columns.

Sample Output

```
Medication Copayment Income Thresholds                                                                  MAR 15,1993  08:29    PAGE 1
EFFECTIVE                          1          2          3          4          5          6          7          8   ADDITIONAL
DATE       BASE RATE  DEPENDENT  DEPENDENTS  DEPENDENTS  DEPENDENTS  DEPENDENTS  DEPENDENTS  DEPENDENTS  DEPENDENTS      AMOUNT
-----------------------------------------------------------------------------------------------------------------------------------


        TYPE: PENSION PLUS A&A
DEC  1,1992   12187.00   14548.00   15844.00    17140.00    18436.00   19732.00    21028.00    22324.00    23620.00     1296.00
```

Print Patient Exemptions or summary

This option allows you to print a list of copayment exemption statistics. Both exempt and non-exempt patients are included.

You are given the option to print a detailed patient listing or a summary. The detailed report may be sorted by either exemption status or exemption reason. The information given includes the patient name, patient ID, primary eligibility code, status, reason for exemption/non-exemption, and status date. This data is followed by a summary showing subtotals for each exemption reason and totals for exempt and non-exempt patients. If you choose to "Print Summary Only", the detailed portion of the output is omitted. Deceased patients are not included in the summary provided with the detailed listing; however, if you choose to print the summary only, deceased patients are included.

When printing only a summary, sorting by the EXEMPTION STATUS default reduces the time required to produce the report.

The detailed patient listing requires 132 columns. You may wish to queue this output to print during non-work hours as it may be very lengthy.

Sample Output

```
Patient Medication Copayment Exemption Report
MAR 15,1993  17:00    PAGE 1
PATIENT             PT ID        PRIMARY ELIGIBILITY  STATUS      REASON              STATUS DATE
-----------------------------------------------------------------------------------------------------

IBpatient,one       000-11-1111  NSC                  NON-EXEMPT  INCOME>PENSION      JAN 25,1993
IBpatient,two       000-22-2222  SC                   NON-EXEMPT  INCOME>PENSION      FEB  1,1993
IBpatient,three     000-33-3333  NSC                  NON-EXEMPT  INCOME>PENSION      JAN 21,1993
IBpatient,four      000-44-4444  SC                   NON-EXEMPT  NO INCOME DATA      FEB  4,1993
IBpatient,five      000-55-5555  SC                   NON-EXEMPT  NO INCOME DATA      FEB  4,1993
IBpatient,six       000-66-6666  NSC                  EXEMPT      DIS. RETIREMENT     FEB 10,1993
IBpatient,seven     000-77-7777  NSC                  EXEMPT      DIS. RETIREMENT     FEB 17,1993
IBpatient,eight     000-88-8888  NSC                  EXEMPT      DIS. RETIREMENT     JAN 25,1993
IBpatient,nine     000-99-9999  NSC                  EXEMPT      HARDSHIP            FEB  5,1993
IBpatient, ten      000-00-0000  HUMANITARIAN         EXEMPT      NON-VETERAN         FEB 10,1993
IBpatient, eleven   000-11-1111  HUMANITARIAN         EXEMPT      NON-VETERAN         JAN 25,1993

=====================================================
Non-Exempt Status:
     INCOME>PENSION                     = 3
     NO INCOME DATA                     = 2
Exempt Status:
     DIS. RETIREMENT                    = 3
     HARDSHIP                           = 1
     IN RECEIPT OF A&A                  = 8
     IN RECEIPT OF HB                   = 0
     IN RECEIPT OF PENSION              = 0
     INCOME<PENSION                     = 0
     NON-VETERAN                        = 2

Total Exempt Patients                   = 5
Total Non-Exempt Patients               = 6
```

Reprint Single Income Test Reminder Letter

This option is used to generate an Income Test reminder letter for a patient whose effective copay exemption is based upon income.

If the patient is currently non-exempt due to no income data reported, a letter may be generated if the patient's previous exemption status is based on income.

Sample Letter

```
Department of Veterans Affairs Medical Center
113 Holland Avenue
Albany, New York   12208



DEC 14, 1995
                                                    In Reply Refer To:
                                                    000-11-1111





     ONE IBPATIENT
     00 BROADWAY
     BOSTON, MA  04443

The VA is required by law to charge veterans who receive medications
on an outpatient basis for the treatment of nonservice-connected
conditions, a copayment of $2.00 for each 30-day (or less) supply
of medication provided.  Based on the income information requested
each year, some veterans may be exempt from the copayment.

Our records indicate that your medication copayment exemption
status will expire on December 31, 1995.

To update your income information so we may review your
copayment exemption status, please call 462-3311 x9372
to set up an appointment to provide us with current
income information.


Chief, MAS
```

Add Income Thresholds

This option is used to enter/edit the income thresholds used in the medication copayment income exemption.

The thresholds are determined and released by VBA (Veterans Benefits Administration) December 1 of each year. These are the same thresholds used for A&A pensions.

Once the ADDITIONAL DEPENDENT AMOUNT is entered, the amount for each additional dependent can be automatically calculated when the copayment income exemptions are built. However, if the amount for each additional dependent does not have to be calculated, the exemption can be built much faster; therefore, it is advantageous to enter the amount for each dependent.

In the event that the new income thresholds are released or entered after the normal effective date, this package was designed to note exemptions created with thresholds over one year old and to allow automatic recomputation of just those exemptions.

Print/Verify Patient Exemption Status

This option will search the BILLING EXEMPTIONS file (#354.1) and compare the currently stored active exemption for each patient against what the system calculates to be the correct exemption status for the patient based on current data from the MAS files.

Once you select a date range, you are asked whether or not you wish to update each incorrect exemption status. If you enter NO, a list of discrepancies is printed without updating the incorrect statuses. If you enter YES, the same report will print and the statuses are updated. Initially, the report should be run without updating the exemptions.

The Manually Change Copay Exemptions (Hardship) option may also be used to update exemptions to the correct status one patient at a time.

This output requires 132 columns. You may wish to queue to print during non-work hours as it can be quite lengthy.

Sample Output

```
Medication Copayment Exemption Problem Report                                    MAR 17, 1993 09:42 Page 1
Patient             PT. ID       Error                Current Exemption        Computed Exemption       Action
-----------------------------------------------------------------------------------------------------------------
IBpatient,one       000-11-1111  Exemption incorrect  02/10/93 NO INCOME DATA  02/10/93 INCOME<PENSION  Nothing Updated
IBpatient,two       000-22-2222  Exemption incorrect  02/17/93 NO INCOME DATA  02/17/93 INCOME<PENSION  Nothing Updated
IBpatient,three     000-33-3333  Exemption incorrect  01/25/93 DIS. RETIREMENT 01/25/93 INCOME<PENSION  Nothing Updated




There were 3 discrepancies found in 75 exemptions checked.
```

MCCR System Definition Menu

The MCCR System Definition Menu is locked with the IB SUPERVISOR security key.

Enter/Edit Automated Billing Parameters

The Enter/Edit Automated Billing Parameters option is used to enter or edit the parameters that control automated third party billing. Only entries in the Claims Tracking module will be billed automatically. Currently, only inpatient stays, outpatient encounters, and prescription refills are included in automated billing.

Following is a brief description of the parameters.

AUTO BILLER FREQUENCY
Number of days between each execution of the automated biller. For example, if the auto biller should run once a week, enter 7; if it should run every night, enter 1. If this field is left blank, the auto biller will never run.

INPATIENT STATUS (AB)
This is the status that a PTF record must be in before the automated biller will attempt to create an inpatient bill. The PTF record must be closed before an automated bill can be created.

AUTOMATE BILLING
This parameter controls the automated creation of bills. If this field is set to YES, the bills will be automatically created for possible billable events with no user interaction. If this field is left blank, the EARLIEST AUTO BILL DATE must be added to each event in Claims Tracking before a bill is automatically created by the auto biller.

BILLING CYCLE
This is the maximum number of days allowed to be billed on a single bill. If this field is left blank, the date range will default to the event date through the end of the month in which the event took place or for inpatient interim bills, the next month after the last interim bill.

Claims Tracking events may be added to the list of events for which an auto bill should be created by adding a date to the EARLIEST AUTO BILL DATE in Claims Tracking. Events may be removed from the auto biller list by adding a REASON NOT BILLABLE or deleting the EARLIEST AUTO BILL DATE.

DAYS DELAY
This field controls the number of days after the end of the BILLING CYCLE that a bill should be created. This parameter is used at two different points to determine if a bill should be created. The first is when the Claims Tracking entry is first created. At that time, the EARLIEST AUTO BILL DATE will be set to the current date plus the number of DAYS DELAY. The second time this parameter is used is when the auto biller is trying to set up a date range for the events bill. In that case, DAYS DELAY is added to the BILLING CYCLE to determine if the correct amount of time has elapsed for the bill to be created.

For example, if DAYS DELAY is 3 and BILLING CYCLE is 10, a bill will not be created for at least 13 days after the initial entry was created in Claims Tracking. Inpatients are slightly different. If an inpatient is discharged, the auto biller will try to create a bill for that stay DAYS DELAY after the discharge date. The auto biller cannot, however, create a bill until the PTF record is closed. Therefore, the actual delay before bill creation for inpatient bills may be longer than DAYS DELAY.

Charge Master Menu

Enter/Edit Charge Master

This option is used for the maintenance of Third Party rates and charges. It contains the List Manager screens, which display all rate elements/fields. It also includes enter and edit actions so each element can be updated. All edit actions within these screens require the IB SUPERVISOR key.

Screen Descriptions

Introduction Screen
This screen displays a brief description of the elements of the Charge Master that may be viewed/edited through this option. You can display/edit rate types, billing rates, charge sets, and rate schedules.

Rate Type Screen
This is a display/edit screen for Billing Rate Types. All Rate Types currently defined are displayed.

Billing Rates Screen
This is a display/edit screen for Billing Rates. All Billing Rates currently defined are displayed. Part of the definition of a Billing Rate includes what types of item the rate's charges are associated with (Billable Item) and how the charge should be calculated (Charge Method).

Charge Set Screen
This is a display/edit screen for Charge Sets. All Charge Sets currently defined will be displayed. These sets define a sub-set of charges for a Billing Rate. The editing of Charge Sets is restricted to non-critical elements if there are Charge Items defined for the set. Since Revenue Code and Bedsection are required to add charges to a bill, the Default Revenue Code and Default Bedsection are required unless these are defined for each individual Charge Item in the Set.

Charge Item Screen
This is a display/edit screen for Charge Items. These are the actual records of the item and its corresponding charge. This screen displays items that have active charges in a specified date range for the selected Charge Set. All active Charge Items are displayed for a Charge Set with a Billable Item of Bedsection. However, this screen has been specifically limited to displaying either one CPT or one AWP item at a time. The Effective Date is required for all entries and controls when the charge is active. Each item entry overrides any previously effective charge for the item. A Revenue Code is only required if the Revenue Code for the item is different from the Default Revenue Code of the Charge Set.

Billing Regions Screen

This is a display/edit screen for Billing Regions. All Billing Regions currently defined will be displayed. Billing Regions can be set-up which show the set of divisions that are billed the same charges for a particular Billing Rate. A Billing Region need only be defined if the charges for a rate vary by region/locality/division and more than one Region will be billed at the site. Currently only Billing Rates based on CPT charges may vary by region.

Rate Schedule Screen

This is a display/edit screen for Rate Schedules. These schedules link the charges and the types of bills they may be added to. All Rate Schedules currently defined are displayed. Rate Schedules must be defined for both inpatient and outpatient charges for a Rate Type and all Charge Sets that may be charged to that type of bill should be added. A Charge Set can set-up to be automatically added to bills or to require user input before the charges are added. The effective dates should only be added if there is a specific date that billing to the payer can start or stop.

Sample Screens

```
Introduction                 May 29, 1997 13:09:26          Page:    1 of    1
Only authorized persons may edit this data: IB SUPERVISOR key required to edit.

Rate Type:               Type of Payer.

Billing Rate:            Type of Charge.

Charge Set:              Charges for a specific Billing Rate, broken down by
                         type of event to be billed/charged.

                         Charge Item:       The individual items for a Set
                                            and their charge amounts.
                         Billing Region:    The region or divisions the
                                            charges apply to.

Rate Schedule:           Definition of charges billable to specific payers.
                         Link between Charge Sets and Rate Types.
                         Once the Rate Type is set for a bill, the
                         Rate Schedule will be used to find all charges to
                         add to the bill.
          Enter ?? for more actions
RS  Rate Schedules        RT  Rate Types
CS  Charge Sets           BR  Billing Rates
Select Action: Quit//
```

```
Rate Types                    May 29, 1997 13:14:25          Page:    1 of    5
This is a Standard file with entries released nationally.


     Rate Type: CHAMPUS
     Bill Name: CHAMPUS                  AR Category: CHAMPUS
  Abbreviation: CHAMPUS                 Who's Respns: INSURER
  Third Party?: YES                    RI Statement?: YES
      Inactive:                       NSC Statement?: YES

     Rate Type: CHAMPVA REIMB. INS.
     Bill Name: REIMBURSABLE INS.        AR Category: CHAMPVA THIRD PARTY
  Abbreviation: REIM INS                Who's Respns: INSURER
  Third Party?: YES                    RI Statement?: YES
      Inactive:                       NSC Statement?: YES

     Rate Type: CRIME VICTIM
     Bill Name: THIRD PARTY              AR Category: CRIME OF PER.VIO.
  Abbreviation: CRIME                   Who's Respns: INSURER
  Third Party?: YES                    RI Statement?:
      Inactive:                       NSC Statement?: YES
+         Enter ?? for more actions
ED  Edit Rate Type        MS  Main Screen           EX  Exit
Select Action: Next Screen//
```

```
Billing Rates                May 29, 1997 13:16:47          Page:    1 of    1

  Rate                           Abbrv       Distrb     Bill Item    Chg Mthd

  INTERAGENCY                    IA          NATIONAL   BEDSECTION   COUNT
  TORTIOUSLY LIABLE              TORT        NATIONAL   BEDSECTION   COUNT
  VA COST                        VA COST     NATIONAL                VA COST

  AMBULATORY SURGERY             ASC         LOCAL      CPT          COUNT
  AVERAGE WHOLESALE PRICE        AWP         LOCAL      NDC #        QUANTITY
  CMAC                           CMAC        LOCAL      CPT          COUNT




          Enter ?? for more actions
ED  Edit Rate             MS  Main Screen           EX  Exit
Select Action: Quit//
```

```
Charge Sets                  May 29, 1997 13:19:06          Page:    1 of    2
                                                   Default
 Charge Set                 Bill Event  Type  Rv Cd  Bedsection  Region

         Billing Rate: AMBULATORY SURGERY
AMB SURG REGION 1           PROC              500    OUTPATIENT
AMB SURG REGION 2           PROC              490    OPT DNTL

         Billing Rate: INTERAGENCY
IA-INPT                     INPT BEDS         001
IA-OPT DENTAL               OPT VST DT        512
IA-OPT VST                  OPT VST DT        500
IA-RX FILL                  RX FILL           257

         Billing Rate: TORTIOUSLY LIABLE
TL-INPT (INCLUSIVE)         INPT BEDS         001
TL-INPT (NPF)               INPT BEDS   INST
TL-INPT (PF)                INPT BEDS   PROF  960
TL-CAT C OPT COPAY          OPT VST DT        500
TL-OPT DENTAL               OPT VST DT        512
+         Enter ?? for more actions
CI  Charge Items          RG  Billing Regions       BR  Billing Rates
ED  Edit Charge Set       MS  Main Screen           EX  Exit
Select Action: Next Screen//
```

```
Charge Items                 May 29, 1997 13:25:32          Page:    1 of    1
BEDSECTION items billable to Charge Set TL-INPT (INCLUSIVE) on 05/29/97
Default Revenue Code: 001
  Charge Item                      Unit Charge   Rv Cd    Effective  Inactive
  ALCOHOL AND DRUG TREATMENT         300.00               05/27/97
  BLIND REHABILITATION               973.00               10/01/96
  GENERAL MEDICAL CARE              1046.00               10/01/96
  INTERMEDIATE CARE                  428.00               10/01/96
  NEUROLOGY                         1014.00               10/01/96
  NURSING HOME CARE                  288.00               10/01/96
  PSYCHIATRIC CARE                   501.00               10/01/96
  REHABILITATION MEDICINE            822.00               10/01/96
  SPINAL CORD INJURY CARE            977.00               10/01/96
  SURGICAL CARE                     1923.00               10/01/96



          Enter ?? for more actions
CD  Change Dates          CI  Change Item           BI  Billing Item Edit
ED  Edit Charge Item      MS  Main Screen           EX  Exit
Select Action: Quit//
```

```
Billing Regions              May 29, 1997 13:34:38          Page:    1 of    1
Sets of divisions covered by the same charges
  Region                 Division

No Billing Regions defined


          Enter ?? for more actions
ED  Edit Region           MS  Main Screen           EX  Exit
Select Action: Quit//
```

```
Rate Schedules               May 29, 1997 13:37:01          Page:    1 of    4
Link types of payers and charges
 Schedule             Bill Svs   Charge Set(s)          Effectiv  Inactive Adj
    CRIME VICTIM: Inpatient
CV-INPT               INPT       TL-INPT (NPF)
                                 TL-INPT (PF)

    CRIME VICTIM: Outpatient
CV-OPT                           TL-OPT VST
                                 TL-RX FILL

    DENTAL: Outpatient
DNTL-OPT DENTAL                  TL-OPT DENTAL

    HUMANITARIAN: Inpatient
HMN-INPT              INPT       TL-INPT (INCLUSIVE)

    HUMANITARIAN: Outpatient
HMN-OPT                          TL-OPT VST
                                 TL-RX FILL
+         ~ charges not auto added to bills                                >>>
ED  Edit Schedule         MS  Main Screen           EX  Exit
Select Action: Next Screen//
```

Print Charge Master

This option provides reports for all elements of the Charge Master and maintenance of Third Party rates. The full Charge Item report could be lengthy if many items have been added, such as CMAC (CHAMPUS Maximum Allowable Charges) charges.

Sample Output

```
RATE TYPE LIST                                                                                                  MAY 27,1997  08:48    PAGE 1
                                                                                                                                NSC
                                                                                                                                STATEMENT
                                                                                THIRD                                           ON UB
NAME                  BILL NAME             INACTIVE  ABBREVIATION  PARTY  ACCOUNTS RECEIVABLE   WHO'S        REIMB  INS?   BILLS
BILL?  CATEGORY               RESPONSIBLE
-----------------------------------------------------------------------------------------------------------------------------------------

CHAMPUS               CHAMPUS                         CHAMPUS       YES    CHAMPUS                INSURER      YES    YES
CHAMPVA REIMB. INS.   REIMBURSABLE INS.               REIM INS      YES    CHAMPVA THIRD PARTY    INSURER      YES    YES
CRIME VICTIM          THIRD PARTY                     CRIME         YES    CRIME OF PER.VIO.      INSURER      NO     YES
DENTAL                DENTAL                          DENTAL        NO     EMERGENCY/HUMANITARI   PATIENT      YES    YES
HUMANITARIAN          HUMANITARIAN                    HUMAN         NO     EMERGENCY/HUMANITARI   PATIENT      NO     NO
INTERAGENCY           INTERAGENCY                     INTER         YES    INTERAGENCY            OTHER (INST         YES
MEANS TEST/CAT. C     MEANS TEST/CAT. C     NO        MT/CAT C      NO     C (MEANS TEST)         PATIENT      NO     YES
MEDICARE ESRD         MEDICARE ESRD                   MEDICARE      YES    INTERAGENCY            OTHER (INST  NO     YES
MILITARY              MILITARY              NO        MIL           YES    INTERAGENCY            OTHER (INST         YES
NO FAULT INS.         NO FAULT INS.                   NO FAULT      YES    REIMBURS.HEALTH INS.   INSURER      NO     YES
REIMBURSABLE INS.     REIMBURSABLE INS.               REIM INS      YES    REIMBURS.HEALTH INS.   INSURER      YES    YES
SHARING AGREEMENT     SHARING AGREEMENT               SHARING       YES    SHARING AGREEMENTS     OTHER (INST         YES
```

Activate Revenue Codes

The Activate Revenue Codes option allows users to activate the revenue codes which their sites have chosen to use for third party billing.

The revenue codes are provided by the National Uniform Billing Committee. The full set of 999 codes is sent to each site. All codes have an INACTIVE status when received. The site chooses which codes they wish to use for billing purposes by activating them through this option. Some of the codes are reserved for national assignment (no definition as yet). These reserve codes cannot be activated. Only activated revenue codes may be selected during the billing process.

Adding codes to or deleting them from the REVENUE CODE file is NOT allowed.

Enter/Edit Billing Rates

The Enter/Edit Billing Rates option is used to edit billing rates for per diem rates; the Medicare deductible (this is the only place the Medicare deductible is entered); the HCFA ambulatory surgery rates, pharmacy copayment amounts, and CHAMPVA subsistence rates that are used in the automatic calculation of costs when preparing a third party bill.

Although the option allows entry of new rates, it should only be used for editing and for the entry of duplicate rates. Duplicate rates are those where two different rates are used for the same revenue code/bedsection/effective date dependent on payor. All other new billing rates should be entered through the Fast Enter New Billing Rates option.

If YES is answered at the "NON-STANDARD RATE" prompt, that billing rate will only be used with insurance companies where the selected revenue code has been listed in the DIFFERENT REVENUE CODES TO USE field of the INSURANCE COMPANY file.

You may enter an additional amount as well as the basic amount to be charged for all rates. This is a fixed additional dollar amount that will be added to the basic charge after it has been computed. An example would be the additional charge of $200 added to HCFA Ambulatory Surgery rate groups for inter-ocular lens implants.

Accuracy in entering billing rates is critical. Incorrect entries will result in erroneous bills. After new rates are entered, it is suggested you print the Billing Rates List (Billing Rates List option on the Management Reports Menu) to verify that all entries are correctly recorded.

Flag Stop Codes/Dispositions/Clinics

Outpatient encounters recorded in the Scheduling package as either registrations or "stand-alone" stop codes will be billed automatically as those events are checked out. The Flag Stop Codes/Dispositions/Clinics option is used to flag/unflag those stop codes and dispositions which should not be billed. The option may also be used to flag clinics where Means Test billing is not appropriate.

If you make more than one selection, you will be given the opportunity to review the selections and deselect any, if necessary. All selections will be assigned the same effective date and billable status.

Note that once a selection has been flagged as non-billable, it may later be flagged as billable if it is subsequently determined it would be appropriate to continue billing.

Flag Stop Codes/Clinics for Third Party

Non-billable stop codes or clinics are those that should not be billed to a Third Party payer. By default, if a stop code or clinic is non-billable, it will not be billed by the auto biller; and therefore, is non-auto billable.

Non-auto billable stop codes or clinics are those that may be billable to a Third Party payer, but the auto biller should not be used for billing. These are visits that may need more research than can be performed by the auto biller to determine if they *are* billable.

These parameters are flagged by date and may be inactivated and reactivated.

Insurance Company Entry/Edit

The Insurance Company Entry/Edit option is used to enter new insurance companies into the INSURANCE COMPANY file and edit data on existing companies. An insurance company must be in the INSURANCE COMPANY file before it can be entered into a patient's record.

When entering new insurance companies, you will be prompted for the company street address, city, and whether or not the company will reimburse for treatment.

Following is a listing of the actions found on the screen in this option and a brief description of each. Once an action has been selected, <??> may be entered at most of the prompts that appear for lists of acceptable responses or instruction on how to respond.

Insurance Company Editor Screen

Once the insurance company is selected, this screen is displayed listing the following groups of information for that company: billing parameters, main mailing address, inpatient claims office data, outpatient claims office data, prescription claims office data, appeals office data, inquiry office data, remarks, and synonyms.

BP Billing Parameters - Allows you to add/edit the billing parameters for the selected insurance company.

MM Main Mailing Address - Allows you to add/edit the company's main mailing address. The address entered here will automatically be entered for the other office addresses.

IC Inpt Claims Office - Allows you to add/edit the company's inpatient claims office name, address, phone and fax numbers.

OC Opt Claims Office - Allows you to add/edit the company's outpatient claims office name, address, phone and fax numbers.

PC Prescr Claims Of - Allows you to add/edit the company's prescription claims office name, address, phone and fax numbers.

AO Appeals Office - Allows you to add/edit the company's appeals office name, address, phone and fax numbers.

IO Inquiry Office - Allows you to add/edit the company's inquiry office name, address, phone and fax numbers.

RE Remarks - Allows the user to enter comments concerning the selected insurance company.

SY Synonyms - Allows you to add/edit any synonyms for the selected company.

EA Edit All - Lists editable fields line by line for quick data entry.

AI (In)Activate Company - Allows you to activate/inactivate the selected insurance company. This may be used to inactivate duplicate companies in the system. When an insurance company is no longer valid, it is important to inactivate the company rather than delete it from the system. The IB INSURANCE SUPERVISOR security key is required. Once a company has been inactivated, it may not be selected when entering billing information.

You may also obtain a report of patients insured by a given company through this action.

CC Change Insurance Co. - Allows you to change to another company without returning to the beginning of the option.

DC Delete Company - Allows you to delete an entry from the INSURANCE COMPANY (#36) file. If claims have been submitted to the company, another company must be selected in which to point all claims and receivables information.

PL Plans (accesses Insurance Plan List screen) - Allows you to display and change plan attributes associated with the insurance company.

Insurance Plan List Screen
This screen lists all plans (active and inactive, group and individual) for the selected insurance company.

Actions

VP View/Edit Plan (accesses the View/Edit Plan screen) - Allows you to display/change plan detailed information.

IP Inactive Plan - Allows you to inactivate an insurance plan, or move subscribers from multiple insurance plans into one master plan.

AB Annual Benefits - (accesses Annual Benefits Editor screen) - Used to enter annual benefits data for the selected policy.

Annual Benefits Editor Screen
Once the benefit year is selected, this screen is displayed listing all the benefits for the selected insurance policy and benefit year. Benefit categories may include inpatient benefits, outpatient benefits, mental health, home health care, hospice, rehabilitation, and IV management.

Actions

PI Policy Information - Allows entry/edit of maximum out of pocket and ambulance coverage.

IP Inpatient - Allows entry/edit of inpatient benefits data.

OP Outpatient - Allows entry/edit of outpatient benefits data.

MH Mental Health - Allows entry/edit of mental health inpatient and outpatient benefits data.

HH Home Health - Allows entry/edit of home health care benefits data.

HS Hospice - Allows entry/edit of hospice benefits data.

RH Rehab - Allows entry/edit of rehabilitation benefits data.

IV IV Mgmt. - Allows entry/edit of intravenous management benefits data.

EA Edit All - Lists editable fields line by line for quick data entry.

CY Change Year - Allows you to change to another benefit year.

View/Edit Plan Screen
This screen displays plan information for viewing/editing including utilization review info, plan coverage limitations, annual benefit dates, user information, and plan comments.

Actions

PI Policy Information - Allows entry/edit of maximum out of pocket and ambulance coverage.

UI UR Info - Allows entry/edit of utilization review information.

CV Add/Edit Coverage - Allows you to add or edit coverage limitations for a specific plan.

PC Plan Comments - Allows editing of comments for the plan.

IP Inpatient - Allows entry/edit of inpatient benefits data.

AB Annual Benefits - (accesses Annual Benefits Editor screen) - Used to enter annual benefits data for the selected policy.

CP Change Plan - Allows you to select another plan for this insurance company without having to exit back to the previous screen.

Sample Screen

```
Insurance Company Editor    May 30, 1997 10:32:43     Page:    1 of    5
Insurance Company Information for: FOUNDATION HEALTH
Type of Company: CHAMPUS                     Currently Active
_____________________________________________________________________________
                            Billing Parameters
  Signature Required?: NO                     Attending Phys. ID:
           Reimburse?: WILL REIMBURSE         Hosp. Provider No.:
    Mult. Bedsections:                         Primary Form Type:
     Diff. Rev. Codes:                             Billing Phone:
       One Opt. Visit: NO                      Verification Phone:
  Amb. Sur. Rev. Code:                        Precert Comp. Name:
  Rx Refill Rev. Code:                             Precert Phone:
    Filing Time Frame:                                Bin Number:




_____________________________________________________________________________
+         Enter ?? for more actions                                     >>>
BP  Billing Parameters    AO  Appeals Office        AI  (In)Activate Company
MM  Main Mailing Address  IO  Inquiry Office        CC  Change Insurance Co.
IC  Inpt Claims Office    RE  Remarks               DC  Delete Company
OC  Opt Claims Office     SY  Synonyms              PL  Plans
PC  Prescr Claims Of      EA  Edit All              EX  Exit
Select Action: Next Screen//
```

List Flagged Stop Codes/Dispositions/Clinics

The List Flagged Stop Codes/Dispositions/Clinics option is used to generate a list of all stop codes, dispositions, and clinics which have been flagged as not being billable for Means Test billing.

You are prompted for the effective date of the list and a device. The output contains a separate page for non-billable dispositions, stop codes, and clinics.

Sample Output

```
==============================================================================
                       LIST OF NON-BILLABLE DISPOSITIONS
                                 As Of: 12/16/93
                                                                   Page: 1
                                                             Run Date: 12/16/93
==============================================================================

DEAD ON ARRIVAL



==============================================================================
                     LIST OF NON-BILLABLE CLINIC STOP CODES
                                 As Of: 12/16/93
                                                                   Page: 2
                                                             Run Date: 12/16/93
==============================================================================

EMPLOYEE HEALTH



==============================================================================
                          LIST OF NON-BILLABLE CLINICS
                                 As Of: 12/16/93
                                                                   Page: 3
                                                             Run Date: 12/16/93
==============================================================================

ALLERGY RESEARCH
```

List Flagged Stop Codes/Clinics for Third Party

This output is used to generate a list of all stop codes and clinics that are flagged through the Flag Stop Codes/Clinics for Third Party option as *non-billable* or *non-auto billable*. These flags can be deactivated and reactivated through the above mentioned option.

Non-billable stop codes or clinics are those that should not be billed to a Third Party payer. By default, if a stop code or clinic is non-billable, it will not be billed by the auto biller; and therefore, is non-auto billable.

Non-auto billable stop codes or clinics are those that may be billable to a Third Party payer, but the auto biller should not be used for billing. These are visits that may need more research than can be performed by the auto biller to determine if they *are* billable.

Sample Output

```
==============================================================================
           LIST OF CLINIC STOP CODES FLAGGED FOR THIRD PARTY BILLING
                                As Of: 10/01/96
                                                                  Page: 1
                                                             Run Date: 10/01/96
==============================================================================


                                 NON-BILLABLE

AMPUTATION CLINIC                       CARDIAC SURGERY
CARDIOVASCULAR NUCLEAR MED              CWT SUBSTANCE ABUSE
CWT/TR-HCMI                             CWT/TR-SUBSTANCE ABUSE
EMPLOYEE HEALTH                         ENT
RMS COMPENSATED WORK THERAPY            RMS COMPENSATED WORK THERAPY
RMS INCENTIVE THERAPY                   RMS INCENTIVE THERAPY
RMS VOCATIONAL ASSISTANCE               RMS VOCATIONAL ASSISTANCE
TELEPHONE TRIAGE                        TELEPHONE/ALCOHOL DEPENDENCE
TELEPHONE/ANCILLARY                     TELEPHONE/DENTAL
TELEPHONE/DIAGNOSTIC                    TELEPHONE/DIALYSIS
TELEPHONE/DRUG DEPENDENCE               TELEPHONE/GENERAL PSYCHIATRY
TELEPHONE/MEDICINE                      TELEPHONE/PROSTHETICS/ORTHOTIC

Enter RETURN to continue or '^' to exit: <RET>

==============================================================================
           LIST OF CLINIC STOP CODES FLAGGED FOR THIRD PARTY BILLING
                                As Of: 10/01/96
                                                                  Page: 2
                                                             Run Date: 10/01/96
==============================================================================
TELEPHONE/PTSD                          TELEPHONE/REHAB AND SUPPORT
TELEPHONE/SPECIAL PSYCHIATRY            TELEPHONE/SUBSTANCE ABUSE
TELEPHONE/SURGERY

                                NOT AUTO BILLED

GENERAL MEDICINE
```

```
==============================================================================
                LIST OF CLINICS FLAGGED FOR THIRD PARTY BILLING
                                 As Of: 10/01/96
                                                                   Page: 3
                                                              Run Date: 10/01/96
==============================================================================


                                  NON-BILLABLE


No clinics are flagged as NON-BILLABLE


                                 NOT AUTO BILLED

GENERAL MEDICAL
```

Billing Rates List

The Billing Rates List option will print a list of billing rates for a selected date range. It is an efficient way to verify that all billing rate entries have been entered correctly.

The output generated by this option displays the CHAMPVA, Health Care Finance Administration (HCFA) ambulatory surgery rates, Medicare deductible, and copayments. The effective date, amount (basic rate), and additional amount will be shown for each rate, if applicable. Certain ambulatory surgeries may be billed at the HCFA rate. The amount shown (if any) in the "Additional Amount" column is an extra amount which may be charged for all procedures within that rate group. The amount shown under "Inpatient Per Diem" and "NHCU Per Diem" is the daily charge for Category C patients.

Any billing rate that is effective for any date within the selected range is displayed. If more than one rate was effective within the date range, both rates are displayed.

Sample Output

```
JUN 11,1997       ***Billing Rates Listing***                    PAGE 1
                            Rates in effect from: JAN 01, 1997
                                                 to: JUN 11, 1997
==============================================================================

CHAMPVA LIMIT
  Effective Date      Amount    Additional Amount
  OCT 01, 1991        $25

CHAMPVA SUBSISTENCE
  Effective Date      Amount    Additional Amount
  OCT 01, 1994        $9.50
HCFA AMB. SURG. RATE 1
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $285

HCFA AMB. SURG. RATE 2
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $382
```

```
JUN 11,1997       ***Billing Rates Listing***                    PAGE 2
                            Rates in effect from: JAN 01, 1997
                                                to: JUN 11, 1997
==============================================================================

HCFA AMB. SURG. RATE 3
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $438

HCFA AMB. SURG. RATE 4
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $539

HCFA AMB. SURG. RATE 5
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $615

HCFA AMB. SURG. RATE 6
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $580      $200
```

```
JUN 11,1997       ***Billing Rates Listing***                    PAGE 3
                            Rates in effect from: JAN 01, 1997
                                                to: JUN 11, 1997
==============================================================================

HCFA AMB. SURG. RATE 7
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $853

HCFA AMB. SURG. RATE 8
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $705      $200

HCFA AMB. SURG. RATE 9
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $0

INPATIENT PER DIEM
  Effective Date      Amount    Additional Amount
  OCT 01, 1990        $10
```

```
JUN 11,1997       ***Billing Rates Listing***                    PAGE 4
                            Rates in effect from: JAN 01, 1997
                                                to: JUN 11, 1997
==============================================================================

MEDICARE DEDUCTIBLE
  Effective Date      Amount    Additional Amount
  JAN 01, 1996        $736

NHCU PER DIEM
  Effective Date      Amount    Additional Amount
  OCT 01, 1990        $5

NSC PHARMACY COPAY
  Effective Date      Amount    Additional Amount
  OCT 01, 1992        $2
  JUN 09, 1997        $5.00     $2.00

SC PHARMACY COPAY
  Effective Date      Amount    Additional Amount
  OCT 01, 1990        $2
```

MCCR Site Parameter Enter/Edit

The MCCR Site Parameter Enter/Edit option allows the user to define and edit the MCCR site specific billing parameters. The parameters are displayed upon entering the option. They are divided into groups for editing. Each group is labeled with a number to the left of the data items. Some values may be filled in by the system.

Group 1: The medical center name is automatically filled in and is not editable. The federal tax number is the tax ID# assigned to the medical center and is a required field. There may be more than one Blue Cross/Blue Shield provider number assigned to a site for different categories of care. The main Blue Cross/Blue Shield provider number should be entered here. This is a required field. The Medicare provider number is furnished to your facility by Medicare. The MAS Service Pointer is Medical Administration Service the way it is entered in your HOSPITAL SERVICE file. The default division will appear as the default to the division question when entering Billable Ambulatory Surgical Codes on a bill.

Group 2: The name and title of bill signer will appear on the third party billing form. The billing supervisor name does not appear on the form. This is used in conjunction with the Bill Cancellation and Bill Disapproval Mail Groups. If these groups are not specified, the billing supervisor will be one of the few recipients of both messages.

Group 3: The MULTIPLE FORM TYPES parameter should be set to YES if your facility uses more than one health insurance billing form. UB forms and HCFA-1500 are the forms currently available. If this field is left blank or answered NO, only UB forms will be allowed. Beginning with version 1.5 of Integrated Billing, the review step of creating a bill has been eliminated. If the CAN INITIATOR AUTHORIZE parameter is set to YES and the initiator holds the IB AUTHORIZE security key, the initiator of the bill will be allowed to authorize the bill. If this parameter is set to NO, another user who holds the IB AUTHORIZE key will have to authorize the bill.

The CAN CLERK ENTER NON-PTF CODES parameter affects editing of diagnosis and procedure codes on inpatient bills. If this parameter is set to YES, diagnosis and procedure codes not found in the PTF record may be entered into the billing record. The ASK HINQ IN MCCR parameter, if set to YES, will allow the billing clerk to enter a request in the HINQ Suspense file while entering a bill for a patient whose eligibility has not been verified. If set to YES, the USE OP CPT SCREEN parameter will allow the Current Procedural Terminology Codes Screen for outpatient bills to be displayed on Billing Screen 5. The date range of this listing will be determined by the OP VISIT DATE(S) on file in the bill. If there are none, the STATEMENT COVERS FROM and TO dates will be used to determine which CPT codes can be selected for inclusion in the bill.

When billing Billable Ambulatory Surgical Codes (BASC), the entry at the DEFAULT AMB SURG REV CODE parameter will be the default revenue code stored in the bill. If this is not appropriate for any particular insurance company, the AMBULATORY SURG. REV. CODE field in the INSURANCE COMPANY file may be entered and used for that particular insurance company entry.

CPT procedures may be stored as ambulatory procedures in the SCHEDULING VISITS file (using the Add/Edit Stop Code option), and they may be stored in the billing record as procedures to print on a bill. There is now a two way sharing of information between these two files. If the TRANSFER PROCEDURES TO SCHED parameter is answered YES, as CPT procedures that are also ambulatory procedures are entered into a bill, the user will be prompted to indicate whether they should also be transferred to the SCHEDULING VISITS file. Conversely, the USE OP CPT SCREEN parameter allows importing of ambulatory procedures into a bill. Only CPT procedures that are either Billable Ambulatory Surgical Codes or nationally or locally active ambulatory procedures may be transferred.

The per diem start date is the date that your facility informed Category C patients of the new per diem charges and began per diem billing. This field represents the earliest date for which the hospital or nursing home per diem charge may be billed to a Category C patient. This billing is mandated by Public Law 101-508, which was implemented on November 5, 1990. Please note that per diem billing will not occur if this field is blank.

A default revenue code, diagnosis code, and CPT procedure code can be set to be used on every bill that has prescription refills. The revenue code default will be overridden by the PRESCRIPTION REFILL REV. CODE for an insurance company, if one exists. Only activated revenue codes can be entered.

Set the SUPPRESS MT INS BULLETIN parameter to YES to suppress the bulletin sent when any Means Test charge covered by the patient's health insurance is billed.

Group 4: The first parameter in this group, if set to YES, will allow printing of "001" next to the total charges on the bill. This number is the revenue code for total charges. If the HOLD MT BILLS W/INS parameter is answered YES, automated Category C bills will automatically be placed on hold if the patient has active insurance. The bills may be released to Accounts Receivable after claim disposition from the insurance company. The next parameter allows the user to enter remarks to appear on every printed UB billing form type. The UB-92 Address Col and HCFA 1500 Addr Col parameters determine where the mailing address will begin printing on the billing form. The cancellation remark is the message which will be sent to Fiscal Service every time a bill is cancelled in MAS.

The next two parameters in this group allow mail groups to be set up so that whenever a bill is cancelled or disapproved, members of these groups are notified via electronic mail. If these groups are not specified, only the billing supervisor, user who cancelled/disapproved, and the initiator of the bill (for disapproval message only) will be notified. The Copay Background Error group is the mail group that will receive mail messages from the IBE filer when an unsuccessful attempt to file is detected. The Category C Billing mail group members will receive messages when Means Test/Category C billing processing errors have been encountered, and when movements and Means Tests for Category C patients have been edited or deleted. The mail groups must have been established through MailMan in order to be entered at these prompts.

Group 5: The agent cashier's mailing symbol, complete address, and telephone number are specified here. The street address will not appear on the screen. All billing payments made to the site should be received at the agent cashier's office.

The default form type is the form most commonly used at your facility (UB-82 or UB-92). All new bills and all follow-up bills will be printed on this form unless the primary insurer has the other UB form defined as their form type. The DEFAULT FORM TYPE parameter helps to control the transition between the UB-82 and the UB-92.

The MCCR System Definition Menu and this option is locked with the IB SUPERVISOR security key.

If necessary, please refer to the Data Supplement at the end of this option documentation for an explanation of the required response for each parameter.

Sample Screen

```
             MEDICAL CARE COST RECOVERY PARAMETER ENTER/EDIT
=====================================================================
[1] Medical Center Name: SAN DIEGO        Federal Tax #     : 13-8887799
    Default BC/BS #    : 1029765384123    Medicare Number   : 12332143
    MAS Service Pointer: MEDICAL ADMIN.   Default Division  : SAN DIEGO

[2] Bill Signer Name   : HARVEY           Title: CHIEF, MAS
    Billing Supervisor : PATRICIA

[3] Multiple Form Types: YES             Initiator Authorize: YES
    Use Non-PTF Codes? : UNSPECIFIED       Ask Hinq in MCCR?: UNSPECIFIED
    Use OP CPT Screen? : UNSPECIFIED     Default ASC Rev. Cd: 490
    Xfer Proc to Sched?: YES             Per Diem Start Date: NOV  5, 1990
    Default RX Rev. Cd : 257        Suppress MT Ins Bulletin: UNSPECIFIED
    Default RX Dx Cd   : V68.1             Default RX CPT Cd: 99070

[4] '001' for Total?   : YES             Hold MT Bills W/Ins: YES
    Remark on each bill: TEST BILL         UB-92 Address Col: UNSPECIFIED
    Cancellation Remark: TESTING          HCFA 1500 Addr Col: 25
    Cancelled Mailgroup: PTF                Disap. Mailgroup: PTF
    Copay Mailgroup    : IB ERROR            Cat C Mailgroup: IB CAT C

[5] Agent Cashier      : ISC-04
    Phone              : 518-562-4307    Default Form Type  : UB-92
Enter 1-5 to EDIT, or '^' to QUIT:
```

DATA SUPPLEMENT

AGENT CASHIER MAIL SYMBOL	Mailing symbol of agent cashier at your facility.
AGENT CASHIER STREET ADDRESS	Mailing address of agent cashier at your facility.
AGENT CASHIER CITY	
AGENT CASHIER STATE	
AGENT CASHIER ZIP CODE	
AGENT CASHIER PHONE NUMBER	Telephone number of agent cashier at your facility.
ASK HINQ IN MCCR	YES or NO: Allow billing clerk to enter a request in the HINQ Suspense file while entering a bill for a patient whose eligibility is not verified.
BILL CANCELLATION MAIL GROUP	Specify the mail group you want notified whenever a third party bill is cancelled.
BILL DISAPPROVED MAIL GROUP	Specify the mail group you want notified whenever a third party bill is disapproved.
BILLING SUPERVISOR NAME	Name of billing supervisor at your facility.
BLUE CROSS/SHIELD PROVIDER #	Main provider number (3 - 13 characters).
CAN CLERK ENTER NON-PTF CODES	YES or NO - Can diagnosis and procedure codes not found in the PTF record be entered into the billing record.
CAN INITIATOR AUTHORIZE	YES or NO - Beginning with Version 1.5 of Integrated Billing, the review step of creating a bill has been eliminated. If this parameter is answered YES and the initiator holds the IB AUTHORIZE key, the initiator of the bill will be allowed to authorize the bill. If this field is answered NO, another user who holds the IB AUTHORIZE key must authorize the bill.

CANCELLATION REMARK FOR FISCAL	Remark (reason for cancellation, 3-75 characters) which will be sent to Fiscal Svc. every time a bill is cancelled in MAS.
CATEGORY C BILLING MAIL GROUP	Members of this mail group will receive messages when Means Test/Category C billing processing errors have been encountered, and when movements and Means Tests for Category C patients have been edited or deleted.
COPAY BACKGROUND ERROR GROUP	This is the mail group that will receive mail messages from the IBE filer when an unsuccessful attempt to file is detected.
DEFAULT AMB SURG REV CODE	When billing BASCs (Billable Ambulatory Surgical Codes), this will be the default revenue code stored in the bill. If this is not appropriate for any particular insurance company, the AMBULATORY SURG. REV. CODE field in the INSURANCE COMPANY file may be used for that particular insurance company entry.
DEFAULT DIVISION	This field will appear as the default answer to the division question when entering Billable Ambulatory Surgeries on a bill.
DEFAULT FORM TYPE	Enter the form type most commonly used at your facility. Choose from UB-82 or UB-92.
DEFAULT RX REFILL CPT	Enter a CPT procedure code that should be printed on every bill that contains RX refills. If entered, this procedure will automatically be added to every bill that has a prescription refill.
DEFAULT RX REFILL DX	Enter a diagnosis code that should be added to every RX refill bill. If entered, this diagnosis will automatically be added to every bill that has a prescription refill.
DEFAULT RX REFILL REV CODE	Enter the revenue code that should be used for RX refills. This default will be over-ridden by the PRESCRIPTION REFILL REV. CODE for an insurance company, if one exists. Only activated revenue codes can be selected.

FEDERAL TAX NUMBER	Enter the federal tax number for your facility in NN-NNNNNNN format.
HCFA 1500 ADDRESS COLUMN	This is the column the mailing address should begin printing on row 1 of the HCFA-1500 form.
HOLD MT BILLS W/INS	If this parameter is answered YES, the automated Category C bills will automatically be placed on hold for patients with active insurance. The bills may be released to Accounts Receivable after claim disposition from the insurance company.
MAS SERVICE POINTER	Medical Administration Service as it is entered in your HOSPITAL SERVICE file.
MEDICARE PROVIDER NUMBER	Provided by Medicare to your facility (1-8 characters). This number will print in Form Locator 7 on the UB-82 form.
MULTIPLE FORM TYPES	YES or NO - Set this field to YES if your facility uses more than one type of health insurance form. The UB forms and the HCFA-1500 are the form types currently available. If this parameter is set to NO or left blank, only UB forms will be allowed.
NAME OF CLAIM FORM SIGNER	Name of person responsible for signing
PER DIEM START DATE	This is the date that your facility informed Category C patients of the new per diem charges and began per diem billing. Per diem billing will not occur if this field is left blank.
PRINT '001' FOR TOTAL CHARGES	YES or NO - Print '001' (revenue code for total charges) next to total charges on third party bill.
REMARKS TO APPEAR ON EACH FORM	Facility specific remarks to print on every UB type bill.
SUPPRESS MT INS BULLETIN	YES or NO - Set this parameter to YES to suppress the bulletin sent when any Means Test charge covered by the patient's health insurance is billed.

TITLE OF CLAIM FORM SIGNER	Title of person responsible for signing
TRANSFER PROCEDURES TO SCHED	YES or NO - If this parameter is answered
UB-92 ADDRESS COLUMN	This is the column on which the mailing address should begin printing on the UB-92.
USE OP CPT SCREEN	YES or NO - Allow Current Procedural Terminology Codes Screen to appear when editing procedure codes on Screen 5. The screen will list CPT codes for the dates associated with the bill.

Purge Insurance Buffer

When a Buffer entry is processed, most of the data is immediately deleted from that entry leaving only a stub entry for tracking and reporting purposes. This option deletes Insurance Buffer entries that were processed (accepted or rejected) before the selected date. A minimum of 1 year of buffer processed records is maintained on line; therefore, the latest selectable date is one year prior to the current date.

Sample Screen

```
                          INSURANCE BUFFER PURGE


   This option will purge Buffer file records Processed before a given date.

   When a Buffer record is Processed a stub entry remains in the Buffer file
   for tracking and reporting purposes.  This option deletes all stub entries
   of Buffer records processed at least a year ago.  Once a record is purged,
   it can not be retrieved and will no longer be included in Buffer reports.
   To maintain a record of the Buffer activity, consider printing the Buffer
   reports for the date range you are going to be purging.


Purge Buffer Records Processed Before:  Nov 05, 1997// 6/1/97  (JUN 01, 1997)


Ok to Purge Buffer records Processed before Jun 01, 1997? y  YES

Purge of Insurance Buffer queued for this evening at 8:00pm.
```

MCCR Site Parameter Display/Edit

Parameter Group	Security Key Required
IB Site Parameters	IB SUPERVISOR
Claims Tracking Parameters	IB CLAIMS SUPERVISOR
Third Party Auto Billing Parameters	IB SUPERVISOR

This option consolidates parameters from the Enter/Edit IB Site Parameters, MCCR Site Parameter Enter/Edit, Claims Tracking Parameter Edit, and Enter/Edit Automated Billing Parameters options. The initial screen lists three parameter groups.

Following is a list of the screens, the actions they provide, and a brief description of each action. Actions shown in *italics* access other screens.

MCCR Site Parameters Screen

IB Site Parameters - accesses the IB Site Parameter screen which displays general Integrated Billing site parameters.

Claims Tracking Parameters - accesses the Claims Tracking Parameters screen which displays parameters specific to the set-up and control of Claims Tracking functions.

Third Party Auto Billing Parameters - accesses the Automated Billing Parameters screen which displays the control parameters for the Third Party Automated Biller.

IB Site Parameters Screen

Descriptions for most of the parameters included on this screen can be found in the Enter/Edit IB Site Parameters and MCCR Site Parameter Enter/Edit option documentation. Following is a description of the six parameters (group 12) used to configure the Tricare Pharmacy billing interfaces that are user set. The other seven parameters in this group that appear on the right hand side of the screen are set by the system.

Rx Billing Port - This is the logical port that is opened to establish a TCP/IP connection with the RNA package to submit Pharmacy claims. This is normally a number between 2000 and 10000. The number that is selected is programmed into the RNA package, as this is the port that the RNA package constantly polls for input from VISTA. The Billing port must be entered to start the billing engine.

AWP Update Port - This is the logical port that is opened to establish a TCP/IP connection with the RNA package to receive AWP updates. This is normally a number between 2000 and 10000. This number is also programmed into the RNA package, as it is the port through which the RNA package transmits the AWP updates. This port number must be different from the Billing port number, or the background job to receive AWP updates will not be queued to run.

TCP/IP Address - This is the TCP/IP address used to reach the RNA package. This address is usually determined by the facility systems manager and supplied to RNA on the Plan Installation Worksheet. This address must be entered to start the billing engine.

Task UCI,VOL - This is UCI and Volume set on which the queued background jobs should run. If this field has no value (i.e., for Alpha sites), the jobs will be queued to run on the current UCI and Volume.

AWP Charge Set This is the Charge Set within the Charge Master which was used to load the AWP. The interface must know which Charge Set should be used to extract a unit price for a specific NDC number (drug). A valid Charge Set must be entered to start the billing engine.

Prescriber ID - This is the DEA number assigned to your facility, which you should determine prior to the installation of the RNA package. This number must be submitted with the Pharmacy Billing transaction. The number must be entered to start the billing engine.

Edit Set - This action allows you to view/edit the fields included in the 12 sets displayed.

Claims Tracking Parameters Screen

Descriptions of the parameters included on this screen can be found in the Claims Tracking Parameter Edit option documentation.

Tracking - allows you to edit the data displayed under the Tracking Parameters heading. These parameters control which episodes of care are added to Claims Tracking.

Random Sample - allows you to edit the data displayed under the Random Sample Parameters heading. These parameters control the selection of random samples.

General - allows you to edit the data displayed under the General Parameters heading.

Edit All - allows you to edit all data displayed on the Claims Tracking Parameters screen.

Automated Billing Parameters Screen

Descriptions of the parameters included on this screen can be found in the Enter/Edit Automated Billing Parameters option documentation.

General - allows you to edit the data displayed under the General Parameters heading.

Inpatient - allows you to edit the data displayed under the Inpatient Admission heading. These parameters control if and when inpatient episodes of care are processed by the Third Party automated biller.

Outpatient - allows you to edit the data displayed under Outpatient Visit the heading. These parameters control if and when outpatient visits are processed by the Third Party automated biller.

Prescription - allows you to edit the data displayed under the Prescription Refill heading. These parameters control if and when prescription refills are processed by the Third Party automated biller.

Sample Screens

```
MCCR Site Parameters         May 13, 1996 10:45:52          Page:    1 of    1
Display/Edit MCCR Site Parameters.
Only authorized persons may edit this data.


 IB Site Parameters                          Claims Tracking Parameters
    Facility Definition                         General Parameters
    Mail Groups                                 Tracking Parameters
    Patient Billing                             Random Sampling
    Third Party Billing

 Third Party Auto Billing Parameters
    General Parameters
    Inpatient Admission
    Outpatient Visit
    Prescription Refill


          Enter ?? for more actions
IB  Site Parameter        CT  Claims Tracking       AB  Automated Billing
                                                    EX  Exit Action
Select Action: Quit//
```

```
 IB Site Parameters          Mar 10, 1998 11:49:27          Page:    1 of    3

Only authorized persons may edit this data.

[1] Copay Background Error Mg: IB ERROR
    Copay Exemption Mailgroup: IB ERROR
    Use Alerts for Exemption : NO

[2] Hold MT Bills w/Ins      : YES            # of Days Charges Held: 90
    Suppress MT Ins Bulletin : NO
    Cat C Mailgroup          : IB CAT C
    Per Diem Start Date      : 01/01/91

[3] Disapproval Mailgroup    :
    Cancellation Mailgroup   :
    Cancellation Remark      : CANCELLED BY MAS

[4] New Insurance Mailgroup  : IB NEW INSURANCE
    Unbilled Mailgroup       : IB UNBILLED AMOUNTS
    Auto Print Unbilled List : NO

+         Enter ?? for more actions
EP  Edit Set                                        EX  Exit Action
Select Action: Next Screen//_MCCR System Definition Menu
```

```
Claims Tracking Parameters   May 13, 1996 10:52:27         Page:    1 of    1
Only authorized persons may edit this data.

            Tracking Parameters                    Random Sample Parameters
     Track Inpatient: ALL PATIENTS                Medicine Sample: 5
    Track Outpatient: INSURED ONLY           Medicine Admissions: 5
             Track Rx: ALL PATIENTS                Surgery Sample: 5
   Track Prosthetics: INSURED ONLY            Surgery Admissions: 5
  Reports Can Add CT: YES                            Psych Sample: 0
                                                 Psych Admissions: 5

            General Parameters
 Initialization Date: 09/01/94
 Use Admission Sheet: YES
       Header Line 1: ALBANY VAMC
       Header Line 2: 113 HOLLAND AVE
       Header Line 3: ALBANY, NY 12305

          Enter ?? for more actions
TP  Tracking              RS  Random Sample         GP  General
EA  Edit All                                        EX  Exit Action
Select Action: Quit//
```

```
Automated Billing Parameters  May 13, 1996 10:54:11                Page:    1 of    1
Only authorized persons may edit this data.

          GENERAL PARAMETERS                      INPATIENT ADMISSION
 Auto Biller Frequency: 1                     Automate Billing: YES
   Date Last Completed: 04/30/96                 Billing Cycle: 20
      Inpatient Status: Closed                      Days Delay: 1

          OUTPATIENT VISIT                        PRESCRIPTION REFILL
      Automate Billing: YES                    Automate Billing: YES
         Billing Cycle: 10                        Billing Cycle: 3
            Days Delay: 1                            Days Delay: 1


          Enter ?? for more actions
GP  General                IP  Inpatient              OP  Outpatient
RX  Prescription                                      EX  Exit Action
Select Action: Quit//
```

Re-Generate Average Bill Amounts

This option is used to rebuild and store the monthly and yearly counts and dollar amounts of inpatient and outpatient bills for a single month. This data will overwrite any previously stored data.

If a past month is selected, the monthly totals for that month are recomputed and the subsequent yearly totals are updated. Previous months' data is also calculated, when required, in order to obtain yearly values. This information is used to compute the average bill amount for the Unbilled Amounts Report.

Once the average bill amounts are calculated, the Unbilled Amounts Report is automatically generated , via electronic mail, for the selected month. This mail message is sent to the mail group specified in the UNBILLED MAIL GROUP field of the IB SITE PARAMETERS file.

Re-Generate Unbilled Amounts Report

This option is used to regenerate the Unbilled Amounts Report for a single month. This recomputes the unbilled care for the month and updates the unbilled amounts. To simply view previously computed data, please use the View Unbilled Amounts option.

Sample Output

```
Unbilled Inpatient Patient Listing for: 01/95                      Page 1  Mar 20, 1995@10:40:09
                                                        Claims
Patient Name        Pt. ID.      Date of Care        Tracking ID  Eligibility       Insurance Companies
-----------------------------------------------------------------------------------------------------
IBpatient,one       000-11-1111  Nov 27, 1993@11:22  500382       NON-SERVICE CONN  GHI,BIG TREE I
IBpatient,two       000-22-2222  Mar 29, 1994@13:00  500410       SC, LESS THAN 50  BLUE CROSS
IBpatient,three     000-33-3333  Mar 24, 1994@07:34  500399       HUMANITARIAN EME  HEALTH INS
IBpatient,four      000-44-4444  Sep 01, 1993@17:07  50020        SC, 50% TO 100%   GHI
```

Send Test Unbilled Amounts Bulletin

This option allows you to send a test mail message to the mail group receiving the unbilled amounts messages. This option should be used prior to reporting problems to assist sites in determining whether the mail groups are set up correctly. The mail group you wish to receive the message should be specified in the UNBILLED MAIL GROUP (6.25) field in the IB SITE PARAMETERS file (350.9).

Sample Message

```
Subj: UNBILLED AMOUNTS Report for Oct. 2099  [#121659] 06 Jul 95 09:38
  20 Lines
From: INTEGRATED BILLING PACKAGE  in 'IN' basket.   Page 1  **NEW**
-------------------------------------------------------------------------------

The Unbilled Amounts for Oct. 2099 has successfully completed for
ALBANY (633).

Test Data Only, Test Data Only, Test Data Only
Inpatient Care
   Number of Unbilled Inpt Cases :        1,111
   Average Inpt. Bill Amount     :       $9,999.99
   Total Unbilled Inpt Care      :  $11,109,988.89

Outpatient Care:
   Number of Unbilled Opt Cases  :       33,333
   Average Opt. Bill Amount      :         $222.22
   Total Unbilled Opt. Care      :   $7,407,259.26

Total Unbilled Amount all care   :  $18,517,248.15
Enter RETURN to continue or '^' to exit: <RET>
```

```
Subj: UNBILLED AMOUNTS Report for Oct. 2099  [#121659]    Page 2
-------------------------------------------------------------------------------

Note:  Average bill Amount is based on Bills Authorized during the 12
       months preceding the month of this report.
Note:  Number of cases is insured cases in Claims Tracking that are
       not billed (or bill not authorized) but appear to be billable.


Select MESSAGE Action: IGNORE (in IN basket)//
```

View Unbilled Amounts

This option is used to view previously computed unbilled amounts without having to re-compile the data.

Sample Output

```
Unbilled Amounts Report                          Page 1  Mar 22, 1995@09:09:28
-------------------------------------------------------------------------------

           Inpatient Care: 02/95
   Number of Unbilled Inpt. Cases:           54
        Average Inpt. Bill Amount:       $5,552.22
         Total Inpatient Unbilled:     $299,819.88

           Outpatient Care: 02/95
   Number of Unbilled Opt.  Cases:          192
         Average Opt. Bill Amount:         $179.00
        Total Outpatient Unbilled:      $34,368.00

           Inpatient Care: 01/95
   Number of Unbilled Inpt. Cases:           16
        Average Inpt. Bill Amount:       $5,832.75
         Total Inpatient Unbilled:      $93,324.00

           Outpatient Care: 01/95
   Number of Unbilled Opt.  Cases:            0
         Average Opt. Bill Amount:         $178.93
        Total Outpatient Unbilled:           $0.00
```

Third Party Joint Inquiry

This option provides information needed to answer questions from insurance carriers regarding specific bills or episodes of care. This information is presented in List Manager Screens.

Because the same actions are available on most screens, and most screens can be accessed from any other screen; these "Common Actions" are listed first and are not repeated under each screen description. Only actions specific to a screen are included with that screen description.

You may QUIT from any screen which will bring you back one level or screen. EXIT is also available on most screens. EXIT returns you to the menu. For more information on the use of the List Manager utility, please refer to the appendix at the end of this manual.

Actions shown in italics access other screens.

Common Actions

BC Bill Charges - Accesses the Bill Charges screen.

DX Bill Diagnoses - Accesses the Bill Diagnoses screen.

PR Bill Procedures - Accesses the Bill Procedures screen.

CI Go to Claim Screen - Returns you to the Claim Information screen. Available on all screens that may be opened from the Claim Information screen.

AR Account Profile - Accesses the AR Account Profile screen.

CM Comment History - Accesses the AR Comment History screen.

IR Insurance Reviews - Accesses the Insurance Reviews/ Contacts screen.

HS Health Summary - Displays a Health Summary report. The information displayed on the Health Summary is site specified through the MCCR Site Parameter Display/Edit option.

AL Go to Active List - Returns you to the Third Party Active Bills screen if that screen was accessed upon entering this option; otherwise, this action returns you to the menu.

VI Insurance Company - Accesses the Insurance Company screen.

VP Policy - Accesses the Patient Policy Information screen.

AB Annual Benefits - Accesses the Annual Benefits screen.

EL Patient Eligibility - Accesses the Patient Eligibility screen.

EX Exit Action - Exits the option.

Third Party Active Bills Screen
This is the first screen displayed if you enter a patient name at the first prompt of this option. It lists all active third party bills for the specified patient in order of date created. All bills created in the Integrated Billing Third Party Billing module can be found on this screen or the Inactive Bills screen.

Actions
IL Inactive Bills - Accesses the Inactive Bills screen.

PI Patient Insurance - Accesses the Patient Insurance screen.

CP Change Patient - Allows you to choose another patient and re-displays the Third Party Active Bills screen for that patient.

Inactive Bills Screen
This screen lists inactive bills for a specified patient. All bills created in the Integrated Billing Third Party Billing module are found on this screen or the Third Party Active Bills screen. Bills are displayed beginning with most recent “statement from” date.

Actions
CD Change Dates - Allows you to change the bills listed by
changing the most recent “statement from” date to be displayed.

Patient Insurance Screen
This screen displays the list of insurance policies for a patient. It is based on the Patient Insurance Management screen of the Patient Insurance Info View/Edit option. It is only available from the Third Party Active Bills screen.

Claim Information Screen
This screen contains bill data and status information to provide an overall status of the bill. This is the primary claim screen for the inquiry, and many actions are provided to expand on the details of the claim.

If a policy has been updated but the bill has not, those changes are not reflected on this screen. Updated or current insurance information may be viewed using the three insurance screens.

Actions
CB Change Bill - Allows you to change the bill being displayed. If you entered a patient name at the first prompt of this option, only bills for that patient may be selected. If you entered a bill number at the first prompt, any bill may be selected.

Bill Charges Screen
cont. This screen displays a bill's charge information as it would
print on the bill. For UB-92 bills, this closely corresponds to Form Locators 42-49; therefore, any prosthetic items, Rx refills, or additional diagnoses and procedures are included. For HCFA 1500 bills, this closely corresponds to Block 24.

Bill Diagnosis Screen
This screen displays all diagnoses assigned to the bill, in the order they are printed on the bill.

Bill Procedures Screen
This screen lists all procedures assigned to a bill, in the order they are printed on the bill.

AR Account Profile Screen
This screen provides the financial history of a claim's account. This includes the current status of the bill in both IB and AR, as well as the payment or transaction history of the bill from Accounts Receivable. This screen is loosely based on the Profile of Accounts Receivable option.

Actions
VT Transaction Profile - Accesses the AR Transaction Profile screen for a selected transaction.

AR Transaction Profile Screen
This screen displays detailed account transaction information for individual claim transactions. It is loosely based on the Accounts Receivable Transaction Profile option.

AR Comment History Screen
This screen displays AR comments for the claim's account.

Actions
AD Add AR Comment - Allows you to add an AR Transaction Comment to the bill being displayed. Comment transactions may not be added to a bill that has not been authorized in IB.

Insurance Reviews/Contacts Screen
This screen displays all insurance reviews and contacts for the episodes of care on a bill. It is based on the Insurance Reviews/Contacts screen of the Claims Tracking Insurance Review Edit option. The primary difference between the two screens is that this screen consolidates all contacts for each episode being billed on a claim, while the Claims Tracking screen displays the contacts for a single episode of care.

Actions
VR Reviews/Appeals - Displays expanded information on a selected insurance contact. The screen accessed by this action will depend on the type of contact selected. If the contact is an appeal or denial, the Expanded Appeals/Denials screen is opened; otherwise, the Expanded Insurance Reviews screen is opened.

Expanded Appeals/Denials Screen
This screen displays expanded information on insurance appeals and denials listed on the Insurance Review/Contacts screen. This screen is based on the Expanded Appeals/Denials screen of the Claims Tracking Appeal/Denial Edit option.

Expanded Insurance Reviews Screen
This screen displays expanded information on insurance reviews listed on the Insurance Reviews/Contacts screen. This screen is based on the Expanded Insurance Reviews screen of the Claims Tracking Insurance Review Edit option.

Insurance Company Screen
This screen displays extended information on an Insurance Company. It is based on the Insurance Company Editor screen of the Insurance Company Entry/Edit option. This screen may be entered from the Patient Insurance screen or from any of the bill specific screens. Once a bill is selected, this screen displays only information related to the insurance carriers assigned to that bill.

Patient Policy Information Screen
This screen displays extended information on insurance policies. It is based on the Patient Policy Information screen of the Patient Insurance Info View/Edit option. This screen may be entered from either the Patient Insurance screen or from any of the bill specific screens. Once a bill is selected, this screen will only display information related to the insurance policies assigned to the bill.

Annual Benefits Screen

This screen displays extended information on the annual benefits of insurance policies. It is based on the Annual Benefits Editor screen of the Patient Insurance Info View/Edit option. This screen may be entered from the Patient Insurance screen or from any of the bill specific screens. Once a bill has been chosen, this screen displays information related to the insurance policies assigned to that bill.

Patient Eligibility Screen

This screen displays the current information on the patient's eligibility for care and service connection status. It is loosely based on the Eligibility Inquiry for Patient Billing option. This screen is available from the Third Party Active Bills screen and the bill specific screens.

If this screen is accessed from one of the bill specific screens, such as the Claim Information screen, the standard list of bill screen actions will be available from this screen.

If this screen is accessed from the Patient Insurance screen, no other screens are available as actions from this screen; and you must return to a previous screen to access other screens.

Sample Screens

```
Third Party Active Bills          May 31, 1995 @10:07:11                    Page 1 of 1
IBpatient,one          1111                                                        NSC
Bill #        From       To         Type   Stat Rate        Insurer    Orig Amt Curr Amt
1  L10263     04/20/92   04/20/92   OP     BI   REIM INS      HEALTH       0.00     0.00
2  L10270     04/20/92   04/24/92   OP     PC   REIM INS      HEALTH     698.30   698.30
3  N10072 *   11/16/93   11/17/93   OP     N    REIM INS    + HEALTH     199.00   199.00
4  N10094     02/16/94   02/16/94   OP     PC   REIM INS    + HEALTH     196.00   196.00
5  N10123 *   03/01/94   03/15/94   OP     BI   REIM INS    + HEALTH       0.00     0.00
6  N10150 *   03/14/94   03/15/94   OP     BI   REIM INS    + ABC          0.00     0.00
7  N10173 *   03/02/94   03/03/94   OP     BI   REIM INS      ABC          0.00     0.00
8  N10174 *   03/06/94   03/07/94   OP     N    REIM INS      ABC        356.00   356.00
9  N10222     05/01/94   05/31/94   IP-F   BI   REIM INS      HEALTH       0.00     0.00
10 N10236     06/01/94   06/05/94   IP-L   BI   REIM INS      HEALTH       0.00     0.00
11 N10273 *   03/03/94   03/31/94   IP-F   A    REIM INS    + HEALTH   11221.00   856.45
12 N10275     08/30/94   09/30/94   IP     BI   REIM INS      ABC          0.00     0.00
+          | * Cat C Charges on Hold | + 2nd/3rd Carrier |
CI  Claim Information     IL  Inactive Bills        PI  Patient Insurance
CP  Change Patient        HS  Health Summary        EL  Patient Eligibility
Select Action: Next Screen//
```

```
Inactive Bills                 May 17, 1996 13:30:26                 Page:    1 of    2
IBpatient,one          1111                                ** All Inactive Bills **  (9)
Bill #       From        To          Type   Stat Rate       Insurer  Orig Amt   Curr Amt
1  N10397    06/01/94    06/05/94    IL-L   CC   REIM INS   + ABC      935.00       0.00
2  N10198    06/01/94    06/05/94    IP-L   CB   REIM INS   + HEALTH     0.00       0.00
3  N10212    05/07/94    05/12/94    IP-C   CB   REIM INS     HEALTH     0.00       0.00
4  N10148 *  03/02/94    03/03/94    OP     CB   REIM INS                0.00       0.00
5  N10162 *  03/02/94    03/03/94    OP     CB   REIM INS                0.00       0.00
6  N10095    02/16/94    02/16/94    OP     CB   REIM INS                0.00       0.00
7  L10260    04/14/92    04/20/92    OP-F   CB   REIM INS     ABC     1026.02    1026.02
8  L00389    02/08/90    02/08/90    OP     CC   REIM INS     BC/BS     26.00       0.00
9  00036A    02/07/90    02/07/90    OP     CC   REIM INS     BC/BS     26.00       0.00
+         |* Cat C Charges on Hold |+ 2nd/3rd Carrier |
CI  Claim Information     AL  Go to Active List     CD  Change Dates
                                                    EX  Exit Action
Select Action: Next Screen//
```

```
Claim Information              May 17, 1996 13:44:58          Page:    1 of    2
N10072   IBpatient,one      1111           DOB: 5/22/50   Subsc ID: 000111111

      Insurance Demographics                  Subscriber Demographics
  Carrier Name:  HEALTH INS LIMITED         Group Number:  GN 48923222
 Claim Address:  789 3RD STREET               Group Name:
                 ALBANY, NY 44438          Subscriber ID:  000111111
   Claim Phone:  333-444-5676                   Employer:  Snow Movers
                                           Insured's Name:  IBpatient,one
                                             Relationship:  PATIENT

                              Claim Information
     Bill Type:  OUTPATIENT                Service Dates:  11/16/93 - 11/17/93
    Time Frame:  ADMIT THRU DISCHARGE CLAIM Date Entered:  12/23/93
     Rate Type:  REIMBURSABLE INS             Orig Claim:  199.00
     AR Status:  NEW BILL                    Balance Due:  199.00
     Secondary:  ABC

       Entered:  12/23/93  by   JOHN
    Authorized:  01/04/94  by   JANE
 First Printed:  01/04/94  by   JANE
  Last Printed:  04/01/94  by   DEB
+         Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CB  Change Bill           HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Next Screen//
```

```
Patient Insurance              May 31, 1995 @10:07:11        Page 1 of   1
Insurance Management for Patient: IBpatient,one         1111
  Insurance Co.    Type of Policy  Group        Holder   Effect.     Expires
1 HEALTH INS LTD                  GN 48923222  SELF     01/01/87
2 ABC              MAJOR MEDICAL  AE 76899354  SPOUSE   10/1/90     19/30/95
3 XYZ INS          INDEMNITY      T109         OTHER    10/1/94     01/01/95
4 BC/BS            MAJOR MEDICAL  GN 392043    SELF     01/01/90    12/31/92



VI  Insurance Company          VP Policy          AB  Annual Benefits
AL  Go to Active List                             EX  Exit Action
Select Action: Quit//
```

```
Bill Charges                May 31, 1995 @10:07:11                 Page 1 of 1
N10072  IBpatient,one       1111 DOB: 00/00/00            Subsc ID: 000111111
11/16/93 - 11/17/93         ADMIT THRU DISCHARGE          Orig Amt:    199.00

      OUTPATIENT VISIT
500   OUTPATIENT SVS        178.00      1     178.00
      PRESCRIPTION
257   DRGS/NONSCRPT         21.00       1     21.00

001   TOTAL CHARGE                            199.00

      OP VISIT DATE(S) BILLED:         NOV 16, 1993

      PRESCRIPTION REFILLS:
      30948          NOV 17, 1993      ABBOCATH-T 18G 1.25 IN
                           QTY: 20 for 10 days supply


Bill Remark:  This is a demonstration bill created for Joint Billing Inquiry.

          Enter ?? for more actions
DX  Bill Diagnosis        AR  Account Profile       VI  Insurance Company
PR  Bill Procedures       CM  Comment History       VP  Policy
CI  Go to Claim Screen    IR  Insurance Reviews     AB  Annual Benefits
                          HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Bill Charges                    May 31, 1995 @10:07:11              Page 1 of 1
N10273  IBpatient,one      1111 DOB: 00/00/00            Subsc ID:  000111111
03/02/94 - 03/31/94        INTERIM - FIRST CLAIM         Orig Amt: 11221.00

30 DAYS INPATIENT CARE
      INTERMEDIATE CARE
101   ALL INCL R&B           246.00         30            7380.00
240   ALL INCL ANCIL          48.00         30            1440.00
960   PRO FEE                 49.00         30            1470.00
274   PROSTH/ORTH DEV        931.00         1              931.00

001   TOTAL CHARGE                                       11221.00

      PROSTHETIC ITEMS:
      Sep 18, 1994  WHEELCHAIR
      Sep 21, 1994  CANE-ALL OTHER

          Enter ?? for more actions
DX  Bill Diagnosis        AR  Account Profile       VI  Insurance Company
PR  Bill Procedures       CM  Comment History       VP  Policy
CI  Go to Claim Screen    IR  Insurance Reviews     AB  Annual Benefits
                          HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Bill Diagnosis                  May 17, 1996 14:07:56         Page:    1 of    1
N10072   IBpatient,one      1111        DOB: 00/00/00     Subsc ID: 000111111
 11/16/93 - 11/17/93        ADMIT THRU DISCHARGE CLAIM   Orig Amt:    199.00

       1)  490.    BRONCHITIS NOS
       2)  030.1   TUBERCULOID LEPROSY
       3)  101.    VINCENT'S ANGINA
       4)  330.1   CEREBRAL LIPIDOSES
       5)  461.0   AC MAXILLARY SINUSITIS
       6)  310.0   FRONTAL LOBE SYNDROME
       7)  200.01  RETICULOSARCOMA HEAD

          Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
PR  Bill Procedures       CM  Comment History       VP  Policy
CI  Go to Claim Screen    IR  Insurance Reviews     AB  Annual Benefits
                          HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Bill Procedures                 May 17, 1996 14:12:58          Page:    1 of    1
N10072   IBpatient,one      1111        DOB: 00/00/00     Subsc ID: 000111111
 11/16/93 - 11/17/93        ADMIT THRU DISCHARGE CLAIM   Orig Amt:    199.00

 11000   SURGICAL CLEANSING OF SKIN      11/16/93
 11001   ADDITIONAL CLEANSING OF SKIN    11/16/93
 12001   REPAIR SUPERFICIAL WOUND(S)     11/16/93

          Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
CI  Go to Claim Screen    IR  Insurance Reviews     AB  Annual Benefits
                          HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
AR Account Profile              May 31, 1995 @10:07:11         Page:    1 of    1
N10273   IBpatient,one         1111       DOB: 5/22/50   Subsc ID:  000111111
AR Status: ACTIVE         Orig Amt:    11221.00       Balance Due:  856.45

            04/01/94      IB Status:  Printed  (Last)      11221.00  11221.00
1   1578    05/07/94      PAYMENT (IN PART)                 7856.21   3364.79
2   1598    07/07/94      PAYMENT (IN PART)                 2508.34    856.45
3   1601    07/08/94      COMMENT                              0.00    856.45

    Total Collected:  10364.55
    Percent Collected:    92.37%
          Enter ?? for more actions
BC  Bill Charges          VT  Transaction Profile   VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
AR Transaction Profile          May 31, 1995 @10:07:11                Page 1 of 1
N10273  IBpatient,one          1111        DOB: 00/00/00  Subsc ID:  000111111
AR Status:  ACTIVE              Orig Amt:    11221.00   Balance Due:  856.45

      TRANS. NO:  1578               TRANS. TYPE:  PAYMENT (IN PART)
    TRANS. DATE:  05/07/94           DATE POSTED:  05/10/94    (ARH)
  TRANS. AMOUNT:  7856.21              RECEIPT #:  D2982398

                                       BALANCE    COLLECTED
                                 ------------- ---------------
                  PRINCIPLE:          3364.79      7856.21
                  INTEREST:              0.00         0.00
                  ADMINISTRATIVE:        0.00         0.00
                  MARSHALL FEE:          0.00         0.00
                  COURT COST:            0.00         0.00
                                     --------    ---------
                  TOTAL:              3364.79      7856.21

       FY:  94            PR AMT: 3364.79            FY TR AMT: 7856.21

COMMENTS:   Date of Deposit: MAY 10, 1994

          Enter ?? for more actions
CI  Go to Claim Screen          AL Go to Active List        EX Exit Action
Select Action: Quit//
```

```
AR Comment History              May 17, 1996 14:21:37         Page:    1 of    1
L10260   IBpatient,one          1111        DOB: 5/22/50    Subsc ID:  AH33334
AR Status:  CANCELLED           Orig Amt: 1026.02       Balance Due: 1026.02

1582  04/21/92  Copy of bill sent.                 FOLLOW-UP DT:  05/12/92
                Carrier did not receive initial bill.

1594  05/20/92  Bill canceled, wrong form type.    FOLLOW-UP DT:  06/01/92
                Carrier refuses to process this type of bill on a UB-92.
                They are requiring the HCFA 1500 form.

          Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        AD  Add AR Comment        VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Insurance Reviews/Contacts     May 31, 1995 @10:07:11        Page:    1 of    1
Insurance Review Entries for:  N10072     IBpatient,one         1111
    Date       Ins. Co.           Type Contact       Action    Auth. No.  Days

    OUTPATIENT VISIT of AMBULATORY SURGERY OFFICE on 11/16/93
1   11/30/93   HEALTH INS LIMITED  1st Appeal-Clin    APPROVED  AU 39824
2   11/17/93   HEALTH INS LIMITED  OPT                DENIAL               0

    PRESCRIPTION REFILL of 30948 on 11/17/93
3   11/17/93   HEALTH INS LIMITED  OPT                APPROVED  RN 9384222

         Service Connected: NO   Previous Spec. Bills: TORT                >>>
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       VR  Reviews/Appeals       AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Expanded Appeals/Denials      May 31, 1995 @10:07:11              Page 1 of  2
Insurance Appeal/Denial for: IBpatient,one         1111 ROI: NOT REQUIRED

            Visit Information                 Action Information
        Visit Type:  OUTPATIENT VISIT       Type Contact:  INITIAL APPEAL
        Visit Date:  03/09/94 9:00 am        Appeal Type:  CLINICAL
            Clinic:  AMBULATORY SURGERY      Case Status:  OPEN
      Appt. Status:  CHECKED OUT         No Days Pending:
        Appt. Type:  REGULAR               Final Outcome:
      Special Cond:

          Clinical Information            Appeal Address Information
           Provider:                     Ins. Co. Name:  HEALTH INS LIMITED
           Provider:                    Alternate Name:
          Diagnosis:                     Street line 1:  HIL - APPEALS OFFICE
          Diagnosis:                     Street line 2:  1099 THIRD AVE, SUITE
      Special Cond:                      Street line 3:
                                        City/State/Zip:  TROY, NY  12345

                     Insurance Policy Information
    Ins. Co. Name:  HEALTH INS LIMITED   Subscriber Name:  IBpatient,one
     Group Number:  GN 48923222            Subscriber ID:  000111111
  Whose Insurance:  VETERAN               Effective Date:  01/01/87
   Pre-Cert Phone:  444-444-444 E         Expiration Date:

    User Information                     Contact Information
      Entered By:  EMPLOYEE                Contact Date:  04/01/94
      Entered On:  11/16/93 3:30 pm   Person Contacted:  SPOUSE
  Last Edited By:                       Contact Method:  PHONE
  Last Edited On:                     Call Ref. Number:  RN 3320944
                                           Review Date:  06/02/95
 Comments
 Policy should cover treatment.
 Service Connected Conditions:
 Service Connected: NO
 NO SC DISABILITIES LISTED
          Enter ?? for more actions                                          >>>
CI  Go to Claim Screen       AL Go to Active List    EX Exit Action
Select Action: Quit//
```

```
Expanded Insurance Reviews    May 31, 1995 @10:07:11            Page 1 of   2
Insurance Review Entries for:             IBpatient,one        1111     ROI:
NOT REQUIRED

   Contact Information                    Action Information
     Contact Date:  11/17/93          Type Contact:  OUTPATIENT TREATMEN
 Person Contacted:  Steve            Opt Treatment:  RX REFILL
   Contact Method:  PHONE                   Action:  APPROVED
 Call Ref. Number:  RN 9384222        Auth. Number:  RN 9384222
      Review Date:  06/02/95

                       Insurance Policy Information
  Ins. Co. Name:  HEALTH INS LIMITED  Subscriber Name:  IBpatient,one
   Group Number:  GN 48923222           Subscriber ID:  000111111
Whose Insurance:  VETERAN              Effective Date:  01/01/87
 Pre-Cert Phone:  933-3434            Expiration Date:

   Appeal Address Information           User Information
  Ins. Co. Name:  HEALTH INS LIMITED             Entered By: EMPLOYEE
 Alternate Name:                                 Entered On: 11/17/93 12:54 pm
  Street line 1:  HIL - APPEALS OFFICE       Last Edited By: EMPLOYEE
  Street line 2:  1099 THIRD AVE, SUITE 301  Last Edited On: 11/20/93 12:55 pm
  Street line 3:
 City/State/Zip:  TROY, NY 12345

 Comments
 One refill of prescription approved.

 Service Connected Conditions:
 Service Connected: NO
 NO SC DISABILITIES LISTED
          Enter ?? for more actions                                      >>>
CI  Go to Claim Screen        AL Go to Active List          EX Exit Action
Select Action: Quit//
```

```
Insurance Company            May 17, 1996 15:25:42          Page:    1 of    5
Insurance Company Information for: HEALTH INS LIMITED                  Primary
Type of Company: HEALTH INSURANCE                     Currently Active

                          Billing Parameters
 Signature Required?:  YES              Attending Phys. ID:  AT PH ID VAH500000
          Reimburse?:  WILL REIMBURSE   Hosp. Provider No.:
   Mult. Bedsections:  YES               Primary Form Type:
    Diff. Rev. Codes:                        Billing Phone:
      One Opt. Visit:  NO               Verification Phone:
 Amb. Sur. Rev. Code:                   Precert Comp. Name:  ABC INSURANCE
 Rx Refill Rev. Code:                        Precert Phone:  444-444-4444 E
   Filing Time Frame:

                         Main Mailing Address
             Street:  2345 CENTRAL AVENUE      City/State:  ALBANY, NY 12345
           Street 2:  FREAR BUILDING                Phone:  555-1234
           Street 3:                                  Fax:  555-4884

               Inpatient Claims Office Information
             Street:  2345 CENTRAL AVENUE      City/State:  ALBANY, NY 12345
           Street 2:  FREAR BUILDING                Phone:  555-0392
           Street 3:                                  Fax:  555-4432

               Outpatient Claims Office Information
             Street:  789 3RD STREET           City/State:  ALBANY, NY 12345
           Street 2:                                Phone:  333-555-5676
           Street 3:                                  Fax:  333-555-9245

              Prescription Claims Office Information
   Company Name:  GHI PROCESSING             Street 3:
         Street:  1933 CORPORATE DRIVE     City/State:  RIVERSIDE, NY 39332
       Street 2:  TANGLEWOOD PARK               Phone:  555-0000
            Fax:
                      Appeals Office Information
         Street:  HIL - APPEALS OFFICE     City/State:  TROY, NY 12345
       Street 2:  1099 THIRD AVE, SUITE 301     Phone:  555-1923
       Street 3:                                  Fax:  555-5464

                      Inquiry Office Information
         Street:  2345 CENTRAL AVENUE      City/State:  ALBANY, NY 12345
       Street 2:  FREAR BUILDING                Phone:  555-1923
       Street 3:                                  Fax:  555-5336


  Remarks

  Synonyms

          Enter ?? for more actions                                      >>>
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Patient Policy Information    May 31, 1995 @10:07:11       Page:     1 of    3
Extended Policy Information for:   IBpatient,one       000-11-1111     Primary
HEALTH INS LIMITED Insurance Company               ** Plan Currently Active **

      Plan Information                      Insurance Company
  Is Group Plan:  YES                      Company:  HEALTH INS LIMITED
     Group Name:                            Street:  2345 CENTRAL AVENUE
   Group Number:  GN 48923222            Street 2:  FREAR BUILDING
   Type of Plan:                         Street 3:
                                       City/State:  ALBANY, NY 12345

    Utilization Review Info           Effective Dates & Source
          Require UR:              Effective Date:  01/01/87
    Require Pre-Cert:             Expiration Date:
    Exclude Pre-Cond:              Source of Info:  INTERVIEW
 Benefits Assignable:  YES

     Subscriber Information         Subscriber's Employer Information
   Whose Insurance:  VETERAN   Claims to Employer:  No, Send to Insurance
   Subscriber Name:  IBpatient,one        Company:
      Relationship:  PATIENT               Street:
  Insurance Number:  000111111         City/State:
  Coord.  Benefits:  PRIMARY                Phone:

         User Information              Insurance Contact (last)
        Entered By:  EMPLOYEE        Person Contacted:
        Entered On:  09/07/93       Method of Contact:
  Last Verified By:  EMPLOYEE         Contact's Phone:
  Last Verified On:  01/03/95            Contact Date:
   Last Updated By:  EMPLOYEE
   Last Updated On:  04/06/94

 Comment -- Patient Policy
 None

 Comment -- Group Plan

 Personal Riders
    Rider #1:     EXTEND COVERAGE TO 365 DAYS
    Rider #2:     AMBULANCE COVERAGE

+         Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Annual Benefits                May 17, 1996 15:39:23         Page:    1 of    3
Annual Benefits for: ABC Ins. Co                                        Primary
             Policy: GN 48923222               Ben Yr:  MAR 01, 1993

      Policy Information
      Max. Out of Pocket:     $     500
      Ambulance Coverage (%): 85    %

      Inpatient
      Annual Deductible:      $     500   Drug/Alcohol Lifet. Max:      $
      Per Admis. Deductible:  $     100   Drug/Alcohol Annual Max:      $
      Inpt. Lifetime Max:     $           Nursing Home (%):
      Inpt. Annual Max: $           Other Inpt. Charges (%):
      Room & Board (%):

      Outpatient
      Annual Deductible:      $     50    Surgery (%):
      Per Visit Deductible:   $     50    Emergency (%):          85%
      Lifetime Max:     $           Prescription (%):       80%
      Annual Max: $           Adult Day Health Care?: UNK
      Visit (%):              Dental Cov. Type: PERCENTAGE AMOU
      Max Visits Per Year:                Dental Cov. (%):  48%

      Mental Health Inpatient Mental Health Outpatient
      MH Inpt. Max Days/Year:             MH Opt. Max Days/Year:
      MH Lifetime Inpt. Max:  $           MH Lifetime Opt. Max:   $
      MH Annual Inpt. Max:    $           MH Annual Opt. Max:     $
      Mental Health Inpt. (%):                  Mental Health Opt. (%):

      Home Health Care  Hospice
      Care Level:             Annual Deductible:      $
      Visits Per Year:              Inpatient Annual Max.:  $
      Max. Days Per Year:                 Lifetime Max.:    $
      Med. Equipment (%):                 Room and Board (%):
      Visit Definition:             Other Inpt. Charges (%):

      Rehabilitation    IV Management
      OT Visits/Yr:                 IV Infusion Opt?: UNK
      PT Visits/Yr:                 IV Infusion Inpt?:      UNK
      ST Visits/Yr:                 IV Antibiotics Opt?:    UNK
      Med Cnslg. Visits/Yr:               IV Antibiotics Inpt?:   UNK

      User Information
      Entered By: EMPLOYEE
      Entered On: 02/02/94
      Last Updated By:  EMPLOYEE
      Last Updated On:  02/18/94

          Enter ?? for more actions                                      >>>
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Patient Eligibility          May 20, 1996 07:45:44         Page:    1 of    1
N10273   IBpatient,one      1111            DOB: 07/07/50   Subsc ID:

             Means Test: CATEGORY A                      Insured: Yes
           Date of Test: 08/24/94                   A/O Exposure:
  Co-pay Exemption Test:                           Rad. Exposure:
           Date of Test:

     Primary Elig. Code: NSC
    Other Elig. Code(s): EMPLOYEE
                         AID & ATTENDANCE
      Service Connected: No
     Rated Disabilities: BONE DISEASE (0%-NSC)
                         DEGENERATIVE ARTHRITIS (40%-NSC)



          Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EX  Exit Action
                          AL  Go to Active List
Select Action: Quit//
```

Fast Enter of New Billing Rates

The IB SUPERVISOR security key is required to edit.

This option is designed to allow quick entry of new rates into the Charge Master for Interagency and Tortiously Liable Billing Rates. This option should only be used for the annual updated Interagency and Tortiously Liable Rates. The charges will be asked for by charge type category: inpatient, outpatient, prescription, outpatient dental, Cat C copayment. Enter all charges for a category, then move to the next section for the next category. For example, you are first prompted for Inpatient Charges. When you have entered all inpatient bedsections and their related charges, a <RET> entered at the "Select Inpatient Bedsection" prompt will bring you to the next charge type, Outpatient, and so on until you have entered the charges for all charge types.

Revenue codes may be edited through the Enter/Edit Charge Master option.

Delete Charges from the Charge Master

The IB SUPERVISOR security key is required to edit.

This option is used to delete charges from a Charge Set that are no longer needed. All charges that are inactive or that have been replaced before the specified date are deleted. A report of charges that *will be* deleted based on the date entered can be printed before the actual deletion to confirm the charges should be deleted.

Sample Output

```
Charges (to be deleted) in TL-OPT DENTAL set (ALL CHARGES IN SET) May 28, 1997  09:49  Page 1
Charge Item                       Effective   Inactive        Charge   Rev Cd
-----------------------------------------------------------------------------

                    CHARGE SET: TL-OPT DENTAL

OUTPATIENT DENTAL                 10/01/92                     97.00
OUTPATIENT DENTAL                 10/01/93                    102.00
OUTPATIENT DENTAL                 10/01/94                    119.00
OUTPATIENT DENTAL                 10/01/95                    104.00
OUTPATIENT DENTAL                 10/01/96                    121.00

5 Charges to be deleted
Enter RETURN to continue or '^' to exit:
```

Inactivate/List Inactive Codes in Charge Master

This option searches the charges in the Charge Master for inactive CPT codes. It then inactivates all charges associated with those inactive CPT codes. To confirm the charges should be inactivated, a report of charges for inactive CPT codes may be printed.

Sample Output

```
Charges for Inactive CPT's                          May 29, 1997  13:47  Page 1
Charge Item        Effective   Inactive    Charge Set          Charge   Rev Cd
-------------------------------------------------------------------------------
00806              02/01/95                AMB SURG REGION     394.00    333
11701              02/01/95                AMB SURG REGION     343.34
11701 - 54         05/01/96                AMB SURG REGION      34.20
25146 - 66         02/01/95                AMB SURG REGION     942.00
25153              05/01/96                AMB SURG REGION     234.23

5 Charges for Inactive CPT's
```

IRM System Manager's Integrated Billing Menu

Purge Functionality

The first option in the Purge Menu, Purge Update File, is used to delete all CPT entries from the temporary file, UPDATE BILLABLE AMBULATORY SURGICAL CODE (#350.41), after they have been transferred to the permanent file, BILLABLE AMBULATORY SURGICAL CODES (#350.4). This is usually done yearly, after a HCFA update of the CPT codes.

The remainder of the options in this menu are used to archive and purge billing data. The files which may be archived and subsequently purged are the INTEGRATED BILLING ACTION file (#350) (pharmacy copayment transactions only), the CATEGORY C BILLING CLOCK file (#351), and the BILL/CLAIMS file (#399).

Billing data from the current and one previous fiscal year, at a minimum, must be maintained on-line; however, you may choose to maintain data from additional fiscal years, if desired.

The following criteria must be met to purge billing data.

INTEGRATED BILLING ACTION file (pharmacy copayment actions)	The prescription that caused the action to be created must have been purged from the pharmacy database before the action may be archived. In addition, the bill must be closed in Accounts Receivable. The date the bill was closed is the date used to determine whether it will be included.
CATEGORY C BILLING CLOCK file	Only clocks with a status of CLOSED or CANCELLED and a clock end date prior to the selected time frame are included.
BILL/CLAIMS file	The bill must be closed in Accounts Receivable. The date the bill was closed is the date used to determine whether it will be included.

There are three steps involved in the archiving and purging of these files.

- A search is conducted to find all entries which may be archived through the Find Billing Data to Archive option. You choose which of the three files you wish to include in the search. The entries found are temporarily stored in a sort (search) template in the SORT TEMPLATE file (#.401). An entry is also made to the IB ARCHIVE/PURGE LOG file (#350.6). This log may be viewed through the Archive/Purge Log Inquiry and List Archive/Purge Log Entries options.

  The List Search Template Entries option allows you to view the contents of a search template. You may delete entries from the search template using the Delete Entry from Search Template option.

- The entries are archived using the Archive Billing Data option. It is highly recommended that you archive the entries to paper (print to a non-slave printer) as there is currently no functionality to retrieve or restore data that has been archived.

- The data is purged from the database using the Purge Billing Data option. The search template containing the purged entries is also deleted. An electronic signature code and the XUMGR security key are required to archive and purge data.

Select Default Device for Forms

This option is used to select the default devices on which third party claim forms will print. The devices entered through this option will appear as the default devices when using options which generate these forms. Separate devices may be entered for each type of form.

You will be prompted for the form type. To avoid making duplicate entries of the same form type, it is suggested you type <??> at this prompt to first view the selections.

You will then be prompted for a default printer (in Billing) and a follow-up printer (in Accounts Receivable). You **must** enter an Accounts Receivable default device for follow-ups for every form except the UB-82.

In order to utilize the Print Authorized Bills option on the Third Party Billing Menu, you must set up billing default printers for each form type through this option. Any form type not set up with a billing default printer will not print when utilizing the Print Authorized Bills option.

The billing default printer must be added for the BILL ADDENDUM form type in order for the addendums to automatically print for every HCFA-1500 bill with prescription refills or prosthetic items.

Display Integrated Billing Status

The Display Integrated Billing Status option allows you to view data from the IB SITE PARAMETER file and pertinent information about the status of the IB background filer. For further explanation of the IB site parameters, please refer to the Enter/Edit IB Site Parameters option documentation.

One or more of the following messages may appear.

"The Integrated Billing filer has more than 10 transactions in the queue."

"The Integrated Billing filer is not running and has transactions to file."

"The Integrated Billing filer is late. It hasn't run since {date/time}."

If the second message appears, use the Start the Integrated Billing Background Filer option to start the filer. If the first or third message appear, recheck the status in a few minutes. If the message(s) persists or the "Number of Transactions in Queue" increases, use the Start the Integrated Billing Background Filer option to start the filer.

Enter/Edit IB Site Parameters

The Enter/Edit IB Site Parameters option allows you to enter or edit the INTEGRATED BILLING SITE PARAMETER file.

The following is a list of the parameters which may be entered/edited through this option. It should be noted that modification of these parameters may affect the performance of the Integrated Billing background filer.

FACILITY NAME - The name of your facility from your INSTITUTION file (there must be a station number associated with this entry). This value will be used by IFCAP in determining the bill number.

FILE IN BACKGROUND - If set to YES, the background filer will run as a background job. If set to NO or left blank, filing will occur as applications pass data to Integrated Billing.

FILER UCI,VOL - The UCI and volume set where you want the IBE filer to run. It is recommended that the filer run on the volume set that contains either the IB globals or the PRC globals. VAX sites should leave this field blank.

FILER HANG TIME - The number of seconds that the filer will remain idle after finishing all transactions and before checking for more transactions to file. The filer will shut itself down after 200 hangs with no activity detected. If this field is left blank, the default value is two.

COPAY BACKGROUND ERROR GROUP - This is the mail group you wish to receive mail messages from the IBE filer when an unsuccessful attempt to file is detected. "IB ERROR" will be entered during installation and will appear as a default the first time this option is used; however, it may be edited to any mail group you choose.

COPAY EXEMPTION MAIL GROUP - This is the mail group you wish to receive the copay exemption messages. The mail group specified as the Copay Background Error Group will be entered during installation and will appear as the default the first time this option is used. It may be edited to any mail group you choose.

USE ALERTS - If your facility has Version 7 or higher of Kernel installed, you may choose whether or not to use alerts or bulletins for internal messages in Integrated Billing. The same mail group (Copay Background Error Group) will receive both alerts and bulletins. This functionality is only available for the Medication Copayment Exemption software; however, if this is a desirable feature it may be expanded in the future. If this field is left unanswered, it defaults to NO and IB will use bulletins.

CATEGORY C BILLING MAIL GROUP - Members of this mail group will receive messages when Means Test/Category C billing processing errors have been encountered and when movements and Means Tests for Category C patients have been edited or deleted. "IB CAT C" will be entered during installation and will appear as a default the first time this option is used; however, it may be edited to any mail group you choose.

PER DIEM START DATE - The date that your facility informed Category C patients of the new per diem charges and began per diem billing. This field represents the earliest date for which the hospital ($10.00) or nursing home ($5.00) per diem charge may be billed to a Category C patient as mandated by Public Law 101-508 (implemented on November 5, 1990). Per diem billing will not occur if this field is left blank.

Inquire an IB Action

The Inquire an IB Action option provides a display of a captioned inquiry for a specified IB action. The purpose of this inquiry is to provide a quick reference of all the fields for all IB actions for a particular reference number.

Patient IB Action Inquiry

The Patient IB Action Inquiry option provides a brief display of IB actions for a selected patient and date range. The purpose of this inquiry is to provide a quick reference of all the fields for all IB actions for a particular patient.

Purge Menu

Purge Update File

The XUMGR security key is required to access this option.

The Purge Update File option is used to delete all CPT entries in the temporary file, UPDATE BILLABLE AMBULATORY SURGICAL CODE (#350.41) that have been successfully transferred to the permanent file, BILLABLE AMBULATORY SURGICAL CODE (#350.4). Upon completion, a total number of entries deleted is provided.

If the UPDATE BILLABLE AMBULATORY SURGICAL CODE file is not purged, the next time you transfer the file through the Run Amb. Surg. Update option, all of the entries that were previously transferred successfully will show as errors under "Codes already have entries for given effective date" and "Codes unable to transfer".

Archive Billing Data

The XUMGR security key and an electronic signature code are required to complete the archive process.

This option is used to archive data contained in search templates. Search templates are created from the INTEGRATED BILLING ACTION file (#350) (pharmacy copayment transactions only), the CATEGORY C BILLING CLOCK file (#351), and/or the BILL/CLAIMS file (#399) using the Find Billing Data to Archive option. You may select which of the files you wish to archive.

It is recommended that you archive the entries to paper (print to a device) as there is currently no functionality to retrieve or restore archived data.

The archive process is automatically queued. All data elements in the file for each entry in the search template are archived.

You will be notified of the results via electronic mail. The ARCHIVE/PURGE LOG file (#350.6) is updated when the purge is completed. The log # provided in the mail message may be used for inquiries to this file.

Sample Message

```
Subj: INTEGRATED BILLING ARCHIVING OF BILLING DATA  [#109348] 24 Jun 92 15:32  8 Lines
From: INTEGRATED BILLING PACKAGE  in 'IN' basket.  Page 1  **NEW**
-------------------------------------------------------------------------------------

The subject job has yielded the following results:
                                     Archive           Archive       # Records
File                        Log#  Begin Date/Time    End Date/Time     Archived
-----------------------------------------------------------------------------
CATEGORY C BILLING CLOCK    120  06/24/92@15:29:26  06/24/92@15:51:07    235

BILL/CLAIMS                 121  06/24/92@15:51:10  06/24/92@16:32:39    463


Select MESSAGE Action: IGNORE (in IN basket)//
```

Sample Outputs

```
Archived CATEGORY C BILLING CLOCK        JUN 24, 1992@15:29:28         Page: 1
-----------------------------------------------------------------------------

REFERENCE NUMBER: 50045                        PATIENT: IBpatient,one
  CLOCK BEGIN DATE: JAN 11, 1986               STATUS: CLOSED
  1ST 90 DAY INPATIENT AMOUNT: 1738.00         NUMBER INPATIENT DAYS: 2
  CLOCK END DATE: JAN 10, 1987

REFERENCE NUMBER: 50178                        PATIENT: IBpatient,two
  CLOCK BEGIN DATE: MAR 16, 1989               STATUS: CANCELLED
  1ST 90 DAY INPATIENT AMOUNT: 754.00          NUMBER INPATIENT DAYS: 1
  CLOCK END DATE: MAR 17, 1989                 USER ADDING ENTRY: JOHN
  DATE ENTRY ADDED: MAR 19, 1989
```

```
Archived BILL/CLAIMS                      JUN 24, 1992@15:30:30         Page: 1
-------------------------------------------------------------------------------

ACCOUNTS RECEIVABLE NUMBER: 500-K20987         BILL NUMBER: K20987
PATIENT NAME: IBpatient,one                    EVENT DATE: NOV  3, 1988
LOCATION OF CARE: HOSPITAL (INCLUDES CLINIC) - INPT. OR OPT.
BILL CLASSIFICATION: OUTPATIENT
TIMEFRAME OF BILL: ADMIT THRU DISCHARGE CLAIM
RATE TYPE: MEANS TEST/CAT. C                   WHO'S RESPONSIBLE FOR BILL?: PATIENT
STATUS: PRINTED                                STATUS DATE: JAN 30, 1990
PRIMARY BILL: K20987                           SC AT TIME OF CARE: YES
FORM TYPE: UB-82
MAILING ADDRESS NAME: ONE IBPATIENT
MAILING ADDRESS STREET: 123 MAIN STREET
MAILING ADDRESS CITY: ALBANY                   MAILING ADDRESS STATE: NEW YORK
MAILING ADDRESS ZIP CODE: 12208
NUMBER: 500                                    REVENUE CODE: 500
CHARGES: 127.00                                UNITS OF SERVICE: 1
TOTAL: 127.00                                  BEDSECTION: OUTPATIENT VISIT
DATE ENTERED: NOV  3, 1988
ENTERED/EDITED BY: RICHARD
INITIAL REVIEW: YES                            INITIAL REVIEW DATE: NOV  3, 1988
INITIAL REVIEWER: RICHARD
SECONDARY REVIEW: YES                          SECONDARY REVIEW DATE: NOV  3, 1988
SECONDARY REVIEWER: RICHARD
AUTHORIZE BILL GENERATION?: YES                AUTHORIZATION DATE: NOV  3, 1988
AUTHORIZER: RICHARD                            DATE FIRST PRINTED: NOV  3, 1988
FIRST PRINTED BY: RICHARD
DATE LAST PRINTED: NOV  3, 1988                LAST PRINTED BY: RICHARD
STATEMENT COVERS FROM: NOV  3, 1988            STATEMENT COVERS TO: NOV  3, 1988
IS THIS A SENSITIVE RECORD?: NO                BC/BS PROVIDER #: 000111222
TOTAL CHARGES: 127.00                          FISCAL YEAR 1: 89
FY 1 CHARGES: 127.00
```

Archive/Purge Log Inquiry

The XUMGR security key is required to access this option.

This option is used to provide a full inquiry of any entry in the IB ARCHIVE/PURGE LOG file (#350.6). Once you enter the log #, all fields in the file for the selected entry will be displayed.

This output may be used to determine the status of a search template, whether archiving or purging has been completed, and who completed the search and/or archive/purge. The number of records, log status, initiator, and begin and end time for each of the three stages of the process (if applicable) are provided. The number of records found, archived, or purged will differ if records are deleted from the search template between processing steps.

Sample Output

```
LOG #: 121    BILL/CLAIMS                              JUN 24, 1992@17:38:16
==============================================================================

         Search Template : IB ARCHIVE/PURGE #121
        # Records Purged : 33
              Log Status : CLOSED

  Search Begin Date/Time : JUN 24, 1992@14:51:38
    Search End Date/Time : JUN 24, 1992@15:24:08
        Search Initiator : EMPLOYEE

 Archive Begin Date/Time : JUN 24, 1992@15:40:10
   Archive End Date/Time : JUN 24, 1992@16:15:39
       Archive Initiator : EMPLOYEE

   Purge Begin Date/Time : JUN 24, 1992@16:32:47
     Purge End Date/Time : JUN 24, 1992@17:10:05
         Purge Initiator : EMPLOYEE
```

Delete Entry from Search Template

Once an entry meets the search criteria to be archived and subsequently purged and has been included in a search template, this option may be used to remove the entry from the template and prevent it from being purged. This option might be used for entries that meet the search criteria but because of unusual circumstances must be maintained on-line.

If more than one search template exists, they will be displayed for selection. Once selected, all records in that template will be displayed. You will then be allowed to choose which records to delete from the template.

Find Billing Data to Archive

The Purge Menu and this option are locked with the XUMGR security key.

This option is used to identify records that meet the criteria to be archived and purged from the INTEGRATED BILLING ACTION file (#350), the CATEGORY C BILLING CLOCK file (#351), and the BILL/CLAIMS file (#399). Entries which are selected to be archived and subsequently purged are placed in a search (sort) template in the SORT TEMPLATE file (#.401). These entries may be viewed/printed through the List Search Template Entries option.

You may choose which of the three files to include in the search and specify a different archive/purge time frame for each file; however, a minimum of the current plus one previous fiscal year must be maintained on-line. In cases where interim claims exist, they may only be archived/purged if the final claim can be archived/purged.

The following criteria must be met in order for the prescription, clock, or bill to be included.

INTEGRATED BILLING ACTION file (pharmacy copay actions)
The prescription which caused the action to be created must have been purged from the pharmacy database before the action may be archived. In addition, the bill must be closed in Accounts Receivable. The date the bill was closed is the date used to determine whether it will be included.

BILLING CLOCK file
Only clocks with a status of CLOSED or CANCELLED and a clock end date prior to the selected time frame are included.

BILL/CLAIMS file
The bill must be closed in Accounts Receivable. The date the bill was closed is used to determine whether it will be included.

The search is automatically queued and you are notified of the results via electronic mail. An entry is made in the ARCHIVE/PURGE LOG file (#350.6) each time a search template is created. The log # provided in the mail message may be used for inquiries to this file.

Sample Message

```
Subj: INTEGRATED BILLING SEARCH OF BILLING DATA  [#114481] 16 Dec 93 14:41
  8 Lines
From: INTEGRATED BILLING PACKAGE  in 'IN' basket.   Page 1  **NEW**
-------------------------------------------------------------------------------

The subject job has yielded the following results:
                                     Search            Search        # Records
File                        Log#  Begin Date/Time    End Date/Time      Found
-------------------------------------------------------------------------------
CATEGORY C BILLING CLOCK    154  12/16/93@14:40:50  12/16/93@14:40:54     82

BILL/CLAIMS                 155  12/16/93@14:40:55  12/16/93@14:40:58      1



Select MESSAGE Action: IGNORE (in IN basket)//
```

List Archive/Purge Log Entries

The XUMGR security key is required to access this option.

This option is used to list all log entries in the IB ARCHIVE/PURGE LOG file (#350.6). Entries are listed in the order in which they were added to the file. A new entry is filed each time a new search template is created through the Find Billing Data to Archive option. The log number, archive file, date created, initiator, and status is provided for each entry.

For a more detailed display on specific entries, please use the Archive/Purge Log Inquiry option.

Sample Output

```
INTEGRATED BILLING ARCHIVE/PURGE LOG ENTRIES   JUN 25,1992  07:57    PAGE 1
                                 DATE
LOG#  ARCHIVE FILE               CREATED    INITIATOR               STATUS
-------------------------------------------------------------------------------

1     INTEGRATED BILLING ACTION  05/01/92   IBpatient,one           CLOSED
2     CATEGORY C BILLING CLOCK   05/01/92   IBpatient,two           CANCELLED
3     CATEGORY C BILLING CLOCK   05/01/92   IBpatient,three         CLOSED
4     BILL/CLAIMS                05/01/92   IBpatient,four          CLOSED
5     INTEGRATED BILLING ACTION  06/01/92   IBpatient,five          CLOSED
6     CATEGORY C BILLING CLOCK   06/01/92   IBpatient,six           CLOSED
7     BILL/CLAIMS                06/01/92   IBpatient,seven         CLOSED
8     INTEGRATED BILLING ACTION  07/02/92   IBpatient,eight         CLOSED
9     CATEGORY C BILLING CLOCK   07/02/92   IBpatient,nine         CANCELLED
10    BILL/CLAIMS                07/02/92   IBpatient, ten          CLOSED
```

List Search Template Entries

A search template is created in the SORT TEMPLATE file (#.401) each time the Find Billing Data to Archive option is used. The List Search Template Entries option is used to list all entries in a search template that are scheduled to be archived and subsequently purged. This list may be used to review the entries and ensure that they should be included in the archive/purge of the file. If you have an entry that meets the purge criteria, but due to unusual circumstances must be maintained on-line, it may be deleted from the search template through the Delete Entry from Search Template option.

If more than one template exists, they will be listed for selection. The output may be sorted by patient as well as an additional specified field. <??> may be entered for a list of appropriate fields for selection and additional commands which may be used to customize your list. The selectable fields differ depending on the file. You will be prompted to enter a range for patient name(s) and the additional field (if selected). If you accept the default of FIRST, the system will assume you wish to include all entries.

The fields included in the display will depend on which of the three files the template is created from. The patient name and status is displayed for all three files. The INTEGRATED BILLING ACTION file (#350) also displays a brief description of the pharmacy prescription and the date it was added to the field. The CATEGORY C BILLING CLOCK file (#351) displays the clock begin and end dates. The BILL/CLAIMS file (#399) displays the rate type and status date.

Sample Output

```
CATEGORY C BILLING CLOCK SEARCH TEMPLATE       JUN 23,1992  16:35    PAGE 1
                                CLOCK BEGIN             CLOCK END
PATIENT                         DATE         STATUS     DATE
-------------------------------------------------------------------------------

IBpatient,one                   JUN 28,1988  CLOSED     JUN 27,1989
IBpatient,two                   MAY 30,1989  CANCELLED  MAY 29,1990
IBpatient,three                 MAR 15,1989  CLOSED     MAR 14,1990
IBpatient,four                  SEP  1,1988  CLOSED     AUG 31,1989
IBpatient,five                  JAN  2,1989  CLOSED     JAN  1,1990
```

Purge Billing Data

This option is used to purge data from the INTEGRATED BILLING ACTION file (#350) (pharmacy copayment transactions only), the CATEGORY C BILLING CLOCK file (#351), and/or the BILL/CLAIMS file (#399). In order for entries to be purged, they must first be stored in a search template created by the Find Billing Data to Archive option, and archived through the Archive Billing Data option. If there is more than one search template created and archived, you may select which file(s) you wish to purge.

The XUMGR security key and an electronic signature code are required to complete the purge process. The purge is automatically queued, all data elements in the file for each entry in the search template are purged, and the search template is deleted.

You will be notified of the results via electronic mail. The ARCHIVE/PURGE LOG file (#350.6) is updated when the archive is completed. The log # provided in the mail message may be used for inquiries to this file.

Sample Message

```
Subj: INTEGRATED BILLING PURGING OF BILLING DATA  [#109349] 24 Jun 92 15:41
  8 Lines
From: INTEGRATED BILLING PACKAGE  in 'IN' basket.  Page 1  **NEW**
-------------------------------------------------------------------------

The subject job has yielded the following results:
                                        Purge             Purge        # Records
File                        Log#  Begin Date/Time    End Date/Time      Purged
---------------------------------------------------------------------------
CATEGORY C BILLING CLOCK    120  06/24/92@15:35:56  06/24/92@15:50:29    235

BILL/CLAIMS                 121  06/24/92@15:50:47  06/24/92@16:41:05    463

Select MESSAGE Action: IGNORE (in IN basket)//
```

Repost IB Action to Filer

The Repost IB Action to Filer option allows Integrated Billing action entries that did not successfully pass to Accounts Receivable to be reposted to the IB filer.

Though this option will seldom, if ever, be used, it allows transactions with a status of COMPLETE (which do not have an Accounts Receivable transaction number assigned to them) to be reposted.

If there is not enough data to repost the action or if the number selected already has an Accounts Receivable transaction number assigned to it, an appropriate message will be displayed and the first prompt will be repeated. If the reposting is successful, you will simply return to the first prompt.

Start the Integrated Billing Background Filer

When a filer job has terminated unexpectedly, this option may be used to force a filer to start running.

If a filer is currently running, the following message will be displayed.

```
"<<<<WARNING!!! Filer appears to have been started on (date/time)>>>>".
```

You will then be given the option of starting a second filer.

Stop the Integrated Billing Background Filer

This option may be used to shutdown the IB background filer. The filer will cease when it has finished processing all its known transactions. Processing with Accounts Receivable will then be accomplished in the foreground.

When you shutdown the filer through this option, the FILE IN BACKGROUND site parameter is automatically edited to NO. The IB engine will file in the foreground until that parameter is edited to YES through the Enter/Edit IB Site Parameters option.

Verify RX Co-Pay Links

The Verify RX Co-Pay Links option compares the softlink stored in Integrated Billing with the pointer in the PRESCRIPTION file pointing back to Integrated Billing to provide a display/printout of all integrated billing actions which do not verify for a selected range of reference numbers.

Means Test charges may appear on this report if they are listed in the B cross-reference when there is no actual entry for the reference (this should rarely happen) or if the Means Test charge has no softlink.

This option should be used as a tool for resolving problems. False errors may be reported for a number of legitimate occurrences, such as the RX was deleted or the copay cancelled.

Sample Output

```
Verify Integrated Billing links to Pharmacy              APR 10, 1991  Page:1
Verify IB Reference Number 5001 to 50010
REF. NO.     PATIENT                 SSN   RX#       REFILL    IB LINK
CHARGE ID   TRANS ERROR MESSAGE
-------------------------------------------------------------------------------
5001         IBpatient,one          1111  RX#125 120          52:125
500-M10003 5      RX ENTRY MISSING IB NODE
5002         IBpatient,two          2222  RX#111125 51        52:111125;1:1
500-M10003 5      RX ENTRY MISSING IB NODE
5003         IBpatient,three        3333  RX#111128 1         52:111128;1:1
500-M10004 6      RX ENTRY MISSING IB NODE
5004         IBpatient,four         4444  RX#111199 99991     52:111199;1:1
500-M10004 6      RX ENTRY MISSING IB NODE
5007         IBpatient,five         5555  RX#125 120          52:125
500-M10006 11     RX ENTRY MISSING IB NODE
5008         IBpatient,six          6666  RX#111125 51        52:111125;1:1
500-M10006 11     RX ENTRY MISSING IB NODE
5009         IBpatient,seven        7777  RX#111128 1         52:111128;1:1
500-M10007 12     RX ENTRY MISSING IB NODE
5009         IBpatient,eight        8888  RX#111128 1         52:111128;1:1
500-M10007 12     IB CROSS-REFERENCE BUT NO ENTRY
50010        IBpatient,nine        9999  RX#111199 99991     52:111199;1:1
500-M10007 12     RX ENTRY MISSING IB NODE
```

Forms Output Utility

This option displays a list of local forms defined for your site and the associated actions allow you to add local forms and data elements and to override specific fields on a local form associated with the national one. It also allows you to define a local SCREEN 9 for bill data entry.

List of Local Forms Screen

Add Local Form

This action allows you to define local output billing forms and local input data screens that are not supported nationally but are needed for specific insurance companies or bill types. It provides the ability to create new forms/screens from scratch, as well as provides for two ways to easily create a new form "copy" based on an existing nationally released form.

The WANT TO ASSOCIATE THIS FORM WITH A NATIONAL FORM? field allows you to associate a new local form with a nationally released form without actually copying any data. This association allows each site to create a local form, but only require modifications to the fields of the form that are different from the nationally released definitions. Any form field definition that is not changed on the local form will continue to use the standard national definition. Any changes from the national definition however, will be stored as local entries that, when a bill is generated using this local form definition, will override the nationally released definition for these changed fields only. This way, data changes can be made without the site having to take responsibility for maintaining the entire form. Only forms that have the same BASE FILE NUMBER and FORM TYPE can be copied. Any local changes made must be tracked carefully as the site will be responsible for maintaining any locally modified fields should future changes become necessary. Since unmodified fields still rely on the national form for their definition, any changes made via a nationally released update to unmodified fields on the form will be automatically incorporated into a local form definition associated with a national form definition.

The WANT TO COPY ALL FIELDS FROM AN EXISTING FORM? field allows a straight copy, where the field definitions for a selected form are all copied into new entries referencing the new local form. Any local form created via an "unassociated" copy will have NO link back to the national form once the copy is completed.
Since no changes to nationally released software will be made to these local entries, you are free to modify the new form definition in whatever way you need to and are responsible for any and all changes that are made or will need to be made in the future.

Form View/Edit

Allows you to view and edit a selected form. This action brings you to the Detailed View of Local Form Screen. See below.

Add/Edit Local Data Elements
Allows you to define local data elements that are not supported nationally but are needed to be included on one or more local billing form(s). Nationally released data element definitions CANNOT be modified via this action.

View Data Element
Allows you to view the description, extract code, and other attributes of any data element defined at the site, both national and local.

Test Form
Allows you to test the output of a selected form.

Detailed View of Local Form Screen

Edit Local Form Demographics
Allows you to edit the name, description, pre and post processing logic and the extract and output logic for local forms.

Delete A Local Form
Allows you to delete a locally defined form. When the form is deleted, all form fields and form field definitions (not data element definitions) associated with that form are also deleted.

Edit Form Fields
Allows you to edit the field content defined for a local form associated with a national form that has local "override" field content definitions; or to edit any local, unassociated form field's form position data and field content definitions. This action brings you to the Bill Form Fields Screen. See below.

Switch Form
Allows you to switch between forms without exiting the option.

Bill Form Fields Screen

Add Local/Override Field
Allows you to add fields to a local unassociated form and allows the addition of ‘override’ fields for local modifications to any form.

Delete Local Form Field
Allows you to delete the 'override' form field content definitions for a local form associated with a national form or to delete any fields defined for an unassociated local form that do not have override fields defined for them (You must delete any override fields first).

Edit Local Form Field
Allows you to edit the field content for a local form such as page or sequence, first line number, starting column or piece, maximum number of lines, short description, etc.

Local Field Content Definition
Allows you to edit the "override" form field content definitions for a local form associated with a national form, or to edit the form field content of any field on an unassociated local form.

Add/Edit Local Data Elements
Allows you to define local data elements that are not supported nationally but are needed to be included on one or more local billing form(s). Nationally released data element definitions CANNOT be modified via this action.

View Data Element
Allows you to view the description, extract code, and other attributes of any data element defined at the site, both national and local.

View Form Fields
Allows you to view the composition of a local ‘override’ or national form field for a local form. This includes both the form field's form position data as well as the associated form field content definition.

Example 1 - CUSTOM BILL PRINT
Your site needs to print the total charge, not unit charge, in Block 24F on the HCFA 1500.

1. If there is not currently a local form defined for the HCFA 1500, use the ADD A LOCAL FORM option to add a form that will become the local HCFA 1500. Base file will be 399, print form type will be P (printed). Respond Yes to associate with national form question and choose the HCFA 1500 as the parent form. Give it a form length of 66 and enter a short description like Local 1500. Since this form is now "associated" with the national HCFA 1500 form, all of the fields will default to the definition provided by the national HCFA 1500 form when the bills are printed. The only time you'll want to change the pre and post processing, edit or output routines is if you do not want the national defaults, but want to write your own. Be very careful if you change any of these executable fields.

2. Select View Form and, if prompted for selection, enter the local HCFA 1500 form sequence # from the list displayed. This will display the general characteristics of this form.

3. Choose the Edit Form Fields action (FF). This will display a list of the form fields that make up this form.

4. Press return for NEXT SCREEN until the field CHARGES (BX-24F) appears in the field list.

5. The charge field is a data element that is not able to be extracted on its own. Its value depends on the "line" within box 24 that it will print on because it depends on revenue, code, date, etc. This kind of data element is considered part of a "group" element and that group element must be extracted before any of its group member data element can be output. The group data element for charges is N-HCFA 1500 SERVICES (PRINT). If you use the View Data Element option and enter this group element name, you'll see it sets up the array, IBXSAVE("BOX24",line #) for later use by its group member elements. You will also see that the 9th "^" piece of this array is the # of units. This is a calculate only field (no output from it when it is processed).

6. Select the Add Local/Override Field option and enter the sequence number of the CHARGES field.

7. Respond Yes to OK? prompt and to the copy over from the original field question. This is almost always a good idea so you can see what the original format of the field was.

8. Leave the data element field the same and do not enter an insurance company or bill type unless you want to restrict this change to a specific insurance company and/or bill type.

9. Now change the format field to multiply the value of charges (in variable IBXDATA(line #)) by the value of the units on the corresponding line # (in the 9th "^" piece of IBXSAVE("BOX24",line #)).

   Replace $J(IBXDATA(Z)
   With $J(IBXDATA(Z)*$P($G(IBXSAVE("BOX24",Z)),"^",9)

10. Now modify the format description to reflect the change you just made, and the override of the field is complete.

11. To make the formatter print the local copy of the HCFA 1500, use the IRM menu option, Select Default Device For Forms, and enter the name of your local form as the value of the PRINT FORM field. The next time a HCFA 1500 bill prints, it will print the charges as total charges, not a unit charge.

Example 2 - LOCAL SCREEN 9

Your site needs to print the provider's phone number in Form Locator 11 on the UB-92 for inpatient bills for insurance company Blue Cross of East Wherever and this data is not currently captured in V*IST*A.

There are several steps involved in this task. First, you must set up a local field for this data in the bill/claims file and define a local data element in the forms data element file, then create or modify a local Screen 9 to enable the clerks to input this data for this insurance company's bills. You then need to edit your local UB-92 print form to include this data in Form Locator 11 for this insurance company and attach this local Screen 9 to the national UB-92 bill form. Only the steps for the creation of local Screen 9 are included here.

1. Use FileMan to add a local form field, numbered at least 10000 and stored on a numeric node of at least 10000 for this new data element. These are the only kind of fields that can be INPUT on a local Screen 9 (any field can be displayed).

2. Using the output formatter, select the Add/Edit Local Data Elements action. Enter a name for this new data element. Only national fields can start with N-, so any other name is valid. Set the base file to 399 and the type of element to "F" (FileMan). Type the name that you gave the local field in step 1 as the FileMan field reference. Make sure you type it correctly as no edit checks are made on the field at this point. For FileMan return format, use "I" if you want the "raw" data returned or "E" if you want FileMan to return it in display format. Then enter a description of the field so you can identify it the next time you need to see the list of local data elements.

3. Again using the output formatter, if there is not currently a local form defined for local Screen 9 for the national UB-92 form, use the ADD A LOCAL FORM option to add this form. Base file will be 399, print form type will be S (screen). Respond No to associate with national form question and to the copy fields form another form question. Enter a short description. For now, do not put any code in the form pre and post processing fields. Code can be written to do edits for the data on the screen that will prevent it from being authorized unless the edits are passed (post-processing). The pre-processing is used to set up any variables that may be needed to process this screen. The pre-processing is executed before the screen is displayed, the post-processing takes place after the standard authorize edits are executed upon leaving the bill.

4. Select View Form (VF) and, if prompted for selection, enter the local UB-92 screen form sequence #. This will display the general characteristics of this form.

5. Choose the Edit Form Fields action (FF). This will display a list of the form fields that make up this form or, if a new form, will display "No fields currently defined for this form".

6. Choose Add Local/Override Field action (AF). If there are any fields already defined for this screen, there will be a prompt to allow you to override an existing field. Respond No if this question is asked. Respond 1 for page/seq then enter the number of the line on the screen where you want to prompt for this field to appear and the column the prompt should start in. Skip max # of lines since this data element can have only one value per bill. Enter a length for the field and it should be long enough to hold the data and its prompt, if one is desired. Leave pad as none, and edit status as editable. Give it an edit group number that is different from any other group that may already be on the screen. For this data element, assume the field will be output exactly as it is stored, so no format code is needed.

7. Now follow steps 1-3 in the first example, but use the UB-92 national form wherever it says to use the HCFA 1500.

8. Press return for NEXT SCREEN until the field FORM LOCATOR 11 (FL-11/1) appears in the field display area.

9. Select the Add Local/Override Field action and enter the sequence number of the FORM LOCATOR 11 (FL-11/1) field.

10. Respond Yes to OK? prompt and No to the copy over from the original field question. This is OK in this case because the new data element is a single-valued field that has absolutely nothing to do with the field it is overriding.

11. Enter the name of your local data element for the provider phone number in the data element field. Enter the BLUE CROSS of EAST WHEREVER insurance company name at the insurance company prompt. Enter bill type as inpatient to restrict this change to a specific bill type for this one insurance company. There is no need to enter Format code or description as we're assuming the data is displayed the same way it is stored in the database. If you want it displayed with dashes, but store just the numerics, you can reformat it using M code here. Make sure there is a FileMan input transform on the data field to strip out the dashes before it stores it. This will now be the override field output for inpatient bills for the BL CR of EAST WHEREVER insurance company's form locator 11.

12. To make the formatter print the local copy of the UB-92 and to associate this local Screen 9 with the UB-92 form type, use the IRM menu option, Select Default Device For Forms, and enter the name of your local form as the value of the PRINT FORM field and the name of your local UB-92 Screen 9 as the local form you just created/edited.

13. The next time a UB-92 bill is entered/edited whose insurance company is BL CROSS of EAST WHEREVER, there will be a Screen 9 available to allow entry of the provider phone #. This field will also print on the UB-92 as the first line in Form Locator 11 when the bill is printed.

Charge Master IRM Menu

Load Host File Into Charge Master

This option allows new rates and charges to be added to the Charge Master form host files. This is only available for specific rates and charges. The Host file must be in a predefined format to be read correctly. Following are the available choices.

Load CMAC into XTMP - Upload the CMAC from a host file.

Load AWP into XTMP - Upload Average Wholesale Price list from a host file.

Assign Charge Set - Assign charges loaded into XTMP to Charge Sets.

Check Data Validity - Check files waiting to be loaded into the Charge Master for data validity.

Load into Charge Master - Check files waiting to be loaded into the Charge Master for data validity, and upload them.

Delete XTMP files - Delete files in XTMP.

Rate Schedule Adjustment Enter/Edit

This option allows the enter/edit of the Rate Schedule Adjustment field (#363.10). This field causes all charges for a particular schedule to be adjusted by a site defined amount. It requires M-code that is executed to provide the adjusted amounts and; therefore, requires programmer access (DUZ(0)="@").

This Adjustment will have an immediate effect on the charges of the Rate Schedule. The Adjustment must be correct before the option can be exited.

Start the CHAMPUS Rx Billing Engine

This option is used by IRM personnel to queue the background filer. Several parameters must be set before this job can be queued to run; if they are not set, the job will not be queued. This job actually will cause four jobs to be queued. The first job is the background filer itself. After this job has been queued and has successfully opened a TCP/IP channel with the RNA system, this job will queue off a secondary filer job. If the first job aborts in any way, the secondary filer will assume the responsibilities of the primary filer and spawn another secondary filer. The option also directly queues a second job to open a separate TCP/IP channel with the RNA system to receive updates of the Average Wholesale Pricelist (AWP). This update is normally received weekly. The AWP Update job will also spawn a secondary job, in a manner similar to the background filer, which will take over for the primary AWP update job if that job aborts. Note that after the AWP Update is received, members of the IB CHAMP RX START mail group will receive an alert notifying the user that the update has completed.

Stop the CHAMPUS Rx Billing Engine

This option may be used to gracefully shut down the billing engine if a planned system shutdown is scheduled to occur, or if the RNA system is scheduled to be shutdown. The option sets a flag which calls for both the background filer and AWP update engine to stop running. The secondary jobs for both of these jobs will shutdown as well.

Edit the CIDC Insurance Switch

The IB SUPERVISOR security key is required to access this option.

This option is used to edit the CIDC (Clinical Indicators Data Capture) insurance switch. The CIDC switch controls how CIDC will function in related VistA applications.
Depending on how the parameter is set, users who hold a PROVIDER KEY will, or will not be prompted with CIDC questions.

Following are the parameters for the CIDC switch. The default is set to ‘0’. Changing this default parameter will affect how other CIDC related applications interact with both Providers and Back Door users.

0 = Do not prompt any patients (CIDC prompts do not appear).
1 = Prompt patients only with active billable insurance (CIDC prompts appear; conditional).
2 = Prompt for all patients (CIDC prompts appear).

Glossary

Admission Sheet	Worksheet commonly used in front of inpatient charts with a workspace available for concurrent reviews.
ALOS	Average Length of Stay
AMIS	Automated Management Information System
Automated Biller	Utility which establishes third party bills with no user intervention.
Background Filer	A background job that accumulates charges and causes adjustment transactions to a bill.
BASC	Billable Ambulatory Surgical Code
Billing Clock	A 365 day period, usually beginning when a patient is Means Tested and is placed in Category C, through which a patient's Means Test charges are tracked. An inpatient's Medicare deductible copayment entitles the patient to 90 days of hospital/nursing home care. These 90 days must fall within the 365 day billing clock.
Category C Patient	Those patients responsible for making copayments as a result of Means Test legislation.
Check-off Sheet	A site-configurable printed form containing CPT codes, descriptions, and dollar amounts (optional). Each check-off sheet may be assigned to an individual clinic or multiple clinics.
Claims Tracking	Module which allows for the tracking of an episode of care, from scheduling through final disposition of the bill.
Collateral Visit	A visit by a non-veteran patient whose appointment is related to or associated with a patient's treatment.
Continuous Patient	Patients continuously hospitalized at the same level of care since July 1, 1986.
Converted Charges	During the conversion, the BILLS/CLAIMS file (#399) is checked to insure that each outpatient visit has been billed. For each visit without an established bill, one is established and given a status of CONVERTED.

Copayment	The charges, required by legislation, that a patient is billed for services or supplies.
CPT	Current Procedural Terminology A coding method developed by the American Hospital Association to assign code numbers to procedures which are used for research, statistical, and reimbursement purposes.
Diagnosis Code	A numeric or alpha-numeric classification of the terms describing medical conditions, causes, or diseases.
Encounter Form	A paper form used to display data pertaining to an out-patient visit and used to collect additional data pertaining to that visit.
Form Locator	A block on the UB-82 or UB-92 bill form.
HCFA	Health Care Finance Administration
HCFA-1500	AMA approved health insurance claim form used for outpatient third party billings.
HINQ	Hospital Inquiry
ICD-9	International Classification of Diseases, Ninth Modification A coding system designed by the World Health Organization to assign code numbers to diagnoses and procedures for statistical, research, and reimbursement purposes.
Integrated Billing Action	The billing record of an event or an increase/decrease in the charges related to an event. An event is any billable goods or services provided by theVA.
Interqual Criteria	A method of evaluating appropriateness of care.
Locality Rate Modifier	The Geographic Wage Index that is used to account for wage differences in different localities when calculating the ambulatory surgery charge. It is multiplied by the wage component to get the final geographic wage component of the charge.
MCCR	Medical Care Cost Recovery - The collection of monies by the Department of Veterans Affairs (VA).
Means Test	A financial report used to determine if a patient may be required to make copayments for care.
Principal	Condition, established after study, to be chiefly responsible

Diagnosis	for the patient's admission.
Provider	A person, facility, organization, or supplier which furnishes health care services.
Reimbursable Insurance	Health insurance that will reimburse VA for the cost of medical care provided to its subscribers.
Revenue Code	A code on a third party bill identifying a specific accommodation, ancillary service, or billing calculation.
Stop Code	A three-digit number corresponding to an additional stop/service a patient received in conjunction with a clinic visit. Stop code entries are used so that medical facilities may receive credit for the services rendered during a patient visit.
Third Party Billings	Instances where a party other than the patient is charged.
UB-82	AMA approved health insurance claim form previously used for third party billings.
UB-92	AMA approved health insurance claim form used for third party billings.
Utilization Review	Review carried out by allied health personnel at predeter-mined times during the hospital stay to assess the appropriateness of care.
Wage Percentage	The percentage of the rate group unit charge that is the wage component to be used in calculating the HCFA charge for ambulatory surgical procedures.

Military Time Conversion Table

STANDARD	MILITARY
12:00 MIDNIGHT	2400 HOURS
11:00 PM	2300 HOURS
10:00 PM	2200 HOURS
9:00 PM	2100 HOURS
8:00 PM	2000 HOURS
7:00 PM	1900 HOURS
6:00 PM	1800 HOURS
5:00 PM	1700 HOURS
4:00 PM	1600 HOURS
3:00 PM	1500 HOURS
2:00 PM	1400 HOURS
1:00 PM	1300 HOURS
12:00 NOON	1200 HOURS
11:00 AM	1100 HOURS
10:00 AM	1000 HOURS
9:00 AM	0900 HOURS
8:00 AM	0800 HOURS
7:00 AM	0700 HOURS
6:00 AM	0600 HOURS
5:00 AM	0500 HOURS
4:00 AM	0400 HOURS
3:00 AM	0300 HOURS
2:00 AM	0200 HOURS
1:00 AM	0100 HOURS

List Manager Appendix

The List Manager is a tool that displays a list of items in a screen format and provides the following functionality.

- browse through the list
- select items that need action
- take action against those items
- select other List Manager actions without leaving the option

Actions(s) are entered by typing the name(s) or mnemonics(s) at the "Select Action" prompt. Where applicable, multiple actions may be selected with one entry by separating them with a semicolon (;). For example, the single entry "AL;CI" would cause the software to advance through two separate actions (Appointment Lists and Check In).

You can also select an action and entry number by using an equals sign (=).

CI=1	will process entry 1 for check in
CI=3 4 5	will process entries 3, 4, 5 for check in
CI=1-3	will process entries 1, 2, 3 for check in

In addition to the various actions that may be available specific to the option you are working in, List Manager provides generic actions applicable to any List Manager screen. You may enter double question marks (??) at the "Select Action" prompt for a list of all actions available. On the following page is a list of generic List Manager actions with a brief description. The mnemonic for each action is shown in brackets [ ] following the action name. Entering the mnemonic is the quickest way to select an action.

Action	Description
Next Screen [+]	move to the next screen
Previous Screen [-]	move to the previous screen
Up a Line [UP]	move up one line
Down a Line [DN]	move down one line
Shift View to Right [>]	move the screen to the right if the screen width is more than 80 characters
Shift View to Left [<]	move the screen to the left if the screen width is more than 80 characters
First Screen [FS]	move to the first screen
Last Screen [LS]	move to the last screen
Go to Page [GO]	move to any selected page in the list
Re Display Screen (RD)	redisplay the current screen
Print Screen [PS]	prints the header and the portion of the list currently displayed
Print List [PL]	prints the list of entries currently displayed
Search List [SL]	finds selected text in list of entries
Auto Display(On/Off) [ADPL]	toggles the menu of actions to be displayed/not displayed automatically
Quit [QU]	exits the screen