# Revision History

<table>
<thead>
<tr>
<th>Date</th>
<th>Revision</th>
<th>Description</th>
<th>Author</th>
</tr>
</thead>
</table>
| August 2016| 2.0      | Updated to reference patient policy comments within the Patient Insurance Screens due to patch IB*2.0*549. | PM: T.T  
Tech Writer: D.W.          |
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Tech Writer: A. D.          |
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1. **Introduction**

The Claims Tracking module within VistA is designed to be used by both billing personnel and utilization review (UR) staff. Claims Tracking tracks patient care events such as inpatient admissions, outpatient appointments, prescription releases and issuances of prosthetic devices. These events are most often added to Claims Tracking automatically but they may also be added manually when necessary.

Parameters that control Claims Tracking are defined in the Medical Care Cost Recovery (MCCR) Site Parameter Display/Edit option.

Claims Tracking is used by the automated billing processes in VistA to determine when and if an event should be billed to a third-party payer.

In 1996, Congress passed into law, the Health Insurance Portability and Accountability Act (HIPAA). This Act directs providers and payers to adopt national electronic standards for automated transfer of certain healthcare data between healthcare providers and payers.

One of the standardize transactions for exchange of data is the ASC X12N Health Care Services Review – Request for Review and Response (278). The 278 transaction is designed to allow a provider to request authorization or certification of healthcare services from a Utilization Management Organization (UMO). Initiation of requests and receipt of responses are managed from within Claims Tracking.

The 278 transaction is designed to support the following business events:

- Admission certification review requests and associated responses
- Referral review requests and associated responses
- Health care services certification review requests and associated responses
- Extend certification review requests and associated responses
- Certification appeal review requests and associated responses
- Reservation of medical services review requests and associated responses
- Cancellation of service reservations review requests and associated responses

1.1. **Purpose**

The purpose of this user guide is to provide end-users with instructions for using the Claims Tracking software.

1.2. **Overview**

VistA users (UR/RUR nurses) have the ability to manage insurance reviews and hospital reviews through the Claims Tracking module.

VistA users (UR/RUR nurses) have the ability to request authorization for healthcare events such as admissions and clinic appointments for claims tracking events identified by the software. Authorization for care numbers are then added to the claims creation process so that authorization numbers are submitted to the third-party payers as part of the claims.

The implementation of the electronic 278 transaction is intended to replace the manual processes that the sites’ Revenue Utilization Review (RUR) nurses use to obtain authorization numbers as
well as the manual processes the billing personnel use to look up the authorization numbers and to add them to the healthcare claims.

Claims Tracking works in conjunction with other VistA modules such as clinical, admission/discharge and transfer (ADT), pharmacy, accounts receivable (AR) and integrated billing (IB).

Outpatient encounters are added to Claims Tracking by the IB MT NIGHT COMP task that runs each night.

VistA is an existing system with a 2 color, roll and scroll interface. There are no changes to the existing architecture, security or backup processes associated with the Claims Tracking software.

The outbound 278 request transactions will be HL7 messages from a VistA site to the Financial Services Center (FSC) in Austin, TX. FSC will then convert the HL7 messages to HIPAA compliant messages which will then be sent to a health care clearing house (HCCH). The HCCH will be responsible for transmitting the messages to the third-party payers or their utilization management organization (UMO).

The inbound 278 response transactions will be HL7 messages received by a VistA site from the FSC. The HCCH will receive HIPAA compliant responses from the payers and will send the responses to FSC. FSC will convert these responses to HL7 before sending them to the originating VistA sites.

1.3. Project References

<table>
<thead>
<tr>
<th>Reference</th>
<th>Location</th>
<th>Date</th>
</tr>
</thead>
</table>

1.4. Organization of the Manual

This document contains the following sections:

- Claims Tracking Master Menu
  - Claims Tracking Menu (Combined Functions) ...
  - Claims Tracking Menu for Billing ...
  - CT ENHANCED for CODERS/MCCR MENU ...
  - Claims Tracking Menu (Hospital Reviews) ...
  - Claims Tracking Menu (Insurance Reviews) ...
1.5. **Acronyms and Abbreviations**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADT</td>
<td>Admission/Discharge/Transfer</td>
</tr>
<tr>
<td>AR</td>
<td>Accounts Receivable</td>
</tr>
<tr>
<td>ASC</td>
<td>Accredited Standards Committee</td>
</tr>
<tr>
<td>CT</td>
<td>Claims Tracking</td>
</tr>
<tr>
<td>ECME</td>
<td>Electronic Claims Management Engine is the real-time claims processing engine for prescription (RX) claims</td>
</tr>
<tr>
<td>FSC</td>
<td>Financial Service Center</td>
</tr>
<tr>
<td>HCCH</td>
<td>Health Care Clearing House</td>
</tr>
<tr>
<td>HCSR</td>
<td>Health Care Services Review</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
</tr>
<tr>
<td>HL7</td>
<td>Health Level Seven International (HL7) is a not-for-profit, ANSI-accredited standards developing organization</td>
</tr>
<tr>
<td>IB</td>
<td>Integrated Billing</td>
</tr>
<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
</tr>
<tr>
<td>Ins.</td>
<td>Insurance</td>
</tr>
<tr>
<td>MCCR</td>
<td>Medical Care Cost Recovery</td>
</tr>
<tr>
<td>MT</td>
<td>Means Test</td>
</tr>
<tr>
<td>NUMI</td>
<td>National Utilization Management Integration (NUMI)</td>
</tr>
<tr>
<td>Opt.</td>
<td>Outpatient</td>
</tr>
<tr>
<td>Psych</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>QA</td>
<td>Quality Assurance</td>
</tr>
<tr>
<td>ROI</td>
<td>Release of Information</td>
</tr>
<tr>
<td>RUR</td>
<td>Revenue Utilization Review</td>
</tr>
<tr>
<td>RX</td>
<td>Outpatient Prescription for Medication</td>
</tr>
<tr>
<td>TPJII</td>
<td>Third Party Joint Inquiry</td>
</tr>
<tr>
<td>UR</td>
<td>Utilization Review</td>
</tr>
<tr>
<td>UMO</td>
<td>Utilization Management Organization</td>
</tr>
</tbody>
</table>

2. **System Summary**

2.1. **System Configuration**

There are no specific system configurations associated with this project except those mentioned previously:

- Schedule IB MT NIGHT COMP
- Schedule IBT HCSR NIGHTLY PROCESS
- Define MCCR Site Parameter Display/Edit
2.2. Data Flows

Figure 1: Health Care Services Review – Part 1
Figure 2: Health Care Services Review – Part 2
2.3. **User Access Levels**

This functionality is designed to be used by the RUR nurses and the billing personnel at the sites. The following security keys exist to support this functionality:

- IB Supervisor – controls access to the MCCR Site Parameter Display/Edit option
- IB Claims Supervisor – controls access to the Supervisors Menu (Claims Tracking) ... option
- IB HCSR Param Edit – controls access to the Health Care Services Review (HCSR) parameters within the MCCR Site Parameters

2.4. **Contingencies and Alternate Modes of Operation**

The request of authorization of health care services or events can be accomplished via the telephone and/or via some payers’ websites.

Claims can be created manually if a biller has access to data from a patient care event.

3. **Getting Started**

There are no special requirements for logging on to or off of VistA associated with the Claims Tracking module.

3.1. **Troubleshooting**

There are no specific problems or issues associated with the use of the Claims Tracking software.

If there are no events being added automatically to the Claims Tracking software, contact your site’s Information Resource Management (IRM) to make sure the IB MT NIGHT COMP task is scheduled to run each night and make sure the site’s Claims Tracking parameters are set as desired by the RUR and billing personnel.

If there are no events being added automatically to the HCSR Worklist, contact your site’s IRM to make sure the IBT HCSR NIGHTLY PROCESS task is scheduled to run each night and make sure the site’s Claims Tracking parameters are set as desired by the RUR and billing personnel.

4. **Claims Tracking Master Menu**

The Claims Tracking module has a master menu that provides access to claims tracking for different groups of users. Each of the following menus is tailored to the expected users’ workflow:

- **Claims Tracking Master Menu**

<table>
<thead>
<tr>
<th>Select Integrated Billing Master Menu &lt;TEST ACCOUNT&gt; Option: CT Claims Tracking Master Menu</th>
</tr>
</thead>
<tbody>
<tr>
<td>BI Claims Tracking Menu for Billing ...</td>
</tr>
<tr>
<td>CT Claims Tracking Menu (Combined Functions) ...</td>
</tr>
<tr>
<td>EN CT ENHANCED for CODERS/MCCR MENU</td>
</tr>
<tr>
<td>HR Claims Tracking Menu (Hospital Reviews) ...</td>
</tr>
<tr>
<td>IR Claims Tracking Menu (Insurance Reviews) ...</td>
</tr>
</tbody>
</table>

Select Claims Tracking Master Menu <TEST ACCOUNT> Option:
• Integrated Billing Menu

Select Claims Tracking Master Menu <TEST ACCOUNT> Option: bi Claims Tracking Menu for Billing

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
<td>Claims Tracking Edit</td>
</tr>
<tr>
<td>FS</td>
<td>Print CT Summary for Billing</td>
</tr>
<tr>
<td>RN</td>
<td>Assign Reason Not Billable</td>
</tr>
<tr>
<td>TP</td>
<td>Third Party Joint Inquiry</td>
</tr>
</tbody>
</table>

Select Claims Tracking Menu for Billing <TEST ACCOUNT> Option:

• Combined Menu

Select Claims Tracking Master Menu <TEST ACCOUNT> Option: ct Claims Tracking Menu (Combined Functions)

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PR</td>
<td>Pending Reviews</td>
</tr>
<tr>
<td>CT</td>
<td>Claims Tracking Edit</td>
</tr>
<tr>
<td>SP</td>
<td>Single Patient Admission Sheet</td>
</tr>
<tr>
<td>IR</td>
<td>Insurance Review Edit</td>
</tr>
<tr>
<td>AD</td>
<td>Appeal/Denial Edit</td>
</tr>
<tr>
<td>IC</td>
<td>Inquire to Claims Tracking</td>
</tr>
<tr>
<td>SM</td>
<td>Supervisors Menu (Claims Tracking)</td>
</tr>
<tr>
<td>RM</td>
<td>Reports Menu (Claims Tracking)</td>
</tr>
<tr>
<td>HR</td>
<td>Hospital Reviews</td>
</tr>
<tr>
<td>HW</td>
<td>Health Care Services Review (HCSR) Worklist</td>
</tr>
<tr>
<td>HC</td>
<td>Health Care Services Review (HCSR) 278 Response</td>
</tr>
</tbody>
</table>

Select Claims Tracking Menu (Combined Functions) <TEST ACCOUNT> Option:

• Coder Menu - Note: No longer used

• Hospital Reviewer Menu

Select Claims Tracking Master Menu <TEST ACCOUNT> Option: HR Claims Tracking Menu (Hospital Reviews)

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PR</td>
<td>Pending Reviews</td>
</tr>
<tr>
<td>CT</td>
<td>Claims Tracking Edit</td>
</tr>
<tr>
<td>HR</td>
<td>Hospital Reviews</td>
</tr>
<tr>
<td>IC</td>
<td>Inquire to Claims Tracking</td>
</tr>
<tr>
<td>RM</td>
<td>Reports Menu (Claims Tracking)</td>
</tr>
<tr>
<td>SM</td>
<td>Supervisors Menu (Claims Tracking)</td>
</tr>
<tr>
<td>SP</td>
<td>Single Patient Admission Sheet</td>
</tr>
</tbody>
</table>

Select Claims Tracking Menu (Hospital Reviews) <TEST ACCOUNT> Option:

**Note:** Hospital reviews are no longer done using VistA Claims Tracking. National Utilization Management Integration (NUMI) is a web-based application that supports hospital reviews.
• Insurance Reviewer Menu

Select Claims Tracking Master Menu <TEST ACCOUNT> Option: HR Claims Tracking Menu (Hospital Reviews)

PR  Pending Reviews
AD  Appeal/Denial Edit
CT  Claims Tracking Edit
HC  Health Care Services Review (HCSR) 278 Response
HW  Health Care Services Review (HCSR) Worklist
IC  Inquire to Claims Tracking
IR  Insurance Review Edit
RM  Reports Menu (Claims Tracking) ...
SM  Supervisors Menu (Claims Tracking) ...
SP  Single Patient Admission Sheet
TP  Third Party Joint Inquiry

Select Claims Tracking Menu (Hospital Reviews) <TEST ACCOUNT> Option:

5. Claims Tracking Menu (Combined Functions) ...

This menu combines many of the Claims Tracking options including the Supervisors Menu and the Claims Tracking parameters. This menu would be appropriate for a supervisory RUR Nurse or a RUR Nurse with multiple duties or a Billing Supervisor.

5.1. 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, sorted by ward, patient, assignment or date, should be printed and used 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 on the day they are added. Please refer to the Insurance Reviews and Hospital Reviews option documentation for information on when reviews are automatically created.

The following screens show the actions accessed through this option and the actions available on each subsequent screen:

Pending Reviews

<table>
<thead>
<tr>
<th>QE  Quick Edit</th>
<th>IR  Ins. Reviews</th>
<th>RL  Remove from List</th>
</tr>
</thead>
<tbody>
<tr>
<td>VE  View/Edit Entry</td>
<td>SC  SC Conditions</td>
<td>DU  Diagnosis Update</td>
</tr>
<tr>
<td><strong>CT  Claims Tracking Edit</strong></td>
<td>CS  Change Status</td>
<td>PU  Procedure Update</td>
</tr>
<tr>
<td>PW  Print Worksheet</td>
<td>CD  Change Date Range</td>
<td>PV  Provider Update</td>
</tr>
</tbody>
</table>

Expanded Claims Tracking Entry

<table>
<thead>
<tr>
<th>BI  Billing Info Edit</th>
<th>IR  Insurance Reviews</th>
<th>PV  Provider Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>RI  Review Info</td>
<td>DU  Diagnosis Update</td>
<td>EX  Exit</td>
</tr>
<tr>
<td>TA  Treatment Auth.</td>
<td>PU  Procedure Update</td>
<td></td>
</tr>
</tbody>
</table>
### Notes:

- 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.

#### 5.1.1. 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).
5.1.2. 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 MCCN 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 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 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 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.

5.1.3. Pending Reviews Screen

The following actions are available from the 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.

5.1.4. **Expanded Claims Tracking Entry Screen**

The following actions are available from the Expanded Claims Tracking 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.

5.1.5. **Insurance Reviews/Contacts Screen**

The following actions are available from the Insurance Reviews/Contacts screen:

- **Add Ins. Review** - This action will add a new review for the visit. The default Review Types are:
  - Pre-admission Certification Review (a scheduled admission with no previous review)
  - Urgent/Emergent Admission Review (a scheduled admission with no previous review)
  - Continued Stay Review (for follow-up reviews)
  - Other available Review Types are:
    - DISCHARGE REVIEW
    - INPT RETROSPECTIVE REVIEW
    - OPT RETROSPECTIVE REVIEW
    - OTHER
    - OUTPATIENT TREATMENT
PATIENT
SNF/NHCU REVIEW
SUBSEQUENT APPEAL

- **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.

### 5.1.6. Expanded Insurance Reviews

The following actions are available from the Expanded Insurance Reviews screen:

- **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. Note: From this instance of the Patient Insurance Screen users may not add, edit, or delete Patient Policy Comments. It is in view only mode. For more detailed information on Patient Insurance Menu, refer to the IB V. 2.0 User Manual.

### 5.1.7. Hospital Reviews Screen

The following actions are available from the 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 was not 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.

### 5.1.8. Expanded Hospital Reviews Screen

The following actions are available from the 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 RUR purposes on days 3, 6, 9, 14, 21, 28, and every 7 days thereafter. Usually, the INTERQUAL method is used as
the methodology for RUR required reviews. 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

### 5.2. Claims Tracking Edit

This option allows you to access the Claims Tracking Editor for a selected patient. From this option, you can do the following additional tasks:

- Delete the tracking entry
- Edit the entry
- Assign the hospital review to a particular user
- Edit billing information
- View or add ROI

**Sample Screen**

```
Claims Tracking Editor          Oct 22, 2014@10:53:42          Page:  l of  1
Claims Tracking Entries for: IB,PATIENT 1 IXXXX
                          for Visits beginning on: 10/22/13 to 11/05/14
                         Type Urgent Date  Ins.  UR    ROI          Bill Ward
                          1  *INPT.   NO      10/21/14 1:22 pm YES                       YES   C MEDICI

Service Connected: NO   *=Current Admission                     >>>
DT Delete Tracking Entry SC SC Conditions    VP  View Pat. Ins.
QE Quick Edit          AE Appeals Edit  RO ROI Consent
AC Assign Case         CP Change Patient    EX Exit
BI Billing Info Edit   CD Change Date Range
VE View/Edit Episode   DU Diagnosis Update
HR Hospital Reviews    PU Procedure Update
Select Action: Quit/
```

### 5.3. 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.

### 5.4. 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 on which the next review is required. It will then appear in the Pending Reviews option.

The following screens show the actions accessed through this option and the actions available on each subsequent screen:

<table>
<thead>
<tr>
<th>Insurance Reviews/Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>AI Add Ins. Review</td>
</tr>
<tr>
<td>DR Delete Ins. Review</td>
</tr>
<tr>
<td>CS Change Status</td>
</tr>
<tr>
<td>QE Quick Edit</td>
</tr>
<tr>
<td>VE View/Edit Ins. Review</td>
</tr>
<tr>
<td>SC SC Conditions</td>
</tr>
<tr>
<td>AE Appeals Edit</td>
</tr>
<tr>
<td>AC Add Comment</td>
</tr>
<tr>
<td>DU Diagnosis Update</td>
</tr>
<tr>
<td>FU Procedure Update</td>
</tr>
<tr>
<td>PV Provider Update</td>
</tr>
<tr>
<td>RW Review Wksheet Print</td>
</tr>
<tr>
<td>CP Change Patient</td>
</tr>
<tr>
<td>EX Exit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expanded Insurance Reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA Appeal Address</td>
</tr>
<tr>
<td>CI Contact Info</td>
</tr>
<tr>
<td>CS Change Status</td>
</tr>
<tr>
<td>IU Ins. Co. Update</td>
</tr>
<tr>
<td>AI Action Info</td>
</tr>
<tr>
<td>AC Add Comments</td>
</tr>
<tr>
<td>VP View Pat. Ins.</td>
</tr>
<tr>
<td>DU Diagnosis Update</td>
</tr>
<tr>
<td>FU Procedure Update</td>
</tr>
<tr>
<td>PV Provider Update</td>
</tr>
<tr>
<td>RW Review Wksheet Print</td>
</tr>
<tr>
<td>EX Exit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appeal and Denial Tracking</th>
</tr>
</thead>
<tbody>
<tr>
<td>VE View Edit Entry</td>
</tr>
<tr>
<td>QE Quick Edit</td>
</tr>
<tr>
<td>AA Add Appeal</td>
</tr>
<tr>
<td>DA Delete Appeal/Denial</td>
</tr>
<tr>
<td>SC SC Conditions</td>
</tr>
<tr>
<td>IC Ins. Co. Edit</td>
</tr>
<tr>
<td>EX Exit</td>
</tr>
</tbody>
</table>

5.4.1. 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).

5.4.2. 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 International Classification of Diseases (ICD) 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 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.

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.

### 5.4.3. Insurance Reviews/Contacts

The following actions are available from the Insurance Reviews/Contacts screen:

• **Add Ins. Review** - This action will add a new review for the visit. The default Review Types are:
  - Pre-admission Certification Review (a scheduled admission with no previous review)
  - Urgent/Emergent Admission Review (a scheduled admission with no previous review)
  - Continued Stay Review (for follow-up reviews)
  - Other available Review Types are:
    - DISCHARGE REVIEW
    - INPT RETROSPECTIVE REVIEW
    - OPT RETROSPECTIVE REVIEW
    - OTHER
    - OUTPATIENT TREATMENT
    - PATIENT
    - SNF/NHCU REVIEW
    - SUBSEQUENT APPEAL

• **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 can be appealed. This action is not available on the Claims Tracking for Hospital Reviews option.
- **Change Patient** - This action allows you to change to another patient without going back to the beginning of the option.

### 5.4.4. Expanded Insurance Reviews

The following actions are available from the Expanded Insurance Reviews screen:

- **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. Note: From this instance of the Patient Insurance Screen users may not add, edit, or delete Patient Policy Comments. It is in view only mode. For more detailed information on Patient Insurance Menu, refer to the IB V. 2.0 User Manual.

### 5.4.5. Appeal and Denial Tracking Screen

The following actions are available from the 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.

*Note:* 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 previous pages.

- **Edit Pt. Ins.** - This action brings you to the Patient Insurance Screen. Note: From this instance of the Patient Insurance Screen users may add, edit, or delete Patient Policy Comments. For more detailed information on Patient Insurance Menu, refer to the IB V. 2.0 User Manual.

### 5.5. 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> (e.g., 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 and 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 shows the Claims Tracking Screens accessed through this option and the actions available on each screen:

<table>
<thead>
<tr>
<th>Appeals and Denial Tracking</th>
</tr>
</thead>
<tbody>
<tr>
<td>VE View Edit Entry</td>
</tr>
<tr>
<td>DA Delete Appeal/Denial</td>
</tr>
<tr>
<td>IC Ins. Co. Edit</td>
</tr>
<tr>
<td>QE Quick Edit</td>
</tr>
<tr>
<td>SC SC Conditions</td>
</tr>
<tr>
<td>EX Exit</td>
</tr>
<tr>
<td>AA Add Appeal</td>
</tr>
<tr>
<td>PI Patient Ins. Edit.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expanded Appeals/Denials</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA Appeal Address</td>
</tr>
<tr>
<td>Al Action Info</td>
</tr>
<tr>
<td>EX Exit</td>
</tr>
<tr>
<td>CI Contact Info</td>
</tr>
<tr>
<td>AC Add Comment</td>
</tr>
<tr>
<td>TU Ins. Co. Update</td>
</tr>
</tbody>
</table>

5.5.1. 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.

5.5.2. Appeal and Denial Tracking Screen

The following actions are available from the 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.
5.5.3. **Expanded Appeals/Denials Screen**

The following actions are available from the Expanded Appeals/Denials screen:

- **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.

5.6. **Inquire to Claims Tracking**

This option is used to 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.

The following screen is an example of what is displayed for a patient using the Inquire to Claims Tracking option:
### 5.7. Supervisors Menu (Claims Tracking)...

#### 5.7.1. Manually Add Opt. Encounters to Claims Tracking

Outpatient encounters that have been checked out through the Scheduling module are normally added when the IB nightly background job is run. Only primary outpatient encounters that have
been processed using the Check Out option of the Scheduling module are 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 to 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 to run in the background 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 execution 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 [#204668]
10/22/14@15:52  13 lines
From: INTEGRATED BILLING PACKAGE In 'IN' basket. Page 1
--------------------------------------------------
The process to automatically add Opt Encounters has successfully completed.

        Start Date: 05/01/09
        End Date: 05/02/09

        Total Encounters Checked: 1214
        Total Encounters Added: 0
        Total Non-billable Encounters Added: 0

*The SC, Agent Orange, Southwest Asia, Ionizing Radiation, Military Sexual Trauma, Head Neck Cancer, Combat Veteran and Project 112/SHAD status visits have been added for insured patients but automatically indicated as not billable.

Enter message action (in IN basket): Ignore//
```

**5.7.2. Claims Tracking Parameter Edit**

This option allows you to edit the MCCR Site Parameters that affect the Claims Tracking module. The parameters can also be edited in the option, MCCR Site Parameters.
Sample Screen

<table>
<thead>
<tr>
<th>Claims Tracking Parameter Enter Edit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initialization Date: 01/01/94</td>
</tr>
<tr>
<td>Use Admission Sheet: NO</td>
</tr>
<tr>
<td>Header line 1: CHEYENNE VAMC</td>
</tr>
<tr>
<td>Header line 2: 2360 E. PERSHING BLVD</td>
</tr>
<tr>
<td>Header line 3: CHEYENNE, WY</td>
</tr>
<tr>
<td>Track Inpatient: INSURED AND UR ONLY</td>
</tr>
<tr>
<td>Track Outpatient: INSURED ONLY</td>
</tr>
<tr>
<td>Track Rx: INSURED ONLY</td>
</tr>
<tr>
<td>Track Prosthetics: INSURED ONLY</td>
</tr>
<tr>
<td>Reports can Add CT: YES</td>
</tr>
<tr>
<td>Medicine Sample: 5</td>
</tr>
<tr>
<td>Surgery Sample: 5</td>
</tr>
<tr>
<td>Medicine Admissions: 5</td>
</tr>
<tr>
<td>Surgery Admissions: 5</td>
</tr>
<tr>
<td>Psych Sample: 1</td>
</tr>
<tr>
<td>Psych Admissions: 5</td>
</tr>
</tbody>
</table>

INSURANCE EXTENDED HELP: ON//
CLAIMS TRACKING START DATE: JAN 1,1994//
INPATIENT CLAIMS TRACKING: INSURED AND UR ONLY//
OUTPATIENT CLAIMS TRACKING: INSURED ONLY//
PRESCRIPTION CLAIMS TRACKING: INSURED ONLY//
PROSTHETICS CLAIMS TRACKING: INSURED ONLY//
REPORTS ADD TO CLAIMS TRACKING: YES//
USE ADMISSION SHEETS: NO//
MEDICINE SAMPLE SIZE: 5//
MEDICINE WEEKLY ADMISSIONS: 5//
SURGERY SAMPLE SIZE: 5//
SURGERY WEEKLY ADMISSIONS: 5//
PSYCH SAMPLE SIZE: 1//
PSYCH WEEKLY ADMISSIONS: 5//
Inquiry can be Triggered for Appointment: 14
Inquiry can be Triggered for Admission: 0
Days to wait to purge entry on HCSR Response: 20

The 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

- **Claims Tracking Start Date**
  If you choose to run the Claims Tracking module and populate the files with past episodes of care, this is the earliest visit date for which the Claims Tracking software will automatically add visits.

- **Inpatient Claims Tracking**
  This field determines which inpatients will automatically be added to the Claims Tracking module. It is recommended that this field be 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, Service Connected (SC) care for example, or there is a visit date associated with that prescription or refill, this will be noted in the reason not billable.

It is recommended that this field be 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

- **Prosthetic Claims Tracking**

This field will be used to determine if issuance of 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 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 the flagging of these visits as unbillable so that they can be removed from these reports.

- **Use Admission Sheets**

Indicate whether your facility is using Admission Sheets as part of the MCCR/UR functionality. If the answer to this parameter is YES, users will be asked for the device to which admissions sheets are printed. A default device can be defined in the BILL FORM TYPE file.
- **Admission Sheet Header Line 1**
Enter the text that your facility would like to print as the first line of the header on the admission sheet. This is usually the name of your medical center.

- **Admission Sheet Header 2**
Enter the text that your facility would like to print 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 print 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 Quality Assurance (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.

- Inquiry can be Triggered for Appointments

This is the number of days after the creation of an HCSR Worklist entry from an appointment to wait before automatically triggering an X12N Health Care Services Review – Request for Review and Response (278).

- Inquiry can be Triggered for Admissions

This is the number of days after the creation of an HCSR Worklist entry from an admission to wait before automatically triggering an X12N Health Care Services Review – Request for Review and Response (278).

- Days to wait to purge entry on HCSR Response

This is the number of days an HCSR Transmission entry with a completed response status will remain on the HCSR Response Worklist.

5.7.3. Manually Add Rx Refills to Claims Tracking

Prescription refills that have been released within ten days of the fill date are automatically added to Claims Tracking when the IB MT NIGHT COMP task is run. This option allows you to search for refills that were not released within ten days of the fill date 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 to run in the background 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

<table>
<thead>
<tr>
<th>Subject: Rx Refills added to Claims Tracking Complete</th>
<th>$114894</th>
<th>02 Feb 94 08:52</th>
</tr>
</thead>
<tbody>
<tr>
<td>From: INTEGRATED BILLING PACKAGE in 'IN' basket.</td>
<td>Page 1 <strong>NEW</strong></td>
<td></td>
</tr>
</tbody>
</table>

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)\

5.7.4. Reports Menu (Claims Tracking)...

The following is a list of the reports available through the Reports Menu (Claims Tracking):
• **278 Statistical Volume Report**

This report is used to monitor the X12 278 transaction process including statistics based on outgoing request, inquiry and incoming responses of authorization received, pending received and rejection received. You can print a statistical report based on the following:

- Report by Staff (All Staff Members or Selected Staff Members)
- Report by Patient (All Patients or Selected Patient)
- Report by Date Range

**Sample Report**

```
278 Statistical Volume Report  Nov 10, 2015@00:57:39  Page: 1
Sort by: Staff

Report Timeframe:
03/01/2015 - 11/10/2015
All Staff

<table>
<thead>
<tr>
<th>Staff</th>
<th>Date</th>
<th>#278s</th>
<th>#217</th>
<th>#215</th>
<th>#215</th>
<th>#Auth</th>
<th>#Rej</th>
<th>#Pend</th>
<th>AAA</th>
<th>Await</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB, STAFF 1</td>
<td>03/05/15</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>IB, STAFF 1</td>
<td>03/26/15</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>IB, STAFF 1</td>
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<td>3</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IB, STAFF 1</td>
<td>04/02/15</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
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<td>04/27/15</td>
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<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IB, STAFF 1</td>
<td>09/09/15</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IB, STAFF 1</td>
<td>11/04/15</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total
---
12 12 0 0 1 1 1 1 0 9
```

```
278 Statistical Volume Report  Nov 10, 2015@00:57:39  Page: 2
Sort by: Staff

Report Timeframe:
03/01/2015 - 11/10/2015
All Staff

<table>
<thead>
<tr>
<th>Staff</th>
<th>Date</th>
<th>#278s</th>
<th>#217</th>
<th>#215</th>
<th>#215</th>
<th>#Auth</th>
<th>#Rej</th>
<th>#Pend</th>
<th>AAA</th>
<th>Await</th>
</tr>
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<tbody>
<tr>
<td>IB, STAFF 1</td>
<td>03/05/15</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>IB, STAFF 1</td>
<td>03/26/15</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>IB, STAFF 1</td>
<td>03/31/15</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IB, STAFF 1</td>
<td>04/02/15</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
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<td>04/27/15</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IB, STAFF 1</td>
<td>08/04/15</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IB, STAFF 1</td>
<td>09/09/15</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IB, STAFF 1</td>
<td>11/04/15</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total
---
12 12 0 0 1 1 1 1 0 9
```
**278 Certification Report**

This report provides information based on the X12 278 transaction based on the outgoing request, inquiry and incoming responses with all types of certification. You can print a certification report based on the following:

- Report by Payer (All Payers or Selected Payers)
- Report by Staff (All Staff Members or Selected Staff Members)
- Report by Patient (All Patients or Selected Patient)
- Report by Date Range

This report is formatted to print 132 columns.
### Sample Report

<table>
<thead>
<tr>
<th>Payer</th>
<th>#278s</th>
<th>#A1</th>
<th>#A2</th>
<th>#A6</th>
<th>#A4</th>
<th>#A3</th>
<th>#C</th>
<th>CT</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>AETNA US HEALTHCARE</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BLUE CROSS/BS WY</td>
<td>4</td>
<td>1</td>
<td></td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CIGNA</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

*** END OF REPORT ***
• 278 Deletion Disposition Report

This report provides information on the deleted entries. You can print a deletion disposition report based on the following:

- Report by Staff (All Staff Members or Selected Staff Members)
- Report by Patient (All Patients or Selected Patient)
- Report by Date Range

Sample Report

<table>
<thead>
<tr>
<th>Staff</th>
<th>Date</th>
<th>#278s Submitted</th>
<th>#Delete Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB,STAFF 1</td>
<td>11/02/15</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>IB,STAFF 1</td>
<td>10/14/15</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

*** END OF REPORT ***

• Print CT Summary for Billing

You can print a Claims Tracking Summary which can be used for preparation of a bill/claim. The content of the summary is based upon the type of Claims Tracking event.

Sample Report 1 – Inpatient Admission

<table>
<thead>
<tr>
<th>IB,PATIENT 78</th>
<th>XX-XX-XXXX</th>
<th>DOB: XXX XX, XXXX</th>
</tr>
</thead>
<tbody>
<tr>
<td>INPATIENT ADMISSION on XXX XX, XXXX@13:22:16</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Visit Information
- Visit Type: INPATIENT ADMISSION
- Visit Billable: YES
- Admission Date: XXX XX, XXXX@13:22:16
- Second Opinion: NOT REQUIRED
- Ward: C MEDICINE
- Auto Bill Date: XXX XX, XXXX
- Specialty: MEDICINE
- Special Consent: ROI NOT DETERMINED
- Discharge Date: Special Billing:

Insurance Information
- Ins. Co 1: AETNA US HEALTHCARE
- Subsc.: IB,PATIENT 78
- Subsc. ID: WXXXXXX
- Coord Ben: SECONDARY
- Pre-Cert Phone: 800/523-7978
- Type: COMPREHENSIVE MAJO
- Group: GRP NUM 8802
- Billing Phone: 800/523-7978

Filing Time Fr: Claims Phone: 800/523-7978

Group Plan Comments:

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

---

Claims Tracking
User Guide

29 August 2016
Eligibility Information
Primary Eligibility: NSC, VA PENSION
Means Test Status: Service Connected Percent: Patient Not Service Connected

Diagnosis Information
Nothing on File

Associated Interim DRG Information
Nothing on File

Procedure Information
Nothing on File

Provider Information
Nothing on File

Insurance Review Information
Type Review: CONTINUED STAY REVIEW Review Date: XX/XX/XX@1:41 pm
Action: DENIAL Insurance Co.: AETNA US HEALTHCARE
Denied From: XX/XX/XX Person Contacted:
Denied To: XX/XX/X Contact Method: PHONE
Denial Reasons: FAILURE TO MEET PAYER Call Ref. Number:
Status: PENDING
Last Edited By: UR,NURSE
Comment:

Type Review: URGENT/EMERGENT ADMIT Review Date: XX/XX/XX
Action:
Insurance Co.: AETNA US HEALTHCARE
Person Contacted:
Contact Method:
Call Ref. Number:
Status: ENTERED
Last Edited By:
Comment:

Sample Report 2 – Prescription Refill

Bill Preparation Report Page 1  Oct 23, 2014@15:10:38
IB,PATIENT 37 XX-XX-XXXX DOB: XXX XX, XXXX
PRESCRIPTION REFILL on Jan 13, 2011

Visit Information
Visit Type: PRESCRIPTION REFILL Visit Billable: NO-NO PHARMACY COVE
Prescription #: XXXXXXX Second Opinion: NOT REQUIRED
Refill Date: XXX XX, XXXX Auto Bill Date:
Drug: LISINOPRIL 20MG TAB Special Consent: ROI NOT DETERMINED
Quantity: 90 Special Billing:
Days Supply: 90
NDC#: 00904-5809-89
Physician: IB,DOCTOR C

Insurance Information
Ins. Co 1: NORTHWEST ADMINISTRATOR Pre-Cert Phone: 800/872-5439
Subsc.: IB,PATIENT 37 Type: RETIREE
Subsc. ID: XXXXXXXX Group: GRP NUM 13377
Group Plan Comments:

PER NOTE, EFF 090103 ALL RX ARE PD @ 20% UNDER MEDICAL PLAN. SAYS SHOULD‘VE NEVER PROCESSED UNDER PRESCRIPTION PLAN.

POLICY PAYS 70% MEDICARE INPT DEDUCTIBLE.

HAS RX COVERAGE. EFF 010196, NO RX DEDUCTIBLE. INSURANCE WILL REIMBURSE A MAXIMUM 34-DAY SUPPLY. LARGER AMTS REIMBURSE 0--DON‘T BILL UNLESS THE RX MEETS THIS CRITERIA. 051598: RX PAY @ 20% ALLOWABLE AFTER DEDUCTIBLE. NO COVERAGE FOR ASCORBIC ACID 500 MG, NUTRITION SUPPL ENSURE,

SMOKING DETERRENTS, MULTIVITAMIN/MINERALS CAP/TAB 011200: PER APRIL, THIS POLICY WILL COVER RX 20% ALLOWABLE AFTER DEDUCTIBLE; HOWEVER, CLMS APPEAR TO BE PAYING IN EXCESS OF THAT. DIABETIC & OTHER SUPPLIES ARE COVERED.

122700: PER TAUSHA, EFFECT. 100100 VA IS CONSIDERED IN-NETWORK AND WE WILL BE REIMBURSED 60% ON BRAND NAME RX. INS WILL TAKE $8 COPAY OUT OF OUR REIMBURSEMENT ON GENERIC RX FOR IN-NETWORK. PRIOR TO THAT DATE VA WAS CONSIDERED OUT-OF-NETWORK AND OUR REIMBURSEMENT SHOULD'VE BEEN 50% FOR BRAND NAME RX. THERE IS NO RX DEDUCTIBLE.

NO ROUTINE CARE INCL VISION. NO PRECERT REQ'D VERIFIED W/BLAINE 013098.

WHEN BILLING ANESTHESIA, INCL TIME PER DEE-DEE 032400.
### Inquire to Claims Tracking

You can 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.

The following information is displayed:

- Visit,
- Billing
- Insurance information
- Reviews performed

**Note:** This report does not contain the word processing fields from the reviews.

## Sample Report

<table>
<thead>
<tr>
<th>Claim Tracking Inquiry</th>
<th>Page 1</th>
<th>Jan 14, 1994@15:55:54</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB, PATIENT 1</td>
<td>XX-XX-XXXX</td>
<td>DOB: XX, XX, XXXX</td>
</tr>
<tr>
<td>INPATIENT ADMISSION on XXX XX, XXXX@09:30:35</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Visit Information**

- Visit Type: INPATIENT ADMISSION
- Visit Billable: YES
- Admission Date: XXX XX, XXXX@09:30:35
- Second Opinion: NOT REQUIRED
- Ward: 11-B MEDICINE XREF
- Auto Bill Date: 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: $

**Insurance Review Information**

- Type Review: INITIAL APPEAL
- Review Date: XX/XX/XX
- Appeal Type: ADMINISTRATIVE
- Review Date: Insurance Co.: IB INS. CO. 30
- Case Status: OPEN
- Person Contacted: UMO, CONTACT
- No Days Pending: 3
- Contact Method: Letter
- Final Outcome: Call Ref. Number:
  - Status: COMPLETE
  - Last Edited By: 

- Type Review: CONTINUED STAY REVIEW
- Review Date: XX/XX/XX
- Action: DENIAL
- Insurance Co.: IB INS. CO. 1
- Denied From: XX/XX/XX
- Person Contacted: SPOUSE
- Denied To: XX/XX/XX
- Contact Method: PHONE
- Denied Reasons: NOT MEDICALLY NECESSARY
- Call Ref. Number: XXXXXXXX
- Status: COMPLETE
- Last Edited By: UR, NURSE

- Type Review: URGENT/EMERGENT ADMIT
- Review Date: XX/XX/XX
- Action: APPROVED
- Insurance Co.: IB INS. CO. 14
- Authorized From: XX/XX/XX
- Person Contacted: UMO, CONTACT
- Authorized To: XX/XX/XX
- Contact Method: VOICE MAIL
- Authorized Diag: 259.0 - DELAY SEXUAL D
- Call Ref. Number: XXXXXXXX
- Auth. Number: 88889354A
- Status: COMPLETE
- Last Edited By: UR, NURSE

| TRAUMATIC ARTHRITIS | 10% |
| POST-TRAUMATIC STRESS DISORDER | 30% |
| TRAUMATIC ARTHRITIS | 10% |
| TRAUMATIC ARTHRITIS | 10% |
Days Denied Report

You can print a summary or a detailed listing of denials. The report can be sorted by the following:

- 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.

The detail section includes the following:

- Inpatient Admission's Service, which is the Service the patient was under at either the admission, if that date is included in the report, or the Service the patient was under on the begin date of the report. This Service is used to provide the summary.

- The Amount Denied is also displayed for each denied stay in the detail section. The Amount Denied is either the full charge of the admission, if the entire admission was denied and the entire stay is within the date range of the report, or an average charge based on the full charge and the number of denied days on the report, if only a partial denial. The charges displayed as the Amount Denied are the current active charges per Reasonable Charges.

This report is formatted to print 132 columns.
### MCCR/UR DENIED DAYS INPATIENT Denials Dated Jan 01, 2005 to Jan 01, 2006

<table>
<thead>
<tr>
<th>Patient</th>
<th>PtID</th>
<th>Dates of Care</th>
<th>Attending</th>
<th>Dates Denied</th>
<th>Denial Reason</th>
<th>Appealed</th>
<th>Days Approved</th>
<th>SRVS</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB,PATIENT 1</td>
<td>XXXX</td>
<td>01/24/05 to 520634204</td>
<td>ALL (3)</td>
<td>OBSERVATION IS MORE APPRO</td>
<td>NO</td>
<td>0</td>
<td>SURG</td>
<td>$19,224</td>
<td></td>
</tr>
<tr>
<td>IB,PATIENT 23</td>
<td>XXXX</td>
<td>02/24/05 to 02/28/05</td>
<td>ALL (4)</td>
<td>NOT MEDICALLY NECESSARY</td>
<td>YES</td>
<td>2</td>
<td>NHCU</td>
<td>$12,777</td>
<td></td>
</tr>
<tr>
<td>IB,PATIENT 54</td>
<td>XXXX</td>
<td>12/27/04 to 520629761</td>
<td>ALL (1)</td>
<td>NOT MEDICALLY NECESSARY</td>
<td>NO</td>
<td>0</td>
<td>NHCU</td>
<td>$629</td>
<td></td>
</tr>
<tr>
<td>IB,PATIENT 6</td>
<td>XXXX</td>
<td>09/13/05 to 520644029</td>
<td>ALL (2)</td>
<td>NOT MEDICALLY NECESSARY</td>
<td>NO</td>
<td>0</td>
<td>MEDI</td>
<td>$13,109</td>
<td></td>
</tr>
</tbody>
</table>

### MCCR/UR DENIED DAYS OUTPATIENT Denials Dated Jan 01, 2005 to Jan 01, 2006

<table>
<thead>
<tr>
<th>Patient</th>
<th>PtID</th>
<th>Episode Date</th>
<th>Outpatient Treatment</th>
<th>Appealed</th>
<th>Approved</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB,PATIENT 7</td>
<td>XXXX</td>
<td>12/25/05@13:20</td>
<td>OPT OPHTHALMOLOGY ST</td>
<td>NO</td>
<td>NO</td>
<td>$0</td>
</tr>
<tr>
<td>IB,PATIENT 288</td>
<td>XXXX</td>
<td>10/9/05@08:30</td>
<td></td>
<td>YES</td>
<td>YES</td>
<td>$126</td>
</tr>
<tr>
<td>IB,PATIENT 67</td>
<td>XXXX</td>
<td>10/17/05@15:54</td>
<td>Physical Therapy</td>
<td>NO</td>
<td>NO</td>
<td>$0</td>
</tr>
</tbody>
</table>

### MCCR/UR DENIED DAYS PROSTHETIC Denials Dated Jan 01, 2005 to Jan 01, 2006

<table>
<thead>
<tr>
<th>Patient</th>
<th>PtID</th>
<th>Episode Date</th>
<th>Outpatient Treatment</th>
<th>Appealed</th>
<th>Approved</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB,PATIENT 23</td>
<td>XXXX</td>
<td>1/27/05</td>
<td>Av Prosth Auto Blood</td>
<td>NO</td>
<td>NO</td>
<td>$25</td>
</tr>
<tr>
<td>IB,PATIENT 1</td>
<td>XXXX</td>
<td>10/1/05</td>
<td>Delivery/Labor</td>
<td>NO</td>
<td>NO</td>
<td>$150</td>
</tr>
</tbody>
</table>

### MCCR/UR DENIED DAYS PRESCRIPTION Denials Dated Jan 01, 2005 to Jan 01, 2006

<table>
<thead>
<tr>
<th>Patient</th>
<th>PtID</th>
<th>Episode Date</th>
<th>Outpatient Treatment</th>
<th>Appealed</th>
<th>Approved</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB,PATIENT 6</td>
<td>XXXX</td>
<td>1/27/05</td>
<td>Av RxFill #: 7399X89</td>
<td>NO</td>
<td>NO</td>
<td>$0</td>
</tr>
<tr>
<td>IB,PATIENT 45</td>
<td>XXXX</td>
<td>10/7/05</td>
<td>Rx #: 76699X9</td>
<td>NO</td>
<td>NO</td>
<td>$45</td>
</tr>
</tbody>
</table>

### MCCR/UR DENIED DAYS Summary Report for Reviews Dated Jan 01, 2005 to Jan 01, 2006

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
<th>Days Denied</th>
<th>Days Approved</th>
<th>Days won</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denials</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount</td>
<td>$24</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days won</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Number</td>
<td>Amount</td>
<td>Denied</td>
<td>Appealed</td>
</tr>
<tr>
<td>----------------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>----------</td>
</tr>
<tr>
<td>MEDICINE</td>
<td>1</td>
<td>2</td>
<td>$13,109</td>
<td>0</td>
</tr>
<tr>
<td>NHCU</td>
<td>2</td>
<td>5</td>
<td>$2,839</td>
<td>2</td>
</tr>
<tr>
<td>SURGERY</td>
<td>1</td>
<td>3</td>
<td>$19,224</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OUTPATIENT</td>
<td>3</td>
<td>$126</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>PRESCRIPTION</td>
<td>2</td>
<td>$45</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PROSTHETICS</td>
<td>2</td>
<td>$175</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
**MCCR/UR Summary Report**

You can print a summary of hospital activity by either admission or discharge for a specified date range. A Penalty Report is included and, if appropriate, a Days Approved Report, and a Days Denied Report. These are sorted by specialty.

**Sample Report**

```
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**

You can print a list of visits based on the following:

- Insurance Review,
- Hospital Review
- Both

Only inpatient admission visits are included in the report. This report can be used to list the random sample cases being tracked for hospital reviews by selecting only hospital reviews for admissions.

**Sample Output**

<table>
<thead>
<tr>
<th>PATIENT</th>
<th>PT. ID</th>
<th>WARD</th>
<th>TYPE</th>
<th>DATE</th>
<th>CASE</th>
<th>CASE</th>
<th>COND.</th>
<th>CASE</th>
<th>REVIEWER</th>
<th>INS REVIEWER</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB, PATIENT 2</td>
<td>XX-XX-XXXX</td>
<td>8C ORTHO S</td>
<td>ADMIT</td>
<td>FEB 7,1994</td>
<td>YES</td>
<td>YES</td>
<td></td>
<td></td>
<td>UR, NURSE</td>
<td></td>
</tr>
<tr>
<td>IB, PATIENT 52</td>
<td>XX-XX-XXXX</td>
<td>SCH ADM.</td>
<td>FEB 4,1994</td>
<td>YES NO</td>
<td>COPD NO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>UR, NURSE</td>
</tr>
<tr>
<td>IB, PATIENT 111</td>
<td>XX-XX-XXXX</td>
<td>OUTPT</td>
<td>FEB 11,1994</td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>UR, NURSE</td>
<td></td>
</tr>
<tr>
<td>IB, PATIENT 77</td>
<td>XX-XX-XXXX</td>
<td>7A (NHCU)</td>
<td>ADMIT</td>
<td>FEB 7,1994 NO YES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>UR, NURSE</td>
<td></td>
</tr>
<tr>
<td>IB, PATIENT 9</td>
<td>XX-XX-XXXX</td>
<td>11-B MEDIC</td>
<td>ADMIT</td>
<td>JAN 12,1994 YES YES NONE NO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>UR, NURSE</td>
<td></td>
</tr>
</tbody>
</table>

---

**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 Worksheet**

```plaintext
<table>
<thead>
<tr>
<th>Date</th>
<th>Diagnosis</th>
<th>Procedure</th>
<th>DRG</th>
<th>LOS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Insurance Contact: ________________________ Phone: ____________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Comments (#day approved, next review date, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reviewer: ________________________ Date: ____________________
```
• **Scheduled Admissions w/Insurance**

You can print 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 132 columns.

**Sample Report**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Pt. ID</th>
<th>Adm. Date</th>
<th>Billable</th>
<th>Ward</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB, PATIENT 33</td>
<td>XX-XX-XXXX</td>
<td>XX/XX/XX 1:00 pm</td>
<td>YES</td>
<td>5D SURG</td>
<td>SCHEDULED</td>
</tr>
<tr>
<td>IB, PATIENT 33</td>
<td>XX-XX-XXXX</td>
<td>XX/XX/XX 2:40 pm</td>
<td>YES</td>
<td>9D MED</td>
<td>SCHEDULED</td>
</tr>
<tr>
<td>IB, PATIENT 33</td>
<td>XX-XX-XXXX</td>
<td>XX/XX/XX 11:40 pm</td>
<td>YES</td>
<td>2D CARD</td>
<td>SCHEDULED</td>
</tr>
<tr>
<td>IB, PATIENT 33</td>
<td>XX-XX-XXXX</td>
<td>XX/XX/XX 10:11 am</td>
<td>NO</td>
<td>4a nurs</td>
<td>SCHEDULED</td>
</tr>
<tr>
<td>IB, PATIENT 33</td>
<td>XX-XX-XXXX</td>
<td>XX/XX/XX 9:00 am</td>
<td>YES</td>
<td>9D MED</td>
<td>SCHEDULED</td>
</tr>
<tr>
<td>IB, PATIENT 33</td>
<td>XX-XX-XXXX</td>
<td>XX/XX/XX 2:52 pm</td>
<td>YES</td>
<td>2B ICU</td>
<td>SCHEDULED</td>
</tr>
</tbody>
</table>

TOTAL = 6
• **Single Patient Admission Sheet**

You can 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 Worksheet**

```
ADMISSION SHEET
ALBANY VAMC
113 HOLLAND AVE
ALBANY, NY

Patient: IB, PATIENT 456
Pt ID: XX-XX-XXXX
Dob: XX XX, XXXX
SC: YES - 20%
Sex: MALE

Address: 123 TEST ST.
Pt ID: XX-XX-XXXX
Dob: XX XX, XXXX
SC: YES - 20%

---
Adm. Date: XXX XX, XXXX
Adm. Type: URGENT
Provider: IB, PATIENT 456
Specialty: MEDICINE
Ward: 11-B MEDICINE
Room/Bed: 
Adm. Diag: 466.0 - ACUTE BRONCHITIS

---
Employer: 
Phone: 
E-Cont.: 
Phone: 

---
Ins. Co 1: IB INS. CO, 44
Subsc.: IB, PATIENT 456
Subsc. ID: WXXXXXXX
Phone: 555-555-4312
Type: MAJOR MEDICAL EXPENS
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: IB, PATIENT 456           XX-XX-XXXX                     Printed: XXX XX, XXXX@13:18
```
**Pending Work Report**

You can print a Pending Work List similar to the Pending Reviews option.

The report can be sorted by the following:

- Assigned to
- Due Date,
- Patient,
- Type of Review
- Current Ward

You can print the report for either Insurance Reviews, Hospital Reviews, or both. 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 132 columns.

**Sample Report**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Pt. ID</th>
<th>Ward</th>
<th>Review Type</th>
<th>Due Date</th>
<th>Status</th>
<th>Assigned to</th>
<th>Visit Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB,PATIENT 22</td>
<td>XXXX</td>
<td>8C ORTHO SU Hosp Review-Admission</td>
<td>XX/XX/XX ENTERED UR,NURSE</td>
<td>ADMIT 02/07/94 2:42 pm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IB,PATIENT 22</td>
<td>XXXX</td>
<td>2B ICU Hosp Review-Admission</td>
<td>XX/XX/XX ENTERED Unassigned</td>
<td>ADMIT 02/01/94 2:01 am</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IB,PATIENT 22</td>
<td>XXXX</td>
<td>11-B MEDICI Hosp Review-CONT. STAY</td>
<td>XX/XX/XX ENTERED UR,NURSE</td>
<td>ADMIT 01/13/94 9:30 am</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IB,PATIENT 22</td>
<td>XXXX</td>
<td>2D ICU Ins. Review-URG ADM</td>
<td>XX/XX/XX ENTERED Unassigned</td>
<td>ADMIT 02/01/94 2:01 am</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IB,PATIENT 22</td>
<td>XXXX</td>
<td>11-B MEDICI Ins. Review-URG ADM</td>
<td>XX/XX/XX COMPLETE UR,NURSE</td>
<td>ADMIT 01/13/94 9:30 am</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IB,PATIENT 22</td>
<td>XXXX</td>
<td>8C ORTHO SU Hosp Review-Admission</td>
<td>XX/XX/XX ENTERED UR,NURSE</td>
<td>ADMIT 02/07/94 2:42 pm</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Unscheduled Admissions w/Insurance

You can print a list of patients who had active insurance on the date of their unscheduled admission. The report prints information about the number of reviews completed and the insurance companies’ actions.

This report is formatted to print 132 columns.

Sample Report

<table>
<thead>
<tr>
<th>Patient</th>
<th>Pt. ID</th>
<th>Adm. Date</th>
<th>Billable</th>
<th>Ward</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB, PATIENT 22</td>
<td>XX-XX-XXXX</td>
<td>XX/XX/XX</td>
<td>5:07 pm</td>
<td>YES</td>
<td>9D MED</td>
</tr>
<tr>
<td>IB, PATIENT 221</td>
<td>XX-XX-XXXX</td>
<td>XX/XX/XX</td>
<td>11:00 am</td>
<td>YES</td>
<td>13B PSYCH</td>
</tr>
<tr>
<td>IB, PATIENT 3</td>
<td>XX-XX-XXXX</td>
<td>XX/XX/XX</td>
<td>2:42 pm</td>
<td>YES</td>
<td>8C ORTHO SUR  URGENT</td>
</tr>
<tr>
<td>IB, PATIENT 66</td>
<td>XX-XX-XXXX</td>
<td>XX/XX/XX</td>
<td>11:38 am</td>
<td>YES</td>
<td>2D ICU URGENT</td>
</tr>
<tr>
<td>IB, PATIENT 987</td>
<td>XX-XX-XXXX</td>
<td>XX/XX/XX</td>
<td>2:01 am</td>
<td>YES</td>
<td>5D SURGICAL URGENT</td>
</tr>
</tbody>
</table>

*TOTAL = 5*

• UR Activity Report

The UR Activity Report includes the **total** activity during a date range. It provides a detailed listing of the following:

- Insurance Reviews
- Hospital Reviews
- Both
- Summary Report by Admission
- 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 the following:

- Reviewer
- Specialty
- Patient

When the report is sorted by reviewer, it sorts within reviewer by type of review.

This report is formatted to print 132 columns.
**Sample Report**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Pt. ID</th>
<th>Dates of Care</th>
<th>Review Type</th>
<th>Review Date</th>
<th>Ins. Co.</th>
<th>Action</th>
<th>Last Reviewer</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB,PATIENT 22</td>
<td>XX-XX-XXXX</td>
<td>XX/XX/XX</td>
<td>URG ADM</td>
<td>02/07/94</td>
<td>ABC INS</td>
<td>APPROVED</td>
<td>UR,NURSE</td>
</tr>
<tr>
<td>IB,PATIENT 67</td>
<td>XX-XX-XXXX</td>
<td>XX/XX/XX to PRE-ADM</td>
<td>XX/XX/XX</td>
<td>01/07/94</td>
<td>CDPHP</td>
<td>APPROVED</td>
<td>UR,NURSE</td>
</tr>
<tr>
<td>IB,PATIENT 456</td>
<td>XX-XX-XXXX</td>
<td>XX/XX/XX to URG ADM</td>
<td>XX/XX/XX</td>
<td>02/11/94</td>
<td>BLUE SHIELD</td>
<td>APPROVED</td>
<td>UR,NURSE</td>
</tr>
</tbody>
</table>

**UR ACTIVITY SUMMARY REPORT**

For Insurance Reviews Dated 01/01/94 to 02/15/94

From: JAN 1, 1994
To: FEB 15, 1994
Date Printed: Feb 15, 1994@10:17:10

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Admissions</td>
<td>15</td>
</tr>
<tr>
<td>Total Admissions to NHCU</td>
<td>4</td>
</tr>
<tr>
<td>Total Admissions to Domiciliary</td>
<td>1</td>
</tr>
<tr>
<td>Total Admissions Requiring Reviews</td>
<td>0</td>
</tr>
<tr>
<td>Number of Scheduled Adm. Reviewed</td>
<td>0</td>
</tr>
<tr>
<td>Total Admissions with Insurance</td>
<td>4</td>
</tr>
<tr>
<td>Total Billable Admissions</td>
<td>3</td>
</tr>
<tr>
<td>Cases with Pre-Cert and Follow-up</td>
<td>0</td>
</tr>
<tr>
<td>Cases with Pre-Cert no Follow-up</td>
<td>0</td>
</tr>
<tr>
<td>Number of Closed Cases</td>
<td>0</td>
</tr>
<tr>
<td>Number of Billable Closed Cases</td>
<td>0</td>
</tr>
<tr>
<td>Number of Unbillable Closed Cases</td>
<td>0</td>
</tr>
<tr>
<td>Number of New Case Still Open</td>
<td>0</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Days Approved</th>
<th>Days Denied</th>
<th>Amount Approved</th>
<th>Amount Denied</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENERAL MEDICINE</td>
<td>0</td>
<td>0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>MEDICINE</td>
<td>5</td>
<td>10</td>
<td>$4,135</td>
<td>$8,270</td>
</tr>
<tr>
<td>ORTHOPEDIC SURGERY</td>
<td>0</td>
<td>0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>UROLOGY</td>
<td>0</td>
<td>1</td>
<td>$0</td>
<td>$1,164</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>---</td>
<td>5</td>
<td>11</td>
<td>$4,135</td>
<td>$9,434</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Reviewer</th>
<th>Pt. ID</th>
<th>Dates of Care</th>
<th>Review Type</th>
<th>Admission Met Criteria</th>
<th>Days Met Criteria</th>
<th>Days Not Met Criteria</th>
<th>Assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td>IBpatient, one</td>
<td>000-11-1111</td>
<td>02/07/94</td>
<td>RANDOM</td>
<td>YES</td>
<td>1</td>
<td>0</td>
<td>JOHN</td>
</tr>
<tr>
<td>IBpatient, two</td>
<td>000-22-2222</td>
<td>12/23/93</td>
<td>RANDOM</td>
<td>YES</td>
<td>1</td>
<td>0</td>
<td>ED</td>
</tr>
<tr>
<td>IBpatient, three</td>
<td>000-33-3333</td>
<td>02/01/94 to</td>
<td>COPD</td>
<td>YES</td>
<td>1</td>
<td>0</td>
<td>STEVE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>02/09/94</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IBpatient, four</td>
<td>000-44-4444</td>
<td>12/29/93</td>
<td>LOCAL</td>
<td></td>
<td>1</td>
<td>0</td>
<td>SEAN</td>
</tr>
<tr>
<td>Category</td>
<td>Value</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Admissions</td>
<td>15</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Total Cases Reviewed</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of New Case Still Open</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Previous Cases</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Previous Cases still Open</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Random Sample Cases</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Special Condition Cases</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CVD</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TURP</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Locally Added Cases</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Cases Meeting Criteria on Adm.</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Cases Not Meeting Crit. on Adm.</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Days Reviewed</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Days Meeting Criteria</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Days Not Meeting Criteria</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Hospital Review Specialty Summary Report

For Hospital Reviews Dated 01/01/94 to 02/15/94

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Admissions Met Criteria</th>
<th>Admissions Not Met Crit</th>
<th>Days Met Criteria</th>
<th>Days Not Met Crit</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Medicine</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Neurology</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Surgery</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Urology</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

---

| Total                  | 13                      | 1                       | 6                | 14               |
5.8. Hospital Reviews

Note: Hospital reviews are no longer done using VistA Claims Tracking. National Utilization Management Integration (NUMI) is a web-based application that supports 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.

The following screens show the Claims Tracking screens accessed through this option and the actions available on each screen:

<table>
<thead>
<tr>
<th>Hospital Reviews</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>AI Add Next Hosp.Review</td>
<td>VE View/Edit Review</td>
</tr>
<tr>
<td>DR Delete Review</td>
<td>DU Diagnosis Update</td>
</tr>
<tr>
<td>QE Quick Edit</td>
<td>PU Procedure Update</td>
</tr>
<tr>
<td>CS Change Status</td>
<td>PV Provider Update</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expanded Hospital Reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>AI Add Ins. Review</td>
</tr>
<tr>
<td>DR Delete Review</td>
</tr>
<tr>
<td>QE Quick Edit</td>
</tr>
<tr>
<td>CS Change Status</td>
</tr>
<tr>
<td>VE View/Edit Review</td>
</tr>
<tr>
<td>SC SC Conditions</td>
</tr>
<tr>
<td>AE Appeals Edit</td>
</tr>
<tr>
<td>AC Add Comment</td>
</tr>
<tr>
<td>DU Diagnosis Update</td>
</tr>
<tr>
<td>EX Exit</td>
</tr>
</tbody>
</table>

5.8.1. 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 enter the Exit action.

5.8.2. Common Actions

The following are actions common to both screens accessed through this option:

- **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 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 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.

### 5.8.3. Hospital Reviews Screen

This following actions are available from the Hospital Reviews screen:

• **Add Next Hosp. Review** - This action allows you to 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 was not 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 you to access to the Expanded Hospital Reviews Screen.

• **Change Patient** - This action allows you to change the selected patient without leaving the option.

**Sample Screen**

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Type</th>
<th>Ward</th>
<th>Status</th>
<th>Specialty</th>
<th>Day</th>
<th>Next Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/15/94</td>
<td>CONT. STA</td>
<td>11-B ME</td>
<td>COMPLETE</td>
<td>MEDICINE</td>
<td>3</td>
<td>01/17/94</td>
</tr>
<tr>
<td>01/14/94</td>
<td>CONT. STA</td>
<td>11-B ME</td>
<td>COMPLETE</td>
<td>MEDICINE</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>01/13/94</td>
<td>Admission</td>
<td>11-B ME</td>
<td>COMPLETE</td>
<td>MEDICINE</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

**Random Sample**

<table>
<thead>
<tr>
<th>AN</th>
<th>Add Next Hosp. Review</th>
<th>VE</th>
<th>View/Edit Review</th>
<th>CP</th>
<th>Change Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>DR</td>
<td>Delete Review</td>
<td>DU</td>
<td>Diagnosis Update</td>
<td>EX</td>
<td>Exit</td>
</tr>
<tr>
<td>QE</td>
<td>Quick Edit</td>
<td>PU</td>
<td>Procedure Update</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CS</td>
<td>Change Status</td>
<td>PV</td>
<td>Provider Update</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Select Action: Quit//

### 5.8.4. Expanded Hospital Reviews Screen

The following actions are available from the 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**

```
Visit Information
Visit Type: INPATIENT ADMISSION
Admission Date: XXXXX09:30:35
Ward: 11-B MEDICINE XREF
Specialty: MEDICINE

Review Information
Review Type: CONTINUED STAY REVIEW
Review Date: XX/XX/XX
Specialty: MEDICINE
Methodology: INTERQUAL

Criteria Information
Day of Review: 3
Severity of Ill: CARDIOVASCULAR
Intensity of Svc: CARDIOVASCULAR
Apply all Days:
No. Acute Days:
Non-Acute Days:

Enter ?? for more actions
```

```
Status Information
Entered by: UR,NURSE 3
Entered on: XX/XX/XX 2:51 pm
Completed by: UR,NURSE 3
Completed on: XX/XX/XX 2:53 pm
Next Review Date: XX/XX/XX

Clinical Information
Provider: IBprovider,one
Admitting Diag: 101.0 - VINCENTS ANG
Primary Diag:
1st Procedure: 89.44 - CARDIAC STRE
2nd Procedure:
Interim DRG: 0 - on
Estimate ALOS: 0.0
Days Remaining: 0.0

Review Comments
Patient not doing well, consult to psych is recommended.
```

```
Expanded Hospital Reviews Feb 03, 1994 13:58:13 Page: 2 of 3
Expanded Review for: IB,PATIENT 77 XXXX ROI:OBTAINED for: CONTINUED STAY REVIEW on 01/15/94

Status Information
Selected by: IB,PATIENT 77
Completed by: UR,NURSE 3
Admitting Diag: 101.0 - VINCENTS ANG
Primary Diag:
1st Procedure: 89.44 - CARDIAC STRE
2nd Procedure:
Interim DRG: 0 - on
Estimate ALOS: 0.0
Days Remaining: 0.0

Review Comments
Patient not doing well, consult to psych is recommended.
```

```
Expanded Review for: IB,PATIENT 77 XXXX ROI:OBTAINED for: CONTINUED STAY REVIEW on 01/15/94

Criteria Information
Day of Review: 3
Severity of Ill: CARDIOVASCULAR
Intensity of Svc: CARDIOVASCULAR
Apply all Days:
No. Acute Days:
Non-Acute Days:

Enter ?? for more actions
```

---

Claims Tracking 49 September 2016
6. Claims Tracking Menu for Billing ...

This Claims Tracking menu is intended for Billing personnel. Billing personnel sometimes need to obtain Claims Tracking data for the preparation of third-party bills. You may also need to update Claims Tracking if you determine, for example, that an event is not billable though this capability has also been added to IB.

Sample Menu

<table>
<thead>
<tr>
<th>CT</th>
<th>Claims Tracking Edit</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS</td>
<td>Print CT Summary for Billing</td>
</tr>
<tr>
<td>RN</td>
<td>Assign Reason Not Billable</td>
</tr>
<tr>
<td>TP</td>
<td>Third Party Joint Inquiry</td>
</tr>
</tbody>
</table>

Select Claims Tracking Menu for Billing <TEST ACCOUNT> Option:

6.1. Claims Tracking Edit

This option allows you to enter a patient’s name and then view all of the patient’s current Claims Tracking events.

The following screens show the actions accessed through this option and the actions available on each subsequent screen:
6.1.1. 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 enter the Exit action.

6.1.2. Common Actions

The following are actions common to both screens accessed through this option:

- **Billing Info Edit** – This action allows you to enter the reason for which an event is determined to be unbillable. You will also need to enter a comment if you enter a reason equal to Other.

6.1.3. Claims Tracking Editor Screen

The following actions are available from the Claims Tracking Editor screen:

- **View/Edit Episode** – This action allows you to jump to the Expanded Claims Tracking Entry screen.
- **SC Conditions** – This action allows you to see what, if any, service connected conditions are recorded for the patient.
- **Change Patient** – This action allows you to change the selected patient without having to leave and reenter the option.
- **Change Date Range** – This action allows you to change the date range of events without having to leave and reenter the option.
- **View Pat. Ins.** – This action takes you to the Patient Insurance Screens. Note: From this instance of the Patient Insurance Screen users may not add, edit, or delete Patient Policy Comments. It is in view only mode. For more detailed information on Patient Insurance Menu, refer to the IB V. 2.0 User Manual.

Sample Screen
Select Action: Quit//
6.2. **Print CT Summary for Billing**

You can print a Claims Tracking Summary which can be used for preparation of a bill/claim. The content of the summary is based upon the type of Claims Tracking event.

**Sample Report**

<table>
<thead>
<tr>
<th>Bill Preparation Report</th>
<th>Page 1  Oct 23, 2014@14:53:41</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB, PATIENT 78</td>
<td>XXX-XX-XXXXX</td>
</tr>
<tr>
<td>INPATIENT ADMISSION</td>
<td>DOB: XXX XX, XXXX</td>
</tr>
</tbody>
</table>

---

**Visit Information**
- **Visit Type:** INPATIENT ADMISSION
- **Visit Billable:** YES
- **Admission Date:** XXX XX, XXXX@13:22:16
- **Specialty:** MEDICINE
- **Discharge Date:**

**Insurance Information**
- **Ins. Co 1:** AETNA US HEALTHCARE
- **Type:** COMPREHENSIVE MAJOR
- **Subsc.:** IB, PATIENT 78
- **Type:** COMPREHENSIVE MAJOR
- **Subsc. ID:** WXXXXXXX
- **Billing Phone:** 800/523-7978
- **Group Plan Comments:**

---

**Billing Information**
- **Total Charges:** $ 0
- **Estimated Recv (Pri):** $
- **Estimated Recv (Sec):** $
- **Estimated Recv (ter):** $
- **Means Test Charges:** $

---

**Eligibility Information**
- **Primary Eligibility:** NSC, VA PENSION
- **Service Connected Percent:** Patient Not Service Connected

**Diagnosis Information**
- **Nothing on File**

**Associated Interim DRG Information**
- **Nothing on File**

**Procedure Information**
- **Nothing on File**

**Provider Information**
- **Nothing on File**

---

**Insurance Review Information**
- **Type Review:** CONTINUED STAY REVIEW
- **Review Date:** XX/XX/XX@1:41 pm
- **Action:** DENIAL
- **Insurance Co.:** AETNA US HEALTHCARE
- **Denied From:** XX/XX/XX
- **Person Contacted:**
- **Denied To:** XX/XX/XX
- **Contact Method:** PHONE
- **Status:** PENDING
6.3. Assign Reason Not Billable

This option provides the ability to enter a patient’s name and the Claims Tracking event which has been determined to be non-billable. This option also provides the ability for you to enter the following data:

- **REASON NOT BILLABLE:**
- **EARLIEST AUTO BILL DATE:** OCT 22, 2014
- **OTHER TYPE OF BILL:** OTHER/
- **ESTIMATED INS. PAYMENT (PRI):**
- **ESTIMATED INS. PAYMENT (SEC):**
- **ESTIMATED INS. PAYMENT (TER):**
- **ESTIMATED MT CHARGES:**
- **ESTIMATED TOTAL CHARGES:**
- **ADDITIONAL COMMENT:**
- **Current BILLABLE FINDINGS:** <none existing>
  - Do you wish to Add or Change Findings?

For some Reasons Not Billable such as Other, you must add an additional comment of at least 15 characters. If you remove the default date in the Earliest Auto Bill Date field, the autobiller will not create a claim for this event.

6.4. Third Party Joint Inquiry

This option is shared by all the financial modules within VistA and appears on numerous menus and options of the Claims Tracking, IB, and AR modules. You can use the Third Party Joint Inquiry (TPJI) option to look up a specific claim or all the claims, active and inactive, for a selected patient. You can add comments from within TPJI but the option is designed primarily as a source of information.

*Note:* For more detailed information on TPJI, refer to the IB V. 2.0 User Manual.

This option provides the following types of patient and claim information:

- Bill Charges
- Explanation of Benefits
- Bill Diagnoses
- Bill Procedures
- AR Account Profile
7. **Claims Tracking Menu (Hospital Reviews) ...**

This menu was intended for those RUR Nurses who did Hospital reviews. Refer to the Claims Tracking Menu (Combined Functions)… menu for details of the following options:

- Pending Reviews
- Claims Tracking Edit
- Hospital Reviews
- Inquire to Claims Tracking
- Reports Menu (Claims Tracking) ...
- Supervisors Menu (Claims Tracking) ...
- Single Patient Admission Sheet

*Note:* Hospital reviews are now done using the web-based National Utilization Management Integration (NUMI) system.

8. **Claims Tracking Menu (Insurance Reviews)…**

This menu was intended for those RUR Nurses who do Insurance reviews. Refer to the Claims Tracking Menu (Combined Functions)… menu for details of the following options:

- Pending Reviews
- Appeal/Denial Edit
- Claims Tracking Edit
- Inquire to Claims Tracking
- Insurance Review Edit
- Reports Menu (Claims Tracking) ...
- Supervisors Menu (Claims Tracking) ...
- Single Patient Admission Sheet
- Third Party Joint Inquiry

### 8.1. **Health Care Services Review (HCSR) 278 Response**

In addition to the above options, the Claims Tracking Menu (Insurance Reviews)… menu contains the Health Care Services Review (HCSR) 278 Response option. You can use this option
to view an X12N Health Care Services – Request for Review and Response (278) response from the UMO.

You can enter a patient’s name and the system will display a list of events. You can then select the event response you wish to view.

When an X12N Health Care Services – Request for Review and Response (278) response with a final status is received by VistA, the patient’s entry on the HCSR Worklist is removed. To view the response or to take further action such as submitting an Appeal, you may use the Health Care Services Review (HCSR) 278 Response option or the HCSR Response WL action from within the HCSR Worklist.

The following are final statuses:

- A1 – Certified in total
- A3 – Not Certified
- A6 – Modified
- C – Cancelled
- CT – Contact payer
- NA – No Action Required

**Sample 278 Response Screens**

```plaintext
HCSR Response View Nov 13, 2014@10:09:54 Page: 1 of 7

IB, PATIENT 343 XX-XX-XXXX DOB: XXX X,XXXX AGE: XX

Insurance Company Information

Name: CIGNA Reimburse?: WILL REIMBURSE
Phone: 800/525-5803 Billing Phone: 800/525-5803
Precert Phone: 800/877-1209
Address: PO BOX 9358, SHERMAN, TX 75091

Group/Plan Information

Type Of Plan: COMPREHENSIVE MAJOR MEDICAL Require UR: YES
Group?: YES Require Amb Cert:
Group Name: CIGNA Require Pre-Cert: YES
Group Number: WXXXXX Exclude Pre-Cond:
BIN: Benefits Assignable: YES
PCN:

Plan Comments:

+ Enter ?? for more actions

SR (Send 278 Request) RP Remove 'In Progress'
SP Set 'In Progress' VR View Sent Request EX Exit

Select Action: Next Screen//

HCSR Response View Nov 13, 2014@10:10:43 Page: 2 of 7

IB, PATIENT 343 XX-XX-XXXX DOB: XXX X,XXXX AGE: XX

Policy/Subscriber Information

Insured's Name: IB, PATIENT 343 Effective: 1/1/2014
Subscriber Id: 123456789 Expiration:
Relationship: SELF Coord of Benefits: PRIMARY
Insured's DOB: 1/1/1979
```

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User Guide
**Note:** Much of the data in the 278 Response is the same data that you include in your 278 Request.

The following important data is in the Health Care Services Review section of the response:

- Certification Action
- Certification/Authorization Number
- Review Decision Reason
- Certification Effective Date
- Certification Issue Date
- Certification Expiration Date
Note: The certification/authorization number that is received in the response will be automatically added to a third-party bill (billing screen 10) for the patient event when the billing clerk adds each payer to the claim (billing screen 3). The certification/authorization number(s) will then be transmitted in the X12N Health Care Claim (837) transaction to the payer(s).
8.2. Health Care Services Review (HCSR) Worklist

The X12N Health Care Services Review – Request for Review and Response transaction is an Electronic Data Interchange (EDI) standard for the transmission of standardized data for the request of care authorizations or certifications and for the responses to those requests. The messages from VistA to the Financial Services Center (FSC) in Austin, TX are Health Level Seven (HL7) messages. The HL7 messages received by FSC are converted to a HIPAA compliant format and sent to a Health Care Clearing House (HCCH). The HCCH then sends the transaction to the payer or the payer’s Utilization Management Organization. The UMO returns either a Pending notification to the VAMC or a response containing the authorization/certification number or denial of services or error condition. The 278 transactions from VistA are real-time transactions and are transmitted as soon as you trigger a request.

Refer to the eBilling_Build 2 ICD for details of the message structures.

8.2.1. The HCSR Worklist

You can select either only CHAMPVA/TRICARE if you are at a site and responsible for UR for these payers, only CPAC if you are not responsible for CHAMPVA and TRICARE and Both if you are responsible for all types of authorizations and certifications.

Sample HCSR Worklist Screens

Select Claims Tracking Menu (Insurance Reviews) <TEST ACCOUNT> Option: hw
Health Care Services Review (HCSR) Worklist

Select one of the following:

T CHAMPVA/TRICARE
C CPAC
B Both
You can select either Outpatient, Inpatient or Both types of events to be included on your worklist.

If you select Inpatient or Both, you are prompted for one or more wards.

**Note:** If you leave the ward prompt blank, you will get all wards.

If you select Outpatient or Both, you are prompted for one or more clinics.

**Note:** If you leave the Clinic prompt blank, you will get all clinics.

The screen then displays all of your choices.

You are then able to select how you want you worklist displayed (sorted).

Select one of the following:

- O  Outpatient
- I  Inpatient
- B  Both

Show CHAMPVA/TRICARE entries, CPAC entries or Both: B//oth

Select Ward: C SURGERY
Select Another Ward:
Select Clinic: TEST
Select Another Clinic: TEST 1
Select Another Clinic: TEST 2
Select Another Clinic:

Show CHAMPVA/TRICARE entries, CPAC entries or Both: B
Show Inpatient entries, Outpatient entries or Both: B//oth
Clinics to Display: TEST, TEST 1, TEST 2
Wards to Display: C SURGERY

Enter RETURN to continue or '^' to exit:

Select one of the following:

- 1  Oldest Entries First
- 2  Newest Entries First
- 3  Outpatient Appointments First
- 4  Inpatient Admissions First
- 5  Insurance Company Name

Sort the list by: Oldest Entries First//

The worklist is displayed.

**Sample HCSR Worklist**

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>S Apt Date</th>
<th>Ward/Clnce</th>
<th>COB</th>
<th>Insurance Comp U/P SC Re</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB, PATIENT 2</td>
<td>XXXX 08/29/14</td>
<td>TEST</td>
<td>P AETNA US HEALTH</td>
<td>Y Y</td>
</tr>
<tr>
<td>IB, PATIENT 2</td>
<td>XXXX 08/29/14</td>
<td>TEST</td>
<td>S NEW YORK LIFE</td>
<td>Y</td>
</tr>
<tr>
<td>IB, PATIENT 37</td>
<td>XXXX 09/02/14</td>
<td>TEST</td>
<td>P CIGNA</td>
<td></td>
</tr>
<tr>
<td>IB, PATIENT 6</td>
<td>XXXX 09/15/14</td>
<td>TEST</td>
<td>P BCBS SERVICE</td>
<td></td>
</tr>
<tr>
<td>IB, PATIENT 37</td>
<td>XXXX 09/15/14</td>
<td>TEST</td>
<td>P CIGNA HEALTHCA</td>
<td>Y</td>
</tr>
</tbody>
</table>
The following actions are available from the HCSR Worklist:

- **Remove Entry** - This action allows you to remove an entry from the list.
- **Expand Entry** – This action allows you to select and expand an entry from the list.
- **Add Entry** – This actions allows you to add an entry to the list
- **Next Review Date** – This action allows you to delay a review until a specified future date or until an inpatient is discharged. Next Review Date is for inpatient entries only.
- **Add Comment** – This action allows you to enter a free text comment. The comments can be viewed in Expanded Entry. The user’s name and the date and time are added to the comment automatically.
- **Sort List** – This action allows you to sort the worklist based on the following:
  - Oldest Entries First
  - Newest Entries First
  - Outpatient Appointments First
  - Inpatient Admissions First
  - Insurance Company Name
- **HCSR Response WL** – This action allows you to view a list of entries with final 278 Responses.

**Note:** When an X12N Health Care Services – Request for Review and Response (278) response with a final status is received by VistA, the patient’s entry on the HCSR Worklist is removed. To view the response or to take further action such as submitting an Appeal, you may use the either the stand-alone Health Care Services Review (HCSR) 278 Response option or this HCSR Response WL action.

The following are final statuses:

- A1 – Certified in total
- A3 – Not Certified
- A6 – Modified
- C – Cancelled
- CT – Contact payer
- NA – No Action Required

- **Set ‘In Progress’ Mark** – This action allows you to mark an entry as being worked by you. The software places a pound sign (#) before the patient’s name.
Note: If you start a 278 request and need to stop for some reason before you are done, the data you have entered will be saved and the entry will be automatically marked ‘In Progress’.

- **Remove “In Progress’ Mark** – This action allows you to remove the ‘In Progress’ indicator.
- **Refresh** – this action allows you to rebuild the worklist without leaving the option.

The HCSR Worklist provides an on screen legend which provides the following information:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>?Await</td>
<td>This indicator means that a 278 Request has been transmitted and a response has not yet been received.</td>
</tr>
<tr>
<td>#In-Prog</td>
<td>This indicator means someone is working on this entry.</td>
</tr>
<tr>
<td>-RespErr</td>
<td>This indicator means a 278 Request was sent and a 278 Response has been received which contains an error condition.</td>
</tr>
<tr>
<td>!Unable</td>
<td>This indicator means VistA was unable to send a 278 Request for some reason (example: missing required data).</td>
</tr>
<tr>
<td>+Pend</td>
<td>This indicator means a 278 Request was sent and a PENDING 278 Response has been received.</td>
</tr>
<tr>
<td>*NextRev</td>
<td>This indicator means the entry on the worklist has been delayed either until a specific date or until the patient’s discharge date.</td>
</tr>
</tbody>
</table>
Sample Next Review Date Screen

<table>
<thead>
<tr>
<th>HCSR Worklist</th>
<th>Oct 30, 2014@14:00:08</th>
<th>Page: 1 of 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Filtered By:</td>
<td>Both CPAC and CHAMPVA/TRICARE, Selected Outpt, Selected Inpt</td>
<td></td>
</tr>
<tr>
<td>Sorted By:</td>
<td>Oldest Entries First</td>
<td></td>
</tr>
<tr>
<td>Patient Name</td>
<td>S Apt Date Ward/Clncl COB Insurance Comp U/P SC Re</td>
<td></td>
</tr>
<tr>
<td>1  *IB,PATIENT 2</td>
<td>XXXX O 08/29/14 TEST</td>
<td>P AETNA US HEALTH Y Y</td>
</tr>
<tr>
<td>2  ?IB,PATIENT 2</td>
<td>XXXX O 08/29/14 TEST</td>
<td>S NEW YORK LIFE</td>
</tr>
<tr>
<td>3  *IB,PATIENT 37</td>
<td>XXXX O 09/02/14 TEST</td>
<td>P CIGNA Y Y</td>
</tr>
<tr>
<td>4  *IB,PATIENT 6</td>
<td>XXXX O 09/15/14 TEST</td>
<td>P BCBS SERVICE B</td>
</tr>
<tr>
<td>5  ?IB,PATIENT 37</td>
<td>XXXX O 09/15/14 TEST</td>
<td>P CIGNA HEALTHCA Y</td>
</tr>
<tr>
<td>6  ?IB,PATIENT 37</td>
<td>XXXX O 09/15/14 TEST</td>
<td>S CHAMPVA</td>
</tr>
<tr>
<td>7  ?IB,PATIENT 44</td>
<td>XXXX O 09/18/14 TEST 2</td>
<td>S AETNA US HEALTH Y Y</td>
</tr>
<tr>
<td>8  ?IB,PATIENT 44</td>
<td>XXXX O 10/07/14 TEST</td>
<td>P AETNA N A</td>
</tr>
<tr>
<td>9  IB,PATIENT 2</td>
<td>XXXX O 10/09/14 TEST 1</td>
<td>S NEW YORK LIFE</td>
</tr>
<tr>
<td>10 ?IB,PATIENT 777</td>
<td>XXXX O 10/09/14 TEST 2</td>
<td>P BLUE CROSS/BS N N</td>
</tr>
<tr>
<td>11 ?IB,PATIENT 2</td>
<td>XXXX O 10/14/14 TEST 1</td>
<td>P AETNA US HEALTH Y Y</td>
</tr>
<tr>
<td>12 IB,PATIENT 2</td>
<td>XXXX O 10/14/14 TEST 1</td>
<td>S NEW YORK LIFE</td>
</tr>
<tr>
<td>13 IB,PATIENT 98</td>
<td>XXXX I 10/16/14 C SURGERY</td>
<td>P CIGNA</td>
</tr>
<tr>
<td>14 #IB,PATIENT 37</td>
<td>XXXX I 10/17/14 C SURGERY</td>
<td>P BLUE CROSS/BS N N</td>
</tr>
</tbody>
</table>

+ !Await #In-Prog -RespErr !Unable +Pend *NextRev
DE Remove Entry AC Add Comment SP Set 'In Progress' Mark
EE Expand Entry ST Sort List RP Remove 'In Progress' Mark
AE Add Entry NR Next Review Date PR HCSR Response WL
RL Refresh EX Exit
Select Action: Next Screen// NR Next Review Date
Select Event Entry(s): (1-14): 2
Enter 'D' or Future Date for Entry 2: ??

Entry a future date or 'D' to delay until discharge. A 'D' will remove the selected entries from the worklist until the patients have been discharged.
Entering a Date will remove the selected entries from the worklist until the selected date.

Enter 'D' or Future Date for Entry 2: D

Sample Add Comment Screen

<table>
<thead>
<tr>
<th>HCSR Worklist</th>
<th>Oct 30, 2014@14:04:13</th>
<th>Page: 1 of 3</th>
</tr>
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<tr>
<td>Sorted By:</td>
<td>Oldest Entries First</td>
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</tr>
<tr>
<td>Patient Name</td>
<td>S Apt Date Ward/Clncl COB Insurance Comp U/P SC Re</td>
<td></td>
</tr>
<tr>
<td>1  *IB,PATIENT 2</td>
<td>XXXX O 08/29/14 TEST</td>
<td>P AETNA US HEALTH Y Y</td>
</tr>
<tr>
<td>2  ?IB,PATIENT 2</td>
<td>XXXX O 08/29/14 TEST</td>
<td>S NEW YORK LIFE</td>
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<tr>
<td>3  *IB,PATIENT 37</td>
<td>XXXX O 09/02/14 TEST</td>
<td>P CIGNA Y Y</td>
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<tr>
<td>4  *IB,PATIENT 6</td>
<td>XXXX O 09/15/14 TEST</td>
<td>P BCBS SERVICE B</td>
</tr>
<tr>
<td>5  ?IB,PATIENT 37</td>
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</tr>
<tr>
<td>6  ?IB,PATIENT 37</td>
<td>XXXX O 09/15/14 TEST</td>
<td>S CHAMPVA</td>
</tr>
<tr>
<td>7  ?IB,PATIENT 44</td>
<td>XXXX O 09/18/14 TEST 2</td>
<td>S AETNA US HEALTH Y Y</td>
</tr>
<tr>
<td>8  ?IB,PATIENT 44</td>
<td>XXXX O 10/07/14 TEST</td>
<td>P AETNA N A</td>
</tr>
<tr>
<td>9  IB,PATIENT 2</td>
<td>XXXX O 10/09/14 TEST 1</td>
<td>S NEW YORK LIFE</td>
</tr>
<tr>
<td>10 ?IB,PATIENT 777</td>
<td>XXXX O 10/09/14 TEST 2</td>
<td>P BLUE CROSS/BS N N</td>
</tr>
<tr>
<td>11 ?IB,PATIENT 2</td>
<td>XXXX O 10/14/14 TEST 1</td>
<td>P AETNA US HEALTH Y Y</td>
</tr>
<tr>
<td>12 IB,PATIENT 2</td>
<td>XXXX O 10/14/14 TEST 1</td>
<td>S NEW YORK LIFE</td>
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<tr>
<td>13 IB,PATIENT 98</td>
<td>XXXX I 10/16/14 C SURGERY</td>
<td>P CIGNA</td>
</tr>
<tr>
<td>14 #IB,PATIENT 37</td>
<td>XXXX I 10/17/14 C SURGERY</td>
<td>P BLUE CROSS/BS N N</td>
</tr>
</tbody>
</table>

+ !Await #In-Prog -RespErr !Unable +Pend *NextRev
DE Remove Entry AC Add Comment SP Set 'In Progress' Mark
EE Expand Entry ST Sort List RP Remove 'In Progress' Mark
AE Add Entry NR Next Review Date PR HCSR Response WL
RL Refresh EX Exit
Select Action: Next Screen// AC Add Comment
This is a test comment for an entry on the HCSR WL.

Sample HCSR Response WL

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>S Apt Date</th>
<th>Ward/Clnc</th>
<th>COB</th>
<th>Insurance</th>
<th>Comp</th>
<th>Cert</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB, PATIENT 2</td>
<td>XXXX</td>
<td>I</td>
<td>08/27/14</td>
<td>C MEDICINE</td>
<td>S</td>
<td>NEW YORK LIFE</td>
<td>A2</td>
</tr>
<tr>
<td>IB, PATIENT 56</td>
<td>XXXX</td>
<td>I</td>
<td>09/15/14</td>
<td>O&amp;E SURGIC</td>
<td>P</td>
<td>CIGNA</td>
<td>A1</td>
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<tr>
<td>IB, PATIENT 203</td>
<td>XXXX</td>
<td>O</td>
<td>09/15/14</td>
<td>TEST</td>
<td>P</td>
<td>CIGNA HEALTHCA</td>
<td>A1</td>
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<tr>
<td>IB, PATIENT 66</td>
<td>XXXX</td>
<td>O</td>
<td>09/22/14</td>
<td>C MEDICINE</td>
<td>S</td>
<td>BLUE CROSS/BS</td>
<td>A1</td>
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<tr>
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<td>O</td>
<td>10/02/14</td>
<td>TESTIB</td>
<td>S</td>
<td>BLUE CROSS CA</td>
<td>A3</td>
</tr>
<tr>
<td>IB, PATIENT 11</td>
<td>XXXX</td>
<td>O</td>
<td>10/09/14</td>
<td>TEST 1</td>
<td>S</td>
<td>NEW YORK LIFE</td>
<td>A3</td>
</tr>
<tr>
<td>IB, PATIENT 92</td>
<td>XXXX</td>
<td>O</td>
<td>10/22/14</td>
<td>TEST</td>
<td>S</td>
<td>BLUE CROSS/BS</td>
<td>A1</td>
</tr>
<tr>
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<td>O</td>
<td>10/30/14</td>
<td>TEST</td>
<td>P</td>
<td>AETNA</td>
<td>C</td>
</tr>
<tr>
<td>IB, PATIENT 6</td>
<td>XXXX</td>
<td>O</td>
<td>10/30/14</td>
<td>TEST 1</td>
<td>S</td>
<td>AETNA HEALTH</td>
<td>P A3</td>
</tr>
<tr>
<td>IB, PATIENT 44</td>
<td>XXXX</td>
<td>O</td>
<td>10/30/14</td>
<td>TEST 1</td>
<td>S</td>
<td>AETNA HEALTH</td>
<td>P NA</td>
</tr>
<tr>
<td>IB, PATIENT 129</td>
<td>XXXX</td>
<td>O</td>
<td>10/31/14</td>
<td>TEST</td>
<td>P</td>
<td>AETNA GROUP IN</td>
<td>C</td>
</tr>
<tr>
<td>IB, PATIENT 377</td>
<td>XXXX</td>
<td>I</td>
<td>11/01/14</td>
<td>O&amp;E MEDICA</td>
<td>P</td>
<td>CIGNA</td>
<td>A1</td>
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<td>IB, PATIENT 10</td>
<td>XXXX</td>
<td>O</td>
<td>11/03/14</td>
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<td>P</td>
<td>AETNA</td>
<td>A1</td>
</tr>
<tr>
<td>IB, PATIENT 76</td>
<td>XXXX</td>
<td>O</td>
<td>11/04/14</td>
<td>TEST 2</td>
<td>P</td>
<td>AETNA GROUP IN</td>
<td>C</td>
</tr>
<tr>
<td>IB, PATIENT 3</td>
<td>XXXX</td>
<td>O</td>
<td>11/10/14</td>
<td>TEST 1</td>
<td>P</td>
<td>AETNA US HEALTH</td>
<td>A1</td>
</tr>
</tbody>
</table>

Select Action: Next Screen//
When you expand an entry from this list, a screen is displayed that looks the same as the stand-alone Health Care Services Review (HCSR) 278 Response option.

<table>
<thead>
<tr>
<th>HCSR Response View</th>
<th>Nov 13, 2014@10:09:54</th>
<th>Page: 1 of 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB, PATIENT 343</td>
<td>XX-XX-XXXX</td>
<td>DOB: XXX X,XXXX AGE: XX</td>
</tr>
</tbody>
</table>

**Insurance Company Information**

- **Name:** CIGNA
- **Reimburse?:** WILL REIMBURSE
- **Phone:** 800/525-5803
- **Billing Phone:** 800/525-5803
- **Precert Phone:** 800/877-1209
- **Address:** PO BOX 9358, SHERMAN, TX 75091

**Group/Plan Information**

- **Type Of Plan:** COMPREHENSIVE MAJOR MEDICAL
- **Require UR:** YES
- **Group?:** YES
- **Group Name:** CIGNA
- **Require Amb Cert:**
- **Group Number:** WXXXX
- **BIN:**
- **Benefits Assignable:** YES
- **PCN:**

**Plan Comments:**
- + Enter ?? for more actions
- SR (Send 278 Request) RP Remove 'In Progress'
- SP Set 'In Progress' VR View Sent Request EX Exit

**Sample Set ‘In Progress’ Mark Screen**

<table>
<thead>
<tr>
<th>HCSR Worklist</th>
<th>Oct 30, 2014@14:21:51</th>
<th>Page: 2 of 3</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
<tr>
<td>Select Event Entry(s):</td>
<td>15-28: 13</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Patient Name</th>
<th>S Apt Date Ward/Clnc</th>
<th>COB Insurance Comp U/P SC Re</th>
<th>U/P</th>
<th>SC</th>
<th>Re</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>*IB, PATIENT 2</td>
<td>XXXX O 08/29/14 TEST</td>
<td>AETNA US HEALTH Y Y</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>IB, PATIENT 2</td>
<td>XXXX O 08/29/14 TEST</td>
<td>AETNA US HEALTH Y Y</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>IB, PATIENT 2</td>
<td>XXXX O 09/29/14 TEST</td>
<td>CIGNA Y Y</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>*IB, PATIENT 6</td>
<td>XXXX O 09/15/14 TEST</td>
<td>BCBS SERVICE B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
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<td>XXXX O 09/15/14 TEST</td>
<td>CIGNA HEALTHCA Y</td>
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<td></td>
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</tr>
<tr>
<td>6</td>
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<td>CHAMPVA</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>IB, PATIENT 44</td>
<td>XXXX O 09/18/14 TEST</td>
<td>AETNA US HEALTH Y Y</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>IB, PATIENT 44</td>
<td>XXXX O 10/07/14 TEST</td>
<td>AETNA N A</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>IB, PATIENT 2</td>
<td>XXXX O 10/09/14 TEST 1</td>
<td>S NEW YORK LIFE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
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<td></td>
</tr>
<tr>
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<td>XXXX O 10/14/14 TEST 1</td>
<td>AETNA US HEALTH Y Y</td>
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</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>13</td>
<td>IB, PATIENT 98</td>
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</tr>
</tbody>
</table>

+ *Await #In-Prog -RespErr !Unable +Pend *NextRev

DE Remove Entry AC Add Comment | **SP Set 'In Progress' Mark**
EE Expand Entry ST Sort List RP Remove 'In Progress' Mark
AE Add Entry NR Next Review Date PR HCSR Response
RL Refresh EX Exit
Select Action: Next Screen/ sp Set 'In Progress' Mark
Select Event Entry(s): (15-28): 13
### Sample Remove ‘In Progress” Mark Screen

<table>
<thead>
<tr>
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<th>Page: 2 of 3</th>
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<td>Sorted By: Newest Entries First</td>
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</tbody>
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<tr>
<th>#</th>
<th>Patient Name</th>
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<th>Insurance</th>
<th>Comp</th>
<th>U/P</th>
<th>SC</th>
<th>Re</th>
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<tr>
<td>1</td>
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<td>08/29/14</td>
<td>TEST</td>
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<td></td>
</tr>
<tr>
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<td>?IB, PATIENT 2</td>
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<td>08/29/14</td>
<td>TEST</td>
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<td>NEW YORK LIFE</td>
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<td>Y</td>
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<td>09/15/14</td>
<td>TEST</td>
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<td>BCBS SERVICE B</td>
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<tr>
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<td>10/09/14</td>
<td>TEST 1</td>
<td>S</td>
<td>NEW YORK LIFE</td>
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<tr>
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<td>?IB, PATIENT 77</td>
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<td>10/09/14</td>
<td>TEST 2</td>
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<td>P</td>
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<td></td>
</tr>
</tbody>
</table>

+ | Wait #In-Prog -RespErr !Unable +Pend *NextRev |

**DE Remove Entry** | AC Add Comment | SP Set 'In Progress' Mark |
**EE Expand Entry** | ST Sort List | RP Remove 'In Progress' Mark |
**AE Add Entry** | NR Next Review Date | PR HCSR Response WL |
**RL Refresh** | EX Exit |

Select Action: Next Screen // rp Remove 'In Progress' Mark
Select Event Entry(s): (15-28): 12

### 8.2.2. HCSR Expanded Entry

This option provides you with the ability to view more information related to an entry and to create an initial X12N Health Care Services Review – Request for Review and Response (278 - 217) request to the UMO. It also provides you with the ability to force a follow-up X12N Health Care Services Review – Request for Review and Response (278 - 215) inquiry to the UMO. If a 278 request results in an error condition, you can fix the error and resubmit the request.

**Note:** An initial 278 transaction is referred to as a 278 - 217 transaction. A follow-on 278 inquiry sent in response to a Pending reply to an initial 217 is referred to as a 278 - 215 transaction.

**Note:** If a UMO responds to a X12N Health Care Services Review – Request for Review and Response (278 - 217) request with a Pending response, then the requester must respond with a follow-up X12N Health Care Services Review – Request for Review and Response (278 - 215) inquiry. VistA will automatically create and submit the 215 inquiry based on the number of days set in the following site parameters:

- Inquiry can be Triggered for Appointment: 2/
- Inquiry can be Triggered for Admission: 1/
# Sample HCSR Expanded Entry Screens

<table>
<thead>
<tr>
<th>HCSR Expanded Entry</th>
<th>Oct 30, 2014@14:59:32</th>
<th>Page: 1 of 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB, PATIENT M</td>
<td>XX-XX-XXXX</td>
<td>DOB: XX-XX-XXXX</td>
</tr>
</tbody>
</table>

### Insurance Company Information
- **Name:** BLUE CROSS CA (65-WY)
- **Reimburse?:** WILL REIMBURSE
- **Billing Phone:** 877/737-7776
- **Address:** PO BOX 60007, LOS ANGELES, CA 90060

### Group/Plan Information
- **Type Of Plan:** PREFERRED PROVIDER ORGANIZATION (PPO)
- **Require UR:**
- **Require Amb Cert:**
- **Require Pre-Cert:**
- **Exclude Pre-Cond:**
- **Benefits Assignable:** YES

### Plan Comments:
- **THIS GROUP NAME "CALPERS" STANDS FOR CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM.**

### Policy/Subscriber Information
- **Insured's Name:** IB, PATIENT M
- **Effective:** 3/2/2014
- **Subscriber Id:** RXXXXXXX
- **Expiration:**
- **Relationship:** SELF
- **Coord of Benefits:** SECONDARY
- **Insured's DOB:** X/X/XXXX
- **Employer Sponsored Group Health Plan?:**

### User Added Comments for This Entry
- **User's Name:** UR, NURSE 2
- **Date Comment Entered:** 10/30/2014@15:03:38
- **Comment:** This is a Test comment.

### Select Action: Next Screen//

### Sample HCSR Expanded Entry

<table>
<thead>
<tr>
<th>HCSR Expanded Entry</th>
<th>Oct 30, 2014@15:05:19</th>
<th>Page: 2 of 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB, PATIENT M</td>
<td>XX-XX-XXXX</td>
<td>DOB: XX-XX-XXXX</td>
</tr>
</tbody>
</table>

### Plan Comments:
- **Enter ?? for more actions**

### Policy/Subscriber Information
- **Insured's Name:** IB, PATIENT M
- **Effective:** 3/2/2014
- **Subscriber Id:** RXXXXXXX
- **Expiration:**
- **Relationship:** SELF
- **Coord of Benefits:** SECONDARY
- **Insured's DOB:** X/X/XXXX

### User Added Comments for This Entry
- **User's Name:** UR, NURSE 2
- **Date Comment Entered:** 10/30/2014@15:03:38
- **Comment:** This is a Test comment.

### Select Action: Next Screen//
The following actions are available from the HCSR Expanded Entry screen:

- **Send 278 Request Full** – This action allows you to send an initial X12N Health Care Services Review – Request for Review and Response (278) request to the UMO.
  
  This action also allows you to edit a 278 request for resubmission when the original results in an error condition.
  
  Note: This action is currently disabled

- **Send 278 Request Brief** – This action allows you to send an initial X12N Health Care Services Review – Request for Review and Response (278) request to the UMO by selecting one of the following brief request formats:
  - Admission (Initial)
  - Appointment (Initial)

- **Copy 278 Request** – This action allows you to enter the data for a X12N Health Care Services Review – Request for Review and Response (278) request to a primary payer and then to copy that data to a new request for a secondary and/or tertiary payer.
  
  Note: This action is currently disabled

- **View Pending Response** – This action allows you to view a Pending response from the UMO.

- **Add Comment** - This action allows you to enter a free text comment. The comments can be viewed in Expanded Entry. The user’s name and the date and time are added to the comment automatically.

- **Send 278 Inquiry** – This action allows you to send a X12N Health Care Services Review – Inquiry and Response for a 278 request or inquiry with a Pending status. It also allows you to send a X12N Health Care Services Review – Inquiry and Response to cancel a 278 request or inquiry with a Pending status.

- **Set ‘In Progress’ Mark** – This action allows you to mark an entry as being worked by you. The software places a pound sign (#) before the patient’s name.

- **Remove “In Progress” Mark** – This action allows you to remove the ‘In Progress’ indicator.
- **View Sent Request** – This action allows you to view the request or inquiry that was sent to payer in X12 format

## Sample Send 278 Request Screens – Outpatient Brief

<table>
<thead>
<tr>
<th>HCSR 278 Appointment - Brief</th>
<th>Nov 04, 2014@15:29:07</th>
<th>Page: 1 of 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB, PATIENT 543</td>
<td>XX-XX-XXXXX</td>
<td>DOB: XXX XX,XXXX AGE: XX</td>
</tr>
</tbody>
</table>

**UM Organization**

- **Name**: Aetna
- **National Payer ID**: XXXXXXXXXX
- **HPID**: XXXXXX

**Requester**

- **Name**: CHEYENNE VAMC
- **NPI**: XXXXXXXXXX
- **Tax ID**: XXXXXXXXXX
- **Taxonomy Code**: XXXXXXXXXX
- **Address**: 1234 Test Blvd

**Subscriber**

- **Name**: IB, SPOUSE
- **City**: CHEYENNE
- **Primary ID**: WXXXXXXXXXX
- **Address**: 123 TEST BLVD
- **City/State/ZIP**: FORT COLLINS WY 82007
- **Contact Name**: UR, NURSE 34
- **Contact Phone/Ext.**: 
- **Contact Fax**:

+ Enter ?? for more actions

SR Send 278 Request AD Add Data EX Exit

Select Action: Next Screen/

---

<table>
<thead>
<tr>
<th>HCSR 278 Appointment - Brief</th>
<th>Nov 04, 2014@15:29:07</th>
<th>Page: 2 of 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB, PATIENT 543</td>
<td>XX-XX-XXXXX</td>
<td>DOB: XXX XX,XXXX AGE: XX</td>
</tr>
</tbody>
</table>

**Dependent**

- **Name**: IB, PATIENT 543

**Diagnosis**

- **Diagnosis Qualifier**:
- **Diagnosis**: Health Care Service Review

**Provider Information**

- **Category**: Health Services Review
- **Certification Type**: Initial
- **Service Type**: Medical
- **Facility Type**: ON CAMPUS-OUTPATIENT HOSPITAL

+ Enter ?? for more actions

SR Send 278 Request AD Add Data EX Exit

Select Action: Next Screen/

---

<table>
<thead>
<tr>
<th>HCSR 278 Appointment - Brief</th>
<th>Nov 04, 2014@15:29:07</th>
<th>Page: 3 of 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB, PATIENT 543</td>
<td>XX-XX-XXXXX</td>
<td>DOB: XXX XX,XXXX AGE: XX</td>
</tr>
</tbody>
</table>

**Service Line**

- **Service Line #**: 
- **Date of Service**: Appointment Date
- **Procedure Code**: 

**Paperwork Attachments**

- **Report Type**: 
- **Transmission Method**: 
- **Attachment Control Number**:

**Request Comments**

- **Message**: 

+ Enter ?? for more actions
PATIENT EVENT DETAIL

Patient Event Service Type: Medical Care // Medical Care
Diagnosis Qualifier: ABF // ICD-10 Diagnosis
Patient Event Diagnosis: M25.539

Searching for a ICD-10 Diagnosis

One match found

M25.539 Pain in unspecified wrist

OK? Yes // YES M25.539 Pain in unspecified wrist

The following Diagnoses are currently on file.

# Type Diagnosis
-- ----- -----------------
1 ABF M25.539

Enter the # of a Diagnosis to edit, 'NEW' to add one or press Return to skip.

Selection #:

Product or Service ID Qualifier: HC // CPT/HCPCS Code
Procedure: 73100

Searching for a HCPCS (CPT) Procedure Codes
73100 X-RAY EXAM OF WRIST
...OK? Yes // (Yes)

The following Service Lines are currently on file.

# Proc Code
-- -----------------
1 73100

Enter the # of a line to edit, 'NEW' to add one or press Return to skip.

Selection #:

Patient Event Provider Data
Provider Type: DK // Ordering Physician
Provider: IB, DOCTOR R

Searching for a VA providers
IB, DOCTOR R VMS 111 PHYSICIAN
...OK? Yes // (Yes)

The following Provider Data Information is currently on file.

# Provider Type Provider
-- ----------------- -----------------
1 Ordering Physician IB, DOCTOR R

Enter the # of an entry to edit, 'NEW' to add one or press Return to skip.
Selection #:

No Additional Patient Information is currently on file.

Add Additional Patient Information? NO// YES
  Report Type: RADIOLOGY REPORTS RR Radiology reports
  Report Transmission: AVAI Available on request at provider site
  Attachment Control #:

The following Additional Patient Information is currently on file.

<table>
<thead>
<tr>
<th>#</th>
<th>Report Type</th>
<th>Delivery Method</th>
<th>Attachment Control #</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Radiology reports</td>
<td>Available on request</td>
<td></td>
</tr>
</tbody>
</table>

Enter the # of an entry to edit, 'NEW' to add one or press Return to skip.

Selection #:

Message Text:

1>

Requester Contact Name: UR, STAFF 1//

Type of Requester Contact Number #1: TE// Telephone
  Requester Contact Number #1: 1112223333

Type of Requester Contact Number #2: FX Facsimile
  Requester Contact Number #2: 444555666

Type of Requester Contact Number #3:

HCSR 278 Appointment - Brief

<table>
<thead>
<tr>
<th>Dependent</th>
<th>Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: IB, PATIENT 543</td>
<td>Diagnosis Qualifier: ICD-10 Diag</td>
</tr>
<tr>
<td>Diagnosis: M25.539</td>
<td>Diagnosis:</td>
</tr>
</tbody>
</table>

Health Care Service Review

<table>
<thead>
<tr>
<th>Category*: Health Services Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certification Type*: Initial</td>
</tr>
<tr>
<td>Service Type*: Diagnostic X-Ray</td>
</tr>
<tr>
<td>Facility Type*: ON CAMPUS-OUTPATIENT HOSPITAL</td>
</tr>
</tbody>
</table>

+ Enter ?? for more actions

Select Action: Next Screen//

Service Line

<table>
<thead>
<tr>
<th>Service Line #: 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Service: Appointment Date</td>
</tr>
<tr>
<td>Procedure Code*: 73100</td>
</tr>
</tbody>
</table>

Paperwork Attachments

<table>
<thead>
<tr>
<th>Report Type: Radiology Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transmission Method: Available on Request</td>
</tr>
<tr>
<td>Attachment Control Number:</td>
</tr>
</tbody>
</table>

Request Comments
9. **MCCR Site Parameters**

The MCCR Site Parameter Display/Edit option is an IB option that can be used to update IB, Claims Tracking, Automated Billing and Insurance Verification parameters. Refer to the IB V. 2.0 User Manual for a full description of all of the parameters.

**Sample Screen**

```
MCCR Site Parameters          Oct 28, 2014@12:39          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                        HCSR Parameters
Provider Id
EDI Transmission

**Third Party Auto Billing Parameters**    **Insurance Verification**
General Parameters                         General Parameters
Inpatient Admission                        Batch Extracts Parameters
Outpatient Visit                           Service Type Codes
Prescription Refill

Enter ?? for more actions
IB Site Parameter AB Automated Billing EX Exit
CT Claims Tracking IV Ins. Verification
Select Action: Quit//
```

The difference between the MCCR Site Parameter Display/Edit option and the Claims Tracking - Claims Tracking Parameter Edit option is that you can view all of the Claims Tracking parameters from MCCR Site Parameters Display/Edit option. The Claims Tracking Parameter Edit option only allows you to view/edit those parameters that are editable. Refer to the Claims Tracking Menu (Combined Functions)... → Supervisor Menu (Claims Tracking)... → Claims Tracking Parameter Edit.

**9.1. The MCCR Site Parameter Display/Edit**

The MCCR Site Parameter Display/Edit allows you to see all the following Claims Tracking parameter values:

- Tracking Parameters
  - Track Inpatient:
    - OFF
- INSURED AND UR ONLY
- ALL PATIENTS

- Track Outpatient
  - OFF
  - INSURED ONLY
  - ALL PATIENTS

- Track Rx
  - OFF
  - INSURED ONLY
  - ALL PATIENTS

- Track Prosthetics
  - OFF
  - INSURED ONLY
  - ALL PATIENTS

- General Parameters
  - Extended Help
    - OFF
    - ON
  - Initialization Date
    - Date
  - Use Admission Sheet
    - NO
    - YES
  - Header Line 1
    - Free text
  - Header Line 2
    - Free text
  - Header Line 3
    - Free text

- Random Sample Parameters
  - Medicine Sample
    - Number
  - Medicine Admissions
    - Number
  - Surgery Sample
    - Number
  - Surgery Admissions
    - Number
  - Psych Sample
    - Number
  - Psych Admissions
The sample number and the admissions number are used by the system to compute a random number.

- Health Care Services Review (HCSR) Parameters
  - CPAC Future Appointments Search: 30 days - Not editable
  - CPAC Future Admissions Search: 30 days – Not editable
  - CPAC Past Appointments Search: 14 days – Not editable
  - CPAC Past Admissions Search: 14 days – Not editable
  - TRICARE/CHAMPVA Future Appointments Search: 30 days – Not editable
  - TRICARE/CHAMPVA Future Admissions Search: 30 days – Not editable
  - TRICARE/CHAMPVA Past Appointments Search: 14 days – Not editable
  - TRICARE/CHAMPVA Past Admissions Search: 14 days – Not editable
  - Inquiry can be Triggered for Appointment
    - Number of days before an automatic 278 is triggered
    - Inquiry can be Triggered for Admission
    - Number of days before an automatic 278 is triggered
    - Days to wait to purge entry on HCSR Response
    - Number of days before a 278 response is removed from the worklist
  - Clinics Included In the Search – Defined in MCCR Site Parameters
  - Wards Included In the Search - Defined in MCCR Site Parameters
  - Insurance Companies Included In Appointments Search - Defined in MCCR Site Parameters
  - Insurance Companies Included In Admissions Search - Defined in MCCR Site Parameters

Sample Screens

<table>
<thead>
<tr>
<th>Tracking Parameters</th>
<th>Random Sample Parameters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Track Inpatient: INSURED AND UR ONLY</td>
<td>Medicine Sample: 5</td>
</tr>
<tr>
<td>Track Outpatient: INSURED ONLY</td>
<td>Medicine Admissions: 5</td>
</tr>
<tr>
<td>Track Rx: INSURED ONLY</td>
<td>Surgery Sample: 5</td>
</tr>
<tr>
<td>Track Prosthetics: INSURED ONLY</td>
<td>Surgery Admissions: 5</td>
</tr>
<tr>
<td>Reports Can Add CT: YES</td>
<td>Psych Sample: 1</td>
</tr>
<tr>
<td></td>
<td>Psych Admissions: 5</td>
</tr>
</tbody>
</table>

**General Parameters**

Initialization Date: 01/01/94
Use Admission Sheet: NO
Header Line 1: CHEYENNE VAMC
Header Line 2: 2360 E. PERSHING BLVD
Header Line 3: CHEYENNE, WY
+ Enter ?? for more actions
TP Tracking RS Random Sample GP General
EA Edit All HS HCSR EX Exit
Select Action: Next Screen//
Health Care Services Review (HCSR) Parameters

CPAC Future Appointments Search: 30 days
CPAC Future Admissions Search: 30 days
CPAC Past Appointments Search: 14 days
CPAC Past Admissions Search: 14 days
TRICARE/CHAMPVA Future Appointments Search: 30 days
TRICARE/CHAMPVA Future Admissions Search: 30 days
TRICARE/CHAMPVA Past Appointments Search: 14 days
TRICARE/CHAMPVA Past Admissions Search: 14 days
Inquiry can be Triggered for Appointment: 2 days
Inquiry can be Triggered for Admission: 1 day
Days to wait to purge entry on HCSR Response: 20 days
Inquiry can be Triggered for Appointment: 2 days
Inquiry can be Triggered for Admission: 1 day

Clinics Included In the Search: 3
Wards Included In the Search: 0
Insurance Companies Included In Appointments Search: 6
Insurance Companies Included In Admissions Search: 8

9.1.1. Clinics Included In the Search

This parameter is defined in an option within the HCSR parameters. You can add an existing clinic for all payers or selected payers from the Hospital Location file to a list of clinics that will be included in the nightly search for appointment events. If a patient has an appointment in one of these clinics, his/her appointment event will be added to the HCSR Worklist.

If circumstances change, a clinic can be deleted from this inclusion list or a payer can be deleted from the clinic.

Note: If you remove a clinic from the list, it will affect future searches. Entries already on the list from earlier searches, will remain on the worklist.
Enter ?? for more actions
AC  Add Clinic   AP  Add Payer to Clinic   EX  Exit
DL  Delete Clinic  DP  Delete Payer from Clinic
Select Action: Quit// ac  Add Clinic

**Warning**
Changing the value in CPAC/TRICARE/CHAMPVA parameters will affect the Health Care Services Review Worklist.

Select a Clinic to be added: FTC DIABETIC IB,DOCTOR L
Clinic is currently included in the list for no payers

INCLUDE FOR ALL PAYERS?: NO// y  YES
Select a Clinic to be added:

Select Action: Quit// ap  Add Payer to Clinic
Select HCSR Clinic(s):  (1-5): 2
Clinic is currently included in the list for the following 2 payers:
AETNA
CIGNA

INCLUDE FOR ALL PAYERS?: NO//
Select Payer: BCBS KANSAS CITY
Payer added to the list.
Select Payer:

9.1.2. **Wards Included in the Search**

This parameter is defined in an option within the HCSR parameters. You can add an existing ward for all payers or selected payers from the Hospital Location file to a list of wards that will be included in the nightly search for admission events. If a patient has an admission to one of these wards, his/her admission event will not be added to the HCSR Worklist if the wards are not specified in the inclusion list.

**Note:** If circumstances change, a ward can be deleted from this inclusion list or a payer can be deleted from the ward.
Note: If you remove a ward from the list, it will affect future searches. Entries already on the list from earlier searches, will remain on the worklist.

Sample Screens

```
HCSR Parameters          Oct 28, 2014@15:10:55          Page: 1 of 1

Only authorized persons may edit this data.

Health Care Services Review (HCSR) Parameters
CPAC Future Appointments Search: 14 days
CPAC Future Admissions Search: 14 days
CPAC Past Appointments Search: 7 days
CPAC Past Admissions Search: 7 days
TRICARE/CHAMPVA Future Appointments Search: 14 days
TRICARE/CHAMPVA Future Admissions Search: 14 days
TRICARE/CHAMPVA Past Appointments Search: 7 days
TRICARE/CHAMPVA Past Admissions Search: 7 days
Inquiry can be Triggered for Appointment: 0 days
Inquiry can be Triggered for Admission: 0 days
Days to wait to purge entry on HCSR Response: 20 days
Clinics Included In the Search: 3
Wards Included In the Search: 0
Insurance Companies Included In Appointments Search: 6
Insurance Companies Included In Admissions Search: 9

Enter ?? for more actions
HC Clinics        HW Wards        OP Other
HA Adm Ins       HI Appt Ins     EX Exit
```

```
HCSR Ward Inclusions  Nov 19, 2014@10:56:13          Page: 1 of 0

Only authorized persons may edit this data.

Wards Included In the Search:
1  O&E MEDICAL - for 2 payers
2  TRANSITIONAL - for all payers

Enter ?? for more actions
AW Add Ward       AP Add Payer to Ward       EX Exit
DW Delete Ward    DP Delete Payer from Ward
Select Action: Quit// AW Add Ward

**Warning**
Changing the value in CPAC/TRICARE/CHAMPVA parameters will affect the Health Care Services Review Worklist.

Select a Ward to be added: C MEDICINE
INCLUDE FOR ALL PAYERS?: NO// Y
Select a Ward to be added:

Select Action: Quit// AP Add Payer to Ward
```
**9.1.3. Insurance Companies Included In Appointment Search**

This parameter is defined in an option within the HCSR parameters. You can add an existing insurance company from the Insurance Company file to a list of companies that will be included in the nightly search for appointment events. If a patient has insurance with one of these insurance companies, his/her appointment event will be added to the HCSR Worklist.

**Note:** If circumstances change, an insurance company can be deleted from this inclusion list.

**Note:** If you remove an insurance company from the list, it will affect future searches. Entries already on the list from earlier searches, will remain on the worklist.

**Sample Screens**

```
Select HCSR Ward(s): (1-2): 1

Ward is currently included in the list for the following 2 payers:
CIGNA NATIONAL
CIGNA

INCLUDE FOR ALL PAYERS?: NO/
Select Payer: bcbs of Kansas
Payer added to the list.
Select Payer:

Insurance Companies Included From Appointments Search: 6

Enter ?? for more actions
```

```
Health Care Services Review (HCSR) Parameters
Oct 28, 2014@14:20:48          Page:    1 of    1

Only authorized persons may edit this data.

Health Care Services Review (HCSR) Parameters
CPAC Future Appointments Search: 14 days
CPAC Future Admissions Search: 14 days
CPAC Past Appointments Search: 7 days
CPAC Past Admissions Search: 7 days
TRICARE/CHAMPVA Future Appointments Search: 14 days
TRICARE/CHAMPVA Future Admissions Search: 14 days
TRICARE/CHAMPVA Past Appointments Search: 7 days
TRICARE/CHAMPVA Past Admissions Search: 7 days
Inquiry can be Triggered for Appointment: 0 days
Inquiry can be Triggered for Admission: 0 days
Days to wait to purge entry on HCSR Response: 20 days
In the Search: 3
Wards Included From the Search: 0
Insurance Companies Included From Appointments Search: 6

Enter ?? for more actions
```

```
HCSR Insurance Inclusions
Nov 19, 2014@11:03:09          Page:    1 of    1

Only authorized persons may edit this data.

Insurance Companies Included In The Appointment Search:

<table>
<thead>
<tr>
<th>Insurance Company Name</th>
<th>Address Line 1</th>
<th>ST</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 AETNA</td>
<td>PO BOX 2600</td>
<td>CA</td>
</tr>
<tr>
<td>2 CIGNA</td>
<td>PO BOX 9999</td>
<td>KY</td>
</tr>
</tbody>
</table>

Enter ?? for more actions
```
Select Action: Quit// Al Add Ins

**Warning**
Changing the value in CPAC/TRICARE/CHAMPVA parameters will affect the Health Care Services Review Worklist.

Select an Insurance Company to be added: AETNA US HEALTHCARE PO BOX 2559 FT WAYNE INDIANA Y
Include all payers with the same electronic Payer ID?? NO// y YES
Select an Insurance Company to be added:

9.1.4. Insurance Companies Included In Admissions Search

This parameter is defined in an option within the HCSR parameters. You can add an existing insurance company from the Insurance Company file to a list of companies that will be included in the nightly search for admission events. If a patient has insurance with one of these insurance companies, his/her admission event will be added to the HCSR Worklist.

Note: If circumstances change, an insurance company can be deleted from this inclusion list.

Note: If you remove an insurance company from the list, it will affect future searches. Entries already on the list from earlier searches, will remain on the worklist.

Sample Screens

<table>
<thead>
<tr>
<th>Health Care Services Review (HCSR) Parameters</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPAC Future Appointments Search: 14 days</td>
</tr>
<tr>
<td>CPAC Future Admissions Search: 14 days</td>
</tr>
<tr>
<td>CPAC Past Appointments Search: 7 days</td>
</tr>
<tr>
<td>CPAC Past Admissions Search: 7 days</td>
</tr>
<tr>
<td>TRICARE/CHAMPVA Future Appointments Search: 14 days</td>
</tr>
<tr>
<td>TRICARE/CHAMPVA Future Admissions Search: 14 days</td>
</tr>
<tr>
<td>TRICARE/CHAMPVA Past Appointments Search: 7 days</td>
</tr>
<tr>
<td>TRICARE/CHAMPVA Past Admissions Search: 7 days</td>
</tr>
<tr>
<td>Days to wait to purge entry on HCSR Response: 20 days</td>
</tr>
<tr>
<td>Inquiries can be Triggered for Appointment: 10 days</td>
</tr>
<tr>
<td>Inquiries can be Triggered for Admission: 10 days</td>
</tr>
<tr>
<td>Insurance Companies Included In Appointments Search: 6</td>
</tr>
</tbody>
</table>

Select Action: Quit//

<table>
<thead>
<tr>
<th>Insurance Companies Included In Admissions Search: 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Company Name</td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td>AETNA</td>
</tr>
<tr>
<td>CIGNA</td>
</tr>
</tbody>
</table>

Select Action: Quit//
Select Action: Quit// AI  Add Ins

**Warning**
Changing the value in CPAC/TRICARE/CHAMPVA parameters will affect the Health Care Services Review Worklist.

Select an Insurance Company to be added: UNITED HEALTHCARE  PO BOX 30555
SALT LAKE CITY       UTAH       Y
Include all payers with the same electronic Payer ID?? NO// y  YES
Select an Insurance Company to be added:
10. **Appendix A – Follow-up Actions Codes**

The following is a list of the AAA error segments and follow-up codes that may be returned to the requester when there is a problem with an X12N Health Care Services Review – Request for Review and Response (278):

<table>
<thead>
<tr>
<th>Loop</th>
<th>Valid Request</th>
<th>Segment Name</th>
<th>Reject Reason Codes</th>
<th>Follow-up Action Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000A</td>
<td>Yes or No</td>
<td>AAA – Request Validation</td>
<td>Authorization Quantity Exceeded Authorization/Access Restrictions Unable to Respond at Current Time Invalid Participant Identification</td>
<td>Please Correct and Resubmit Resubmission Not Allowed Please Resubmit Original Transaction Do Not Resubmit; We Will Hold Your Request and Respond Shortly</td>
</tr>
<tr>
<td>2010A</td>
<td>Always No</td>
<td>AAA – UMO Request Validation</td>
<td>Unable to Respond at Current Time Invalid Participant Identification No Response received – Transaction Terminated Payer Name or Identifier Missing</td>
<td>Resubmission Not Allowed Please Resubmit Original Transaction Do Not Resubmit; We Will Hold Your Request and Respond Shortly</td>
</tr>
<tr>
<td>2010B</td>
<td>Always No</td>
<td>AAA – Requester Request Validation</td>
<td>Required application data missing Out of Network Authorization/Access Restrictions Invalid/Missing Provider Identification Invalid/Missing Provider Name Invalid/Missing Provider Specialty Invalid/Missing Provider Phone Number Invalid/Missing Provider State Provider is Not Primary Care Physician Provider Not on File Invalid Participant Identification Invalid or Missing Provider Address</td>
<td>Please Correct and Resubmit Resubmission Not Allowed Resubmission Allowed</td>
</tr>
<tr>
<td>2010C</td>
<td>Always No</td>
<td>AAA – Subscriber Request Validation</td>
<td>Invalid/Missing Date-of-Birth Invalid/Missing Patient ID Invalid/Missing Patient Name</td>
<td>Please Correct and Resubmit Resubmission Not Allowed</td>
</tr>
<tr>
<td>Claims Tracking</td>
<td>User Guide</td>
<td>82</td>
<td>September 2016</td>
<td></td>
</tr>
<tr>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Always No</th>
<th>AAA – Dependent Request Validation</th>
<th>Required application data missing</th>
<th>Please Correct and Resubmit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Required application data missing</td>
<td>Resubmission Not Allowed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Input Errors</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Invalid/Missing Date-of-Birth</td>
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<td></td>
<td></td>
<td>Invalid/Missing Patient ID</td>
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<td></td>
<td></td>
<td></td>
<td>Invalid/Missing Patient Name</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Invalid/Missing Patient Gender Code</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Patient Not Found</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Duplicate Patient ID Number</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Patient Birth Date Does Not Match That for the Patient on the Database</td>
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<td></td>
<td>Subscriber Found/Patient Not Found</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Invalid Participant Identification</td>
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<td></td>
<td></td>
<td></td>
<td>Patient Not Eligible</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Always No</th>
<th>AAA – Patient Event Request Validation</th>
<th>Required application data missing</th>
<th>Please Correct and Resubmit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td>Required application data missing</td>
<td>Resubmission Not Allowed</td>
</tr>
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<td></td>
<td>Input Errors</td>
<td></td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>Service Date Not Within Provider Plan Enrollment</td>
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<td></td>
<td>Inappropriate Date</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Invalid/Missing Date(s) of Service</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Date of Birth Follows Date(s) of Service</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Date of Death Precedes Date(s) of Service</td>
<td></td>
</tr>
</tbody>
</table>
| 2010EA | Always No | AAA – Patient Event Provider Request Validation | Date of Service Not Within Allowable Inquiry Period  
Authorization Number Not Found  
Invalid/Missing Diagnosis Code(s)  
Invalid/Missing Onset of Current Condition or Illness Date  
Invalid/Missing Accident Date  
Invalid/Missing Last menstrual Period Date  
Invalid/Missing Expected date of Birth  
Invalid/Missing Admission Date  
Invalid/Missing Discharge Date  
Certification Information Missing  
| Required application data missing  
Input Errors  
Out of Network  
Authorization/Access Restrictions  
Invalid/Missing Provider Identification  
Invalid/Missing Provider Name  
Invalid/Missing Provider Specialty  
Invalid/Missing Provider Phone Number  
Invalid/Missing Provider State  
Provider is Not Primary Care Physician  
Provider Not on File  
Service Dates Not Within Provider Plan Enrollment  
Invalid Participant Identification  
Invalid or Missing Provider Address  
Inappropriate Provider Role  
| Please Correct and Resubmit  
Resubmission Not Allowed |
| 2010EC | Always No | AAA – Patient Event Transport Location Request Validation | Required application data missing  
Input Errors  
Invalid/Missing Provider State  
Invalid or Missing Provider Address  
| Please Correct and Resubmit  
Resubmission Not Allowed |
<table>
<thead>
<tr>
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<th>Required application data missing</th>
<th>Please Correct and Resubmit Resubmission Not Allowed</th>
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<tbody>
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<td>Service Dates Not Within Provider Plan Enrollment</td>
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<td>Invalid/Missing Date(s) of Service</td>
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<td></td>
<td>Date of Birth Follows Date(s) of Service</td>
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<td></td>
<td>Date of Death Precedes Date(s) of Service</td>
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<td>Invalid/Missing Procedure Code(s)</td>
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<td>Certification Information Missing</td>
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<td>2010FA</td>
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<td>AAA – Service Provider Request Validation</td>
<td>Required application data missing</td>
<td>Please Correct and Resubmit Resubmission Not Allowed</td>
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<td>Invalid/Missing Provider Identification</td>
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<td>Invalid/Missing Provider State</td>
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<td>Provider is Not Primary Care Physician</td>
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<td>Provider Not on File</td>
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<td></td>
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<td>Service Dates Not Within Provider Plan Enrollment</td>
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<td>Invalid Participant Identification</td>
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<td>Invalid or Missing Provider Address</td>
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<td>Inappropriate Provider Role</td>
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