## Revision History

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<th>Author</th>
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<td>IB<em>2</em>184</td>
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1 INTRODUCTION

In 1996, Congress passed into law the Health Insurance Portability and Accountability Act (HIPAA). This Act directs the federal government to adopt national electronic standards for automated transfer of certain health care data between health care payers, plans, and providers. Now that these standards are in place, the Veterans Health Administration (VHA) will submit electronic 270 Health Care Benefits Eligibility Inquiries to payers and receive 271 Health Care Benefits Eligibility Responses from the payers.

1.1 Electronic Insurance Verification (eIV) Process Flow

The VistA users enter patient insurance information through a variety of processes:
- Insurance information may be entered manually during the Registration process
- It may be entered when the patient’s insurance card is read by the insurance card reader
- A user may enter patient’s insurance information directly into the Patient file using the Patient Insurance Info View/Edit option

Regardless of how the patient’s insurance information gets entered into VistA, it must be verified with the insurance company and the verification must be periodically updated. The goal of the eIV process is to automate as much of the verification process as possible to ensure that the insurance information, used to submit claims for services rendered to the patient, is accurate and up-to-date. This in turn, increases the likelihood of timely reimbursement and increased revenue.

The eIV interface is bi-directional. The HIPAA Health Care Eligibility Benefit Inquiry transaction is referred to as the 270 and the Response is referred to as the 271. The 270 Health Care Eligibility Benefit Inquiry originates at a VAMC VistA system and is transmitted as a Health Level Seven (HL7) message to the Eligibility Communicator at the Financial Services Center (FSC) in Austin, TX. At FSC, the HL7 message is translated into a HIPAA compliant 270 Health Care Eligibility Benefit Inquiry message and sent to one of the VA’s clearinghouses. From the clearinghouse, the 270 message is transmitted to the designated payer.

The 271 Health Care Eligibility Benefit Response originates at the payer and is sent to FSC through the clearinghouse. FSC translates the response back into an HL7 message and transmits it to the originating VAMC VistA system.

![Figure 1. eIV Process Flow](Image)
1.2 Intended Audience
The information in this guide is primarily intended for those users who create, update, accept and reject insurance buffer entries or otherwise maintain patients’ insurance data using VistA Integrated Billing (IB) software.

1.3 The Role of the Insurance Verification Interface
The goal of the electronic insurance verification software is to replace much of the telephone work performed by insurance personnel to verify patients’ health care insurance.

Electronic insurance inquiries can be made to any electronically active payer.

Automating the insurance verification process should result in an increase in the accuracy and timeliness of patient insurance information in VistA. These improvements will, in turn, reduce the number of rejected third-party claims for services rendered to the Veteran by the Veteran’s Administration (VA).

VistA performs both a Buffer Extract and an Appointment Extract. For the Appointment Extract; VistA prepares HL7 inquiries during the night in response to appointment events. For the Buffer Extract, VistA immediately prepares HL7 inquiries in response to registration and check in events. The HL7 inquiries are transmitted to the Eligibility Communicator at the FSC. The messages are translated into 270 Health Care Eligibility Benefits Inquiry messages. They are then sent to the VA’s clearinghouses who then distribute them to the correct insurance companies. The 271 Health Care Eligibility Benefits Responses are returned from the payer through the clearinghouses to FSC for translation into an HL7 format and then transmitted to the originating VistA system. There the information is either placed into the insurance buffer for the insurance clerk to review and process to the patient’s insurance file or used to automatically update the patient’s insurance file.
Automatic updates are made only when a response meets pre-determined criteria. The criteria vary slightly depending upon the situation (e.g. Non-Medicare insurance when the Patient is the Insurance Subscriber will be different from Non-Medicare insurance when the Patient is a dependant of the Insurance Subscriber). Below is an example of some of the criteria:

1. Automatic Update Setting = Yes; and
2. Subscriber ID (VistA) = Subscriber ID (271 Response); and
3. Subscriber DOB (VistA) = Subscriber DOB (271 Response); and
4. Subscriber’s Name (VistA) = Subscriber Name (271 Response) and
5. Group Number (VistA) = Group Number (271 Response),

Note: The **Automatic Update Setting** is also referred to as the **Trusted Payer Flag**.

### 1.4 National Insurance Payers

In order for the various VistA sites to be able to request eligibility information from the various payers, a national VA insurance payer list has been established. The national payer list provides a standard identification system for all payers that are participating in this process. Each VistA site has the ability to link the insurance companies in their own database to the appropriate payer in the national payer list. This standardizes the identification of the payer to which each inquiry will be directed.
Figure 3. Flowchart of Inquiries from VistA to Payers and Responses from Payers to VistA
## Site Parameters

Each VistA site can use the **eIV parameters** to configure some aspects of the eIV software in order to meet a site's unique requirements.

<table>
<thead>
<tr>
<th>General Parameter</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freshness Days</td>
<td>How frequently should insurance information be re-verified? 7-180 Days</td>
</tr>
<tr>
<td>Daily Mailman MSG</td>
<td>Should the eIV Statistical Report be sent out in an email each day? YES/NO</td>
</tr>
<tr>
<td>Daily MSG Time</td>
<td>When should the eIV Statistical Report be sent each day?</td>
</tr>
<tr>
<td>Messages MailGroup</td>
<td>To which mailgroup should the eIV Statistical Report be sent?</td>
</tr>
<tr>
<td>HL7 Response Processing</td>
<td>Should FSC return each 270 Health Care Eligibility/Benefit Responses to the site immediately or in larger batches? Immediate or Batch</td>
</tr>
<tr>
<td>Contact Person</td>
<td>Who is the site’s POC for eIV problems? This is the person the FSC will coordinate with if there are any problems.</td>
</tr>
<tr>
<td>Office Phone:</td>
<td>What is the POC’s phone number?</td>
</tr>
<tr>
<td>EMAIL Address</td>
<td>What is the POC’s email address?</td>
</tr>
<tr>
<td>Failure Mailman MSG</td>
<td>Send a mail message for communication failures? YES/NO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Batch - Buffer Extract</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active?</td>
<td>Not Editable – Buffer Extract will be turned on.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Batch – Appointment Extract</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active?</td>
<td>Not Editable – Appointment Extract will be turned on.</td>
</tr>
<tr>
<td>Selection Criteria #1</td>
<td>Not Editable – Appointment extracts will search for appointments scheduled for the next 10 days.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Batch – Non-verified Extract</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active?</td>
<td>Not Editable – Non-Verified Extract will be turned off.</td>
</tr>
<tr>
<td>Selection Criteria #1</td>
<td>Not Editable – Non-Verified Extract will be turned off.</td>
</tr>
<tr>
<td>Selection Criteria #2</td>
<td>Not Editable – Non-Verified Extract will be turned off.</td>
</tr>
<tr>
<td>MAXIMUM EXTRACT NUMBER</td>
<td>Not Editable – Non-Verified Extract will be turned off.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Batch – No Insurance Extract</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removed with Patch IB<em>2</em>416</td>
<td></td>
</tr>
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</table>
2.1 Define General Parameters

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access the SYST MCCR System Definition Menu.</td>
</tr>
<tr>
<td>2</td>
<td>Access the SITE MCCR Site Parameter Display/Edit option.</td>
</tr>
<tr>
<td>3</td>
<td>At the Select Action: prompt, enter IV for Ins. Verification.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IB Site Parameters</th>
<th>Claims Tracking Parameters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Definition</td>
<td>General Parameters</td>
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<tr>
<td>Mail Groups</td>
<td>Tracking Parameters</td>
</tr>
<tr>
<td>Patient Billing</td>
<td>Random Sampling</td>
</tr>
<tr>
<td>Third Party Billing</td>
<td></td>
</tr>
<tr>
<td>Provider Id</td>
<td></td>
</tr>
<tr>
<td>EDI Transmission</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Third Party Auto Billing Parameters</th>
<th>Insurance Verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Parameters</td>
<td>General Parameters</td>
</tr>
<tr>
<td>Inpatient Admission</td>
<td>Batch Extracts Parameters</td>
</tr>
<tr>
<td>Outpatient Visit</td>
<td>Service Type Codes</td>
</tr>
<tr>
<td>Prescription Refill</td>
<td></td>
</tr>
</tbody>
</table>

actions
IB Site Parameter AB Automated Billing EX Exit
CT Claims Tracking IV Ins. Verification
Select Action: Quit// IV Ins. Verification
The following screen will be displayed.

```
Days between electronic re-verification checks: 30
Send daily statistical report via MailMan: YES
Time of day for daily statistical report: 0700
Mail Group for eIV messages: IBCNE EIV MESSAGE
HL7 Response Processing Method: IMMEDIATE
Contact Person: TESTER, IB
Send MailMan message if communication problem: YES

<table>
<thead>
<tr>
<th>Extract</th>
<th>Selection</th>
<th>Maximum # to Extract/Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buffer</td>
<td>ON</td>
<td>n/a</td>
</tr>
<tr>
<td>Appt</td>
<td>ON</td>
<td>10</td>
</tr>
</tbody>
</table>

GP  General Parameters  ST  Service Type Codes  EX  Exit
Select Action: Quit//
```

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>At the <strong>Select Action:</strong> prompt, enter <strong>GP</strong> for <strong>General Parameters</strong>.</td>
</tr>
</tbody>
</table>

**General Parameters**

- **FRESHNESS DAYS:** 180
- **DAILY MAILMAN MSG:** YES
- **DAILY MSG TIME:** 0700
- **MESSAGES MAILGROUP:** IBCNE EIV MESSAGE
- **HL7 RESPONSE PROCESSING:** Immediate
- **CONTACT PERSON:** IBclerk,One
- **OFFICE PHONE:** (777) 777-7777
- **EMAIL ADDRESS:** Clerk.IB@MEDVA.GOV Replace
- **FAILURE MAILMAN MSG:** YES

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>At the <strong>Freshness Days</strong> prompt, enter a number between 7 and <strong>180</strong>.</td>
</tr>
<tr>
<td>6</td>
<td>At the <strong>Daily Mailman MSG</strong> prompt, enter <strong>YES</strong>.</td>
</tr>
<tr>
<td>7</td>
<td>At the <strong>Daily MSG Time</strong> prompt, enter <strong>0700</strong>.</td>
</tr>
<tr>
<td>8</td>
<td>At the <strong>MESSAGES MAILGROUP</strong> prompt, enter <strong>IBCNE EIV MESSAGE</strong>.</td>
</tr>
<tr>
<td>9</td>
<td>At the <strong>HL7 Response Processing</strong> prompt, enter <strong>Immediate</strong>.</td>
</tr>
<tr>
<td>10</td>
<td><strong>Patch IB<em>2</em>416 removed the prompt HL7 MAXIMUM NUMBER. A site can no longer limit the number of daily inquiries.</strong></td>
</tr>
<tr>
<td>11</td>
<td>At the <strong>Contact Person</strong> prompt, enter the <strong>Name</strong> of your site’s contact person.</td>
</tr>
<tr>
<td>12</td>
<td>At the <strong>Office Phone</strong> prompt, enter the <strong>Number</strong> of your site’s contact person.</td>
</tr>
<tr>
<td>13</td>
<td>At the <strong>eMail Address</strong> prompt, enter the <strong>Email</strong> of your site’s contact person.</td>
</tr>
</tbody>
</table>
Step | Procedure
--- | ---
13 | At the **Failure Mailman MSG:** prompt, enter **YES**.

The user will then be returned to the eIV Site Parameters Screen.

### eIV Site Parameters

| Days between electronic re-verification checks: | 30 |
| Send daily statistical report via MailMan: | YES |
| Time of day for daily statistical report: | 0700 |
| Mail Group for eIV messages: | IBCNE EIV MESSAGE |
| HL7 Response Processing Method: | IMMEDIATE |
| Contact Person: | IBclerk, One |
| Send MailMan message if communication problem: | YES |

<table>
<thead>
<tr>
<th>Extract Name</th>
<th>On/Off</th>
<th>Selection Criteria</th>
<th>Maximum # to Extract/Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buffer</td>
<td>ON</td>
<td>n/a</td>
<td>99999</td>
</tr>
<tr>
<td>Appt</td>
<td>ON</td>
<td>10</td>
<td>99999</td>
</tr>
</tbody>
</table>

2.2 **Define Batch Extract Parameters**

Patch IB*2*438 removed the ability for the sites to define Batch Extract Parameters.

- **Patch IB*2*416** removed the ability for sites to define Buffer and Appointment parameters. No insurance parameters were removed as no inquiries will be sent for patients w/o insurance.
- **Patch IB*2*438** set Non-verified parameters to Not Active and Non-editable.
- **Patch IB*2*438** updated the eIV system to no longer check for freshness days (‘Days between electronic re-verification checks’ defined in the MCCR site parameter) for eligibility benefit inquiries that are available in the buffer and are awaiting transmission in the transmission queue.
- Appointment extracts will skip policies whose last verified date is less than the freshness days from creating buffer entries.
- The “Pt. Relationship to Insured” will default as “Self” when the field is null for ANY file source.
### 2.3 Define Service Type Code Parameters

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access the SYST MCCR System Definition Menu.</td>
</tr>
<tr>
<td>2</td>
<td>Access the SITE MCCR Site Parameter Display/Edit option.</td>
</tr>
<tr>
<td>3</td>
<td>At the Select Action: prompt, enter IV for Ins. Verification.</td>
</tr>
<tr>
<td>4</td>
<td>At the Select Action: prompt, enter ST for Service Type Codes.</td>
</tr>
</tbody>
</table>

*This is new for patch IB**2**438. Inquiries may now be sent for multiple Service Type Codes, specified by user. Responses also include multiple Service Type Codes.*

The following screen will be displayed:

```
Service Type Codes

Default Service Type Codes
1 - Medical Care                        7 - Anesthesia
30 - Health Benefit Plan Cov           47 - Hospital
54 - Long Term Care                   62 - MRI/CAT Scan
75 - Prosthetic Device                88 - Pharmacy
97 - Anesthesiologist                98 - Prof(Phy) Visit/Office
IC - Intensive Care

Site Selected Service Type Codes

Enter ?? for more information
AS  Add a Service Type Code   DS  Delete a Service Type Code
EX  Exit
Select Action: Exit//AS  Add a Service Type Code from a list of available codes
```

The following example shows how to add a new Site Selected Service Type Codes. For ex. Service Type Code, 10 – Blood Charges.

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>At the Select Action: prompt, enter AS for Add a Service Type Code.</td>
</tr>
</tbody>
</table>

The following screen will be displayed:

```
2 Surgical
3 Consultation
4 Diagnostic X-Ray
```
At the Enter RETURN to continue, code mnemonic/# to add, or '^' to exit: prompt, enter the **Service Type Code** required, in this example, enter **10** for Blood Charges.

*As demonstrated above, if the Service Type Code is known, it can be selected without paging through the entire list.*

The user will be returned to the **Service Types Codes** screen.

### Service Type Codes

#### Default Service Type Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medical Care</td>
</tr>
<tr>
<td>7</td>
<td>Anesthesia</td>
</tr>
<tr>
<td>30</td>
<td>Health Benefit Plan Cov</td>
</tr>
<tr>
<td>47</td>
<td>Hospital</td>
</tr>
<tr>
<td>54</td>
<td>Long Term Care</td>
</tr>
<tr>
<td>62</td>
<td>MRI/CAT Scan</td>
</tr>
<tr>
<td>75</td>
<td>Prosthetic Device</td>
</tr>
<tr>
<td>88</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>97</td>
<td>Anesthesiologist</td>
</tr>
<tr>
<td>98</td>
<td>Prof(Phy) Visit/Office</td>
</tr>
<tr>
<td>IC</td>
<td>Intensive Care</td>
</tr>
</tbody>
</table>

#### Site Selected Service Type Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Blood Charges</td>
</tr>
</tbody>
</table>

Enter ?? for more information

AS  Add a Service Type Code  DS  Delete a Service Type Code  EX  Exit
Select Action: Exit//

### Delete a Service Type Code

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access the <strong>SYST MCCR System Definition Menu</strong>.</td>
</tr>
<tr>
<td>2</td>
<td>Access the <strong>SITE MCCR Site Parameter Display/Edit</strong> option.</td>
</tr>
<tr>
<td>Step</td>
<td>Procedure</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
</tr>
<tr>
<td>3</td>
<td>At the <strong>Select Action:</strong> prompt, enter IV for Ins. Verification.</td>
</tr>
<tr>
<td>4</td>
<td>At the <strong>Select Action:</strong> prompt, enter ST for Service Type Codes.</td>
</tr>
<tr>
<td>5</td>
<td>At the <strong>Select Action:</strong> prompt, enter DS for Delete a Service Type Code.</td>
</tr>
<tr>
<td>6</td>
<td>Enter the Service Type Code number to be deleted.</td>
</tr>
</tbody>
</table>

**Service Type Codes**

**Default Service Type Codes**

1 - Medical Care  
30 - Health Benefit Plan Cov  
54 - Long Term Care  
75 - Prosthetic Device  
97 - Anesthesiologist  
IC - Intensive Care  
7 - Anesthesia  
47 - Hospital  
62 - MRI/CAT Scan  
88 - Pharmacy  
98 - Prof(Phy) Visit/Office

**Site Selected Service Type Codes**

10 - Blood Charges  
19 - Pneumonia Vaccine  
22 - Social Work  
79 - Allergy Testing  
EX  Exit

Select Action: Exit//DS Delete a Service Type Code from a list of existing codes

Select one of the following:

10  Blood Charges  
19  Pneumonia Vaccine  
22  Social Work  
79  Allergy Testing

Delete Service Type Code: 19  Pneumonia Vaccine..Deleted

---

**This will delete the Site Selected Service Type Code. Only Site Selected Service Type Codes can be deleted. Default Service Type Codes cannot be deleted.**

The user will be returned to the **Service Types Codes** screen.
### Default Service Type Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medical Care</td>
</tr>
<tr>
<td>7</td>
<td>Anesthesia</td>
</tr>
<tr>
<td>30</td>
<td>Health Benefit Plan Cov</td>
</tr>
<tr>
<td>47</td>
<td>Hospital</td>
</tr>
<tr>
<td>54</td>
<td>Long Term Care</td>
</tr>
<tr>
<td>62</td>
<td>MRI/CAT Scan</td>
</tr>
<tr>
<td>75</td>
<td>Prosthetic Device</td>
</tr>
<tr>
<td>88</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>97</td>
<td>Anesthesiologist</td>
</tr>
<tr>
<td>98</td>
<td>Prof(Phy) Visit/Office</td>
</tr>
<tr>
<td>1C</td>
<td>Intensive Care</td>
</tr>
</tbody>
</table>

### Site Selected Service Type Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Blood Charges</td>
</tr>
<tr>
<td>22</td>
<td>Social Work</td>
</tr>
<tr>
<td>79</td>
<td>Allergy Testing</td>
</tr>
</tbody>
</table>

Enter **??** for more information

AS  Add a Service Type Code  DS  Delete a Service Type Code
EX  Exit
Select Action: Exit//
3 Payers
The VistA Payer file (#365.12) is a VA national file of insurance companies within each VistA system. It is automatically updated when a payer is enrolled and registered at the FSC by Chief Business Office (CBO). It is non-editable at the facility level and the same data exists in this file at all VistA locations. However, the VistA locations do have the option to locally activate/deactivate payers.

When a 270 Health Care Eligibility Benefits Inquiry is constructed, it is this payer name in the Payer file (#365.12), not the Insurance Company name, which is transmitted with the inquiry. In order for an individual insurance company to participate in the eIV process, it must be linked to a payer in the Payer file. It is important to note that:
- An insurance company can be linked to only one payer.
- Many insurance companies can be linked to a single payer.
- The payer must also be active locally in order for it to be eligible for inclusion in the eIV process.

3.1 Link Insurance Company to Payers using Link Insurance Company to Payers

The Link Insurance Companies to Payers option provides a tool for identifying potential matches of active Insurance Companies with Professional and Institutional IDs that are not linked to a particular Payer. Professional and Institutional Payer Primary ID fields correspond respectively to the EDI ID NUMBER – PROF and EDI ID NUMBER – INST fields in the Insurance Company Editor.

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access the PI Patient Insurance Menu.</td>
</tr>
<tr>
<td>2</td>
<td>Access the PM Payer Maintenance option.</td>
</tr>
<tr>
<td></td>
<td>Users must hold the IB INSURANCE SUPERVISOR security key to access this option.</td>
</tr>
<tr>
<td>3</td>
<td>Access the LI Link Insurance Companies to Payers option.</td>
</tr>
<tr>
<td></td>
<td>The system finds potential matches for users based on matching Payer Primary ID fields in the Insurance Company Editor. Please note that all matches are not definitive and should be linked at the users discretion.</td>
</tr>
</tbody>
</table>

The following screen of Payers who have potentially matching insurance company entries will be displayed.
Payer Maintenance

<table>
<thead>
<tr>
<th>Payer Name</th>
<th># Potential Matches</th>
</tr>
</thead>
<tbody>
<tr>
<td>IBpayer One</td>
<td>2</td>
</tr>
<tr>
<td>IBpayer Two</td>
<td>1</td>
</tr>
<tr>
<td>IBpayer Three</td>
<td>3</td>
</tr>
<tr>
<td>IBpayer Four</td>
<td>1</td>
</tr>
</tbody>
</table>

Enter ?? for more actions

EE Expand Entry  EX  Exit
Selected Action: Quit/

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>At the <strong>Select Action:</strong> prompt, enter <strong>EE</strong> for <strong>Expand Entry</strong>.</td>
</tr>
<tr>
<td>5</td>
<td>At the <strong>Select entry to Expand, by line #: (1-5):</strong> prompt, enter 2 for this example.</td>
</tr>
</tbody>
</table>

The following screen will be displayed.

<table>
<thead>
<tr>
<th>Insurance Company Name - Active Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Company Name</td>
</tr>
<tr>
<td>IBinsurance Two A</td>
</tr>
<tr>
<td>IBinsurance Two B</td>
</tr>
</tbody>
</table>

Enter ?? for more actions

PL Print List  EX  Exit
LP Link Payer
Selected Action: Quit/

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>At the <strong>Select Action:</strong> prompt, enter <strong>LP</strong> for <strong>Link Payer</strong>.</td>
</tr>
<tr>
<td>7</td>
<td>At the <strong>Select 1 or more Insurance Company Entries:</strong> prompt, enter 1-2 for this example.</td>
</tr>
<tr>
<td>8</td>
<td>At the <strong>OK to proceed? YES//</strong> prompt, press RETURN to accept the default of YES.</td>
</tr>
</tbody>
</table>

*Patch IB*2*416 provided the ability to link more than one insurance company to a payer at one time.*

*Users also have the option to print a list of insurance companies that may match a Payer. The list can be printed to a printer or to the screen.*
Select 1 or more Insurance Company Entries: (1-2): 1-2

You have selected 2 insurance companies to be linked to payer IBpayer Two.
OK to proceed? YES/

Link process is complete.
You may view/edit this relationship by using the Insurance Company Entry/Edit option.

Enter RETURN to continue or '"' to exit:

To print the details, go back to Expand Entry and select Print List as detailed below.

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access the PI Patient Insurance Menu.</td>
</tr>
<tr>
<td>2</td>
<td>Access the PM Payer Maintenance option.</td>
</tr>
<tr>
<td>3</td>
<td>Access the LI Link Insurance Companies to Payers option.</td>
</tr>
<tr>
<td>4</td>
<td>At the Select Action: prompt, enter EE for Expand Entry.</td>
</tr>
<tr>
<td>5</td>
<td>At the Select entry to Expand, by line #: (1-5): (1-5): prompt, enter 2 for this example.</td>
</tr>
<tr>
<td>6</td>
<td>At the Select Action: prompt, enter PL for Print List.</td>
</tr>
<tr>
<td>7</td>
<td>At the Device://Home: prompt enter RETURN to display to the screen or enter a device name.</td>
</tr>
</tbody>
</table>

The following screen will be displayed.

Payer Expand Screen    Sep 22, 2009@14:45:22    Page:    1 of    1
PAYER: IBpayer Two     Prof. EDI#:11111  Inst. EDI#:11111
Insurance Company Name - Active Only

<table>
<thead>
<tr>
<th>Insurance Company Name</th>
<th>Address</th>
<th>Prof#</th>
<th>Inst#</th>
</tr>
</thead>
<tbody>
<tr>
<td>IBinsurance Two A</td>
<td>PO BOX 5555 SCRANTON, PA</td>
<td>11111</td>
<td>11111</td>
</tr>
<tr>
<td>IBinsurance Two B</td>
<td>PO BOX 555555 COLUMBUS OHIO</td>
<td>11111</td>
<td>11111</td>
</tr>
</tbody>
</table>

Enter RETURN to continue or '"' to exit:

3.2 Link Insurance Company to Payers using Insurance Company Editor

When VistA is unable for any reason to identify an insurance company as a potential match to a payer, users can link the insurance company to a payer from within the Insurance Company Editor.

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access the PI Patient Insurance Menu.</td>
</tr>
<tr>
<td>2</td>
<td>Access the EI Insurance Company Entry/Edit option.</td>
</tr>
<tr>
<td>3</td>
<td>At the Select INSURANCE COMPANY NAME: prompt, enter IBinsurance Two A for this example.</td>
</tr>
</tbody>
</table>
The following screen will be displayed.

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>At the Select Action: prompt, enter PA for Payer.</td>
</tr>
<tr>
<td>5</td>
<td>At the Payer: prompt, enter ?? to see a list of Payers.</td>
</tr>
<tr>
<td>6</td>
<td>At the Payer: prompt, enter IBpayer Two for this example.</td>
</tr>
</tbody>
</table>

To view the linked Payer for a particular insurance company, users may access VI for View Insurance Company.

The following screen will be displayed.
To view the linked payer for an insurance company, go back to the **Patient Insurance Menu** and select **View Insurance Company**.

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access the <strong>PI Patient Insurance Menu</strong>.</td>
</tr>
<tr>
<td>2</td>
<td>Access the <strong>VI View Insurance Company</strong> option.</td>
</tr>
<tr>
<td>3</td>
<td>At the <strong>Select INSURANCE COMPANY NAME:</strong> prompt, enter <strong>IBinsurance Two A</strong> for this example.</td>
</tr>
</tbody>
</table>

The following screen will be displayed.
3.3 Payer Edit (Activate/Inactivate)

To edit the payer information users must use the Payer Maintenance Menu. The Payer Edit option is restricted to users with the IB INSURANCE SUPERVISOR security key.

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access the PI Patient Insurance Menu.</td>
</tr>
<tr>
<td>2</td>
<td>Access the PM Payer Maintenance Menu.</td>
</tr>
<tr>
<td>3</td>
<td>Access the PE Payer Edit (Activate/Inactivate) option.</td>
</tr>
<tr>
<td>4</td>
<td>At the Payer Name: prompt, enter IBpayer Two for this example.</td>
</tr>
</tbody>
</table>

Users must hold the IB INSURANCE SUPERVISOR security key to access Payer Edit.

The following screen will be displayed.

```
Payer Edit

This option allows you to view the data in the Payer file for a particular Payer. You may only edit local flags. Most of the fields in the Payer file are not editable. This data comes into VistA electronically. If an application has been deactivated, the local flag cannot be edited.

    Payer Name: IBpayer Two
    VA National ID: VA10
    CMS National ID: 
    Inst Electronic Bill ID: 11111
    Prof Electronic Bill ID: 11111
    Date/Time Created: 09/23/2003@10:54:57

    Payer Application: eIV
    National Active: Active
    Future Service Days: 9999
    Past Service Days: 9999
    Auto-update Pt. Insurance: YES
    Local Active: Active//
```

The following screen will be displayed.

```
Payer Edit

This option allows you to view the data in the Payer file for a particular Payer. You may only edit local flags. Most of the fields in the Payer file are not editable. This data comes into VistA electronically. If an application has been deactivated, the local flag cannot be edited.

    Payer Name: IBpayer Two
    VA National ID: VA10
    CMS National ID: 
    Inst Electronic Bill ID: 11111
    Prof Electronic Bill ID: 11111
    Date/Time Created: 09/23/2003@10:54:57

    Payer Application: eIV
    National Active: Active
    Future Service Days: 9999
    Past Service Days: 9999
    Auto-update Pt. Insurance: YES
    Local Active: Active//
```

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>At the Local Active: prompt, users can locally Activate or Deactivate a Payer. Press RETURN to accept the default for this example.</td>
</tr>
</tbody>
</table>

Users can only Activate/Deactivate a Payer locally. The remainder of the Payer information is set by FSC.

A payer must be nationally ACTIVE and locally ACTIVE for 270/271 Health Care Eligibility Inquiry and Response messages to be transmitted.

Patch IB*2*416 removed the ability for patient SSNs be transmitted as IDs in a 270 Health Care Eligibility Inquiry so those prompts were removed from Payer Edit.
4 PROCESS INSURANCE BUFFER

The Process Insurance Buffer option provides four buffer views from which users may process entries and thus update patients' insurance information in the patient file:

- **Positive Insurance Buffer** – Positive 271 Health Care Eligibility Benefits Responses (that failed to meet the auto-update criteria and are non-Medicare WNR) and Manual Entries
- **Negative Insurance Buffer** - Negative 271 Health Care Eligibility Benefits Responses (non-Medicare WNR)
- **Medicare (WNR) Insurance Buffer** – Positive, Negative or Ambiguous 271 Health Care Eligibility Benefits Responses (that failed to meet the auto-update criteria and are Medicare WNR)
- **Future Appointments Buffer** – List of patients with future appointments for which the system was unable to generate 270 Health Care Eligibility Benefits Inquiries

4.1 Status Flags

4.1.1 Buffer Symbols

<table>
<thead>
<tr>
<th>Flag</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>(blank)</td>
<td>Inquiry not yet sent</td>
</tr>
<tr>
<td>+</td>
<td>Matching patient data was found at payer, payer indicates active policy</td>
</tr>
<tr>
<td>-</td>
<td>Matching patient data was found at payer, payer indicates expired policy</td>
</tr>
<tr>
<td>#</td>
<td>eIV is unable to determine if payer indicates active or expired policy OR matching patient data was NOT found at payer</td>
</tr>
<tr>
<td>?</td>
<td>Inquiry was sent, waiting for response</td>
</tr>
<tr>
<td>!</td>
<td>eIV was unable to send an inquiry for this entry. A manual correction is required before eIV can send inquiry. A descriptive error message will be displayed on the last screen of the expanded buffer entry.</td>
</tr>
</tbody>
</table>

4.1.2 Buffer Entry Status Flags

<table>
<thead>
<tr>
<th>Flag</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>*</td>
<td>This entry has been manually verified and the asterisk is not an eIV indicator.</td>
</tr>
<tr>
<td>d</td>
<td>Patient appears on more than one buffer view (Duplicate).</td>
</tr>
</tbody>
</table>

4.1.3 Patient Status Flags

<table>
<thead>
<tr>
<th>Flag</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>i</td>
<td>Patient currently has active insurance on file</td>
</tr>
<tr>
<td>I</td>
<td>Patient is currently admitted as an inpatient</td>
</tr>
<tr>
<td>E</td>
<td>Patient is deceased (expired)</td>
</tr>
<tr>
<td>Y</td>
<td>Patient is required to pay VA copayment for incurred charges according to Means Test</td>
</tr>
<tr>
<td>Flag</td>
<td>Meaning</td>
</tr>
<tr>
<td>------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>H</td>
<td>Patient has charges on hold</td>
</tr>
</tbody>
</table>

### 4.1.4 Buffer Entry Source of Information Indicators

<table>
<thead>
<tr>
<th>Letter</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Interview</td>
</tr>
<tr>
<td>P</td>
<td>Pre-registration</td>
</tr>
<tr>
<td>M</td>
<td>Medicare</td>
</tr>
<tr>
<td>D</td>
<td>Data Match</td>
</tr>
<tr>
<td>E</td>
<td>eIV Appointment Extract</td>
</tr>
<tr>
<td>R</td>
<td>Insurance Capture Buffer</td>
</tr>
<tr>
<td>V</td>
<td>IVM</td>
</tr>
<tr>
<td>H</td>
<td>HMS</td>
</tr>
<tr>
<td>C</td>
<td>Contract Services</td>
</tr>
</tbody>
</table>

### 4.1.5 Insurance Entry Update Methods

<table>
<thead>
<tr>
<th>Letter</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>Merge - Data from the buffer entry will be saved to the insurance entry ONLY if the corresponding data field in the insurance entry is blank.</td>
</tr>
<tr>
<td>O</td>
<td>Overwrite - ALL non-blank data in the buffer entry will be saved to the insurance entry. If a buffer entry field has a value it will be saved to the corresponding insurance entry field. Blank insurance fields will be filled and existing insurance data replaced.</td>
</tr>
<tr>
<td>R</td>
<td>Replace - ALL fields in the buffer entry will be saved to the insurance entry, including blank fields. Therefore all data in the insurance entry will be deleted then completely replaced by the buffer entry.</td>
</tr>
<tr>
<td>N</td>
<td>No Change - This option may be used to identify the Insurance entry that corresponds to a buffer entry without actually changing any of the Insurance Information. The Buffer data is ignored.</td>
</tr>
<tr>
<td>I</td>
<td>Individually Accept - This option may be used to accept only non-blank specific fields from the buffer entry into the Insurance entry. Only those values accepted by the user will replace the corresponding fields in the Insurance entry.</td>
</tr>
</tbody>
</table>

See Appendix B for a detailed list of error messages associated with entries that were created because a 270 Health Care Eligibility Benefits Inquiry could not be transmitted.

### 4.2 Buffer Actions

All views provide users the same actions although the **Future Appointments Buffer** has no access to 271 Health Care Eligibility Benefits Response data as this list is comprised of Appointment Extract entries that failed to create a 270 Health Care Eligibility Benefits Inquiry. These will most likely be patient policies that are not linked to
an eIV nationally activated payer. Note that patients with no insurance on file will not be included in the nightly Buffer Extract.

These following actions are available in Process Insurance Buffer:

- **PE** – Process Entry
- **RE** – Reject Entry
- **EE** – Expand Entry
- **AE** – Add Entry
- **SL** – Sort Entry
- **CC** – Check Ins. Co.
- **PB** – Positive Buffer
- **NB** – Negative Buffer
- **MB** – Medicare Buffer
- **FA** – Future Appointments Buffer
- **EX** – Exit

These following actions are hidden, but available in Process Insurance Buffer:

- + – Next Screen
- - – Previous Screen
- **UP** – Up a Line
- **DN** – Down a Line
- > - Shift view to Right
- < - Shift view to Left
- **FS** – First Screen
- **LS** – Last Screen
- **GO** – Go to Page
- **RD** – Re Display Screen
- **PS** – Print Screen
- **PL** – Print List
- **SL** – Search List
- **ADPL** – Auto Display (On/Off)
- **Q** - Quit

### 4.2.1 Process Entry

Processing an entry in a Buffer View results in updating the patient’s insurance and removing the entry from the buffer. Once users access Process Entry, they will have access to the following additional actions:

- **Accept Entry** - Allows users to update the patient’s insurance and remove the entry from the buffer
- **Reject Entry** – Allows users to remove the entry from the buffer without updating the patient’s insurance
- **Compare Entry** – Allows users to compare the data in the buffer with the data in the patient’s insurance
- **Expand Entry** – Allows users to Expand an Entry – Refer to Section 4.2.3
- **Insurance Co/Patient** – Allows users to view specific information about an insurance company’s available policies

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access the <strong>PI Patient Insurance Menu</strong>.</td>
</tr>
<tr>
<td>2</td>
<td>Access the <strong>BI Process Insurance Buffer</strong> option.</td>
</tr>
<tr>
<td></td>
<td><em>The default Insurance Buffer view is the Positive Insurance Buffer and users can move between views using the action for each view.</em></td>
</tr>
<tr>
<td></td>
<td><em>Some actions such as Reject Entry are only available to users who hold the <strong>IB INSURANCE SUPERVISOR</strong> key.</em></td>
</tr>
</tbody>
</table>

The following screen will be displayed.
**Positive Insurance Buffer**  
May 21, 2010@10:18:01  
Page: 1 of 1

Sorted by: Positive Response

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Insurance Company</th>
<th>Subscr Id</th>
<th>S Entered</th>
<th>iIEYH</th>
</tr>
</thead>
<tbody>
<tr>
<td>+IBpatient,One</td>
<td>XXXX IBinsurance One</td>
<td>SUB ID XXXX</td>
<td>E 05/18/10</td>
<td>i</td>
</tr>
<tr>
<td>+IBpatient,Two</td>
<td>XXXX IBinsurance One</td>
<td>SUB ID XXXX</td>
<td>E 05/18/10</td>
<td>i</td>
</tr>
<tr>
<td>+IBpatient,Three</td>
<td>XXXX IBinsurance One</td>
<td>SUB ID XXXX</td>
<td>E 05/18/10</td>
<td>i</td>
</tr>
<tr>
<td>+IBpatient,Four</td>
<td>XXXX IBinsurance Two</td>
<td>SUB ID XXXX</td>
<td>P 09/21/04</td>
<td>Y</td>
</tr>
<tr>
<td>+IBpatient,Five</td>
<td>XXXX IBinsurance Four</td>
<td>SUB ID XXXX</td>
<td>P 03/31/05</td>
<td></td>
</tr>
<tr>
<td>+IBpatient,Six</td>
<td>XXXX IBinsurance Four</td>
<td>SUB ID XXXX</td>
<td>P 12/08/04</td>
<td></td>
</tr>
<tr>
<td>+IBpatient,Seven</td>
<td>XXXX IBinsurance Two</td>
<td>SUB ID XXXX</td>
<td>P 11/30/04</td>
<td>Y</td>
</tr>
<tr>
<td>+IBpatient,Eight</td>
<td>XXXX IBinsurance Four</td>
<td>SUB ID XXXX</td>
<td>P 02/28/05</td>
<td>YH</td>
</tr>
<tr>
<td>+IBpatient,Nine</td>
<td>XXXX IBinsurance Two</td>
<td>SUB ID XXXX</td>
<td>I 03/29/05</td>
<td>Y</td>
</tr>
<tr>
<td>+IBpatient,Ten</td>
<td>XXXX IBinsurance Three</td>
<td>SUB ID XXXX</td>
<td>I 11/16/04</td>
<td></td>
</tr>
<tr>
<td>+IBpatient,Eleven</td>
<td>XXXX IBinsurance Two</td>
<td>SUB ID XXXX</td>
<td>P 03/31/05</td>
<td>YH</td>
</tr>
<tr>
<td>+IBpatient,Twelve</td>
<td>XXXX IBinsurance Five</td>
<td>SUB ID XXXX</td>
<td>I 03/24/05</td>
<td>H</td>
</tr>
</tbody>
</table>

+ Verified + Active ? Await/Reply

**Process Entry**  
**AE Add Entry**  
**PB Pos. Buffer**  
**FA Future Appts.**

**RE Reject Entry**  
**ST Sort List**  
**NB Neg. Buffer**  
**EX Exit**

**EE Expand Entry**  
**CC Check Ins Co’s**  
**MB Medicare Buffer**

Select Action: Next Screen//

---

**Step**  
3 At the **Select Action:** prompt, enter **PE** for **Process Entry**.

4 At the **Select Buffer Entry(s):** (1-12): prompt, enter 1 for this example.

---

The following screen will be displayed.

**Insurance Buffer Process**  
May 21, 2010@10:21:24  
Page: 1 of 1

IBpatient,One  
XXX-XX-XXX  DOB: XXX XX,XXXX AGE: XX

IBinsurance One  
(P.O. BOX 555555, CLEVELAND, OH)
- IBinsurance One  
229021915  
142239340  
PATIEN 10/01/00

Patient's Existing Insurance

<table>
<thead>
<tr>
<th>Insurance Company</th>
<th>Group #</th>
<th>Subscriber Id</th>
<th>Holder</th>
<th>Effective Expires</th>
</tr>
</thead>
<tbody>
<tr>
<td>IBinsurance Two</td>
<td>GRP NUM 11269</td>
<td>SUB ID XXXX</td>
<td>PATIEN 04/01/95 10/01/00</td>
<td></td>
</tr>
</tbody>
</table>

Any Group/Plan that may match Group Name or Group Number

<table>
<thead>
<tr>
<th>Insurance Company</th>
<th>Group Name</th>
<th>Group Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 IBinsurance Two</td>
<td>PO BOX 740800</td>
<td>XXXX</td>
</tr>
<tr>
<td>3 IBinsurance Two</td>
<td>PO BOX 740800</td>
<td>XXXX</td>
</tr>
</tbody>
</table>

Enter ?? for more actions

**AE Accept Entry**  
**CE Compare Entry**  
**VP Insurance Co/Patient**

**RE Reject Entry**  
**EE Expand Entry**  
**EX Exit**

Select Action: Quit//
The following screen will be displayed.

<table>
<thead>
<tr>
<th>Insurance Data: Buffer Data</th>
<th>Selected Insurance Company</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company Name: IBinsurance One</td>
<td>IBinsurance Two</td>
</tr>
<tr>
<td>Reimburse?:</td>
<td>WILL REIMBURSE</td>
</tr>
<tr>
<td>Phone Number: 1 800 555 5555</td>
<td>1 555 555 5555</td>
</tr>
<tr>
<td>Billing Phone:</td>
<td>800-555-5555</td>
</tr>
<tr>
<td>Pre-Cert Phone:</td>
<td>X XXX XXX XXX</td>
</tr>
<tr>
<td>Street [Line 1]: P.O. BOX 5555</td>
<td>PO BOX 55555</td>
</tr>
<tr>
<td>Street [Line 2]:</td>
<td></td>
</tr>
<tr>
<td>Street [Line 3]:</td>
<td></td>
</tr>
<tr>
<td>City: CLEVELAND</td>
<td>ATLANTA</td>
</tr>
<tr>
<td>State: OHIO</td>
<td>GEORGIA</td>
</tr>
<tr>
<td>Zip Code: 44101-4776</td>
<td>30374-0800</td>
</tr>
<tr>
<td>(bold=accepted on Merge)</td>
<td>(bold=replaced on Overwrite)</td>
</tr>
</tbody>
</table>

Is this the correct INSURANCE COMPANY to match with this Buffer entry? YES

Select the method to update the INSURANCE COMPANY: (M/O/R/N/I): N

VistA has no control over the information that the payers return, so by selecting N, the details about the payer in the VistA insurance file will not be changed.

See Section 4.1.4 for details of the update methods.

The following screen will be displayed.

<table>
<thead>
<tr>
<th>Group/Plan Data: Buffer Data</th>
<th>Selected Group/Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company Name: IBinsurance One</td>
<td>IBinsurance Two</td>
</tr>
<tr>
<td>Is Group Plan?:</td>
<td>YES</td>
</tr>
<tr>
<td>Group Name: XXXXX</td>
<td>XXXxxx</td>
</tr>
<tr>
<td>Group Number: XXXXXXXXXX</td>
<td>XXX XXX XXXXX</td>
</tr>
<tr>
<td>BIN:</td>
<td></td>
</tr>
<tr>
<td>PCN:</td>
<td></td>
</tr>
<tr>
<td>Require UR:</td>
<td>NO</td>
</tr>
<tr>
<td>Require Pre-Cert:</td>
<td>NO</td>
</tr>
<tr>
<td>Require Amb Cert:</td>
<td>NO</td>
</tr>
<tr>
<td>Exclude Pre-Cond:</td>
<td>NO</td>
</tr>
<tr>
<td>Benefits Assign:</td>
<td>YES</td>
</tr>
<tr>
<td>Type of Plan:</td>
<td>COMPREHENSIVE MAJOR MEDICAL</td>
</tr>
<tr>
<td>(bold=accepted on merge)</td>
<td>(bold=replaced on overwrite)</td>
</tr>
</tbody>
</table>

Is this the correct GROUP/PLAN to match with this Buffer entry? YES

Select the method to update the GROUP PLAN: (M/O/R/N/I): N
Step | Procedure
--- | ---
9 | At the **Is this the correct Group Plan to match with this Buffer entry?**
   | Prompt, enter YES.
10 | At the **Select the method to update the Group Plan:** (M/O/R/N/I): prompt, enter N.
   | *VistA has no control over the information that the payers return, so by selecting N the details about the payer in the VistA insurance file will not be changed.*

The following screen will be displayed.

<table>
<thead>
<tr>
<th>Patient Name: IBpatient,One</th>
<th>IBpatient,One</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Verified:</td>
<td>XXX XX, XXXX</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>XXX XX, XXXX</td>
</tr>
<tr>
<td>Expiration Date:</td>
<td>XXX XX, XXXX</td>
</tr>
<tr>
<td>Subscriber Id:</td>
<td>xxxxxxxxx</td>
</tr>
<tr>
<td>Whose Insurance:</td>
<td>VETERAN</td>
</tr>
<tr>
<td>Relationship:</td>
<td>PATIENT</td>
</tr>
<tr>
<td>Name of Insured:</td>
<td>IBpatient,One</td>
</tr>
<tr>
<td>Insured's DOB:</td>
<td>XXX XX, XXXX</td>
</tr>
<tr>
<td>Insured's SSN:</td>
<td>yyyyyyyyy</td>
</tr>
<tr>
<td>Insured's SEX:</td>
<td>MALE</td>
</tr>
<tr>
<td>Primary Provider:</td>
<td></td>
</tr>
<tr>
<td>Provider Phone:</td>
<td></td>
</tr>
<tr>
<td>Coor of Benefits:</td>
<td>SECONDARY</td>
</tr>
<tr>
<td>Subscr Str Ln 1:</td>
<td></td>
</tr>
<tr>
<td>Patient Id:</td>
<td></td>
</tr>
<tr>
<td>Subscr Str Ln 2:</td>
<td></td>
</tr>
<tr>
<td>Subscr City:</td>
<td></td>
</tr>
<tr>
<td>Subscr State:</td>
<td></td>
</tr>
<tr>
<td>Subscr Zip:</td>
<td></td>
</tr>
</tbody>
</table>

Is this the correct PATIENT POLICY to match with this Buffer entry? YES
Select the method to update the PATIENT POLICY: (M/O/R/N/I): I

11 | At the **Is this the correct Patient Policy to match with this Buffer entry?**
   | Prompt, enter YES.
12 | At the **Select the method to update the Patient Policy:** (M/O/R/N/I): prompt, enter I.
   | *VistA has no control over the information that the payers return, so by selecting I, the user has full control over the details that are changed in the VistA insurance file.*

The following screen shows the prompts to **Accept, Change or Replace** entries.
Policy Data: Buffer Data Selected Policy
Company Name: IBinsurance One | IBinsurance Two
Group #: XXXXXXXX | XXXXXXX
Policy Name: IBpatient,One | IBpatient,One
Last Verified: XXX XX, XXXX | XXX XX, XXXX
Effective Date: XXX XX, XXXX | XXX XX, XXXX
Accept Change, Replace? No// NO
Expiration Date: | 
Subscriber Id: XXXXXXXXX | XXXXXXXX
Accept Change, Replace? No// NO
Whose Insurance: VETERAN | VETERAN
Relationship: PATIENT | PATIENT
Name of Insured: IBpatient,One | IBpatient,One
Insured's DOB: XXX XX, XXXX | 
Accept Change, Replace? No// NO
Insured's SSN: | 
Primary Provider: | 
Provider Phone: | 
Coor of Benefits: PRIMARY | PRIMARY
Insured's Sex: MALE
Patient Id: | 
Subscr Addr Ln 1: | 
Subscr Addr Ln 2: | 
Subscr City: | 
Subscr State: | 
Subscr Zip: | 

End of changes for POLICY related data.

Enter RETURN to continue or '^' to exit:

---

Information for Eligibility/Benefit Data Groups may be available on multiple pages. To scroll through each page, enter RETURN. To skip to the last page, enter ^.

---

*** Non-editable Patient Eligibility/Benefit data from payer ***

<table>
<thead>
<tr>
<th>Payer Response</th>
<th>VISTA Pt.Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>eIV Eligibility/Benefit Data Group# 1 of 2</td>
<td></td>
</tr>
</tbody>
</table>

Eligibility/Benefit Information

<table>
<thead>
<tr>
<th>Elig/Ben Info: Active Coverage</th>
<th>Elig/Ben Info: Active Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage Level:</td>
<td>Coverage Level:</td>
</tr>
<tr>
<td>Date/Time Qual:</td>
<td>Date/Time Qual:</td>
</tr>
<tr>
<td>D/T Period: Time Period:</td>
<td></td>
</tr>
<tr>
<td>Service Type:</td>
<td>Service Type:</td>
</tr>
<tr>
<td>Insurance Type:</td>
<td>Insurance Type:</td>
</tr>
<tr>
<td>Plan Coverage Desc: eIV Eligibility Determination</td>
<td>Plan Coverage Desc: eIV Elig</td>
</tr>
<tr>
<td>Benefit Amount:</td>
<td>Benefit Amount:</td>
</tr>
<tr>
<td>Benefit %: Quantity Qual:</td>
<td></td>
</tr>
<tr>
<td>Quantity Amount:</td>
<td>Quantity Amount:</td>
</tr>
<tr>
<td>Auth/Certification Required:</td>
<td>Auth/Certification Required:</td>
</tr>
<tr>
<td>In-Plan-Network:</td>
<td>In-Plan-Network:</td>
</tr>
</tbody>
</table>
Eligibility/Benefit Information

Enter RETURN to continue or '^' to exit: ^

Replace the Pt's Eligibility/Benefits data? YES// Y

After selecting the information to be changed, the following screen will be displayed.

STEP 1: Insurance Company
There will be NO CHANGE to the existing Insurance Company data.

STEP 2: Group/Plan
There will be NO CHANGE to the existing Group/Plan data.

STEP 3: Patient Policy
The Buffer data will INDIVIDUALLY ACCEPT (SKIP BLANKS) the existing Policy data.

STEP 4: Eligibility/Benefits
The Buffer data will replace the existing EB data.

Is this Correct, update the existing Insurance files now? Y YES ...

Patient Policy Updated...

Warning: Insurance Company selected already on file for this patient.
The previous entry is active.
The WHOSE INSURANCE are the same.
The Effective and Expiration dates may cover overlapping dates.

There are bills On Hold for this patient.

Press 'V' to view the changes or Return to continue:

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>If you want to review the changes that were made when you chose Individually Accept, at the Press 'V' to view the changes or Return to continue: prompt, press RETURN for this example.</td>
</tr>
</tbody>
</table>

4.2.2 Reject Entry
Users can remove an entry from the Buffer by rejecting the entry.

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Note: Users may select more than one entry from the buffer at a time to process. The system will then cycle users through each selected entry.</td>
</tr>
</tbody>
</table>
### Step 1
At the **Select Action:** prompt, enter **RE** for **Reject Entry.**

### Step 2
At the **Select Buffer Entry(s):** (**1-17**): prompt, enter **12** for this example.

The following screen will be displayed.

```
Entered: 9/9/09@13:46 Source: INTERVIEW
Entered By: IBclerk,One Verified:
Patient: IBpatient,Twelve    Sub Id: XXXXXX
Insurance: IBinsurance Five Group #: XXXXX-XX

This action will delete all insurance and patient specific data from a buffer entry without first saving that data to the insurance files, leaving a stub entry for reporting purposes.

Reject this buffer entry (delete without saving to Insurance files)? N// Y
```

### Step 3
At the **Reject this buffer entry (delete without saving to Insurance files)? N// Y** prompt, enter **YES** to remove entry from the buffer.

**Note:** Users may select more than one entry from the buffer at a time to reject. The system will then cycle users through each entry prompting them to reject each selected entry.

#### 4.2.3 Expand Entry

Users can **Expand an Entry.** Expanding an entry will cause the following categories of information to be displayed:

- **Appointment Information** (**Future Appointments Buffer** view ONLY);
- **Insurance Company Information**;
- **Group/Plan Information**;
- **Policy/Subscriber Information**;
- **Buffer Entry Information**.

### Step 1
Access the **BI Process Insurance Buffer.**

### Step 2
At the **Select Action:** prompt, enter **EE** for **Expand Entry.**

### Step 3
At the **Select Buffer Entry(s):** (**1-17**): prompt, enter **1** for this example and page through the screens.

The following screens will be displayed.
**Insurance Buffer Entry**  Jun 03, 2010@10:18:44  Page: 1 of 3

IBpatient,Two  XXX-XX-XXXX  DOB: XXX XX,XXX  AGE: XX  
Buffer entry created on 12/08/06 by IBclerk,One (PRE-REGISTR)

---

**Insurance Company Information**

Name: IBinsurance One  Reimburse?:
Phone: 8005555555  Billing Phone:
Precert Phone:  
Remote Query From:
Address: PO BOX 55555, CLEVELAND, OH  44101

**Group/Plan Information**

Group Plan?:  Require UR:
Group Name: XXXXXXX  Require Amb Cert:
Group Number: XXXXXXXX  Require Pre-Cert:
BIN:  
PCN:  
+  Enter ?? for more actions

**Policy/Subscriber Information**

Type of Plan:  Exclude Pre-Cond:
Benefits Assignable:
Whose Insurance: VETERAN  Effective: 08/03/03
Insured's Name: IBpatient,Two  Expiration:
Subscriber Id: XXXXXXXX  Primary Provider:
Relationship: PATIENT  Provider Phone:
Insured's DOB: XX/XX/XX  Coord of Benefits:

Employer Sponsored Group Health Plan?:  

**Buffer Entry Information**

Date Entered: 12/8/0609:16  Date Verified:
+  Enter ?? for more actions

Select Action: Next Screen//
Insurance Buffer Entry  Jun 03, 2010@10:22:36  Page: 3 of 3
IBpatient,Two  XXX-XX-XXXX  DOB: XXX XX,XXXX  AGE: XX
Buffer entry created on 12/08/06 by IBclerk,One (PRE-REGISTR)
+ 
<table>
<thead>
<tr>
<th>Entered By: IBclerk,One</th>
<th>Verified By:</th>
</tr>
</thead>
<tbody>
<tr>
<td>eIV Trace #:</td>
<td>eIV Processed Date: 4/14/05@19:32</td>
</tr>
<tr>
<td>Source: PRE-REGISTRATION</td>
<td>Current eIV Status: Response Received, Active Policy</td>
</tr>
</tbody>
</table>

Information received via electronic inquiry indicates patient has active insurance.

Action to take: Review the details listed in the eIV Response Report before processing this buffer entry.

Enter ?? for more actions

<table>
<thead>
<tr>
<th>EI</th>
<th>Ins. Co. Edit</th>
</tr>
</thead>
<tbody>
<tr>
<td>VE</td>
<td>Verify Entry</td>
</tr>
<tr>
<td>EB</td>
<td>Expand Benefits</td>
</tr>
<tr>
<td>EA</td>
<td>All Edit</td>
</tr>
<tr>
<td>PI</td>
<td>Pt. Policy Edit</td>
</tr>
<tr>
<td>EX</td>
<td>Exit</td>
</tr>
<tr>
<td>PE</td>
<td>Group/Plan Edit</td>
</tr>
<tr>
<td>RR</td>
<td>Response Report</td>
</tr>
</tbody>
</table>

Select Action: Quit/

Once users access Expand Entry, they will have access to the following additional Actions:

- **Ins. Co. Edit** – Allows users to edit or change the Insurance Company
- **Edit All** – Allows users to edit each of the Expand Entry categories
- **Group/Plan Edit** - Allows users to edit the Group/Plan category
- **Verify Entry** – Allows users to Verify an entry without actually processing it out of the buffer
- **Pt. Policy Edit** – Allows users to edit the Policy/Subscriber category
- **Response Report** – Allows users to view the Response Report for this entry if the entry has an associated 271 Health Care Eligibility Benefits Response
- **Expand Benefits** – Allows users to see the Eligibility/Benefits data that was returned in the associated 271 Health Care Eligibility Benefits Response if there is one for this entry

### 4.2.4 Add Entry

The Add Entry action, allows users to manually add a patient to the insurance buffer.

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>At the <strong>Select Action:</strong> prompt, enter <strong>AE</strong> for Add Entry.</td>
</tr>
<tr>
<td>2</td>
<td>At the <strong>Select PATIENT NAME:</strong> prompt, enter <strong>IBpatient,Thirteen</strong> for this example.</td>
</tr>
</tbody>
</table>

The following screen will be displayed
Select PATIENT NAME: IBpatient, Thirteen X-X-XX XXXXXXXXX YES SC VETERAN

Enrollment Priority: Category: NOT ENROLLED End Date:

Financial query queued to be sent to HEC...

*** Patient Requires a Means Test ***

Primary Means Test Required from APR 15, 1999

Enter <RETURN> to continue.

MEANS TEST REQUIRED

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Follow the prompts shown below to enter the insurance company, group/plan and policy and subscriber information.</td>
</tr>
<tr>
<td>4</td>
<td>When you have added an entry to the insurance buffer, you will be returned to the Positive Insurance Buffer.</td>
</tr>
</tbody>
</table>

Insurance Company: ??

Please enter the name of the insurance company that provides coverage for this patient. This response is a free text response, however, a partial insurance company name look-up is available here.

Insurance Company: IBinsurance
1   IBinsurance One
2   IBinsurance Two
3   IBinsurance Three
4   IBinsurance Four
5   IBinsurance Five

CHOOSE 1-5: 2

Add a new Insurance Buffer entry for this patient and company? YES/

------------------------ INSURANCE COMPANY INFORMATION ------------------------

INSURANCE COMPANY NAME: IBinsurance Two/
1   IBinsurance Two

CHOOSE 1-1: 1

REIMBURSE?:
PHONE NUMBER:
BILLING PHONE NUMBER:
PRECERTIFICATION PHONE NUMBER:
STREET ADDRESS [LINE 1]:
CITY:
STATE:
ZIP CODE:

------------------------ GROUP/PLAN INFORMATION ------------------------

The following data defines a specific Group or Plan provided by an Insurance Company. This may be either a group plan with many potential members or an individual plan with a single member.

IS THIS A GROUP POLICY?: N NO
GROUP NAME:
GROUP NUMBER:
BANKING IDENTIFICATION NUMBER:
PROCESSOR CONTROL NUMBER (PCN):
TYPE OF PLAN:
UTILIZATION REVIEW REQUIRED:
PRECERTIFICATION REQUIRED:
AMBULATORY CARE CERTIFICATION:
EXCLUDE PREEXISTING CONDITION:
BENEFITS ASSIGNABLE:

---------------------- POLICY AND SUBSCRIBER INFORMATION ----------------------
The following data defines the subscriber specific policy information for a particular Insurance Plan. The subscriber, the insured, and the policy holder all refer to the person who is a member of the plan and therefore holds the policy. The patient must be covered under the plan but may not be the policy holder.

EFFECTIVE DATE:
EXPIRATION DATE:
PT. RELATIONSHIP TO INSURED:
SUBSCRIBER PRIMARY ID:
NAME OF INSURED:
INSURED’S DOB:
INSURED'S SEX:
PATIENT PRIMARY ID:
PRIMARY CARE PROVIDER:
PRIMARY PROVIDER PHONE:
COORDINATION OF BENEFITS:
SOURCE OF INFORMATION: INTERVIEW//
ESGHP?:
SUBSCRIBER ADDRESS LINE 1:
SUBSCRIBER ADDRESS LINE 2:
SUBSCRIBER ADDRESS CITY:
SUBSCRIBER ADDRESS STATE:
SUBSCRIBER ADDRESS ZIP: .......................................................|

4.2.5 Sort Buffer Views
The default sort for all Buffer views (except the Positive Insurance Buffer) is alphabetically by patient name. The Positive Insurance Buffer is sorted by Positive Responses first and then alphabetically by patient name.

Users may re-sort the buffer based upon the following criteria:
- Insurance Company
- Source of Information
- Date Entered
- Inpatients
- Means Test
- On Hold
- Verified
- eIV Status
4.2.6 Check Insurance Company

Users may view a list of insurance companies that exist in the insurance buffer that do not match any of the insurance company names or synonyms in the insurance company file. These insurance companies do not match any entries in the IIV AUTO MATCH file.

Once users select the **Check Ins Co’s** action, they will have access to the following actions (Refer to Section 7 Auto Match):

- Select Entry
- Auto Match Enter/Edit

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access the <strong>BI Process Insurance Buffer</strong>.</td>
</tr>
<tr>
<td>2</td>
<td>At the <strong>Select Action:</strong> prompt, enter <strong>CC</strong> for <strong>Check Ins Co’s</strong>.</td>
</tr>
</tbody>
</table>

The following screen will be displayed.

```
Unmatched Buffer Names       Jul 07, 2010@12:02:54       Page: 1 of 1
These are Insurance Company names from the Insurance Buffer file that do not exist in the Insurance Company file (either as Names or as Synonyms). They also do not exist or pattern match with any entry in the Auto Match file.

1  IBinsurance One
2  IBinsurance Twu
3  IBinsurance Three
4  IBinsurance Four
5  IBinsurance Five
6  IBinsurance Six
7  IBinsurance Seven
8  IBinsurance Eight
9  IBinsurance Nine
10 IBinsurance Ten

Enter ?? for more actions
Select Entry          Auto Match Enter/Edit    Exit
Select Action: Next Screen//
```

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Each buffer entry that fails to make any match to an entry in the Insurance Company file (#36) or the IIV AUTO MATCH file (#365.11) is presented to the user.</td>
</tr>
<tr>
<td>2</td>
<td>This example sets up an auto match entry to associate <strong>IBinsurance Twu</strong> with <strong>IBinsurance Two</strong>.</td>
</tr>
<tr>
<td>3</td>
<td>At the <strong>Select Action:</strong> prompt, enter <strong>SE</strong> for <strong>Select Entry</strong>.</td>
</tr>
<tr>
<td>4</td>
<td>At the <strong>Select Entry:</strong> (1-192): prompt select 2 for <strong>IBinsurance Twu</strong>.</td>
</tr>
<tr>
<td>5</td>
<td>At the <strong>Select INSURANCE COMPANY NAME:</strong> prompt enter <strong>IBinsurance Two</strong>.</td>
</tr>
</tbody>
</table>
The following screen will be displayed.

<table>
<thead>
<tr>
<th>Select INSURANCE COMPANY NAME: IBinsurance Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 IBinsurance Two SAMPLE RD NEWARK OHIO Y</td>
</tr>
<tr>
<td>2 IBinsurance Two TEST RD LIVONIA MICHIGAN **</td>
</tr>
<tr>
<td>3 IBinsurance Two PO BOX 5555 MIDDLETOWN NEW YORK **</td>
</tr>
<tr>
<td>CHOOSE 1-3: 1 IBinsurance Two SAMPLE RD NEWARK OHIO Y</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>At the <strong>CHOOSE 1-3:</strong> prompt in this example, enter 1 for <strong>IBinsurance Two SAMPLE RD.</strong></td>
</tr>
<tr>
<td>7</td>
<td>At the <strong>Do you want to add an Auto Match entry that associates IBinsurance Twu with IBinsurance Two? No//:</strong> prompt, enter <strong>YES.</strong></td>
</tr>
</tbody>
</table>

The following prompts are displayed along with a confirmation message.

```
Do you want to add an Auto Match entry that associates IBinsurance Twu with IBinsurance Two? No// Y YES

AUTO MATCH VALUE: IBinsurance Twu //

IBinsurance Twu is now associated with IBinsurance Two.
```

**4.2.7 Positive View/Negative View/Medicare View/Appointment View**

Users may switch back and forth between the different available **Buffer Views** by selecting one of the following actions:

- **PB** – Pos. Buffer
- **NB** – Neg. Buffer
- **MB** – Medicare Buffer
- **FA** – Future Appts. Buffer
5 Request Electronic Insurance Inquiry

This option allows users to create a 270 Health Care Eligibility Benefits Inquiry whenever needed. This option allows users to override the re-verification timeframe that is set in the IB Site Parameters and individually select a specific Service Type Code or utilize multiple Service Type codes. Using this option to create a buffer entry will bypass the auto-update feature, leaving the buffer entry for manual processing.

5.1 Request a 270 Health Care Eligibility Benefits Inquiry

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access the PI Patient Insurance Menu.</td>
</tr>
<tr>
<td>2</td>
<td>Access the eIV Menu.</td>
</tr>
<tr>
<td>3</td>
<td>Access the EI Request Electronic Insurance Inquiry option.</td>
</tr>
<tr>
<td>5</td>
<td>At the Select Patient Name prompt, enter Patient Name (in this example IBpatient,One)</td>
</tr>
</tbody>
</table>

Users must hold the IBCNE IIV SUPERVISOR security key to access this option.

Patch IB*2*438 provided the ability to request insurance inquiries with specific Service Type Codes.

The following screen will be displayed.

```
Request Electronic Insurance Inquiry for Patient: IB,PATIENT C I2222

Enter ?? for more actions
SE   Select Entry   EX   Exit
Select Action: Quit// SE   Select Entry
Select entry to request electronic inquiry: (1-2): 1

Enter Service Type Code: ?

Answer with X12 271 SERVICE TYPE CODE
Do you want the entire 187-Entry X12 271 SERVICE TYPE List? N
Enter Service Type Code: ??

Enter the single SERVICE TYPE CODE to be sent with inquiry or press 'ENTER' to send DEFAULT and SITE SELECTED codes. Utilizing a single SERVICE TYPE CODE will only provide eligibility benefit data for the selected code. Utilizing the DEFAULT and SITE SELECTED codes will provide standard eligibility benefit data. No response generated by this option will auto-update the patient file.

Enter Service Type Code: ?

Answer with X12 271 SERVICE TYPE CODE
Do you want the entire 187-Entry X12 271 SERVICE TYPE List? Y (Yes)
Choose from:
1 Medical Care
2 Surgical
3 Consultation
4 Diagnostic X-Ray
5 Diagnostic Lab
6 Radiation Therapy
7 Anesthesia
8 Surgical Assistance
9 Other Medical
10 Blood Charges
11 Used DME
12 DME Purchase
13 Ambulatory SC Facility
14 Renal Supplies/Home
15 Alt. Method Dialysis
16 CRD Equipment
17 Pre-Admission Testing
18 DME Rental
19 Pneumonia Vaccine
20 2nd Surgical Opinion

'\' TO STOP:

Enter Service Type Code: 11 Used DME

Are you sure you want to request an insurance inquiry? NO// Y YES

Insurance Buffer entry created!

Enter RETURN to continue or '^^' to exit:

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>At the <strong>Select Action</strong> prompt, enter <strong>SE</strong> Select Entry.</td>
</tr>
<tr>
<td>7</td>
<td>At the <strong>Select entry to request electronic inquiry: (1-2):</strong> prompt, enter 1 for this example.</td>
</tr>
<tr>
<td>8</td>
<td>At the <strong>SERVICE TYPE CODE</strong> prompt, enter ? for a list of the Service Type Codes or enter the one required. In this example enter 11. Now select yes and the Insurance Buffer entry will be created</td>
</tr>
</tbody>
</table>

**Note:** An asterisk (*) will indicate that the request already has a buffer entry.
6  Patient Insurance Info View/Edit

The Patient Insurance Info View/Edit option is used to look at a patient’s insurance information and edit that data, if necessary. The system groups information that is specific to the insurance company, specific to the patient, specific to the group plan, specific to the annual benefits available, and the annual benefits already used.

Once a patient is selected, this screen is displayed listing all the patient's insurance policies. Information provided for each policy may include type of policy, group name, holder, effective date, and expiration date.

6.1  View Patient Policy Information

This screen displays expanded policy information for the selected company. Categories include utilization review data, subscriber data, subscriber's employer information, effective dates, plan coverage limitations, last contact, and comments on the patient policy or insurance group plan.

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access the PI Patient Insurance Menu.</td>
</tr>
<tr>
<td>2</td>
<td>Access the PI Patient Insurance Info View/Edit Option</td>
</tr>
<tr>
<td>3</td>
<td>At the Select Patient Name prompt, enter Patient Name.</td>
</tr>
</tbody>
</table>

The following screen will be displayed:

```
Patient Insurance Management  Jul 21, 2010@13:23:59          Page: 1 of 1
Insurance Management for Patient: IBpatient,One 1234

Insurance Co.  Type of Policy  Group        Holder   Effect.    Expires
1   IBinsurance One  COMPREHENSIVE M  GRP NUM 13   SELF     06/20/09

Enter ?? for more actions      >>>
AP  Add Policy  EA  Fast Edit All  CP  Change Patient
VP  Policy Edit/View  BU  Benefits Used  WP  Worksheet Print
DP  Delete Policy  VC  Verify Coverage  PC  Print Insurance Cov.
AB  Annual Benefits  RI  Personal Riders  EB  Expand Benefits
EX  Exit
Select Item(s): Quit//
```
The following series on screens will be displayed.

** Plan Currently Active **

Plan Information
Is Group Plan: YES
Group Name: TEST3
Group Number: GRP NUM 13670
BIN: 
Type of Plan: COMPREHENSIVE MAJOR MED

Insurance Company
Company: IBinsurance,One
Street: PO BOX 55555
City/State: CLEVELAND, OH 44101

Electronic Type: COMMERCIAL
Plan Filing TF: days (1 YEAR(S))

+ Enter ?? for more actions

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

** Plan Currently Active **

Utilization Review Info
Require UR:                      Effective Dates & Source
Effective Date: 06/20/09
Require Amb Cert:                Expiration Date:
Require Pre-Cert:                Source of Info: eIV
Exclude Pre-Cond:                Policy Not Billable: NO

+ Enter ?? for more actions

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

Subscriber Name: IBpatient,One

Primary ID: R34566612

Coord. Benefits: Claims to Employer: No, Send to Insurance

Primary Provider:

Prim Prov Phone: 1-800-test

Insured Person's Information (use Subscriber Update Action)

Insured's DOB: 03/04/1970

Enter ?? for more actions

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

Select Action: Next Screen//
### Coverage Details

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Effective Date</th>
<th>Covered?</th>
<th>Limit</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>INPATIENT</td>
<td></td>
<td>COVERED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OUTPATIENT</td>
<td></td>
<td>COVERED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHARMACY</td>
<td></td>
<td>NOT COVERED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DENTAL</td>
<td></td>
<td>COVERED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MENTAL HEALTH</td>
<td></td>
<td>NOT COVERED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LONG TERM CARE</td>
<td></td>
<td>COVERED</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### User Information
- Entered By: IBclerk,One
- Insurance Contact (last)
- Person Contacted:

### Method of Contact:
- Contact's Phone:
- Call Ref. No.:
- Contact Date:

### Comment -- Group Plan
- None

### Select Action: Next Screen//
### 6.2 View Eligibility Benefit Information

This screen allows eligibility / benefit information to be displayed.

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access the <strong>PI Patient Insurance Menu</strong>.</td>
</tr>
<tr>
<td>2</td>
<td>Access the <strong>PI Patient Insurance Info View/Edit</strong> Option</td>
</tr>
<tr>
<td>3</td>
<td>At the Select <strong>Patient Name</strong> prompt, enter <strong>Patient Name</strong> (in this example IBpatient,One).</td>
</tr>
<tr>
<td>4</td>
<td>At the Select <strong>Action</strong> prompt, enter <strong>EB for Expand Benefits</strong>.</td>
</tr>
</tbody>
</table>

The following screen will be displayed
eIV Elig/Benefit Information

Eligibility/Benefit Information

Elig/Ben Info: Active Coverage
Date/Time Qual: Discharge
D/T Period: 11/28/2010
Date/Time Qual: Plan Begin
D/T Period: 07/01/2001
Service Type: Psychiatric
Service Type: Psychiatric/R & B
Service Type: Psychotherapy
Time Period: 24 Hours

Health Care Service Delivery
Quantity Qual: Minimum
Quantity Amount: 30
Unit/Basis for Measurement: Months
Sampling Frequency: 2

Benefit Related Entity
Entity ID Code: Other Physician
Entity ID Name: EntityLast,EntityFirst EntityMiddle JR
Entity ID Number: 000000415
Entity Address: Southeast PO Box 14079, Chennai
Country Code: IN
Country Subdivision: TN
Location Qual: DOD Health Service Region
7 IIV AUTO MATCH Payers

Auto Match is a VistA feature designed to help match user-entered insurance company names to the correct payers in the database. In VistA, there are several places a user can enter an insurance company name (free text) without a list of valid insurance names from which to pick. Patient registration and the insurance buffer are two examples. This can result in misspelled, improperly formatted or incomplete insurance company names. Auto Match is necessary because the eIV software must be able to identify which insurance company the user is referring to in order to appropriately generate inquiries and process responses. This functionality promotes the use of consistent insurance company names.

There is an IIV AUTO MATCH file (#365.11) in each VistA system. Each record in the file has two fields. The first field, Entered Name, stores the insurance company name that the user entered into the VistA system without validation. The second field, Proper Name, stores the name of the insurance company that can be found in the insurance file of the VistA database.

The Auto Match feature is used to teach the VistA system how to interpret common misspellings or incomplete entries that users enter when typing in free text insurance company names.

It is recommended that users run the Check Ins Co’s action on names from the Insurance Buffer Views to initially populate the Auto Match files based on existing entries in the Insurance Buffer. Selecting this action will generate a list of insurance company names found in the current insurance buffer file that do not exist in the Insurance Company file (#36). The more one “teaches” the IIV AUTO MATCH file the fewer problems eIV will encounter when it creates insurance inquiries for electronic transmission to the payers.

There is also a menu option, Enter/Edit Auto Match Entries that allows users to maintain Auto Match entries. It is described in section 6.2.2.

Users must have the IBCNE IIV AUTO MATCH security key to add, update, or delete an Auto Match entry.

7.1 Auto Match in VistA Applications

Auto Match is currently used in the Insurance Buffer.

When a user types in a free text insurance company name, VistA attempts to match the name with one of the insurance company names currently stored in the insurance file. If that attempt fails, the name is compared to the list of Entered Name(s) in the IIV AUTO MATCH file (#365.11). If there are Entered Name(s) that match it, they are displayed along with their associated Proper Name(s). Users may then select one of the valid names to replace the free text entry.
Users are not required to accept one of the supplied choices. Users are allowed to keep the free text name. The Auto Match process may fail to find a matching insurance company name(s). In this case, no choices are presented to users.

7.2 Types of Auto Match Matches

7.2.1 Simple Auto Match Matches

In a simple Auto Match, the Entered Name field literally contains the name found in the insurance buffer. Leading and trailing spaces are ignored. An entry in this form might have BC/BS as the Entered Name and show IBinsurance BC/BS in the Proper Name field. As the insurance staff encounter misnamed insurance companies (i.e. the name on the insurance card does not match the name in the VistA database), users can correct the name and VistA will prompt users to add it as a new record in the IIV AUTO MATCH file (#365.11).

7.2.2 Wildcard Auto Match Matches

In a wildcard Auto Match, simple matches are supported but now the wildcard character, the asterisk (*), can be utilized. Wildcards may be used to anticipate common spelling mistakes. The asterisk can be substituted for any number of characters. For example, if users enter BC*BS, the system will return all Insurance Company names that begin with BC and end with BS. BC/BS, BC BS, BC-BS, BCBS and BC / BS would all match BC*BS.

An Entered Name may contain more than one asterisk (i.e. BC*BS*). When a wildcard is used, a minimum of four non-wildcard characters must be specified as well.

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access the eIV Menu.</td>
</tr>
<tr>
<td>2</td>
<td>Access the AE Enter/Edit Auto Match Entries option.</td>
</tr>
<tr>
<td>3</td>
<td>At the Select an Auto Match Entry prompt, enter IBinsurance Number Two for this example.</td>
</tr>
<tr>
<td>4</td>
<td>At the Are you adding ‘IBinsurance Number Two’ as a new eIV AUTO MATCH (the 144th)? No// prompt, enter YES to override the default of NO.</td>
</tr>
<tr>
<td>5</td>
<td>At the eIV Auto Match Insurance Company Name: prompt, enter IBinsurance Two for this example.</td>
</tr>
</tbody>
</table>

- **Remember** – the Entered Name must be a minimum of 3 characters and an “*” must be used with four additional characters.
- **Entered Names must be unique.** One Entered Name cannot be associated with more than one Insurance Company Name.
- **Users must have the IBCNE IIV AUTO MATCH security key to add, update, or delete an Auto Match entry.**
Enter/Edit Insurance Company Name Auto Match Entries

This option will allow you to enter, edit, and manage the entries in the Insurance Company Auto Match file. This file will aid in the proper selection of Insurance Companies by associating together a valid, correct Insurance Company name with an incorrect entry that a clerk may enter during data entry.

Select an Auto Match Entry: IBinsurance Number Two

For your information, no insurance company names or synonyms passed a pattern match on 'IBinsurance Number Two'.

Are you adding 'IBinsurance Number Two' as a new eIV AUTO MATCH (the 144TH)? No// Y (Yes)

```
eIV AUTO MATCH INSURANCE COMPANY NAME: IBinsurance Two
```

IBinsurance Number Two is now associated with IBinsurance Two.

7.3 Maintain the Auto Match Entries

VistA offers a separate menu option to create, update, and delete IIV AUTO MATCH file (#365.11) entries.

The auto match file has several fields, of which only the Entered Name and Proper Name are editable:

- The Entered Name which may be a simple company name or a wildcard pattern. In either case, it is this name that is matched to the name entered into the insurance buffer by a user.
- The Proper Name which identifies an insurance company by its name in the insurance files.

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access the eIV Menu.</td>
</tr>
<tr>
<td>2</td>
<td>Access the AB Add Auto Match Entries Using Insurance Buffer Data option.</td>
</tr>
</tbody>
</table>

The following screen will be displayed.
These are Insurance Company names from the Insurance Buffer file that do not exist in the Insurance Company file (either as Names or as Synonyms). They also do not exist or pattern match with any entry in the Auto Match file.

1. IBinsurance One
2. IBinsurance Number Two
3. IBinsurance Three
4. IBinsurance Four
5. IBinsurance Five
6. IBinsurance Six
7. IBinsurance Seven
8. IBinsurance Eight
9. IBinsurance Nine
10. IBinsurance Ten

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>At the <strong>Select Action</strong> prompt, enter <strong>Auto Match Enter/Edit</strong> for this example.</td>
</tr>
<tr>
<td>4</td>
<td>Access the <strong>AE Enter/Edit Auto Match Entries</strong> option.</td>
</tr>
<tr>
<td>5</td>
<td>At the <strong>Select an Auto Match Entry</strong> prompt, enter <strong>IBinsurance Number Two</strong> for this example.</td>
</tr>
<tr>
<td>6</td>
<td>At the <strong>Are you adding ‘IBinsurance Number Two’ as a new eIV AUTO MATCH (the 144th)? No//</strong> prompt, enter <strong>YES</strong></td>
</tr>
<tr>
<td>7</td>
<td>At the <strong>eIV Auto Match Insurance Company Name:</strong> prompt, enter <strong>IBinsurance Two</strong> for this example.</td>
</tr>
</tbody>
</table>

- **Remember** – the Entered Name must be a minimum of 3 characters and an ‘*’ must be used with four additional characters.
- **Entered Names must be unique. One Entered Name can not be associated with more than one Insurance Company Name.**

### 7.4 Check Insurance Buffer Company Names

As described in section 4.2.6, the action **Check Ins Co’s.** in the **Insurance Buffer** screen is another method of accessing the **Auto Match Enter/Edit** option.

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access the <strong>PI Patient Insurance Menu.</strong></td>
</tr>
<tr>
<td>2</td>
<td>Access the <strong>BI Process Insurance Buffer</strong> option.</td>
</tr>
</tbody>
</table>

The following screen will be displayed.
Positive Insurance Buffer

May 21, 2010@10:18:01

Sorted by: Positive Response

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Insurance Company</th>
<th>Subscr Id</th>
<th>S Entered</th>
<th>iIEYH</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 +IBpatient,One</td>
<td>XXXX IBinsurance One</td>
<td>SUB ID XXXX</td>
<td>E 05/18/10</td>
<td>i</td>
</tr>
<tr>
<td>2 +IBpatient,Two</td>
<td>XXXX IBinsurance One</td>
<td>SUB ID XXXX</td>
<td>E 05/18/10</td>
<td>i</td>
</tr>
<tr>
<td>3 +IBpatient,Three</td>
<td>XXXX IBinsurance One</td>
<td>SUB ID XXXX</td>
<td>E 05/18/10</td>
<td>i</td>
</tr>
<tr>
<td>4 +IBpatient,Four</td>
<td>XXXX IBinsurance Two</td>
<td>SUB ID XXXX</td>
<td>P 09/21/04</td>
<td>Y</td>
</tr>
<tr>
<td>5 +IBpatient,Five</td>
<td>XXXX IBinsurance Four</td>
<td>SUB ID XXXX</td>
<td>P 03/31/05</td>
<td></td>
</tr>
<tr>
<td>6 +IBpatient,Six</td>
<td>XXXX IBinsurance Four</td>
<td>SUB ID XXXX</td>
<td>P 12/08/04</td>
<td></td>
</tr>
<tr>
<td>7 +IBpatient,Seven</td>
<td>XXXX IBinsurance Two</td>
<td>SUB ID XXXX</td>
<td>P 11/30/04</td>
<td>Y</td>
</tr>
<tr>
<td>8 +IBpatient,Eight</td>
<td>XXXX IBinsurance Four</td>
<td>SUB ID XXXX</td>
<td>P 02/28/05</td>
<td>YH</td>
</tr>
<tr>
<td>9 +IBpatient,Nine</td>
<td>XXXX IBinsurance Two</td>
<td>SUB ID XXXX</td>
<td>I 03/29/05</td>
<td></td>
</tr>
<tr>
<td>10 +IBpatient,Ten</td>
<td>XXXX IBinsurance Three</td>
<td>SUB ID XXXX</td>
<td>I 11/16/04</td>
<td></td>
</tr>
<tr>
<td>11 +IBpatient,Eleven</td>
<td>XXXX IBinsurance Two</td>
<td>SUB ID XXXX</td>
<td>P 03/31/05</td>
<td>YH</td>
</tr>
<tr>
<td>12 +IBpatient,Twelve</td>
<td>XXXX IBinsurance Five</td>
<td>SUB ID XXXX</td>
<td>I 03/24/05</td>
<td>H</td>
</tr>
</tbody>
</table>

*Verified  +Active  ?Await/Reply

RE Reject Entry  ST Sort List  NB Neg. Buffer  EX Exit
EE Expand Entry  CC Check Ins Co's  MB Medicare Buffer
Select Action: Next Screen/

Step Procedure

3  At the Select Action: prompt, enter CC for Check Ins Co’s.

The following screen will be displayed.

Unmatched Buffer Names  Jul 07, 2010@12:02:54

These are Insurance Company names from the Insurance Buffer file that do not exist in the Insurance Company file (either as Names or as Synonyms). They also do not exist or pattern match with any entry in the Auto Match file.

1  IBinsurance One
2  IBinsurance Number Two
3  IBinsurance Three
4  IBinsurance Four
5  IBinsurance Five
6  IBinsurance Six
7  IBinsurance Seven
8  IBinsurance Eight
9  IBinsurance Nine
10 IBinsurance Ten

Enter ?? for more actions
Select Entry  Auto Match Enter/Edit  Exit
Select Action: Next Screen/
7.5 Change Company Name via the Insurance Buffer

Auto Match entries can also be created when users change an Insurance Buffer entry's insurance company name in the insurance buffer edit screen. When users changes the existing insurance company name, listed on an Insurance Buffer entry, VistA prompts users to keep track of the original typed name and new name as an Auto Match entry. If users concur, the original typed insurance company name is treated as the Entered Name and the new insurance company name is considered the Proper Name. The user is then offered the opportunity to modify the Entered Name, possibly to make it more general.

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access the PI Patient Insurance Menu.</td>
</tr>
<tr>
<td>2</td>
<td>Access the BI Process Insurance Buffer option.</td>
</tr>
</tbody>
</table>

This example sets up an auto match entry to associate IBinsurance Flur with IBinsurance Four.

VistA warns users when the Proper Name matches an insurance company's name synonym and not the company's name, or the Proper Name matches more than one synonym and company name.

The following screens will be displayed.

<table>
<thead>
<tr>
<th>Positive Insurance Buffer</th>
<th>May 21, 2010@10:18:01</th>
<th>Page: 1 of 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sorted by: Positive Response</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Name</td>
<td>Insurance Company</td>
<td>Subscr Id</td>
</tr>
<tr>
<td>1</td>
<td>+IBpatient,One</td>
<td>XXXX</td>
</tr>
<tr>
<td>2</td>
<td>+IBpatient,Two</td>
<td>XXXX</td>
</tr>
<tr>
<td>3</td>
<td>+IBpatient,Three</td>
<td>XXXX</td>
</tr>
<tr>
<td>4</td>
<td>+IBpatient,Four</td>
<td>XXXX</td>
</tr>
<tr>
<td>5</td>
<td>+IBpatient,Five</td>
<td>XXXX</td>
</tr>
<tr>
<td>6</td>
<td>+IBpatient,Six</td>
<td>XXXX</td>
</tr>
<tr>
<td>7</td>
<td>+IBpatient,Seven</td>
<td>XXXX</td>
</tr>
<tr>
<td>8</td>
<td>+IBpatient,Eight</td>
<td>XXXX</td>
</tr>
<tr>
<td>9</td>
<td>+IBpatient,Nine</td>
<td>XXXX</td>
</tr>
<tr>
<td>10</td>
<td>+IBpatient,Ten</td>
<td>XXXX</td>
</tr>
<tr>
<td>11</td>
<td>+IBpatient,Eleven</td>
<td>XXXX</td>
</tr>
<tr>
<td>12</td>
<td>+IBpatient,Twelve</td>
<td>XXXX</td>
</tr>
</tbody>
</table>

*Verified  +Active  ?Await/Reply
RE Reject Entry  ST Sort List  NB Neg. Buffer  EX Exit
EE Expand Entry  CC Check Ins Co's  MB Medicare Buffer
Select Action: Exit//

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>At the Select Action: prompt, enter EE for Expand Entry.</td>
</tr>
<tr>
<td>4</td>
<td>At the Select Buffer Entries: prompt, enter 6 for this example and page through the screens.</td>
</tr>
</tbody>
</table>

The following screens will be displayed.
Insurance Buffer Entry

IBpatient,Six  XXX-XX-XXXX  DOB: XXX XX,XXXX  AGE: XX
Buffer entry created on 12/08/06 by IBclerk,One (PRE-REGISTR)

Insurance Company Information

Name: IBinsurance Flur  Reimburse?:
Phone: 8005555555  Billing Phone:
Precert Phone:
Remote Query From:
Address: PO BOX 55555, CLEVELAND, OH  44101

Group/Plan Information

Group Plan?:  Require UR:
Group Name: XXXXXXX  Require Amb Cert:
Group Number: XXXXXXXXXX  Require Pre-Cert:
BIN:
PCN:
+ Enter ?? for more actions

Type of Plan:  Exclude Pre-Cond:
Benefits Assignable:

Policy/Subscriber Information

Whose Insurance: VETERAN  Effective: XX/XX/XX
Insured’s Name: IBpatient,Six  Expiration:
Subscriber Id: XXXXXXXXXX  Primary Provider:
Relationship: PATIENT  Provider Phone:
Insured’s DOB: XX/XX/XX  Coord of Benefits:

Employer Sponsored Group Health Plan?:

Buffer Entry Information

Date Entered: 12/8/06@08:16  Date Verified:
+ Enter ?? for more actions

EI Ins. Co. Edit  VE Verify Entry  EB Expand Benefits
EA All Edit  PI Pt. Policy Edit  EX Exit
PE Group/Plan Edit  RR Response Report
Select Action: Next Screen//
Insurance Buffer Entry  Jan 03, 2010@10:22:36  Page: 3 of 3

+ IBpatient,Six XXX-XX-XXXX  DOB: XXX XX,XXXX  AGE: XX
Buffer entry created on 12/08/06 by IBclerk,One (PRE-REGISTER)

+ Entered By: IBclerk,One  Verified By:        
eIV Trace #: eIV Processed Date: 4/14/05 08:19:32
Source: PRE-REGISTRATION
Current eIV Status: Response Received, Active Policy

Information received via electronic inquiry indicates patient has active insurance.

Action to take: Review the details listed in the eIV Response Report before processing this buffer entry.

Enter ?? for more actions
EI  Ins. Co. Edit  VE  Verify Entry  EB  Expand Benefits
EA  All Edit  PI  Pt. Policy Edit  EX  Exit
PE  Group/Plan Edit  RR  Response Report
Select Action: Quit//

The following prompts are displayed along with a confirmation message.

------------------------- INSURANCE COMPANY INFORMATION -------------------------
INSURANCE COMPANY NAME: IBinsurance Flur // IBinsurance Four
  1  IBinsurance Four
  2  IBinsurance Four A
  3  IBinsurance Four B
  4  IBinsurance Four C
CHOOSE 1-5: 1

Do you want to add an Auto Match entry that associates IBinsurance Flur with IBinsurance Four? No/ Y YES

AUTO MATCH VALUE: IBinsurance Flur //
IBinsurance Flur is now associated with IBinsurance Four.
### Step 7

There will then be a series of prompts to update the insurance company details. At each prompt, enter **RETURN** to keep the current setting.

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>There will then be a series of prompts to update the insurance company details. At each prompt, enter <strong>RETURN</strong> to keep the current setting.</td>
</tr>
</tbody>
</table>

**REIMBURSE?:**

PHONE NUMBER: 8005555555/
BILLING PHONE NUMBER:
PRECERTIFICATION PHONE NUMBER:
STREET ADDRESS [LINE 1]: PO BOX 55555/
STREET ADDRESS [LINE 2]:
CITY: CLEVELAND/
STATE: OHIO/
ZIP CODE: 44101/|

### Step 8

After accepting all the current insurance company settings the original insurance buffer entry will be displayed showing the revised insurance company.

**Insurance Buffer Entry**

Jun 03, 2010@10:18:44       Page: 1 of 3
IB IBpatient, Six XXX-XX-XXXX  DOB: XXX XX, XXXX  AGE: XXX
Buffer entry created on 12/08/06 by IBclerk, One (PRE-REGISTR) |

**Insurance Company Information**

Name: IBinsurance Four  Reimburse?:
Phone: 8005555555  Billing Phone:
Precert Phone:
Remote Query From:
Address: PO BOX 55555, CLEVELAND, OH  44101 |

**Group/Plan Information**

Group Plan?:  Require UR:
Group Name: XXXXXXXX  Require Amb Cert:
Group Number: XXXXXXXXXXX  Require Pre-Cert:
BIN:  PCN:
+ Enter ?? for more actions |

**Select Action:** Next Screen//

---

**December 2011**

**eIV User Guide**

**51**
(This page included for two-sided copying.)
8 eIV REPORTS

There are seven eIV-related reports. An explanation of and instructions for each report are described in this section.

The first five eIV Reports can be found on the eIV Menu on the Patient Insurance Menu.

| AB | Add Auto Match Entries Using Insurance Buffer Data |
| AE | Enter/Edit Auto Match Entries                      |
| EI | Request Electronic Insurance Inquiry                |
| IU | eIV Patient Insurance Update Report                 |
| LR | eIV Payer Link Report                               |
| NI | Potential New Insurance Found ...                   |
| PR | eIV Payer Report                                   |
| RR | eIV Response Report                                 |
| SR | eIV Statistical Report                              |

Select eIV Menu Option:

The remaining two eIV Reports can be found under the Potential New Insurance Found option on the eIV Menu.

| AR | eIV Ambiguous Policy Report                        |
| IR | eIV Inactive Policy Report                         |

Select Potential New Insurance Found Option:

8.1 eIV Patient Insurance Update Report

Purpose of this Report

This report is used to view the list of patients whose Patient Insurance Information has been either not updated or updated in one of the following manners:

- Automatic updates based on a 271 Response message
- Processing via the Insurance Buffer option

Report Parameters

Search Criteria:

- Summary or Detail
- All or Selected Payers
- Response Received Date Range
- All or Selected Patients

Sort Criteria:

- Payer Name
- Patient Name
- Clerk Name

This is a 132 column report.
8.2 eIV Response Report

Purpose of this Report

This report is used to view the data that was received through the eIV process – receipt of 271 Health Care Eligibility Benefits Response messages.

Report Parameters

Search Criteria:
- Response Received Date Range
- Trace #
- All or Selected Payers
- All or Selected Patients
- All Responses or Most Recent (for a payer/patient combination)

Sort Criteria:
- Payer or Patient

Sample Report  (This screen shot illustrates the previous report with subscriber and patient dates.)
Below is an example of the error information generated by the Payer or FSC displayed in the Response Report.

```plaintext
eIV Response Report by Trace #                     Dec 02, 2010@11:11  Page: 1
Trace #: 163292800

Payer: A Payer
Patient: IB,PATIENT S (SSN:          DOB: 09/01/1940)

Subscriber: IB,PATIENT S
Subscriber ID:                           Subscriber DOB: 09/01/1940
Subscriber SSN:                           Subscriber Sex: F
Group Name:                                 Group ID:                                      
Whose Insurance: VETERAN                                   PATIENT
Member ID:                                      COB:
Service Date:                            Date of Death:
Effective Date:                       Certification Date: 
Expiration Date:                     Payer Updated Policy:
Response Date: 11/29/2010                       Trace #: 163292800

Error Information:

Reject Reason: Invalid/Missing Patient Name
Action Code: Please Correct and Resubmit
HIPAA Loop:    Dependent Name
HL7 Location:  N/A
Error Source:  P
```

The Error Source shows the originator of the returned error. “P” = Payer, “F” = FSC.

8.3 eIV Payer Report

Purpose of this Report
This report is used to monitor the communication between VistA and the payers, including the types of error and warning messages that are received by VistA from the different payers.

Report Parameters
Search Criteria:
- Inquiry Made Date Range
- All or Selected Payers
- Include Rejection Detail (Yes/No)
- All Responses or Most Recent (for a payer/patient combination)
Sort Criteria:
- Payer Name
- Total Inquiries

This is a 132 column report.

Sample Report

<table>
<thead>
<tr>
<th>Payer</th>
<th>Inactive Date</th>
<th>Created</th>
<th>Cancel</th>
<th>Queued</th>
<th>Late At</th>
<th>Retry</th>
<th>Good</th>
<th>Error</th>
<th>Avg Resp</th>
<th>(Days)</th>
<th>Timeout</th>
<th>Pending</th>
</tr>
</thead>
<tbody>
<tr>
<td>IBpayer One</td>
<td></td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>IBpayer Two</td>
<td></td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>IBpayer Three</td>
<td></td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>0</td>
<td>11</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>IBpayer Four</td>
<td></td>
<td>37</td>
<td>0</td>
<td>0</td>
<td>37</td>
<td>3</td>
<td>28</td>
<td>5</td>
<td>0.00</td>
<td>3</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

Grand Totals

<table>
<thead>
<tr>
<th></th>
<th>Created</th>
<th>Cancel</th>
<th>Queued</th>
<th>Late At</th>
<th>Retry</th>
<th>Good</th>
<th>Error</th>
<th>Avg Resp</th>
<th>(Days)</th>
<th>Timeout</th>
<th>Pending</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>67</td>
<td>0</td>
<td>0</td>
<td>67</td>
<td>4</td>
<td>58</td>
<td>6</td>
<td>0.00</td>
<td>3</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

***** SENT ***** *** RECEIVED *** Avg Resp

*** END OF REPORT ***

8.4 eIV Statistical Report

Purpose of this Report
This report is used to monitor the eIV process including statistics based on outgoing inquiries, incoming responses, pending responses and queued inquiries, etc.

This report should be monitored on a daily basis as it provides users the ability to detect eIV communication problems with the FSC in addition to potential problems in the configuration of the eIV Site Parameters. It also provides users with a quick view of new eIV associated payers and a summary of the insurance buffer entries.

This report is distributed daily as a MailMan message to the members of the mail group that is defined in the IB Site Parameters. The MailMan version covers the most recent 24 hours and is based on the default report parameters. The MailMan message is only sent when enabled through the IB Site Parameters.

Report Parameters
Search Criteria:
- Response Received Date Range
- Trace #
- All or Selected Payers
- All or Selected Patients
- All Responses or Most Recent (for a payer/patient combination)
Sample Report

<table>
<thead>
<tr>
<th>Report Timeframe: 11/07/2007 05:00 - 06/29/2009 05:00</th>
</tr>
</thead>
</table>

**Outgoing Data**
=================

<table>
<thead>
<tr>
<th>Inquiries Sent:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Buffer: 0</td>
</tr>
<tr>
<td>Appointment: 0</td>
</tr>
<tr>
<td>Non-verified Insurance: 0</td>
</tr>
</tbody>
</table>

**Incoming Data**
=================

<table>
<thead>
<tr>
<th>Responses Received:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Buffer: 0</td>
</tr>
<tr>
<td>Appointment: 0</td>
</tr>
<tr>
<td>Non-verified Insurance: 0</td>
</tr>
</tbody>
</table>

**Current Status**
==================

| Responses Pending: 1         |
| Queued Inquiries: 0          |
| Deferred Inquiries: 0        |
| Insurance Companies w/o National ID: 891 |
| eIV Payers Disabled Locally: 0 |

| Insurance Buffer Entries: 11 |
| User Action Required: 11 |
| # of * entries (User Verified policy): 4 |
| # of + entries (Payer indicated Active policy): 1 |
| # of - entries (Payer indicated Inactive policy): 1 |
| # of # entries (Policy status undetermined): 0 |
| # of ! entries (eIV needs user assistance for entry): 5 |

| Entries Awaiting Processing: 0 |
| # of ? entries (IIV is waiting for a response): 0 |
| # of blank entries (yet to be processed or accepted): 0 |

**Current Status**
==================

New eIV Payers received during report date range:
No new Payers added

**National Payers - ACTIVE flag changes at FSC**
==================================================

<table>
<thead>
<tr>
<th>IBpayer One</th>
<th>Message Dt: 09/06/09 Set: ON</th>
</tr>
</thead>
<tbody>
<tr>
<td>IBpayer Three</td>
<td>Message Dt: 09/11/09 Set: OFF</td>
</tr>
<tr>
<td>IBpayer Four</td>
<td>Message Dt: 09/14/09 Set: OFF</td>
</tr>
<tr>
<td>IBpayer Five</td>
<td>Message Dt: 09/05/09 Set: ON</td>
</tr>
</tbody>
</table>

**Nationally Active Payers - TRUSTED flag changes at FSC**
=========================================================

<table>
<thead>
<tr>
<th>IBpayer Two</th>
<th>Message Dt: 09/12/09 Set: ON</th>
</tr>
</thead>
<tbody>
<tr>
<td>IBpayer Six</td>
<td>Message Dt: 09/10/07 Set: OFF</td>
</tr>
<tr>
<td>IBpayer Seven</td>
<td>Message Dt: 09/05/07 Set: ON</td>
</tr>
</tbody>
</table>

*** END OF REPORT ***

8.5 eIV Payer Link Report

Purpose of this Report
To be eligible for electronic insurance eligibility communications via the eIV software, participating Insurance Companies must be linked to a payer from the National EDI Payer list.

This report provides information based on the relationship that the users set up in VistA between the insurance companies and the payers. This report can assist with finding insurance companies that are linked to the wrong payer. Also, the report can assist with identifying unlinked insurance companies or payers. Additionally, this report will indicate the payer locally active status.

**Report Parameters**

**Search Criteria:**
- Payer List or Insurance Company List
- All or Selected Payers
- All or Linked or Unlinked Payers
- Linked Detail or Summary

**Sort Criteria:**
- Payer Name
- VA National Payer ID
- Nationally Enabled Status
- Locally Enabled Status
- # of Linked Insurance Companies

This is a 132 column report.

**Sample Report – Payer Link**

<table>
<thead>
<tr>
<th>Payer Name: IBpayer One</th>
<th>VA529</th>
<th>0</th>
<th>YES</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linked Insurance Companies:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IBinsurance Two</td>
<td>P0 BOX 26190</td>
<td>GREENSBORO, NC</td>
<td>60054</td>
<td>60054</td>
</tr>
<tr>
<td>IBinsurance Two</td>
<td>PO BOX 30167</td>
<td>TAMPA, FL</td>
<td>60054</td>
<td>60054</td>
</tr>
<tr>
<td>IBinsurance Two A</td>
<td>PO BOX 937</td>
<td>TOLEDO, OH</td>
<td>60054</td>
<td>60054</td>
</tr>
<tr>
<td>IBinsurance Two B</td>
<td>PO BOX 150409</td>
<td>HARTFORD, CT</td>
<td>60054</td>
<td>60054</td>
</tr>
<tr>
<td>IBinsurance Two C</td>
<td>PO BOX 795080</td>
<td>SAN ANTONIO, TX</td>
<td>60054</td>
<td>60054</td>
</tr>
<tr>
<td>IBinsurance Two D</td>
<td>PO BOX 91555</td>
<td>ARLINGTON, TX</td>
<td>60054</td>
<td>60054</td>
</tr>
<tr>
<td>IBinsurance Two E</td>
<td>PO BOX 91544</td>
<td>ARLINGTON, TX</td>
<td>60054</td>
<td>60054</td>
</tr>
<tr>
<td>IBinsurance Two F</td>
<td>PO BOX 7012</td>
<td>DOVER, DE</td>
<td>60054</td>
<td>60054</td>
</tr>
<tr>
<td>IBinsurance Two G</td>
<td>PO BOX 981157</td>
<td>EL PASO, TX</td>
<td>60054</td>
<td>60054</td>
</tr>
<tr>
<td>IBinsurance Two H</td>
<td>THIRD PARTY CLAIMS M</td>
<td>MEMPHIS, TN</td>
<td>60054</td>
<td>60054</td>
</tr>
<tr>
<td>IBinsurance Two J</td>
<td>PO BOX 35890</td>
<td>LOUISVILLE, KY</td>
<td>60054</td>
<td>60054</td>
</tr>
<tr>
<td>IBinsurance Two K</td>
<td>PO BOX 1725</td>
<td>PEORIA, IL</td>
<td>60054</td>
<td>60054</td>
</tr>
</tbody>
</table>

Enter RETURN to continue or ‘^’ to exit:
8.6 MailMan Summaries

VistA automatically produces a daily MailMan message to summarize the eIV activity for the preceding 24 hours if the IB Site Parameters is set to allow this to occur. This mail message will be sent to those in the pre-determined mail group that is designated in the general parameters section of the IB Site Parameter. The message is based on an eIV Statistical Report created using the default search and sort criteria.

Sample - eIV Statistical Report in MailMan Message

<table>
<thead>
<tr>
<th>Subject: ** eIV Statistical Rpt ** [#13300889]</th>
<th>2 Jul 04 13:01</th>
<th>39 lines</th>
</tr>
</thead>
<tbody>
<tr>
<td>From: INSURANCE IDENTIFICATION &amp; VERIFICATION</td>
<td>In 'IN' basket.</td>
<td>Page 1 <em>New</em></td>
</tr>
<tr>
<td>IIV Statistical Report</td>
<td>Jul 2, 2004@13:00:42</td>
<td>Page: 1</td>
</tr>
<tr>
<td>Report Timeframe:</td>
<td>07/01/2004 13:00 - 07/02/2004 13:00</td>
<td></td>
</tr>
</tbody>
</table>

**Outgoing Data**

- Inquiries Sent: 68
  - Insurance Buffer: 10
  - Appointment (Pre-Registration): 15
  - Non-verified Insurance: 23

**Incoming Data**

- Responses Received: 60
  - Insurance Buffer: 10
  - Appointment (Pre-Registration): 14
  - Non-verified Insurance: 22

**Current Status**

- Responses Pending: 8
- Queued Inquiries: 57
- Deferred Inquiries: 0
- Insurance Companies w/o National ID: 1292
- eIV Payers Disabled Locally: 0
Insurance Buffer Entries: 235
User Action Required: 215
  # of * entries (User Verified policy) 19
  # of + entries (Payer indicated Active policy) 24
  # of - entries (Payer indicated Inactive policy) 7
  # of # entries (Policy status undetermined) 39
  # of ! entries (IIV needs user assistance for entry) 126
Entries Awaiting Processing: 20
  # of ? entries (IIV is waiting for a response) 16
  # of blank entries (yet to be processed or accepted) 4

Current Status
==============

New eIV Payers received during report date range:
Please link the associated active insurance companies to these payers at your earliest convenience. Locally activate the payers after you link insurance companies to them. For further details regarding this process, please refer to the Integrated Billing IIV Interface User Guide.

IBpayer One
IBpayer Three

National Payers - ACTIVE flag changes at FSC
==============================================

IBpayer Two Message Dt: 09/06/09 Set: ON
IBpayer Four Message Dt: 09/11/09 Set: OFF
IBpayer Six Message Dt: 09/14/09 Set: OFF
IBpayer Eight Message Dt: 09/05/09 Set: ON

Nationally Active Payers - TRUSTED flag changes at FSC
==============================================

IBpayer Five Message Dt: 09/12/09 Set: ON
IBpayer Seven Message Dt: 09/10/07 Set: OFF
IBpayer Nine Message Dt: 09/05/07 Set: ON

*** END OF REPORT ***

8.7 MailMan Notification to Link Payers

VistA automatically triggers a mailman message on a weekly basis to the IBCNE EIV Message Mail group if the following information is available:

- Total Number of Nationally Active Unlinked Payers with Potential Matches to active insurance companies.

Sample MailMan Notification

Subj: ACTION REQ: POTENTIAL PAYERS TO BE LINKED  [#159564] 01/14/11@10:46
7 lines
From: EIV INTERFACE (IB) In 'IN' basket. Page 1 *New*

TOTAL NUMBER OF PAYERS WITH POTENTIAL INSURANCE COMPANY MATCHES: 4
Immediate Attention Required:
Please link the associated active insurance companies to these payers at your earliest convenience. Please visit the e-Business Projects Webpage on VistA University Website to download the Link Payer Instructions.

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

8.8 MailMan Notification to Activate Payers

VistA automatically triggers a mailman message on a weekly basis to IBCNE EIV Message Mail group if the following information is available:

- A List of Payers that meet the following criteria:
  - Locally inactive AND
  - Nationally Active AND
  - Have linked insurance companies.

Sample MailMan Notification

Subj: ACTION REQ: PAYERS TO BE LOCALLY ACTIVATED [#159565] 01/14/11@10:46
12 lines
From: EIV INTERFACE (IB)  In 'IN' basket.  Page 1 *New*

Nationally Active Payers that are Locally Inactive:

USAA LIFE INSURANCE
UniCare
UMR (WAUSAU)
Immediate Attention Required:

Please locally activate the payers after you link insurance companies to them.
Please visit the e-Business Projects Webpage on VistA University Website to download the Payer Activation Instructions.

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

8.9 eIV Ambiguous Policy Report

Purpose of Report
This report allows users to view ambiguous payer 270 Health Care Eligibility Benefits Responses. Ambiguous payer responses are those responses that do not have enough information for eIV to safely determine if the policy is active or not active.

Report Parameters
Search Criteria:
- Response Received Date Range
- All or Selected Payers
- All or Selected Patients
- All Responses or Most Recent (for a payer/patient combination)

Sort Criteria:
- Payer Name
- Patient Name

Sample Report

<table>
<thead>
<tr>
<th>eIV Ambiguous Policy Report</th>
<th>Jun 07, 2004@11:35:37 Page: 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sorted by: Payer Name</td>
<td>Responses Displayed: All</td>
</tr>
<tr>
<td>01/01/2003 - 06/07/2004</td>
<td>All Payers</td>
</tr>
<tr>
<td>All Patients</td>
<td></td>
</tr>
</tbody>
</table>

Payer: FAMILY HEALTH SYSTEMS (COMMERCIAL)
Patient: IBpatient,Two (SSN: XXX-XX-XXXX DOB: XX/XX/XXXX)

Subscriber: IBpatient,Two
Subscriber ID: 00000XXXX
Subscriber SSN: XXXXXXXXXX
Subscriber DOB: XX/XX/XXXX
Group Name: XXXXX-XXXXXX
Group ID: XXXXXX-A
Whose Insurance: VETERAN
Pt Rel to Insured: PATIENT
Member ID: XXXXXXX
COB: YES
Service Date: XX/XX/XXXX
Date of Death: 
Effective Date: XX/XX/XXXX
Certification Date:
Expiration Date: 
Payer Updated Policy:
Response Date: XX/XX/XXXX
Trace #: XXXXXXXXXXX
Policy Number: XXXXXXX

Eligibility/Benefit Information:

eIV was unable to determine the status of this patient's policy.

Service Type: Vision (Optometry)
Coverage Level: Family
In-Plan-Network: YES
Plan Coverage Description: Vision One Discount Applies

$80.00, Quantity: 24 Month

*** END OF REPORT ***

8.10 eIV Inactive Policy Report

Purpose of Report
This report displays any inactive insurance policies that the eIV software identified while making 270 Health Care Eligibility Benefits Inquiries.
Users have the ability to define which inactive policies are included in the report based on the reported policy expiration date. This allows users the ability to search for inactive policies that expired within the payer’s filing timeframe.

**Report Parameters**

**Search Criteria:**
- Response Received Date Range
- All or Selected Payers
- All or Selected Patients
- All Responses or Most Recent (for a payer/patient combination)
- Earliest Possible Expiration Date

**Sort Criteria:**
- Payer or Patient

**Sample Report**

<table>
<thead>
<tr>
<th>eIV Inactive Policy Report</th>
<th>Jun 03, 2010@10:55:47</th>
<th>Page: 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sorted by: Payer Name</td>
<td>Responses Displayed: All</td>
<td></td>
</tr>
<tr>
<td>Earliest Policy Expiration Date: 06/03/2009</td>
<td></td>
<td></td>
</tr>
<tr>
<td>05/04/2010 - 06/03/2010</td>
<td>All Payers</td>
<td></td>
</tr>
<tr>
<td>All Patients</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Payer:** FAMILY HEALTH SYSTEMS (COMMERCIAL)

**Patient:** IBpatient,Four (SSN: XXX-XX-XXXX DOB: XX/XX/XXXX)

**Subscriber:** IBpatient,Four

**Subscriber ID:** XXXXXXXB

**Subscriber SSN:** XXXXXXX

**Group Name:** XXXXX-XXXXXX

**Group ID:** XXXXXX

**Whose Insurance:** VETERAN

**Pt Rel to Insured:** PATIENT

**Member ID:** XXXXXXX

**Service Date:** XX/XX/XXXX

**Date of Death:**

**Effective Date:** 08/01/2001

**Certification Date:**

**Expiration Date:** 04/04/2002

**Payer Updated Policy:**

**Response Date:** 06/01/2004

**Trace #:** XXXXXXXXXXX

**Policy Number:** XXXXXXXX

**Eligibility/Benefit Information:**

eIV has determined that this patient's policy is Inactive.

**Service Type:** Vision (Optometry)

**Coverage Level:** Family

**Plan Coverage Description:** Vision One Discount Applies

**In-Plan-Network:** YES

**Service Type:** Vision (Optometry)

**Coverage Level:** Family

$50.00, Quantity: 24 Month

**Time Period: Remaining, $50.00**

**Time Period: Day, $10.00**

*** END OF REPORT ***
(This page included for two-sided copying.)
9 Schedule/Unschedule MailMan Messages

This existing feature allows users to schedule and unscheduled MailMan messages to their preference. Both Activate Payer and Link Payer messages can be scheduled using this one option "IBCNE EIV PAYER LINK NOTIFY" option. Note: This option is controlled by IRM access only.

The following screens will be displayed:

```
Select OPTION to schedule or reschedule: IBCNE
  1  IBCNE EIV PAYER LINK NOTIFY  Unlinked payers notification
  2  IBCNE IIV BATCH PROCESS       eIV NIGHTLY PROCESS

Schedule/Unschedule Options

Select OPTION to schedule or reschedule: unlinked PAYERS NOTIFICATION  IBCNE EIV PAYER LINK NOTIFY  Unlinked payers notification
  Are you adding 'IBCNE EIV PAYER LINK NOTIFY' as a new OPTION SCHEDULING (the 503RD)? No//Y

Edit Option Schedule

Option Name: IBCNE EIV PAYER LINK NOTIFY
Menu Text: Unlinked payers notification

<table>
<thead>
<tr>
<th>TASK ID:</th>
</tr>
</thead>
</table>

QUEUED TO RUN AT WHAT TIME: MMM DD, YYYY@HH:MM

DEVICE FOR QUEUED JOB OUTPUT:

QUEUED TO RUN ON VOLUME SET:

RESCHEDULING FREQUENCY: 7D

TASK PARAMETERS:

SPECIAL QUEUEING: < This field is only for special jobs:
1. That need to start every time the system is rebooted.
2. Need to be persistent.
3. BOTH >

MAIL CODE:
```
(This page included for two-sided copying.)
10 Real Time Insurance Verification Inquiry

A real time eligibility verification inquiry is created when a new buffer entry has been entered in the file 355.33 (INSURANCE BUFFER). The inquiry is triggered immediately if the following information is available in the buffer entry:

- 20.01 - INSURANCE COMPANY NAME,
- 60.01 - PATIENT NAME,
- 60.04 - SUBSCRIBER ID (if patient is the subscriber),
- 60.08 - INSURED'S DOB (if patient is not the subscriber), and
- 62.01 - PATIENT ID (if patient is not the subscriber)

No inquiry will be created if:

- An inquiry already exists in the queue waiting to be transmitted.
- The same patient and policy is waiting for a response from the payer.
- The patient insurance information is locked by another user.

Real time inquiry is triggered by modifications to the following fields in file 355.33 (INSURANCE BUFFER):

- 20.01 - INSURANCE COMPANY NAME; or
- 40.02 - GROUP NAME; or
- 40.03 - GROUP NUMBER; or
- 60.01 - PATIENT NAME; or
- 60.04 - SUBSCRIBER ID; or
- 60.08 - INSURED'S DOB; or
- 62.01 - PATIENT ID

Remember – To utilize the benefit of real-time verification and get immediate responses, the facility should set the “HL7 Response Processing Method” to “Immediate”.

Remember – The Request Electronic Inquiry option can be used to create a buffer entry for real-time verification. The response received for buffer entries created by EI; stay in the buffer and never automatically updates the patient insurance file.

Remember – Real time verification inquiries are not triggered for buffer entries created by HMS data upload. Source = HMS

Remember – The system does not send a registration request message to FSC each time a real time insurance verification is triggered.
(This page included for two-sided copying.)
11  PURGING EIV FILES (IRM USERS)

11.1 Purge Transmission Queue and or Response File

IRM users have the ability to purge files from the IIV TRANSMISSION QUEUE file (#365.1) and IIV RESPONSE file (#365) beyond a date range. The Purge eIV Transactions option is on the Purge Menu which is on the System Manager's Integrated Billing Menu.

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access the IRM System Manager's Integrated Billing Menu.</td>
</tr>
<tr>
<td>2</td>
<td>Access the Purge Menu.</td>
</tr>
<tr>
<td>3</td>
<td>Access the Purge eIV Transaction option.</td>
</tr>
</tbody>
</table>

Note: purged data can fill journal files if the files are not purged routinely. It may be a good idea to temporarily disable journaling of the global that includes the IIV TRANSMISSION QUEUE (#365.1) and IIV RESPONSE (#365) files prior to running the purge if the files have not be purged in a long time.

The Purge eIV Transactions option is locked with the XUMGR security key.

The following screen will be displayed.

Purge Electronic Insurance Identification and Verification (IIV) Data Files

This option will allow you to purge data from the IIV Response File (#365) and the IIV Transmission Queue File (#365.1). The data must be at least six months old before it can be purged. Only insurance transactions that have a transmission status of "Response Received", "Communication Failure", or "Cancelled" may be purged. You will be allowed to select a date range for this purging. The default beginning date will be the date of the oldest eligible record in the system. The default ending date will be six months ago from today's date. You may modify this default date range. However, you may not select an ending date that is more recent than six months ago.

Enter the purge begin date: 10/04/2004 // 3/8/09 (MAR 8, 2009)

Enter the purge end date: 04/08/2009 // (APR 08, 2009)

You want to purge all IIV data created between 03/08/2004 and 04/08/2009.

OK to continue? NO//

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>At the Enter the Purge Begin Date: prompt, enter 6 Months plus 30 days for this example.</td>
</tr>
<tr>
<td>5</td>
<td>At the Enter the Purge End Date: prompt, press RETURN to accept the default.</td>
</tr>
<tr>
<td>6</td>
<td>At the OK to continue: prompt, enter YES.</td>
</tr>
</tbody>
</table>
Step | Procedure
---|---

**Note:** Files that are not older than six months cannot be purged.

11.2 Purge Mailman Reminder

On the first day of each month, during the nightly batch extract process, the eIV application determines if historical data exists that is eligible to be purged. The process utilizes the same search criteria used by the Purge eIV Transactions utility described above. If at least one eligible eIV transaction exists, the mail group defined in the General Parameters section of the IB Site Parameters will receive the following MailMan reminder.

```
Subj: IIV Data Eligible for Purge [#13511224] 11/06/03@17:37  13 lines
From: IB IIV INTERFACE  In 'IN' basket.  Page 1
Subject: IIV Data Eligible for Purge

ATTENTION IRM:  There are IIV TRANSMISSION QUEUE and IIV RESPONSE records eligible to be purged.

<table>
<thead>
<tr>
<th>File</th>
<th>Eligible Count</th>
<th>Total Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>IIV RESPONSE FILE (#365)</td>
<td>267</td>
<td>1993</td>
</tr>
<tr>
<td>IIV TRANSMISSION QUEUE FILE (#365.1)</td>
<td>331</td>
<td>2400</td>
</tr>
<tr>
<td>Total</td>
<td>598</td>
<td>4393</td>
</tr>
</tbody>
</table>

Please run option IBCNE PURGE IIV DATA - Purge IIV Transactions, if you would like to purge the eligible records.
```
12 APPENDIX A – eIV TROUBLESHOOTING

12.1 No eIV Inquiries Transmitted

If the Inquiries Sent and Responses Received entries on the eIV Statistical Report both remain at zero while the Queued Inquiries entry on the report continues to increase over a period of time, then no 270 Health Care Eligibility Benefits Inquiry transmissions are being sent to FSC. If this situation continues and both the Inquiries Sent and Responses Received entries remain at zero, there is a communications problem with FSC. This section provides information to restore connectivity to FSC.

The eIV Statistical report should be reviewed the following day to ensure that 270 Health Care Eligibility Benefits Inquiry transmissions are once again being sent to FSC.

12.1.1 Site Parameters

- Verify MCCR Site Parameters
  - Check General Parameters
    - Messages Mailgroup must be: IBCNE EIV MESSAGE
      - IBCNE EIV MESSAGE mail group must be populated with valid personnel
    - Contact Person Name, Number and Email address must be valid
  - Check eIV Site Parameters
    - Mail Group for eIV Messages must be: IBCNE EIV MESSAGE IBCNE EIV MESSAGE mail group must be populated with valid personnel
    - Contact Person name must be valid

12.1.2 Restoring Connectivity to FSC (IRM)

- Verify that the names of the HL7 Logical Links were not changed. It must be IIV EC
- Verify the following settings for the HL7 Logical Link IIV EC
  - The institution field is blank
  - The domain field is set to IIV.VITRIA-EDI.AAC.VA.GOV
  - The AUTOSTART field is set to enabled
  - The TCP/IP address is set to 10.224.187.133
  - The TCP/IP Port is set to 5100
  - Verify that the HL7 Logical Link IIV EC is running
- Ask the IB Supervisor or insurance personnel to review the eIV Statistical Report the following day and confirm that connectivity has been restored with FSC
- If this does not resolve the connectivity issue with FSC for eIV, ask the IB Supervisor or insurance personnel to log a Remedy Ticket with VA Product Support

12.1.3 Requeue Batch Process (IRM)

- Verify the IBCNE IIV BATCH PROCESS taskman is still running
12.1.4 Restart HL7 Logical Link (IRM)
- Verify the IIV EC HL7 logical link is running
- Stop & Restart IIV EC HL7 logical link

12.2 No link between an Insurance Company and a Payer
For eIV to work, insurance companies must be linked to a payer. This is an important on-going process. To link insurance companies to a payer follow the basic guidelines listed below:
- Run the eIV Payer Link Report option by Insurance Company List, for all unlinked insurance companies. Use the keyword feature when running the report to narrow down the search. This will provide a report showing which insurance companies, whose name contains the keyword, that are not linked to a payer.
- Next, use the Insurance Company Entry/Edit option to link those insurance companies to the correct payer.

12.3 A Buffer or Appointment Extract Entry Failed to Create an Inquiry
When the eIV process is unable to create and transmit a 270 Health Care Eligibility Benefits Inquiry to a payer, the entry in Process Insurance Buffer will be flagged with an exclamation point. To view the error or problem that eIV encountered, expand the buffer entry using the Expand Entry action. Underneath the section Buffer Entry Information, the error message will be displayed as the Current eIV Status. Read the explanation of the problem. Sometimes there is more than one way to correct the problem. For a possible solution, follow the instructions listed below for the specific error. These instructions usually start with, Action to take.

For a list of all Error Messages that may display as the Current eIV Status of an insurance buffer entry, see Appendix B.
13 APPENDIX B – eIV ERROR MESSAGE DESCRIPTIONS

1. **eIV could not create an inquiry for this entry.** eIV could not match the insurance company name in the Insurance Buffer file to a valid insurance company name in the Insurance Company file.

   **Action to take:** Correct the spelling of the insurance company name found in the buffer so that it matches one found in the Insurance Company file. Otherwise, contact the insurance company to manually verify this insurance information.

2. **eIV could not create an inquiry for this entry.** eIV matched the insurance company name in the Insurance Buffer file to more than one uniquely named insurance company in the Insurance Company file. This indicates that the Auto Match check or the Synonym check yielded multiple insurance companies from the Insurance Company file.

   **Action to take:** Correct the spelling of the insurance company name found in the buffer so that it matches one found in the Insurance Company file. Otherwise, contact the insurance company to manually verify this insurance information.

   (*Advanced users: Use the option **Enter/Edit Auto Match Entries** to check the entries in the IIV AUTO MATCH file. Make sure there is no more than one entry in the IIV AUTO MATCH file that corresponds to the insurance company name found in this buffer entry.*)

3. **eIV could not create an inquiry for this entry.** eIV matched the insurance company name in the Insurance Buffer file to more than one insurance company entry with the same name in the Insurance Company file. At least one of these matching entries are linked to a different payer.

   **Action to take:** Run the **eIV Payer Link Report** option by **Insurance Company List**, for all linked insurance companies, using the keyword feature to narrow down the search. This will provide a report showing which payer the different insurance company records are linked to. Next, use the **Insurance Company Entry/Edit** option to correct those insurance companies that are linked to the wrong payer.
4. **eIV could not create an inquiry for this entry.** There is no link for this insurance company between the Insurance Company file and the Payer file.

   **Action to take:** Use the Insurance Company Entry/Edit option to link this insurance company to the correct payer.

5. **eIV could not create an inquiry for this entry.** The payer is not nationally active for eIV.

   **Action to take:** Contact the insurance company to manually verify this insurance information.

6. **eIV could not create an inquiry for this entry.** The payer is not locally active for eIV.

   **Action to take:** Use the option Payer Edit (Activate/Inactivate) to locally activate this payer.

7. **eIV could not create an inquiry for this entry.** The payer does not accept electronic insurance eligibility requests. The eIV application data does not exist in the Payer file for this payer.

   **Action to take:** Contact the insurance company to manually verify this insurance information.

8. **Information received via electronic inquiry indicates patient has active insurance.**

   **Action to take:** Review the details listed in the eIV Response Report before processing this buffer entry.

9. **Information received via electronic inquiry indicates patient does NOT have active insurance.**

   **Action to take:** Review the details listed in the eIV Response Report before processing this buffer entry.
10. **This buffer entry is currently being processed by the eIV application.** Unless instructed otherwise, there is no reason you should do anything with this buffer entry.

   *Action to take:* None.

11. **The electronic response indicated an error of some kind that needs to be corrected before the insurance inquiry can be re-transmitted.**

   *Action to take:* Contact the insurance company to manually verify this insurance information.

12. **An unknown and unforeseen error has occurred with this entry.**

   *Action to take:* Log a Remedy ticket for this issue; include a trace number if available.

13. **eIV could not create an inquiry for this entry.** The insurance company found is listed as inactive in the Insurance Company file.

   *Action to take:* Contact the insurance company to manually verify this insurance information.

14. **eIV was unable to electronically verify this insurance information due to a communication failure.**

   *Action to take:* Contact the insurance company to manually verify this insurance information.

15. **The insurance company name for this buffer entry is blank.**

   *Action to take:* Please review the Remedy ticket ROS-0402-53243. If the cause of the problem described in the Remedy ticket does not apply to the site, please log a new Remedy ticket for this issue; include a trace number, if available. Otherwise, please contact IRM and provide this buffer information and the Remedy ticket ROS-0402-53243.

16. **eIV could not create an inquiry for this entry.** The payer associated with this insurance company has been deactivated.
**Action to take:** Either edit this insurance company and link it to another payer, using the Insurance Company Entry/Edit option or contact the insurance company to manually verify this insurance information.

17. **eIV could not create an inquiry for this entry.** This patient’s insurance must be verified manually because the Subscriber ID is missing.

**Action to take:** Contact the insurance company to manually verify this insurance information.

18. **An ambiguous response has been received.** It could NOT be determined whether the insurance company identified the patient as an active member of the insurance plan. Please contact the insurance company to manually verify this insurance information.

**Action to take:** Review the details listed in the eIV Response Report and contact the insurance company to manually verify this insurance information and correct any inaccuracies that may exist in the patient’s insurance file.

19. **While processing a payer response, an unknown and unforeseen error has occurred with this entry.**

**Action to take:** Log a Remedy ticket for this issue; include a trace number if available. A user may process this buffer entry if a Remedy ticket has been logged with the associated trace number. To process this buffer entry, review the details listed in the eIV Response Report and contact the insurance company to manually verify this insurance information.

20. **When the Patient’s ID is missing. New error message:**

   **Current eIV Status: Problem Identified**

   eIV could not create an inquiry for this entry. This dependant inquiry requires the Patient ID field to be populated before an inquiry can be transmitted electronically.

   **Action to take:** Update the inquiry with the missing Patient ID or contact the insurance company to manually verify this insurance information.

21. **When the Subscriber ID is missing. New error message:**

   **Current eIV Status: Problem Identified**
eIV could not create an inquiry for this entry. This inquiry requires the Subscriber ID field to be populated before an inquiry can be transmitted electronically.

**Action to take:** Update the inquiry with the missing Subscriber ID or contact the insurance company to manually verify this insurance information.
(This page included for two-sided copying.)
## Appendix C – Acronyms/Abbreviations/Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AITC</td>
<td>Austin Information Technology Center.</td>
</tr>
<tr>
<td>EC</td>
<td>Eligibility Communicator – this refers to the National Health Insurance database that is housed at the FSC. The eIV software communicates with the Eligibility Communicator directly through HL7.</td>
</tr>
<tr>
<td>EDI</td>
<td>Electronic Data Interchange.</td>
</tr>
<tr>
<td>eIV</td>
<td>Electronic Insurance Verification. It is also the Insurance buffer entry source name in the Insurance Buffer List to signal entry processing by Electronic Insurance Verification.</td>
</tr>
<tr>
<td>Freshness Days</td>
<td>FRESHNESS DAYS (#350.9.51.01) is a general site parameter that determines how recent the insurance verification must be before eIV seeks to electronically re-verify it.</td>
</tr>
<tr>
<td>FSC</td>
<td>VA Financial Services Center – Austin, TX.</td>
</tr>
<tr>
<td>HL7</td>
<td>Health Level Seven, a standardized application level communications protocol that enables systems to exchange information.</td>
</tr>
<tr>
<td>HMO</td>
<td>Health Maintenance Organization.</td>
</tr>
<tr>
<td>IIV</td>
<td>Insurance Identification and Verification. This nomenclature was used during initial software development. The official title of the software is now eIV, although some programming options are still labeled with the old IIV nomenclature.</td>
</tr>
<tr>
<td>Insurance Buffer</td>
<td>The data store within the VistA database that holds proposed permanent insurance file changes for review and acceptance and upon acceptance, merges the changes into the permanent insurance files. The IBCN Insurance Buffer Process option available in VistA is also known as Process Insurance Buffer.</td>
</tr>
<tr>
<td>IRM</td>
<td>Information Resource Management.</td>
</tr>
<tr>
<td>MailMan</td>
<td>MailMan is an integrated data channel in VistA for the distribution of: Patches (KIDS builds), software releases (KIDS builds), computer-to-computer communications (HL7 transfers, Servers, etc.), Person-to-person messaging (Email).</td>
</tr>
<tr>
<td>MCCF</td>
<td>Medical Care Cost Fund.</td>
</tr>
<tr>
<td>MCCR</td>
<td>Medical Care Cost Recovery. This term has been officially replaced by MCCF though both are used interchangeably.</td>
</tr>
<tr>
<td>Payer</td>
<td>An entity that makes third party payments (the patient is the first party, VHA is the second party) for health care services. Health care insurance companies are payers.</td>
</tr>
<tr>
<td>Provider</td>
<td>A term used to describe both human and organizational entities that provide health care.</td>
</tr>
<tr>
<td>SRS</td>
<td>Software Requirements Specification.</td>
</tr>
<tr>
<td>Trusted Payer</td>
<td>A payer whose responses, the FSC determines can be used for Automatic Updates. It is also referred to as the Automatic Update Setting.</td>
</tr>
<tr>
<td>VA</td>
<td>Veterans Administration.</td>
</tr>
<tr>
<td>VAMC</td>
<td>Veterans Administration Medical Center.</td>
</tr>
<tr>
<td>VHA</td>
<td>Veterans Health Administration.</td>
</tr>
<tr>
<td>VISN</td>
<td>Veterans Integrated Service Network.</td>
</tr>
<tr>
<td>VistA</td>
<td>Veterans Health Information Systems &amp; Technology Architecture, which includes the systems formerly known as the Decentralized Hospital Computer Program (DHCP) System.</td>
</tr>
<tr>
<td>WNR</td>
<td>Will not reimburse.</td>
</tr>
<tr>
<td>X12</td>
<td>A standardized application level communications protocol that enables systems to exchange information.</td>
</tr>
</tbody>
</table>