Medical Care Collection Fund (MCCF) eBilling Compliance Phase 3

**Claims Tracking and Health Care Services Review – Request for Review and Response (278)**

Document Version 2.0

User Guide



September 2016

**Revised May 2018**

**Department of Veterans Affairs**

Office of Information and Technology (OI&T)

Revision History

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Revision | Description | Author |
| May 2018 | 3.0 | Updated for patch IB\*2\*568 which added new security key IB PARAMETER EDIT.Also added new menu option “Manually Add Prosthetics to Claims Tracking” to the Supervisor’s Menu (Claims Tracking) | PM: REDACTEDTech Writer: REDACTED |
| August 2016 | 2.0 | Updated to reference patient policy comments within the Patient Insurance Screens due to patch IB\*2.0\*549. | PM: REDACTEDTech Writer: REDACTED |
| August 2016 | 1.0 | Initial Document | PM: REDACTEDTech Writer:REDACTED |

Table of Contents

[1. Introduction 1](#_Toc514255688)

[1.1. Purpose 1](#_Toc514255689)

[1.2. Overview 1](#_Toc514255690)

[1.3. Project References 2](#_Toc514255691)

[1.4. Organization of the Manual 2](#_Toc514255692)

[1.5. Acronyms and Abbreviations 3](#_Toc514255693)

[2. System Summary 3](#_Toc514255694)

[2.1. System Configuration 3](#_Toc514255695)

[2.2. Data Flows 5](#_Toc514255696)

[2.3. User Access Levels 7](#_Toc514255697)

[2.4. Contingencies and Alternate Modes of Operation 7](#_Toc514255698)

[3. Getting Started 7](#_Toc514255699)

[3.1. Troubleshooting 7](#_Toc514255700)

[4. Claims Tracking Master Menu 7](#_Toc514255701)

[5. Claims Tracking Menu (Combined Functions) ... 9](#_Toc514255702)

[5.1. Pending Reviews 9](#_Toc514255703)

[5.1.1. About the Screens 10](#_Toc514255704)

[5.1.2. Common Actions 10](#_Toc514255705)

[5.1.3. Pending Reviews Screen 11](#_Toc514255706)

[5.1.4. Expanded Claims Tracking Entry Screen 12](#_Toc514255707)

[5.1.5. Insurance Reviews/Contacts Screen 12](#_Toc514255708)

[5.1.6. Expanded Insurance Reviews 13](#_Toc514255709)

[5.1.7. Hospital Reviews Screen 13](#_Toc514255710)

[5.1.8. Expanded Hospital Reviews Screen 13](#_Toc514255711)

[5.2. Claims Tracking Edit 14](#_Toc514255712)

[5.3. Single Patient Admission Sheet 14](#_Toc514255713)

[5.4. Insurance Review Edit 14](#_Toc514255714)

[5.4.1. About the Screens 15](#_Toc514255715)

[5.4.2. Common Actions 15](#_Toc514255716)

[5.4.3. Insurance Reviews/Contacts 16](#_Toc514255717)

[5.4.4. Expanded Insurance Reviews 17](#_Toc514255718)

[5.4.5. Appeal and Denial Tracking Screen 17](#_Toc514255719)

[5.5. Appeal/Denial Edit 17](#_Toc514255720)

[5.5.1. About the Screens 18](#_Toc514255721)

[5.5.2. Appeal and Denial Tracking Screen 18](#_Toc514255722)

[5.5.3. Expanded Appeals/Denials Screen 19](#_Toc514255723)

[5.6. Inquire to Claims Tracking 19](#_Toc514255724)

[5.7. Supervisors Menu (Claims Tracking)… 20](#_Toc514255725)

[5.7.1. Manually Add Opt. Encounters to Claims Tracking 20](#_Toc514255726)

[5.7.2. Claims Tracking Parameter Edit 21](#_Toc514255727)

[5.7.3. Manually Add Prosthetics to Claims Tracking 25](#_Toc514255728)

[5.7.4. Manually Add Rx Refills to Claims Tracking 26](#_Toc514255729)

[5.7.5. Reports Menu (Claims Tracking)… 26](#_Toc514255730)

[5.8. Hospital Reviews 48](#_Toc514255731)

[5.8.1. About the Screens 48](#_Toc514255732)

[5.8.2. Common Actions 48](#_Toc514255733)

[5.8.3. Hospital Reviews Screen 49](#_Toc514255734)

[5.8.4. Expanded Hospital Reviews Screen 49](#_Toc514255735)

[6. Claims Tracking Menu for Billing ... 51](#_Toc514255736)

[6.1. Claims Tracking Edit 51](#_Toc514255737)

[6.1.1. About the Screens 52](#_Toc514255738)

[6.1.2. Common Actions 52](#_Toc514255739)

[6.1.3. Claims Tracking Editor Screen 52](#_Toc514255740)

[6.2. Print CT Summary for Billing 54](#_Toc514255741)

[6.3. Assign Reason Not Billable 55](#_Toc514255742)

[6.4. Third Party Joint Inquiry 55](#_Toc514255743)

[7. Claims Tracking Menu (Hospital Reviews) ... 56](#_Toc514255744)

[8. Claims Tracking Menu (Insurance Reviews)… 56](#_Toc514255745)

[8.1. Health Care Services Review (HCSR) 278 Response 56](#_Toc514255746)

[8.2. Health Care Services Review (HCSR) Worklist 60](#_Toc514255747)

[8.2.1. The HCSR Worklist 60](#_Toc514255748)

[8.2.2. HCSR Expanded Entry 67](#_Toc514255749)

[9. MCCR Site Parameters 73](#_Toc514255750)

[9.1. The MCCR Site Parameter Display/Edit 73](#_Toc514255751)

[9.1.1. Clinics Included In the Search 76](#_Toc514255752)

[9.1.2. Wards Included in the Search 77](#_Toc514255753)

[9.1.3. Insurance Companies Included In Appointment Search 79](#_Toc514255754)

[9.1.4. Insurance Companies Included In Admissions Search 80](#_Toc514255755)

[10. Appendix A – Follow-up Actions Codes 82](#_Toc514255756)

Table of Figures

[Figure 1: Health Care Services Review – Part 1 5](#_Toc514255757)

[Figure 2: Health Care Services Review – Part 2 6](#_Toc514255758)

# Introduction

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

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

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

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

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

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

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

##  Purpose

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

## Overview

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

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

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

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

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

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

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

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

## Project References

|  |  |  |
| --- | --- | --- |
| Reference | Location | Date |
| Health Care Services Review – Request for Review and Response (278) | <http://www.wpc-edi.com/> | May 2006 |
| eBilling 278 ICD | REDACTED | June 2016 |
| Integrated Billing (IB) V. 2.0 User Manual | [http://www.va.gov/vdl/documents/Financial\_Admin/Integrated\_Billing\_(IB)/ib\_2\_0\_um.doc](http://www.va.gov/vdl/documents/Financial_Admin/Integrated_Billing_%28IB%29/ib_2_0_um.doc)  | September 2015 |

##  Organization of the Manual

This document contains the following sections:

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

## Acronyms and Abbreviations

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

# System Summary

## System Configuration

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

* Schedule IB MT NIGHT COMP
* Schedule IBT HCSR NIGHTLY PROCESS
* Define MCCR Site Parameter Display/Edit

## Data Flows



Figure : Health Care Services Review – Part 1



**Figure 2: Health Care Services Review – Part 2**

##  User Access Levels

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

* IB PARAMETER EDIT – controls access to the MCCR Site Parameter Display/Edit option
* IB Claims Supervisor – controls access to the Supervisors Menu (Claims Tracking) ... option
* IB PARAMETER EDIT – controls access to the option Claims Tracking Parameter Edit which is located on the Supervisors Menu (Claims Tracking) parent menu option.
* IB HCSR Param Edit – controls access to the Health Care Services Review (HCSR) parameters within the MCCR Site Parameters

## Contingencies and Alternate Modes of Operation

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

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

# Getting Started

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

## Troubleshooting

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

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

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

# Claims Tracking Master Menu

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

* **Claims Tracking Master Menu**

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

 Master Menu

 BI Claims Tracking Menu for Billing ...

 CT Claims Tracking Menu (Combined Functions) ...

 EN CT ENHANCED for CODERS/MCCR MENU ...

 HR Claims Tracking Menu (Hospital Reviews) ...

 IR Claims Tracking Menu (Insurance Reviews) ...

Select Claims Tracking Master Menu <TEST ACCOUNT> Option:

* **Integrated Billing Menu**

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

nu for Billing

 CT Claims Tracking Edit

 PS Print CT Summary for Billing

 RN Assign Reason Not Billable

 TP Third Party Joint Inquiry

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

* **Combined Menu**

Select Claims Tracking Master Menu <TEST ACCOUNT> Option: ct Claims Tracking Me

nu (Combined Functions)

 PR Pending Reviews

 CT Claims Tracking Edit

 SP Single Patient Admission Sheet

 IR Insurance Review Edit

 AD Appeal/Denial Edit

 IC Inquire to Claims Tracking

 SM Supervisors Menu (Claims Tracking) ...

 RM Reports Menu (Claims Tracking) ...

 HR Hospital Reviews

 HW Health Care Services Review (HCSR) Worklist

 HC Health Care Services Review (HCSR) 278 Response

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

* **Coder Menu - *Note:*** No longer used
* **Hospital Reviewer Menu**

Select Claims Tracking Master Menu <TEST ACCOUNT> Option: HR Claims Tracking Me

nu (Hospital Reviews)

 PR Pending Reviews

 CT Claims Tracking Edit

 HR Hospital Reviews

 IC Inquire to Claims Tracking

 RM Reports Menu (Claims Tracking) ...

 SM Supervisors Menu (Claims Tracking) ...

 SP Single Patient Admission Sheet

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

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

* **Insurance Reviewer Menu**

Select Claims Tracking Master Menu <TEST ACCOUNT> Option: HR Claims Tracking Me

nu (Hospital Reviews)

 PR Pending Reviews

 AD Appeal/Denial Edit

 CT Claims Tracking Edit

 HC Health Care Services Review (HCSR) 278 Response

 HW Health Care Services Review (HCSR) Worklist

 IC Inquire to Claims Tracking

 IR Insurance Review Edit

 RM Reports Menu (Claims Tracking) ...

 SM Supervisors Menu (Claims Tracking) ...

 SP Single Patient Admission Sheet

 TP Third Party Joint Inquiry

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

# Claims Tracking Menu (Combined Functions) ...

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

## Pending Reviews

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

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

|  |
| --- |
| Pending Reviews-------------------------------------------------------------------------------------- |
| QE Quick Edit  | IR Ins. Reviews | RL Remove from List |
| VE View/Edit Entry | SC SC Conditions  | DU Diagnosis Update |
| ***CT Claims Tracking Edit*** | CS Change Status  | PU Procedure Update |
| PW Print Worksheet | CD Change Date Range | PV Provider Update |

|  |
| --- |
| Expanded Claims Tracking Entry-------------------------------------------------------------------------------------- |
| BI Billing Info Edit | ***IR Insurance Reviews***  | PV Provider Update |
| RI Review Info | DU Diagnosis Update | EX Exit |
| TA Treatment Auth. | PU Procedure Update |  |

|  |
| --- |
| Insurance Reviews/Contacts-------------------------------------------------------------------------------------- |
| AI Add Ins. Review | SC SC Conditions  | PV Provider Update |
| DR Delete Ins. Review  | AE Appeals Edit  | RW Review Wksheet Print |
| CS Change Status  | AC Add Comment  | CP Change Patient |
| QE Quick Edit  | DU Diagnosis Update | EX Exit |
| ***VE View/Edit Ins. Review*** | PU Procedure Update |  |

|  |
| --- |
| Expanded Insurance Reviews-------------------------------------------------------------------------------------- |
| AA Appeal Address | AI Action Info  | PU Procedure Update |
| CI Contact Info  | AC Add Comments  | PV Provider Update |
| CS Change Status  | VP View Pat. Ins | RW Review Wksheet Print |
| IU Ins. Co. Update  | DU Diagnosis Update | EX Exit  |

|  |
| --- |
| Pending Reviews-------------------------------------------------------------------------------------- |
| QE Quick Edit | ***HR Hospital Reviews*** | RL Remove from List |
| VE View/Edit Entry | SC SC Conditions | DU Diagnosis Update |
| **CT Claims Tracking Edit** | CS Change Status | PU Procedure Update |
| PW Print Worksheet | CD Change Date Range | PV Provider Update |

|  |
| --- |
|  Hospital Reviews-------------------------------------------------------------------------------------- |
| AI Add Next Hosp.Review | ***VE View/Edit Review*** | CP Change Patient |
| DR Delete Review  | DU Diagnosis Update | EX Exit |
| QE Quick Edit  | PU Procedure Update |  |
| CS Change Status  | PV Provider Update |  |

|  |
| --- |
| Expanded Hospital Reviews-------------------------------------------------------------------------------------- |
| AI Add Ins. Review | SC SC Conditions  | PV Provider Update |
| DR Delete Review  | AE Appeals Edit  | RW Review Wksheet Print |
| CS Change Status  | AC Add Comment  | CP Change Patient |
| QE Quick Edit  | DU Diagnosis Update | EX Exit |
| **VE View/Edit Review** | PU Procedure Update |  |

***Notes:***

* The View Edit Entry action will take you directly to the Expanded Insurance or Expanded Hospital Reviews Screens depending on the type of review.
* The View Pat. Ins action brings you to the Patient Insurance Screens.
* The Appeals Edit action brings you to the Appeal and Denial Tracking screen.

### About the Screens

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

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

### Common Actions

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

* **Quick Edit** - This action allows you to quickly edit all information about the review without leaving the Pending Review option.
* **SC Conditions** - This action allows a quick look at the patient's eligibility, SC status, service-connected conditions, and percent of service connection for service-connected veterans.
* **Change Statu**s - This action allows you to quickly change the status of a review. Only completed reviews are used in the report preparation and by the MCCR NDB roll-up or the QM roll-up (which is tentatively scheduled for release in June 1994).
* Reviews have a status of ENTERED when automatically added. A status of PENDING may be used for those you are still working on or when one person does the data entry and another needs to review it.
* **Add Comment** - This action allows you to edit the word processing (comments) field in Hospital or Insurance Reviews without having to edit other fields.
* **Diagnosis Update** - This action allows input of ICD diagnoses for the patient. Whether diagnoses are input on this screen or another screen, they are available across the Claims Tracking module. You may enter an admitting diagnosis, primary diagnosis, secondary diagnosis and the onset date of the diagnosis for this admission. For outpatient visits this information is stored with the outpatient encounter information.
* **Procedure Update** - This action allows the input of ICD procedures for the patient. You may input the procedure and the date. This is a separate procedure entry from the PTF module and is optional for use.
* **Provider Update** - This action allows you to input the admitting physician, attending physician, and care provider separate from the MAS information. The purpose is to provide a location to document the attending physician and to provide an alternate place to document individual physicians if the administrative record indicates teams, or vice versa.
* **Change Patien**t - This action allows you to change the selected patient without having to leave and reenter the option.
* **Review Worksheet Print** - This action prints a worksheet for use on the wards for writing notes prior to calling the insurance company and entering the review. Basic information about the patient and the visit is included. Please note that the format is slightly different for 80 and 132 column outputs.

### Pending Reviews Screen

The following actions are available from the Pending Reviews screen:

* **View/Edit Entry** - This action allows you to jump to either the Expanded Insurance Review screen or the expanded Hospital Review screen, depending on the type of review.
* **Claims Tracking Edit** - This action allows you to jump to the expanded Claims Tracking screen and perform all necessary edits to the entry in that file. This may include the input of billing information.
* **Print Worksheet** - This action allows you to print a generic worksheet for selected entries. The latest administrative data is printed on the worksheet including patient name, ward, physicians, room-bed, etc.
* **Insurance Reviews** - This action allows you to jump to the Insurance Reviews Screen. For details see the Insurance Reviews option documentation. Please note that if you try to perform an Insurance Review on a pending Hospital Review, the software will automatically take you to the Hospital Review screen. This action is not available on the Claims Tracking Menu (Hospital Reviews).
* **Hospital Reviews** - This action allows you to jump to the Hospital Reviews screen. For details see the Hospital Reviews option documentation. Please note that if you try to perform a Hospital Review on a pending Insurance Review, the software will automatically take you to the Insurance Review screen. This action is not available on the Claims Tracking Menu (Insurance Reviews).
* **Change Date Range** - This action allows you to change the beginning and ending date of the search for pending reviews. You can search into the past or future for pending reviews. Reviews for the past 7 days is the default.
* **Remove From List** - This action allows you to quickly remove the review from the Pending Review List by automatically deleting the Next Review Date. For Insurance Reviews, the TRACK AS INSURANCE CLAIM field is also asked. If this is set to NO, no further reviews are automatically created for this visit.

### Expanded Claims Tracking Entry Screen

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

* **Billing Info Edit** - This action allows you to edit the billing information about expected revenues and next auto bill date. This is useful for comparing expected revenues versus what was received.
* **Review Info** - This action allows you to review/edit whether or not a special consent release of information form (ROI) for this patient for this episode of care is required, obtained, or not necessary; and whether this review should be tracked as a random sample, insurance claim, special condition, or local addition.
* **Treatment Auth.** - This action allows you to enter whether a second opinion for this patient insurance policy was required and obtained. (If a second opinion was obtained but did not meet the insurance company's criteria, enter NO in the SECOND OPINION OBTAINED field.) This field will be used to help determine the estimated reimbursement from the insurance carrier. If a second opinion was not obtained, certain denials and penalties may be assessed.
* **Hospital Reviews** - This action accesses the Hospital Reviews Screen.
* **Insurance Reviews** - This action accesses the Insurance Reviews/Contacts Screen.

### Insurance Reviews/Contacts Screen

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

* **Add Ins. Review** - This action will add a new review for the visit. The default Review Types are:
* Pre-admission Certification Review (a scheduled admission with no previous review)
* Urgent/Emergent Admission Review (a scheduled admission with no previous review)
* Continued Stay Review (for follow-up reviews)
* Other available Review Types are:
	+ - DISCHARGE REVIEW
		- INPT RETROSPECTIVE REVIEW
		- OPT RETROSPECTIVE REVIEW
		- OTHER
		- OUTPATIENT TREATMENT
		- PATIENT
		- SNF/NHCU REVIEW
		- SUBSEQUENT APPEAL
* **Delete Ins. Review** - This action allows an insurance review to be deleted. If a review is automatically created, but the visit does not require reviews and follow-up with the insurance company, it can be deleted. Use care in exercising this action. It can be as important to document that no review is required as it is to document the required reviews.
* **View/Edit Ins. Review** - This action allows access to the Expanded Insurance Reviews Screen.
* **Appeals Edit** - This action allows you to jump to the Appeals and Denials Screen. For details see the Appeals and Denials option. Only denials and penalties may be appealed. This action is not available on the Claims Tracking for Hospital Reviews option.

### Expanded Insurance Reviews

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

* **Appeal Address** - This action allows you to edit the appeals address information for the insurance company.
* **Contact Info** - This action allows you to enter/edit the review date, person contacted, method of contact, phone and reference numbers.
* **Ins. Co. Update** - This action allows you to view/edit the billing, pre-certification, verification, claims, appeals, and inquiry phone numbers for the insurance company.
* **Action Info** - This action allows you to view/edit information pertaining to action taken on a review such as type of contact, care authorization from and to dates, authorization number, and review date and status.
* **View Pat. Ins**. - This action takes you to the Patient Insurance Screens. Note: From this instance of the Patient Insurance Screen users may not add, edit, or delete Patient Policy Comments. It is in view only mode. For more detailed information on Patient Insurance Menu, refer to the IB V. 2.0 User Manual.

### Hospital Reviews Screen

The following actions are available from the Hospital Reviews screen:

* **Add Next Hosp. Review** - This action will add the next review and automatically set it to either an admission review or continued stay review. The day for review and review date are automatically computed but can be edited. The category of severity of illness and intensity of service that was met can be entered; or if not met, the reason it was not met.
* **Delete Review** - This action allows a hospital review to be deleted. If a review is automatically created, but the visit does not require reviews and follow-up with the insurance company, it can be deleted. Use care in exercising this action. It can be as important to document that no review is required as it is to document the required reviews.
* **View/Edit Review** - This action allows access to the Expanded Hospital Reviews Screen.

### Expanded Hospital Reviews Screen

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

* **Review Information** - This action allows you to enter/edit the type of review (admission or continued stay), review date, and the specialty and methodology for the review. There should be only one admission review for an admission. Normally, reviews are done for RUR purposes on days 3, 6, 9, 14, 21, 28, and every 7 days thereafter. Usually, the INTERQUAL method is used as the methodology for RUR required reviews. Insurance carriers may require other review methodologies.
* **Criteria Update** - This action allows you to enter or edit data regarding criteria met/not met for an acute admission within 24 hours, such as the review date and methodology; severity of illness and intensity of service; and whether additional reviews are required

## Claims Tracking Edit

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

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

**Sample Screen**

Claims Tracking Editor Oct 22, 2014@10:53:42 Page: 1 of 1

Claims Tracking Entries for: IB,PATIENT 1 IXXXX

 for Visits beginning on: 10/22/13 to 11/05/14

 Type Urgent Date Ins. UR ROI Bill Ward

1 \*INPT. NO 10/21/14 1:22 pm YES YES C MEDICI

 Service Connected: NO \*=Current Admission >>>

***DT Delete Tracking Entry*** SC SC Conditions VP View Pat. Ins.

QE Quick Edit AE Appeals Edit ***RO ROI Consent***

***AC Assign Case*** CP Change Patient **EX Exit**

***BI Billing Info Edit*** CD Change Date Range

VE View/Edit Episode DU Diagnosis Update

HR Hospital Reviews PU Procedure Update

Select Action: Quit//

## Single Patient Admission Sheet

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

## Insurance Review Edit

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

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

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

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

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

|  |
| --- |
| Insurance Reviews/Contacts-------------------------------------------------------------------------------------- |
| AI Add Ins. Review | SC SC Conditions | PV Provider Update |
| DR Delete Ins. Review | ***AE Appeals Edit***  | RW Review Wksheet Print |
| CS Change Status | AC Add Comment | CP Change Patient |
| QE Quick Edit  | DU Diagnosis Update | EX Exit |
| ***VE View/Edit Ins. Review*** | PU Procedure Update  |  |

|  |
| --- |
| Expanded Insurance Reviews-------------------------------------------------------------------------------------- |
| AA Appeal Address | AI Action Info  | PU Procedure Update |
| CI Contact Info | AC Add Comments  | PV Provider Update |
| CS Change Status | VP View Pat. Ins. | RW Review Wksheet Print |
| IU Ins. Co. Update  | DU Diagnosis Update  | EX Exit |

|  |
| --- |
| Appeal and Denial Tracking-------------------------------------------------------------------------------------- |
| VE View Edit Entry  | DA Delete Appeal/Denial  | IC Ins. Co. Edit |
| QE Quick Edit | SC SC Conditions  | EX Exit |
| AA Add Appeal | PI Patient Ins. Edit. |  |

###  About the Screens

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

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

### Common Actions

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

* **Quick Edit** - This action allows you to edit most of the fields in Claims Tracking, specify if there should be insurance or hospital reviews, add billing information, and assign the visit to a reviewer.
* **SC Conditions** - This action allows a quick look at the patient's eligibility, SC status, service-connected conditions, and percent of service connection for service-connected veterans.
* **Diagnosis Update** - This action allows input of International Classification of Diseases (ICD) diagnoses for the patient. Whether diagnoses are input on this screen or another screen, they are available across the Claims Tracking module. You may enter an admitting diagnosis, primary (DXLS) diagnosis, secondary diagnosis, and the onset of the diagnosis for this admission. For outpatient visits, this information is stored with the outpatient encounter information.
* **Procedure Update** - This action allows the input of ICD procedures for the patient. You may input the procedure and the date. This is a separate procedure entry from the PTF module and is optional for use.
* **Provider Update** - This action allows you to input the admitting physician, attending physician, and care provider separate from the MAS information. The purpose is to provide a location to document the attending physician and to provide an alternate place to document actual physicians if the administrative record indicates teams or vice versa.
* **Change Status** - This action allows you to quickly change the status of a review. Only completed reviews are used in the report preparation and by the MCCR NDB roll-up or the QM roll-up.

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

* **Add Comment** - This action allows you to edit the word processing (comments) field in Hospital or Insurance Reviews without having to edit other fields.
* **Review Worksheet Print** - This action prints a worksheet for use on the wards for writing notes prior to calling the insurance company and entering the review. Basic information about the patient and the visit is included. Please note that the format is slightly different for 80 and 132 column outputs.

### Insurance Reviews/Contacts

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

* **Add Ins. Review** - This action will add a new review for the visit. The default Review Types are:
* Pre-admission Certification Review (a scheduled admission with no previous review)
* Urgent/Emergent Admission Review (a scheduled admission with no previous review)
* Continued Stay Review (for follow-up reviews)
* Other available Review Types are:
	+ - DISCHARGE REVIEW
		- INPT RETROSPECTIVE REVIEW
		- OPT RETROSPECTIVE REVIEW
		- OTHER
		- OUTPATIENT TREATMENT
		- PATIENT
		- SNF/NHCU REVIEW
		- SUBSEQUENT APPEAL
* **Delete Ins. Review** - This action allows an insurance review to be deleted. If a review is automatically created, but the visit does not require reviews and follow-up with the insurance company, it can be deleted. Use care in exercising this action. It can be as important to document that no review is required as it is to document the required reviews.
* **View/Edit Ins. Review** - This action allows access to the Expanded Insurance Reviews Screen.
* **Appeals Edit** - This action allows you to jump to the Appeals and Denials Screen. For details see the Appeals and Denials option. Only denials and penalties can be appealed. This action is not available on the Claims Tracking for Hospital Reviews option.
* **Change Patient** - This action allows you to change to another patient without going back to the beginning of the option.

### Expanded Insurance Reviews

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

* **Appeal Address** - This action allows you to edit the appeals address information for the insurance company.
* **Contact Info** - This action allows you to enter/edit the review date, person contacted, method of contact, phone and reference numbers.
* **Ins. Co. Update** - This action allows you to view/edit the billing, pre-certification, verification, claims, appeals, and inquiry phone numbers for the insurance company.
* **Action Info** - This action allows you to view/edit information pertaining to action taken on a review such as type of contact, care authorization from and to dates, authorization number, and review date and status.
* **View Pat. Ins.** - This action takes you to the Patient Insurance Screens. Note: From this instance of the Patient Insurance Screen users may not add, edit, or delete Patient Policy Comments. It is in view only mode. For more detailed information on Patient Insurance Menu, refer to the IB V. 2.0 User Manual.

### Appeal and Denial Tracking Screen

The following actions are available from the Appeal and Denial Tracking screen:

* **View/Edit Entry** - This action allows you to jump to the Expanded Appeal/Denial Screen where you can view much of the data for one visit and perform related actions.
* **Add Appeal** - This action allows adding an appeal to a denial or penalty. The first appeal will be an initial appeal. All other appeals will be subsequent appeals. You may enter an administrative or clinical appeal. There is no limit to the number of appeals that may be entered.
* **Delete Appeal/Denial** - This action allows deletion of appeals and denials. This was designed for use in cases of erroneous entry.
* **Patient Ins. Edit** - This action allows editing of fields in the Insurance Company file (#36) that pertain to appeals address and phone numbers.
* **Ins. Co. Edit** - This action allows you to edit patient policy information.

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

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

## Appeal/Denial Edit

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

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

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

|  |
| --- |
| Appeals and Denial Tracking-------------------------------------------------------------------------------------- |
| ***VE View Edit Entry*** | DA Delete Appeal/Denial | IC Ins. Co. Edit |
| QE Quick Edit | SC SC Conditions | EX Exit |
| AA Add Appeal | PI Patient Ins. Edit. |  |

|  |
| --- |
| Expanded Appeals/Denials-------------------------------------------------------------------------------------- |
| AA Appeal Address | AI Action Info | EX Exit |
| CI Contact Info | AC Add Comment |  |
| IU Ins. Co. Update | EP Edit Pt. Ins. |  |

### About the Screens

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

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

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

### Appeal and Denial Tracking Screen

The following actions are available from the Appeal and Denial Tracking screen:

* **View/Edit Entry** - This action allows you to jump to the Expanded Appeal/Denial Screen where you can view much of the data for one visit and perform related actions.
* **Quick Edit** - This action allows you to edit nearly all of the fields in the appeal or denial, add comments, maintain its status, and assign follow-up dates.
* **Add Appeal** - This action allows adding an appeal to a denial or penalty. The first appeal will be an initial appeal. All other appeals will be subsequent appeals. You may enter an administrative or clinical appeal. There is no limit to the number of appeals that may be entered.
* **Delete Appeal/Denial** - This action allows deletion of appeals and denials. This was designed to be used in cases of erroneous entry.
* **SC Conditions** - This action allows a quick look at the patient's eligibility, SC status, service-connected conditions, and percent of service connection for service-connected veterans.
* **Ins. Co. Edit** - This action allows editing of fields in the Insurance Company file (#36) that pertain to appeals address and phone numbers.
* **Patient Ins. Edit** - This action allows you to edit patient policy information.

### Expanded Appeals/Denials Screen

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

* **Appeal Address** - This action allows you to edit the name and address for a selected appeal.
* **Contact Info** - This action allows you to enter/edit the review date, person contacted, method of contact, phone and reference numbers.
* **Ins. Co. Update** - This action allows you to view/edit the billing, pre-certification, verification, claims, appeals, and inquiry phone numbers for the insurance company.
* **Action Info** - This action allows you to view/edit information pertaining to action taken on a review such as type of contact, care authorization from and to dates, authorization number, and review date and status.
* **Add Comment** - This action allows you to edit the word processing (comments) field in Hospital or Insurance Reviews without having to edit other fields.
* **Edit Pt. Ins.** - This action brings you to the Patient Insurance Screen. Note: from this instance of the Patient Insurance Screen users may add, edit, or delete Patient Policy Comments. For more detailed information on Patient Insurance Menu, refer to the IB V. 2.0 User Manual.

## Inquire to Claims Tracking

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

The following screen is an example of what is displayed for a patient using the Inquire to Claims Tracking option:

**Sample Screen**

Claim Tracking Inquiry Page 1 XXX XX, XXXX@15:55:54

IB,PATIENT 1 XX-XX-XXXX DOB: XXX XX, XXXX

INPATIENT ADMISSION on XXX XX, XXXX@09:30:35

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

 Visit Information

 Visit Type: INPATIENT ADMISSION Visit Billable: YES

Admission Date: XXX XX,XXXX@09:30:35 Second Opinion: NOT REQUIRED

 Ward: C-MEDICINE Auto Bill Date:

 Specialty: MEDICINE Special Consent: ROI OBTAINED

Discharge Date: Special Billing: FEDERAL OWCP

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

 Billing Information

 Initial Bill: Estimated Recv (Pri): $

 Bill Status: Estimated Recv (Sec): $

 Total Charges: $ 0 Estimated Recv (ter): $

 Amount Paid: $ 0 Means Test Charges: $

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

Diagnosis Information

 Nothing on File

 Associated Interim DRG Information

 Nothing on File

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

 Procedure Information

 Nothing on File

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

 Provider Information

 Nothing on File

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

Insurance Review Information

 Type Review: CONTINUED STAY REVIEW Review Date: XX/XX/XX 1:41 pm

 Action: DENIAL Insurance Co.: AETNA US HEALTHCARE

 Denied From: XX/XX/XX Person Contacted:

 Denied To: XX/XX/XX Contact Method: PHONE

 Denial Reasons: FAILURE TO MEET PAYER Call Ref. Number:

 Status: PENDING

 Last Edited By: UR,NURSE 2

 Type Review: URGENT/EMERGENT ADMIT Review Date: XX/XX/XX

 Action: Insurance Co.: AETNA US HEALTHCARE

 Person Contacted:

 Contact Method:

 Call Ref. Number:

 Status: ENTERED

 Last Edited By:

 Last Edited By:

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

Hospital Review Information

None on file.

## Supervisors Menu (Claims Tracking)…

### Manually Add Opt. Encounters to Claims Tracking

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

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

**Sample Mail Message**

Subj: Outpatient Encounters added to Claims Tracking Complete [#204668]

10/22/14@15:52 13 lines

From: INTEGRATED BILLING PACKAGE In 'IN' basket. Page 1

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

The process to automatically add Opt Encounters has successfully completed.

 Start Date: 05/01/09

 End Date: 05/02/09

 Total Encounters Checked: 1214

 Total Encounters Added: 0

 Total Non-billable Encounters Added: 0

\*The SC, Agent Orange, Southwest Asia, Ionizing Radiation,

Military Sexual Trauma, Head Neck Cancer, Combat Veteran and Project 112/SHAD

status visits have been added for insured patients but automatically

indicated as not billable.

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

### Claims Tracking Parameter Edit

This option allows you to edit the MCCR Site Parameters that affect the Claims Tracking module. The parameters can also be edited in the option, MCCR Site Parameters. This option is locked with the IB PARAMETER EDIT security key.

**Sample Screen**

Claims Tracking Parameter Enter Edit

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

Initialization Date: 01/01/94

Use Admission Sheet: NO

 Header line 1: ANYSITE VAMC

 Header line 2: 2360 E. ANYSTREET

 Header line 3: ANYSITE, WY

 Track Inpatient: INSURED AND UR ONLY Track Outpatient: INSURED ONLY

 Track Rx: INSURED ONLY Track Prosthetics: INSURED ONLY

 Reports can Add CT: YES

 Medicine Sample: 5 Surgery Sample: 5

Medicine Admissions: 5 Surgery Admissions: 5

 Psych Sample: 1

 Psych Admissions: 5

INSURANCE EXTENDED HELP: ON//

CLAIMS TRACKING START DATE: JAN 1,1994//

INPATIENT CLAIMS TRACKING: INSURED AND UR ONLY//

OUTPATIENT CLAIMS TRACKING: INSURED ONLY//

PRESCRIPTION CLAIMS TRACKING: INSURED ONLY//

PROSTHETICS CLAIMS TRACKING: INSURED ONLY//

REPORTS ADD TO CLAIMS TRACKING: YES//

USE ADMISSION SHEETS: NO//

MEDICINE SAMPLE SIZE: 5//

MEDICINE WEEKLY ADMISSIONS: 5//

SURGERY SAMPLE SIZE: 5//

SURGERY WEEKLY ADMISSIONS: 5//

PSYCH SAMPLE SIZE: 1//

PSYCH WEEKLY ADMISSIONS: 5//

Inquiry can be Triggered for Appointment: 14

Inquiry can be Triggered for Admission: 0

Days to wait to purge entry on HCSR Response: 20

The following is a list of each parameter with a brief description:

* **Insurance Extended Help**

Should the extended help display always be on in the Insurance Management options?

ON - if you always want it to display automatically

OFF - if you do not want to see it

* **Claims Tracking Start Date**

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

* **Inpatient Claims Tracking**

This field determines which inpatients will automatically be added to the Claims Tracking module. It is recommended that this field be set to INSURED AND UR ONLY.

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

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

* **Outpatient Claims Tracking**

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

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

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

If a prescription or refill does not appear to be billable, Service Connected (SC) care for example, or there is a visit date associated with that prescription or refill, this will be noted in the reason not billable.

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

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

This field will be used to determine if issuance of prosthetics should be tracked in the Claims Tracking module.

* OFF - no prosthetic items should be tracked
* INSURED ONLY - only prosthetic items for patients with insurance will be tracked
* ALL PATIENTS - prosthetic items for all patients will be tracked
* **Reports Add to Claims Tracking**

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

* **Use Admission Sheets**

Indicate whether your facility is using Admission Sheets as part of the MCCR/UR functionality. If the answer to this parameter is YES, users will be asked for the device to which admissions sheets are printed. A default device can be defined in the BILL FORM TYPE file.

* **Admission Sheet Header Line 1**

Enter the text that your facility would like to print as the first line of the header on the admission sheet. This is usually the name of your medical center.

* **Admission Sheet Header 2**

Enter the text that your facility would like to print as the second line of the header on the admission sheet. This is usually the street address of your medical center.

* **Admission Sheet Header Line 3**

Enter the text that your facility would like to print as the third line of the header on the admission sheet. This is usually the city, state, and ZIP code of your medical center.

* **Medicine Sample Size**

This is the number of required Utilization Reviews that you wish to have done each week for Medicine admissions. The minimum recommended by the Quality Assurance (QA) office is one per week.

* **Medicine Weekly Admissions**

This is the minimum number of admissions that your facility usually averages for Medicine. This is used along with the Medicine Sample Size to compute a random number. Changing this number to a lower value will cause the random sample case to be selected earlier in the week. A higher number provides a more even distribution of cases during the week. If the number exceeds the admissions for the week, the possibility exists that a random sample case may not be generated for this service.

* **Surgery Sample Size**

This is the number of required Utilization Reviews that you wish to have done each week for Surgery admissions. The minimum recommended by the QA office is one per week.

* **Surgery Weekly Admissions**

This is the minimum number of admissions that your medical center usually averages for Surgery. This is used along with the Surgery Sample Size to compute a random number. Changing this number to a lower value will cause the random sample case to be selected earlier in the week. A higher number provides a more even distribution of cases during the week. If the number exceeds the admissions for the week, the possibility exists that a random sample case may not be generated for this service.

* **Psych Sample Size**

This is the number of required Utilization Reviews that you wish to have done each week for Psychiatry admissions. The minimum recommended by the QA office is one per week.

* **Psych Weekly Admissions**

This is the minimum number of admissions that your medical center usually averages for Psychiatry. This is used along with the Psychiatry Sample Size to compute a random number. Changing this number to a lower value will cause the random sample case to be selected earlier in the week. A higher number provides a more even distribution of cases during the week. If the number exceeds the admissions for the week, the possibility exists that a random sample case may not be generated for this service.

* **Inquiry can be Triggered for Appointments**

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

* **Inquiry can be Triggered for Admissions**

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

* **Days to wait to purge entry on HCSR Response**

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

### Manually Add Prosthetics to Claims Tracking

Prosthetic items which have been issued through the Prosthetics module are normally added to Claims Tracking when the IB nightly background job is run based on the date of service of the item and the day of the month. On the tenth (10th) of each month the date range for the IB nightly background job is T-730 days through T-3 days to pull Prosthetics items based on the date of service. On all other days of the month, the date range for the IB nightly background job is T-20 days through T-3 days. This option allows you to search for prosthetic items that have a date of service within a user-specified date range and automatically add them to Claims Tracking. If you choose to run the automated bill preparation portion of IB V. 2.0, you should run this report periodically to insure that all prosthetic items are billed. This option is automatically queued to run in the background and a mail message is sent upon completion.

You may queue this option into the future; however, only prosthetic items issued during the user-specified date range will be added automatically. A message indicating any change will be added to the completion mail message.

**Sample Mail Message**

Subj: Prosthetic Items added to Claims Tracking Complete [#114894] 02 Feb 17 08:52

 10 Lines

From: INTEGRATED BILLING PACKAGE in 'IN' basket. Page 1 \*\*NEW\*\*

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

The process to automatically add Prosthetic Items has successfully completed.

 Start Date: 05/01/16

 End Date: 07/17/17

(Selected end date of 07/20/17 automatically changed to 07/17/17.)

 Total Prosthetics Items checked: 200210

Total NSC Prosthetic Items Added: 14430

 Total SC Prosthetic Items Added: 0

\*The items added as SC require determination and editing to be billed

### Manually Add Rx Refills to Claims Tracking

Prescription refills that have been released within ten days of the fill date are automatically added to Claims Tracking when the IB MT NIGHT COMP task is run. This option allows you to search for refills that were not released within ten days of the fill date and automatically add them to Claims Tracking. If you choose to run the automated bill preparation portion of IB V. 2.0, you should run this report periodically to insure that all outpatient care is billed. This option is automatically queued to run in the background and a mail message is sent upon completion.

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

**Sample Mail Message**

Subj: Rx Refills added to Claims Tracking Complete [#114894] 02 Feb 94 08:52

 10 Lines

From: INTEGRATED BILLING PACKAGE in 'IN' basket. Page 1 \*\*NEW\*\*

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

The process to automatically add Rx Refills has successfully completed.

 Start Date: 01/22/94

 End Date: 01/29/94

(Selected end date of 02/01/94 automatically changed to 01/29/94.)

 Total Rx fills checked: 0

Total NSC Rx fills Added: 0

 Total SC Rx fills Added: 0

\*The fills added as SC require determination and editing to be billed

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

### Reports Menu (Claims Tracking)…

The following is a list of the reports available through the Reports Menu (Claims Tracking):

 SR 278 Statistical Volume Report

 CR 278 Certification Report

 DR 278 Deletion Disposition Report

 BI Print CT Summary for Billing

 DD Days Denied Report

 IC Inquire to Claims Tracking

 MS MCCR/UR Summary Report

 RC List Visits Requiring Reviews

 RW Review Worksheet Print

 SA Scheduled Admissions w/Insurance

 SP Single Patient Admission Sheet

 TODO Pending Work Report

 UA Unscheduled Admissions w/Insurance

 UR UR Activity Report

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

* **278 Statistical Volume Report**

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

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

**Sample Report**

 278 Statistical Volume Report Nov 10, 2015@00:57:39 Page: 1

 Sort by: Staff

 Report Timeframe:

 03/01/2015 - 11/10/2015

 All Staff

Staff Date #278s #217 #215 #215 #Auth #Rej #Pend AAA Await

 Submitted Man Auto Recd Recd

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

IB,STAFF 1 03/05/15 2 2 1 1

IB,STAFF 1 03/26/15 1 1 1

IB,STAFF 1 03/31/15 3 3 1 2

IB,STAFF 1 04/02/15 1 1 1

IB,STAFF 1 04/27/15 2 2 2

IB,STAFF 1 08/04/15 1 1 1

IB,STAFF 1 09/09/15 1 1 1

IB,STAFF 1 11/04/15 1 1 1

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

 Total 12 12 0 0 1 1 1 0 9

 278 Statistical Volume Report Nov 10, 2015@00:57:39 Page: 2

 Sort by: Staff

 Report Timeframe:

 03/01/2015 - 11/10/2015

 All Staff

Staff Date #278s #217 #215 #215 #Auth #Rej #Pend AAA Await

 Submitted Man Auto Recd Recd

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

IB,STAFF 2 03/26/15 1 1 1

IB,STAFF 2 04/02/15 1 1 1

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

 Total 2 2 0 0 0 0 0 0 2

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

Grand Total 14 14 0 0 1 1 1 0 11

 \*\*\* END OF REPORT \*\*\*

* **278 Certification Report**

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

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

This report is formatted to print 132 columns.

 **Sample Report**

 278 Certification Report Nov 10, 2015@01:16:01 Page: 1

 Sort by: Payer Detail: Excluded

 Report Timeframe:

 01/01/2015 - 11/10/2015

 All Payer(s)

Payer #278s #A1 #A2 #A6 #A4 #A3 #C CT NA

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

AETNA US HEALTHCARE 1 1

BLUE CROSS/BS WY 4 1 2 1

CIGNA 1 1

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

Grand Total 6 2 0 0 2 1 0 0 1

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

 \*\*\* END OF REPORT \*\*\*

* **278 Deletion Disposition Report**

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

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

**Sample Report**

 278 Deletion Disposition Report Nov 10, 2015@09:14:36 Page: 1

 Sort by: Staff

 Report Timeframe:

 03/01/2015 - 11/10/2015

 Selected Staff

Staff Date #278s Submitted #Delete Reasons

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

IB,STAFF 1 11/02/15 0 2

IB,STAFF 1 10/14/15 1 1

 Total 1 3

 \*\*\* END OF REPORT \*\*\*

* **Print CT Summary for Billing**

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

**Sample Report 1 – Inpatient Admission**

Bill Preparation Report Page 1 Oct 23, 2014@14:53:41

IB,PATIENT 78 XX-XX-XXXX DOB: XXX XX, XXXX

INPATIENT ADMISSION on XXX XX, XXXX@13:22:16

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

 Visit Information

 Visit Type: INPATIENT ADMISSION Visit Billable: YES

Admission Date: XXX XX,XXXX@13:22:16 Second Opinion: NOT REQUIRED

 Ward: C MEDICINE Auto Bill Date: XXX XX,XXXX

 Specialty: MEDICINE Special Consent: ROI NOT DETERMINED

Discharge Date: Special Billing:

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

 Insurance Information

 Ins. Co 1: AETNA US HEALTHCARE Pre-Cert Phone: 800/523-7978

 Subsc.: IB,PATIENT 78 Type: COMPREHENSIVE MAJO

 Subsc. ID: WXXXXXXXX Group: GRP NUM 8802

 Coord Ben: SECONDARY Billing Phone: 800/523-7978

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

Group Plan Comments:

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

 Billing Information

 Initial Bill: Estimated Recv (Pri): $

 Bill Status: Estimated Recv (Sec): $

 Total Charges: $ 0 Estimated Recv (ter): $

 Amount Paid: $ 0 Means Test Charges: $

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

 Eligibility Information

 Primary Eligibility: NSC, VA PENSION

 Means Test Status:

 Service Connected Percent: Patient Not Service Connected

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

 Diagnosis Information

 Nothing on File

 Associated Interim DRG Information

 Nothing on File

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

 Procedure Information

 Nothing on File

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

 Provider Information

 Nothing on File

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

 Insurance Review Information

 Type Review: CONTINUED STAY REVIEW Review Date: XX/XX/XX@1:41 pm

 Action: DENIAL Insurance Co.: AETNA US HEALTHCARE

 Denied From: XX/XX/XX Person Contacted:

 Denied To: XX/XX/XX Contact Method: PHONE

 Denial Reasons: FAILURE TO MEET PAYER Call Ref. Number:

 Status: PENDING

 Last Edited By: UR,NURSE

Comment:

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

 Type Review: URGENT/EMERGENT ADMIT Review Date: XX/XX/XX

 Action: Insurance Co.: AETNA US HEALTHCARE

 Person Contacted:

 Contact Method:

 Call Ref. Number:

 Status: ENTERED

 Last Edited By:

Comment:

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

**Sample Report 2 – Prescription Refill**

Bill Preparation Report Page 1 Oct 23, 2014@15:10:38

IB,PATIENT 37 XX-XX-XXXX DOB: XXX XX, XXXX

PRESCRIPTION REFILL on Jan 13, 2011

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

 Visit Information

 Visit Type: PRESCRIPTION REFILL Visit Billable: NO-NO PHARMACY COVE

Prescription #: XXXXXXX Second Opinion: NOT REQUIRED

 Refill Date: XXX XX, XXXX Auto Bill Date:

 Drug: LISINOPRIL 20MG TAB Special Consent: ROI NOT DETERMINED

 Quantity: 90 Special Billing:

 Days Supply: 90

 NDC#: 00904-5809-89

 Physician: IB,DOCTOR C

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

 Insurance Information

 Ins. Co 1: NORTHWEST ADMINISTRATOR Pre-Cert Phone: 800/872-5439

 Subsc.: IB,PATIENT 37 Type: RETIREE

 Subsc. ID: XXXXXXXXX Group: GRP NUM 13377

 Coord Ben: SECONDARY Billing Phone: 800/872-5439

 Filing Time Fr: Claims Phone: 800/872-5439

 Policy Comment: POLICY EFF 3-1-03

Group Plan Comments:

 PER NOTE, EFF 090103 ALL RX ARE PD @ 20% UNDER MEDICAL

 PLAN. SAYS SHOULD'VE NEVER PROCESSED UNDER PRESCRIPTION

 PLAN.

 POLICY PAYS 70% MEDICARE INPT DEDUCTIBLE.

 HAS RX COVERAGE. EFF 010196, NO RX DEDUCTIBLE. INSURANCE

 WILL REIMBURSE A MAXIMUM 34-DAY SUPPLY. LARGER AMTS

 REIMBURSE 0--DON'T BILL UNLESS THE RX MEETS THIS CRITERIA.

 051598: RX PAY @ 20% ALLOWABLE AFTER DEDUCTIBLE. NO

 COVERAGE FOR ASCORBIC ACID 001 MG, NUTRITION SUPL ENSURE,

 SMOKING DETERRENTS, MULTIVITAMIN/MINERALS CAP/TAB 011200:

 PER APRIL, THIS POLICY WILL COVER RX 20% ALLOWABLE AFTER

 DEDUCTIBLE; HOWEVER, CLMS APPEAR TO BE PAYING IN EXCESS OF

 THAT. DIABETIC & OTHER SUPPLIES ARE COVERED.

 122700: PER TAUSHA, EFFECT. 100100 VA IS CONSIDERED

 IN-NETWORK AND WE WILL BE REIMBURSED 60% ON BRAND NAME RX.

 INS WILL TAKE $8 COPAY OUT OF OUR REIMBURSEMENT ON GENERIC

 RX FOR IN-NETWORK. PRIOR TO THAT DATE VA WAS CONSIDERED

 OUT-OF-NETWORK AND OUR REIMBURSEMENT SHOULD'VE BEEN 50%

 FOR BRAND NAME RX. THERE IS NO RX DEDUCTIBLE.

 NO ROUTINE CARE INCL VISION. NO PRECERT REQ'D VERIFIED

 W/BLAINE 013098.

 WHEN BILLING ANESTHESIA, INCL TIME PER DEE-DEE 032400.

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

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

 Billing Information

 Initial Bill: Estimated Recv (Pri): $

 Bill Status: Estimated Recv (Sec): $

 Total Charges: $ 0 Estimated Recv (ter): $

 Amount Paid: $ 0 Means Test Charges: $

Reason Not Billable: NO PHARMACY COVERAGE

Additional Comment:

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

 Eligibility Information

 Primary Eligibility: SERVICE CONNECTED 50% to 100%

 Means Test Status: NO LONGER REQUIRED

 Service Connected Percent: 100%

 Service Connected Conditions:

 LIMITED MOTION OF ANKLE 10%

 FLAT FOOT CONDITION 0%

 COLD INJURY RESIDUALS 20%

 COLD INJURY RESIDUALS 20%

 TINNITUS 10%

 DEGENERATIVE ARTHRITIS OF THE SPINE 10%

 TRAUMATIC ARTHRITIS 10%

 TRAUMATIC ARTHRITIS 10%

 IMPAIRED HEARING 0%

 COLD INJURY RESIDUALS 20%

 LIMITED MOTION OF ANKLE 10%

 LIMITED MOTION OF ARM 20%

 COLD INJURY RESIDUALS 10%

 TRAUMATIC ARTHRITIS 10%

 POST-TRAUMATIC STRESS DISORDER 30%

 TRAUMATIC ARTHRITIS 10%

 TRAUMATIC ARTHRITIS 10%

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

* **Inquire to Claims Tracking**

You can display or print stored information about a single visit. You are prompted to select a patient and the Claims Tracking entry you wish to view/print.

The following information is displayed:

* Visit,
* Billing
* Insurance information
* Reviews performed

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

**Sample Report**

Claim Tracking Inquiry Page 1 Jan 14, 1994@15:55:54

IB,PATIENT 1 XX-XX-XXXX DOB: XXX XX,XXXX

INPATIENT ADMISSION on XXX XX,XXXX@09:30:35

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

 Visit Information

 Visit Type: INPATIENT ADMISSION Visit Billable: YES

Admission Date: XXX XX,XXXX@09:30:35 Second Opinion: NOT REQUIRED

 Ward: 11-B MEDICINE XREF Auto Bill Date:

 Specialty: MEDICINE Special Consent: ROI OBTAINED

Discharge Date: Special Billing: FEDERAL OWCP

 Billing Information

 Initial Bill: Estimated Recv (Pri): $

 Bill Status: Estimated Recv (Sec): $

 Total Charges: $ 0 Estimated Recv (ter): $

 Amount Paid: $ 0 Means Test Charges: $

 Insurance Review Information

 Type Review: INITIAL APPEAL Review Date: XX/XX/XX

 Appeal Type: ADMINISTRATIVE Insurance Co.: IB INS. CO. 30

 Case Status: OPEN Person Contacted: UMO,CONTACT

No Days Pending: 3 Contact Method: Letter

 Final Outcome: Call Ref. Number:

 Status: COMPLETE

 Last Edited By:

 Type Review: CONTINUED STAY REVIEW Review Date: XX/XX/XX

 Action: DENIAL Insurance Co.: IB INS. CO. 1

 Denied From: XX/XX/XX Person Contacted: SPOUSE

 Denied To: XX/XX/XX Contact Method: PHONE

 Denial Reasons: NOT MEDICALLY NECESSAR Call Ref. Number: XXXXXXSS

 Denial Reasons: TREATMENT PROVIDED NOT Status: COMPLETE

 Last Edited By: UR,NURSE

Type Review: URGENT/EMERGENT ADMIT Review Date: XX/XX/XX

 Action: APPROVED Insurance Co.: IB INS. CO. 14

Authorized From: XX/XX/XX Person Contacted: UMO,CONTACT

 Authorized To: XX/XX/XX Contact Method: VOICE MAIL

Authorized Diag: 259.0 - DELAY SEXUAL D Call Ref. Number: XXXXXXXXXA

 Auth. Number: 88889354A Status: COMPLETE

 Last Edited By: UR,NURSE

 Hospital Review Information

 Review Date: XX/XX/XX Day of Review: 3

 Review Type: CONTINUED STAY REVIEW Severity of Ill: Generic

 Specialty: MEDICINE Intensity of Svc: Generic

 Methodology: INTERQUAL Non-Acute Reason:

 Status: ENTERED

 Last Edited By: UR,NURSE

* **Days Denied Report**

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

* Patient
* Attending physician, or
* Bed service (i.e., surgery, psychiatry, medicine).

The summary report shows the number of denials, the total days denied, the dollar amount of the denials, and the days won on appeal by service.

The detail section includes the following:

* Inpatient Admission's Service, which is the Service the patient was under at either the admission, if that date is included in the report, or the Service the patient was under on the begin date of the report. This Service is used to provide the summary.
* The Amount Denied is also displayed for each denied stay in the detail section. The Amount Denied is either the full charge of the admission, if the entire admission was denied and the entire stay is within the date range of the report, or an average charge based on the full charge and the number of denied days on the report, if only a partial denial. The charges displayed as the Amount Denied are the current active charges per Reasonable Charges.

This report is formatted to print 132 columns.

**Sample Report**

MCCR/UR DENIED DAYS INPATIENT Denials Dated Jan 01, 2005 to Jan 01, 2006 Page 1 Mar 21, 2013@20:41:30

 Dates of Dates Days Approved

Patient PtID Care Attending Denied Denial Reason Appealed on Appeal SRVS Amount

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

IB,PATIENT 1 XXXX 01/24/05 to 520634204 ALL (3) OBSERVATION IS MORE APPRO NO 0 SURG $19,224

 01/27/05

IB,PATIENT 23 XXXX 02/24/05 to 1404 ALL (4) NOT MEDICALLY NECESSARY YES 2 NHCU $2,777

 02/28/05

IB,PATIENT 54 XXXX 12/27/04 to 520629761 ALL (1) NOT MEDICALLY NECESSARY NO 0 NHCU $629

 01/02/05

IB,PATIENT 6 XXXX 09/13/05 to 520644029 ALL (2) NOT MEDICALLY NECESSARY NO 0 MEDI $13,109

 09/15/05

 ------

 10

MCCR/UR DENIED DAYS OUTPATIENT Denials Dated Jan 01, 2005 to Jan 01, 2006 Page 2 Mar 21, 2013@20:41:30

Patient PtID Episode Date Outpatient Treatment Appealed Approved Amount

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

IB,PATIENT 7 XXXX 12/25/05@13:20 OPT OPHTHALMOLOGY ST NO NO $0

IB,PATIENT 288 XXXX 10/9/05@08:30 YES YES $126

IB,PATIENT 67 XXXX 10/17/05@15:54 Physical Therapy NO NO $0

 ------

 3

MCCR/UR DENIED DAYS PROSTHETIC Denials Dated Jan 01, 2005 to Jan 01, 2006 Page 3 Mar 21, 2013@20:41:30

Patient PtID Episode Date Outpatient Treatment Appealed Approved Amount

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

IB,PATIENT 23 XXXX 1/27/05 Av Prosth Auto Blood NO NO $25

IB,PATIENT 1 XXXX 10/1/05 Delivery/Labor NO NO $150

 ------

 2

MCCR/UR DENIED DAYS PRESCRIPTION Denials Dated Jan 01, 2005 to Jan 01, 2006 Page 4 Mar 21, 2013@20:41:30

Patient PtID Episode Date Outpatient Treatment Appealed Approved Amount

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

IB,PATIENT 6 XXXX 1/27/05 Av RxFill #: 7399X89 NO NO $0

IB,PATIENT 45 XXXX 10/7/05 Rx #:76699X9 NO NO $45

 ------

 2

MCCR/UR DENIED DAYS Summary Report for Reviews Dated Jan 01, 2005 to Jan 01, 2006 Page 5 Mar 21, 2013@20:41:30

 Number Days Amount Days won

Service Denials Denied Denied on Appeal

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

MEDICINE 1 2 $13,109 0

NHCU 2 5 $2,839 2

SURGERY 1 3 $19,224 0

 --------

 10

 Amount Appeals

Service Number Denied Appealed Approved

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

OUTPATIENT 3 $126 1 1

PRESCRIPTION 2 $45 0 0

PROSTHETICS 2 $175 0 0

* **MCCR/UR Summary Report**

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

**Sample Report**

 MCCR/UR SUMMARY REPORT

 for

 SITENAME (001)

 for Discharges

 From: AUG 18, 1993

 To: FEB 14, 1994

 Date Printed: FEB 14, 1994

 Page: 1

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

 Total Discharges: 29

 Total Discharges with Insurance: 5

 Total Billable Discharges: 4

 Total Discharges Requiring Reviews: 4

 Total Discharges Reviewed: 4

Total Discharges Reviewed, Multi Carrier: 0

 Total Reviews Done: 5

 Number of Days Approved: 10

 Amount Collectible Approved for Billing: $3,370

 Number of Days Denied: 4

 Amount Denied for Billing: $1,348

 Total Cases Appealed: 0

 Number of Initial Appeals: 0

 Number of Subsequent Appeals: 0

 Penalty Report: Number of cases Dollars

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

 No Pre Admission Certification: 0 $0

 Untimely Pre Admission Certification: 0 $0

 VA a Non-Provider: 0 $0

 Reason Not Billable Report: Reason Count

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

 OTHER 1

 Days Approved by Specialty: Specialty No. Days Dollars

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

 ALCOHOL 10 $3,370

 Days Denied by Specialty: Specialty No. Days Dollars

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

 ALCOHOL 4 $1,348

* **List Visits Requiring Reviews**

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

* Insurance Review,
* Hospital Review
* Both

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

**Sample Output**

LIST OF VISITS FROM: 01/01/94 TO: 02/18/94 REQUIRING REVIEWS FEB 18,1994 14:40 PAGE 1

 VISIT INS. RANDOM SPECIAL LOCAL HOSP

PATIENT PT. ID WARD TYPE DATE CASE CASE COND. CASE REVIEWER INS REVIEWER

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

IB,PATIENT 2 XX-XX-XXXX 8C ORTHO S ADMIT FEB 7,1994 YES YES UR,NURSE

IB,PATIENT 52 XX-XX-XXXX SCH ADM. FEB 4,1994 YES NO COPD NO UR,NURSE

IB,PATIENT 111 XX-XX-XXXX OUTPT FEB 11,1994 YES UR,NURSE

IB,PATIENT 77 XX-XX-XXXX 7A(NHCU) ADMIT FEB 7,1994 NO YES UR,NURSE

IB,PATIENT 9 XX-XX-XXXX 11-B MEDIC ADMIT JAN 13,1994 YES YES NONE NO UR,NURSE ---- --- ---- ---

COUNT 4 3 1 0

* **Review Worksheet Print**

This option is similar to the Review Worksheet action on the Insurance Review screen. A worksheet for a current inpatient can be printed containing demographic data and information about current room/bed, ward, and provider.

**Sample Worksheet**

INSURANCE REVIEW WORKSHEET

XXX XX, XXXX@15:33:37

 Specialty: MEDICINE Ward: 11-B MEDICINE

 Name: IB,PATIENT 34 Insurance Co: IB INS. CO. 12

 Pt ID: XX-XX-XXXX

 DOB: XXX XX, XXXX

 Admission Date: XXX XX,XXXX@09:30:35 DC Date: \_\_\_\_\_\_\_\_ LOS: \_\_\_\_\_

 Attending MD: IB,DOCTOR A Primary MD: IB,DOCTOR P

 Complaint/Hist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 |Date |Diagnosis |Procedure |DRG |LOS |

 | | | | | |

 |\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_|\_\_\_\_\_\_|

 | | | | | |

 |\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_|\_\_\_\_\_\_|

 | | | | | |

 |\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_|\_\_\_\_\_\_|

 | | | | | |

 |\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_|\_\_\_\_\_\_|

 | | | | | |

 |\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_|\_\_\_\_\_\_|

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

 |Insurance Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|

 |\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|

 |Date |Comments (#day approved, next review date, etc.) |

 | | |

 |\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|

 | | |

 |\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|

 |\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|

 |\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|

 | | |

 |\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|

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

 Reviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Scheduled Admissions w/Insurance**

You can print a list of scheduled admissions in Claims Tracking for insured patients. Included are patients with past scheduled admissions and scheduled admissions up to three days into the future. This differs from the Scheduled Admission List from MAS, as it does not contain all scheduled admissions from MAS. Scheduled admissions are normally moved to Claims Tracking four days prior to the scheduled admission date so that reviews can be completed prior to admission. Included are the number and type of reviews performed and the insurance company actions.

This report is formatted to print 132 columns.

**Sample Report**

Scheduled Admissions with Insurance Page 1 Feb 11, 1994@09:05:48

For Period beginning on XX/XX/XX to XX/XX/XX

Patient Pt. ID Adm. Date Billable Ward Type

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

IB,PATIENT 33 XX-XX-XXXX XX/XX/XX 1:00 pm YES 5D SURG SCHEDULED

IB,PATIENT 33 XX-XX-XXXX XX/XX/XX 2:40 pm YES 9D MED SCHEDULED

IB,PATIENT 33 XX-XX-XXXX XX/XX/XX 11:40 pm YES 2D CARD SCHEDULED

IB,PATIENT 33 XX-XX-XXXX XX/XX/XX 10:11 am NO 4a nurs SCHEDULED

IB,PATIENT 33 XX-XX-XXXX XX/XX/XX 9:00 am YES 9D MED SCHEDULED

IB,PATIENT 33 XX-XX-XXXX XX/XX/XX 2:52 pm YES 2B ICU SCHEDULED

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

TOTAL = 6

* **Single Patient Admission Sheet**

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

**Sample Worksheet**

 ADMISSION SHEET

 SITENAME VAMC

 113 HOLLAND AVE

 SITENAME,NY

 Patient: IB,PATIENT 456 Address: 123 TEST ST.

 Pt ID: XX-XX-XXXX

 Dob: XX XX, XXXX

 SC: YES - 20% TROY, NY 12180

 Sex: MALE Phone:

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

 Adm. Date: XXX XX, XXXX@09:30:35 Adm. Type: URGENT

 Provider: IB,PATIENT 456 Specialty: MEDICINE

 Ward: 11-B MEDICINE Room/Bed:

 Adm. Diag: 466.0 – ACUTE BRONCHITIS

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

 Employer: E-Cont.:

 Phone: Phone:

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

 Ins. Co 1: IB INS. CO, 44 Phone: 555-555-4312

 Subsc.: IB,PATIENT 456 Type: MAJOR MEDICAL EXPENS

 Subsc. ID: WXXXXXXXX Group: 4446333

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

 Date Diagnosis Procedure Final DRG LOS

 | | | | |

 \_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_

 | | | | |

 \_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_

 | | | | |

 \_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_

 Service Connected Conditions: Treated

 NONE STATED

I attest that these are the diagnoses and procedures for which the

Patient was treated during this episode of care.

MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient: IB,PATIENT 456 XX-XX-XXXX Printed: XXX XX, XXXX@13:18

* **Pending Work Report**

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

The report can be sorted by the following:

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

You can print the report for either Insurance Reviews, Hospital Reviews, or both. A plus sign (+) before the patient's name indicates there is both a hospital and insurance review on the list for that patient.

This report is formatted to print 132 columns.

**Sample Report**

Pending Reviews Report for Division SITENAME Page 1 Feb 11, 1994@09:44:52

For Period Feb 01, 1994 to Feb 11, 1994

Patient Pt. ID Ward Review Type Due Date Status Assigned to Visit Date

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

+IB,PATIENT 22 XXXX 8C ORTHO SU Hosp Review-Admission XX/XX/XX ENTERED UR,NURSE ADMIT 02/07/94 2:42 pm

 IB,PATIENT 22 XXXX 2B ICU Hosp Review-Admission XX/XX/XX ENTERED Unassigned ADMIT 02/01/94 2:01 am

 IB,PATIENT 22 XXXX 11-B MEDICI Hosp Review-CONT. STAY XX/XX/XX ENTERED UR,NURSE ADMIT 01/13/94 9:30 am

 IB,PATIENT 22 XXXX 2D ICU Ins. Review-URG ADM XX/XX/XX ENTERED Unassigned ADMIT 02/01/94 2:01 am

 IB,PATIENT 22 XXXX 11-B MEDICI Ins. Review-URG ADM XX/XX/XX COMPLETE UR,NURSE ADMIT 01/13/94 9:30 am

+IB,PATIENT 22 XXXX 8C ORTHO SU Hosp Review-Admission XX/XX/XX ENTERED UR,NURSE ADMIT 02/07/94 2:42 pm

**Unscheduled Admissions w/Insurance**

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

This report is formatted to print 132 columns.

**Sample Report**

Unscheduled Admissions with Insurance Page 1 Feb 11, 1994@10:05:06

For Period beginning on 02/01/94 to 02/11/94

Patient Pt. ID Adm. Date Billable Ward Type

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

IB,PATIENT 22 XX-XX-XXXX XX/XX/XX 5:07 pm YES 9D MED

IB,PATIENT 221 XX-XX-XXXX XX/XX/XX 11:00 am YES 13B PSYCH

IB,PATIENT 3 XX-XX-XXXX XX/XX/XX 2:42 pm YES 8C ORTHO SUR URGENT

IB,PATIENT 66 XX-XX-XXXX XX/XX/XX 11:38 a YES 2D ICU URGENT

IB,PATIENT 987 XX-XX-XXXX XX/XX/XX 2:01 am YES 5D SURGICAL URGENT

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

TOTAL = 5

* **UR Activity Report**

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

* Insurance Reviews
* Hospital Reviews
* Both
* Summary Report by Admission
* Summary Report by Specialty

All completed Insurance Reviews are included. For Hospital Reviews, it lists each case reviewed indicating whether it met admission criteria and the number of days that met/did not meet the criteria for acute care.

The detailed report can be sorted by the following:

* Reviewer
* Specialty
* Patient

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

This report is formatted to print 132 columns.

**Sample Report**

UR Insurance Review Activity Report Page 1 Feb 15, 1994@10:17:10

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

 Dates of Review

Patient Pt. ID Care Review Type Date Ins. Co. Action Last Reviewer

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

IB,PATIENT 22 XX-XX-XXXX XX/XX/XX URG ADM 02/07/94 ABC INS APPROVED UR,NURSE

IB,PATIENT 67 XX-XX-XXXX XX/XX/XX to PRE-ADM 01/07/94 CDPHP APPROVED UR,NURSE

 XX/XX/XX

IB,PATIENT 456 XX-XX-XXXX XX/XX/XX to URG ADM 02/11/94 BLUE SHIELD APPROVED UR,NURSE

 XX/XX/XX

 UR ACTIVITY SUMMARY REPORT

 for Insurance Reviews

 SITENAME (001)

 From: JAN 1, 1994

 To: FEB 15, 1994

 Date Printed: Feb 15, 1994@10:17:10

 Page: 2

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

 Total Admissions: 15

 Total Admissions to NHCU: 4

 Total Admissions to Domiciliary: 1

 Total Admissions Requiring Reviews: 0

 Number of Scheduled Adm. Reviewed: 0

 Total Admissions with Insurance: 4

 Total Billable Admissions: 3

 Cases with Pre-Cert and Follow-up: 0

 Cases with Pre-Cert no Follow-up: 0

 Number of Closed Cases: 0

 Number of Billable Closed Cases: 0

 Number of Unbillable Closed Cases: 0

 Number of New Case Still Open: 0

 Number of Previous Cases: 0

 Number of Previous Cases Closed and Billable: 9

 Number of Previous Cases Closed, not Billable: 0

 Number of Previous Cases still Open: 0

 Number of Outpatient Cases Reviewed: 0

 Reason Not Billable Report: Reason Count

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

 NOT INSURED 1

INSURANCE REVIEW SPECIALTY SUMMARY REPORT Feb 15, 1994@10:17:10 Page 3

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

 Days Days Amount Amount

Specialty Approved Denied Approved Denied

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

GENERAL MEDICINE 0 0 $0 $0

MEDICINE 5 10 $4,135 $8,270

ORTHOPEDIC SURGERY 0 0 $0 $0

UROLOGY 0 1 $0 $1,164

Unknown 0 0 $0 $0

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

 5 11 $4,135 $9,434

UR Hospital Review Activity Report Page 4 Feb 15, 1994@10:17:10

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

 Dates of Admission Days Met Days Not Met

Patient Pt. ID Care Review Type Met Criteria Criteria Criteria Assigned Reviewer

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

IBpatient,one 000-11-1111 02/07/94 RANDOM YES 1 0 JOHN

IBpatient, two 000-22-2222 12/23/93 RANDOM YES 1 0 ED

IBpatient, three 000-33-3333 02/01/94 to COPD YES 1 0 STEVE

 02/09/94

IBpatient, four 000-44-4444 12/29/93 LOCAL 1 0 SEAN

 UR ACTIVITY SUMMARY REPORT

 for Hospital Reviews

 SITENAME (001)

 From: JAN 1, 1994

 To: FEB 15, 1994

 Date Printed: Feb 15, 1994@10:17:10

 Page: 5

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

 Total Admissions: 15

 Total Cases Reviewed: 14

 Number of New Case Still Open: 0

 Number of Previous Cases: 3

 Number of Previous Cases still Open: 0

 Total Random Sample Cases: 12

 Total Special Condition Cases: 1

 COPD: 1

 CVD: 0

 TURP: 0

 Total Locally Added Cases: 1

 Total Cases Meeting Criteria on Adm.: 13

 Total Cases Not Meeting Crit. on Adm.: 1

 Total Days Reviewed: 20

 Total Days Meeting Criteria: 14

 Total Days Not Meeting Criteria: 6

HOSPITAL REVIEW SPECIALTY SUMMARY REPORT Feb 15, 1994@10:17:10 Page 6

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

 Admissions Admissions Days Days

Specialty Met Criteria Not Met Crit. Met Criteria Not Met Crit.

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

GENERAL MEDICINE 5 0 0 5

MEDICINE 1 0 2 1

NEUROLOGY 0 0 1 0

ORTHOPEDIC SURGERY 3 0 0 3

PSYCHIATRY 1 0 0 1

SURGERY 2 0 1 2

UROLOGY 1 1 2 1

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

 13 1 6 14

## Hospital Reviews

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

This option is designed to allow the entry of the utilization management information required by the Quality Management office. The Claims Tracking module will automatically identify a random sample of admissions (see the Claim Tracking Parameter Edit option) that require review. Hospital reviews are the application of Interqual criteria to determine if the admission or continued stay meets specific criteria. This module will allow entry of the category of criteria that was met for Severity of Illness and Intensity of Service or the reasons that criteria was not met. An entry for every day being reviewed is required. This can easily be accomplished by using the Add Next Review action which is designed to reduce the data entry time by duplicating the entries for days where the information is identical.

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

|  |
| --- |
| Hospital Reviews-------------------------------------------------------------------------------------- |
| AI Add Next Hosp.Review | ***VE View/Edit Review*** | CP Change Patient |
| DR Delete Review  | DU Diagnosis Update | EX Exit |
| QE Quick Edit  | PU Procedure Update |  |
| CS Change Status  | PV Provider Update |  |

|  |
| --- |
| Expanded Hospital Reviews-------------------------------------------------------------------------------------- |
| AI Add Ins. Review | SC SC Conditions  | PV Provider Update |
| DR Delete Review  | AE Appeals Edit  | RW Review Wksheet Print |
| CS Change Status  | AC Add Comment  | CP Change Patient |
| QE Quick Edit  | DU Diagnosis Update | EX Exit |
| **VE View/Edit Review** | PU Procedure Update |  |

### About the Screens

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

You may quit from any screen, which will bring you back one level or screen, or you may enter the Exit action.

### Common Actions

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

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

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

* **Diagnosis Update** - This action allows input of ICD diagnoses for the patient. Whether diagnoses are input on this screen or another screen, they are available across the Claims Tracking module. You may enter an admitting diagnosis, primary (DXLS) diagnosis, secondary diagnosis and the onset date of the diagnosis for this admission. For outpatient visits this information is stored with the outpatient encounter information.
* **Procedure Update** - This action allows the input of ICD procedures for the patient. You may input the procedure and the date. This is a separate procedure entry from the PTF module and is optional for use.
* **Provider Update** - This action allows you to input the admitting physician, attending physician, and care provider separate from the MAS information. The purpose is to provide a location to document the attending physician and to provide an alternate place to document individual physicians if the administrative record indicates teams, or vice versa.

### Hospital Reviews Screen

This following actions are available from the Hospital Reviews screen:

* **Add Next Hosp. Review** - This action allows you to add the next review and automatically set it to either an admission review or continued stay review. The day for review and review date are automatically computed but can be edited. The category of severity of illness and intensity of service that was met can be entered; or if not met, the reason it was not met.
* **Delete Review** - This action allows a hospital review to be deleted. If a review is automatically created, but the visit does not require reviews and follow-up with the insurance company, it can be deleted. Use care in exercising this action. It can be as important to document that no review is required as it is to document the required reviews.
* **Quick Edit** - This action allows you to quickly edit all information about the review without leaving the Pending Review option.
* **View/Edit Review** - This action allows you to access to the Expanded Hospital Reviews Screen.
* **Change Patient** - This action allows you to change the selected patient without leaving the option.

**Sample Screen**

Hospital Reviews Feb 03, 1994 13:49:45 Page: 1 of 1

 Hospital Review Entries for: IB,PATIENT 77 XXX ROI: OBTAINED

 for: INPATIENT ADMISSION on 01/13/94 9:30 am

 Review Date Type Ward Status Specialty Day Next Review

1 01/15/94 CONT. STA 11-B ME COMPLETE MEDICINE 3 01/17/94

2 01/14/94 CONT. STA 11-B ME COMPLETE MEDICINE 2

3 01/13/94 Admission 11-B ME COMPLETE MEDICINE 1

 Random Sample >>>

***AN Add Next Hosp. Review*** ***VE View/Edit Review*** ***CP Change Patient***

***DR Delete Review*** DU Diagnosis Update EX Exit

***QE Quick Edit*** PU Procedure Update

CS Change Status PV Provider Update

Select Action: Quit//

### Expanded Hospital Reviews Screen

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

* **Review Information** - This action allows you to enter/edit the type of review (admission or continued stay), review date, and the specialty and methodology for the review. There should be only one admission review (pre-certification or urgent/ emergent admission review) for an admission. Normally, reviews are done for UR purposes on days 3, 6, 9, 14, 21, 28, and every 7 days thereafter. (Usually, the INTERQUAL method is used as the methodology for UR required review. Insurance carriers may require other review methodologies.)
* **Add Comment** - This action allows you to edit the word processing (comments) field in Hospital or Insurance Reviews without having to edit other fields.
* **Criteria Update** - This action allows you to enter or edit data regarding criteria met/not met for an acute admission within 24 hours, such as the review date and methodology; severity of illness and intensity of service; and whether additional reviews are required.

**Sample Screens**

Expanded Hospital Reviews Feb 03, 1994 13:55:38 Page: 1 of 3

Expanded Review for: IB,PATIENT 77 XXXX ROI:OBTAINED

 for: CONTINUED STAY REVIEW on 01/15/94

 Visit Information Review Information

 Visit Type: INPATIENT ADMISSION Review Type: CONTINUED STAY REVI

Admission Date: XXX XX,XXXX@09:30:35 Review Date: XX/XX/XX

 Ward: 11-B MEDICINE XREF Specialty: MEDICINE

 Specialty: MEDICINE Methodology: INTERQUAL

 Ins. Action:

 Criteria Information

 Day of Review: 3

 Severity of Ill: CARDIOVASCULAR

 Intensity of Svc: CARDIOVASCULAR

 Apply all Days:

 Non-Acute Reason:

 No. Acute Days:

 Non-Acute Days:

+ Enter ?? for more actions

RI Review Information CU Criteria Update PV Provider Update

CS Change Status DU Diagnosis Update EX Exit

AC Add Comments PU Procedure Update

Select Action: Quit// Next Page

Expanded Hospital Reviews Feb 03, 1994 13:58:13 Page: 2 of 3

Expanded Review for: IB,PATIENT 77 XXXX ROI:OBTAINED

 for: CONTINUED STAY REVIEW on 01/15/94

+

 Status Information Clinical Information

 Review Status: ENTERED Provider: IBprovider,one

 Entered by: UR,NURSE 3 Admitting Diag: 101.0 - VINCENTS ANG

 Entered on: XX/XX/XX 2:51 pm Primary Diag:

 Completed by: UR,NURSE 3 1st Procedure: 89.44 - CARDIAC STRE

 Completed on: XX/XX/XX 2:53 pm 2nd Procedure:

 Next Review Date: XX/XX/XX Interim DRG: 0 - on

 Estimate ALOS: 0.0

 Days Remaining: 0.0

 Review Comments

 Patient not doing well, consult to psych is recommended.

+ Enter ?? for more actions

RI Review Information CU Criteria Update PV Provider Update

CS Change Status DU Diagnosis Update EX Exit

AC Add Comments PU Procedure Update

Select Action: Quit// Next Page

Expanded Hospital Reviews Feb 03, 1994 14:09:46 Page: 3 of 3

Expanded Review for: IBpatient,one 1111 ROI:OBTAINED

 for: CONTINUED STAY REVIEW on 01/15/94

+

 Visit Information Review Information

 Visit Type: INPATIENT ADMISSION Review Type: CONTINUED STAY REVI

 Admission Date: XXX XX,XXXX@09:30:35 Review Date: XX/XX/XX

 Ward: 11-B MEDICINE XREF Specialty: MEDICINE

 Specialty: MEDICINE Methodology: INTERQUAL

 Ins. Action:

 Criteria Information

 Day of Review: 3

 Severity of Ill: CARDIOVASCULAR

 Intensity of Svc: CARDIOVASCULAR

 Apply all Days:

 Non-Acute Reason:

 No. Acute Days:

+ Enter ?? for more actions

RI Review Information CU Criteria Update PV Provider Update

CS Change Status DU Diagnosis Update EX Exit

AC Add Comments PU Procedure Update

Select Action: Quit//

# Claims Tracking Menu for Billing ...

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

**Sample Menu**

 CT Claims Tracking Edit

 PS Print CT Summary for Billing

 RN Assign Reason Not Billable

 TP Third Party Joint Inquiry

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

## Claims Tracking Edit

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

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

|  |
| --- |
| Claims Tracking Editor-------------------------------------------------------------------------------------- |
| BI Billing Info Edit  | CP Change Patient  | EX Exit |
| ***VE View/Edit Episode***  | CD Change Date Range |  |
| SC SC Conditions  | VP View Pat. Ins. |  |

|  |
| --- |
| Expanded Claims Tracking Entry-------------------------------------------------------------------------------------- |
| BI Billing Info Edit  | TA Treatment Auth.  | EX Exit |
| RI Review Info | SE Submit Claim to ECME |  |

* + 1. **About the Screens**

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

You may quit from any screen, which will bring you back one level or screen, or you may enter the Exit action.

* + 1. **Common Actions**

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

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

### Claims Tracking Editor Screen

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

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

**Sample Screen**

Claims Tracking Editor Oct 27, 2014@17:16:01 Page: 1 of 1

Claims Tracking Entries for: IB,PATIENT 300 IXXXX

 for Visits beginning on: 10/27/13 to 11/10/14

 Type Urgent Date Ins. UR ROI Bill Ward

1 \*INPT. NO 07/16/14 1:48 pm YES YES C MEDICI

2 INPT. NO 05/06/14 9:25 am YES NO

3 Sch Adm NO 01/07/14 10:00 a YES YES

4 OPT. NO 01/06/14 4:00 pm YES YES

 Service Connected: NO \*=Current Admission >>>

BI Billing Info Edit CP Change Patient EX Exit

VE View/Edit Episode CD Change Date Range

SC SC Conditions VP View Pat. Ins.

Select Action: Quit//

## Print CT Summary for Billing

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

**Sample Report**

Bill Preparation Report Page 1 Oct 23, 2014@14:53:41

IB,PATIENT 78 XX-XX-XXXX DOB: XXX XX, XXXX

INPATIENT ADMISSION on XXX XX, XXXX@13:22:16

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

 Visit Information

 Visit Type: INPATIENT ADMISSION Visit Billable: YES

Admission Date: XXX XX,XXXX@13:22:16 Second Opinion: NOT REQUIRED

 Ward: C MEDICINE Auto Bill Date: XXX XX,XXXX

 Specialty: MEDICINE Special Consent: ROI NOT DETERMINED

Discharge Date: Special Billing:

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

 Insurance Information

 Ins. Co 1: AETNA US HEALTHCARE Pre-Cert Phone: 800/523-7978

 Subsc.: IB,PATIENT 78 Type: COMPREHENSIVE MAJO

 Subsc. ID: WXXXXXXXX Group: GRP NUM 8802

 Coord Ben: SECONDARY Billing Phone: 800/523-7978

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

Group Plan Comments:

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

 Billing Information

 Initial Bill: Estimated Recv (Pri): $

 Bill Status: Estimated Recv (Sec): $

 Total Charges: $ 0 Estimated Recv (ter): $

 Amount Paid: $ 0 Means Test Charges: $

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

 Eligibility Information

 Primary Eligibility: NSC, VA PENSION

 Means Test Status:

 Service Connected Percent: Patient Not Service Connected

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

 Diagnosis Information

 Nothing on File

 Associated Interim DRG Information

 Nothing on File

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

 Procedure Information

 Nothing on File

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

 Provider Information

 Nothing on File

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

 Insurance Review Information

 Type Review: CONTINUED STAY REVIEW Review Date: XX/XX/XX@1:41 pm

 Action: DENIAL Insurance Co.: AETNA US HEALTHCARE

 Denied From: XX/XX/XX Person Contacted:

 Denied To: XX/XX/XX Contact Method: PHONE

 Denial Reasons: FAILURE TO MEET PAYER Call Ref. Number:

 Status: PENDING

 Last Edited By: UR,NURSE

Comment:

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

 Type Review: URGENT/EMERGENT ADMIT Review Date: XX/XX/XX

 Action: Insurance Co.: AETNA US HEALTHCARE

 Person Contacted:

 Contact Method:

 Call Ref. Number:

 Status: ENTERED

 Last Edited By:

Comment:

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

## Assign Reason Not Billable

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

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

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

## Third Party Joint Inquiry

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

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

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

* Bill Charges
* Explanation of Benefits
* Bill Diagnoses
* Bill Procedures
* AR Account Profile
* Comment History
* Insurance Reviews
* Health Summary
* Insurance Company
* Insurance Policy
* Annual Benefits
* Patient Eligibility
* Expanded Benefit Information
* Electronic Claims Management Engine (ECME) - Prescription Claims
* EDI Status – electronic claim data

# Claims Tracking Menu (Hospital Reviews) ...

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

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

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

# Claims Tracking Menu (Insurance Reviews)…

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

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

## Health Care Services Review (HCSR) 278 Response

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

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

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

The following are final statuses:

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

**Sample 278 Response Screens**

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

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

 Insurance Company Information

 Name: CIGNA Reimburse?: WILL REIMBURSE

 Phone: 800/525-9999 Billing Phone: 800/525-9999

 Precert Phone: 800/111-1209

 Address: POD 9358, ANYCITY, TX 99999

 Group/Plan Information

 Type Of Plan: COMPREHENSIVE MAJOR MEDICAL Require UR: YES

 Group?: YES Require Amb Cert:

 Group Name: CIGNA Require Pre-Cert: YES

 Group Number: WXXXXX Exclude Pre-Cond:

 BIN: Benefits Assignable: YES

 PCN:

Plan Comments:

+ Enter ?? for more actions

SR (Send 278 Request) RP Remove 'In Progress'

SP Set 'In Progress' VR View Sent Request EX Exit

Select Action: Next Screen//

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

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

+

 Policy/Subscriber Information

 Insured's Name: IB,PATIENT 343 Effective: 1/1/2014

 Subscriber Id: 123456789 Expiration:

 Relationship: SELF Coord of Benefits: PRIMARY

 Insured's DOB: 1/1/1979

 Employer Sponsored Group Health Plan?:

 User Added Comments for This Entry

 UMO Contact Information

 UMO Name:

 UMO Contact #:

 UMO Name:

 UMO Contact #:

 PATIENT EVENT DETAIL

+ Enter ?? for more actions

SR (Send 278 Request) RP Remove 'In Progress'

SP Set 'In Progress' VR View Sent Request EX Exit

Select Action: Next Screen//

HCSR Response View Nov 13, 2014@10:11:05 Page: 3 of 7

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

+

 Health Care Services Review

 ***Certification Action: Certified in total***

 ***Certification/Authorization Number: XXXXXXXXXXXX***

 Review Decision Reason:

 Second Surgical Opinion Ind:

 Admin Ref #:

 Previous Review Autho #:

 Proposed/Actual Event Date:

 Proposed/Actual Admission Date: XXX XX,XXXX@09:00

 Proposed or Discharge Date:

 ***Cert. Effective Date:***

 ***Cert. Issue Date: Cert. Expiration Date:XXX XX, XXXX***

 Health Care Services Delivery

 Quantity Qualifier: Visits Service Unit Count: 1

 Unit/Basis for Measure Code: Sample Selection Modulus:

 Time Period Qualifier: Period Count:

+ Enter ?? for more actions

SR (Send 278 Request) RP Remove 'In Progress'

SP Set 'In Progress' VR View Sent Request EX Exit

Select Action: Next Screen//

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

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

* Certification Action
* Certification/Authorization Number
* Review Decision Reason
* Certification Effective Date
* Certification Issue Date
* Certification Expiration Date

**Note:** The certification/authorization number that is received in the response will be automatically added to a third-party bill (billing screen 10) for the patient event when the billing clerk adds each payer to the claim (billing screen 3). The certification/authorization number(s) will then be transmitted in the X12N Health Care Claim (837) transaction to the payer(s).

HCSR Response View Nov 13, 2014@10:11:31 Page: 4 of 7

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

+

 Delivery Frequency:

 Delivery Pattern:

 Patient Diagnosis Information

 No Diagnosis Information

 Institutional Claim Code

 Admission Type Code: Admission Source Code:

 Patient Status Code: INPATIENT

 Ambulance Transport Information

 Ambulance Transport Code: Unit/Basis for Measure Code:

 Transport Distance:

 Spinal Manipulation Service Information

 No Spinal Manipulation Service Information

+ Enter ?? for more actions

SR (Send 278 Request) RP Remove 'In Progress'

SP Set 'In Progress' VR View Sent Request EX Exit

Select Action: Next Screen//

HCSR Response View Nov 13, 2014@10:12:22 Page: 5 of 7

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

+

 Home Oxygen Therapy Information

 No Home Oxygen Therapy Information

 Home Health Care Information

 Prognosis Code: Home Health Start Date:

 Home Health Certification Period: Start: End:

 Medicare Coverage Indicator:

 Certification Type Code: Initial

 Additional Patient Information

 No Additional Patient Information

 Message Text:

XXXXXXX XX XXX XXXXXXX XXX XXXXXXXX XXX XXXXXX X XXXXXXXXXX XXXXXXXX XXXX.

 Additional Patient Information Contact Data

 No Additional Patient Information Contact Data

+ Enter ?? for more actions

SR (Send 278 Request) RP Remove 'In Progress'

SP Set 'In Progress' VR View Sent Request EX Exit

Select Action: Next Screen//

HCSR Response View Nov 13, 2014@10:13:18 Page: 6 of 7

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

+

 Additional Patient Information Contact

 Response Contact Name:

 Response Contact #:

 Patient Event Provider Information

 Entity Provider Code: 24

 Provider ID: XXXXXXXXXX Provider Taxonomy: Person

 Provider Name: IB,DOCTOR 32

 Provider Address: 123 TEST LN

 ANYSITE, WY 11111

 Patient Event Transport Information

 No Patient Event Transport Information

 SERVICE DETAIL

 No Service Detail Lines available

+ Enter ?? for more actions

SR (Send 278 Request) RP Remove 'In Progress'

SP Set 'In Progress' VR View Sent Request EX Exit

Select Action: Next Screen//

## Health Care Services Review (HCSR) Worklist

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

Refer to the eBilling\_Build 2 ICD for details of the message structures.

### The HCSR Worklist

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

**Sample HCSR Worklist Screens**

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

Health Care Services Review (HCSR) Worklist

 Select one of the following:

 T CHAMPVA/TRICARE

 C CPAC

 B Both

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

You can select either Outpatient, Inpatient or Both types of events to be included on your worklist.

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

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

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

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

The screen then displays all of your choices.

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

Select one of the following:

 O Outpatient

 I Inpatient

 B Both

Show Inpatient entries, Outpatient entries or Both: B//oth

Select Ward: C SURGERY

Select Another Ward:

Select Clinic: TEST

Select Another Clinic: TEST 1

Select Another Clinic: TEST 2

Select Another Clinic:

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

Show Inpatient entries, Outpatient entries or Both: B

Clinics to Display: TEST, TEST 1, TEST 2

Wards to Display: C SURGERY

Enter RETURN to continue or '^' to exit:

 Select one of the following:

 1 Oldest Entries First

 2 Newest Entries First

 3 Outpatient Appointments First

 4 Inpatient Admissions First

 5 Insurance Company Name

Sort the list by: Oldest Entries First//

The worklist is displayed.

**Sample HCSR Worklist**

HCSR Worklist Oct 29, 2014@15:03:41 Page: 1 of 3

Filtered By: Both CPAC and Champ/TRICARE, Selected Outpt, Selected Inpt

Sorted By: Oldest Entries First

 Patient Name S Apt Date Ward/Clnc COB Insurance Comp U/P SC Re

1 \*IB,PATIENT 2 XXXX O 08/29/14 TEST P AETNA US HEALT Y Y

2 ?IB,PATIENT 2 XXXX O 08/29/14 TEST S NEW YORK LIFE

3 \*IB,PATIENT 37 XXXX O 09/02/14 TEST P CIGNA Y Y

4 \*IB,PATIENT 6 XXXX O 09/15/14 TEST P BCBS SERVICE B

5 ?IB,PATIENT 37 XXXX O 09/15/14 TEST P CIGNA HEALTHCA Y

6 ?IB,PATIENT 37 XXXX O 09/15/14 TEST S CHAMPVA

7 ?IB,PATIENT 44 XXXX O 09/18/14 TEST 2 S AETNA US HEALT Y Y

8 ?IB,PATIENT 44 XXXX O 10/07/14 TEST P AETNA N A

9 IB,PATIENT 2 XXXX O 10/09/14 TEST 1 S NEW YORK LIFE

10 ?IB,PATIENT 777 XXXX O 10/09/14 TEST 2 P BLUE CROSS/BS N N

11 ?IB,PATIENT 2 XXXX O 10/14/14 TEST 1 P AETNA US HEALT Y Y

12 IB,PATIENT 2 XXXX O 10/14/14 TEST 1 S NEW YORK LIFE

13 IB,PATIENT 98 XXXX I 10/16/14 C SURGERY P CIGNA

14 #IB,PATIENT 37 XXXX I 10/17/14 C SURGERY P BLUE CROSS/BS N N

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

DE Remove Entry AC Add Comment SP Set 'In Progress' Mark

EE Expand Entry ST Sort List RP Remove 'In Progress' Mark

AE Add Entry NR Next Review Date PR HCSR Response WL

RL Refresh EX Exit

Select Action: Next Screen//

The following actions are available from the HCSR Worklist:

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

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

The following are final statuses:

* A1 – Certified in total
* A3 – Not Certified
* A6 – Modified
* C – Cancelled
* CT – Contact payer
* NA – No Action Required
* **Set ‘In Progress’ Mark** – This action allows you to mark an entry as being worked by you. The software places a pound sign (#) before the patient’s name.

***Note:*** If you start a 278 request and need to stop for some reason before you are done, the data you have entered will be saved and the entry will be automatically marked ‘In Progress’.

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

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

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

* **?Await** – This indicator means that a 278 Request has been transmitted and a response has not yet been received.
* **#In-Prog** – This indicator means someone is working on this entry.
* **-RespErr** – This indicator means a 278 Request was sent and a 278 Response has been received which contains an error condition.
* **!Unable** – This indicator means VistA was unable to send a 278 Request for some reason (example: missing required data).
* **+Pend** - This indicator means a 278 Request was sent and a PENDING 278 Response has been received.
* **\*NextRev** - This indicator means the entry on the worklist has been delayed either until a specific date or until the patient’s discharge date.

**Sample Next Review Date Screen**

HCSR Worklist Oct 30, 2014@14:00:08 Page: 1 of 3

Filtered By: Both CPAC and CHAMPVA/TRICARE, Selected Outpt, Selected Inpt

Sorted By: Oldest Entries First

 Patient Name S Apt Date Ward/Clnc COB Insurance Comp U/P SC Re

1 \*IB,PATIENT 2 XXXX O 08/29/14 TEST P AETNA US HEALT Y Y

2 ?IB,PATIENT 2 XXXX O 08/29/14 TEST S NEW YORK LIFE

3 \*IB,PATIENT 37 XXXX O 09/02/14 TEST P CIGNA Y Y

4 \*IB,PATIENT 6 XXXX O 09/15/14 TEST P BCBS SERVICE B

5 ?IB,PATIENT 37 XXXX O 09/15/14 TEST P CIGNA HEALTHCA Y

6 ?IB,PATIENT 37 XXXX O 09/15/14 TEST S CHAMPVA

7 ?IB,PATIENT 44 XXXX O 09/18/14 TEST 2 S AETNA US HEALT Y Y

8 ?IB,PATIENT 44 XXXX O 10/07/14 TEST P AETNA N A

9 IB,PATIENT 2 XXXX O 10/09/14 TEST 1 S NEW YORK LIFE

10 ?IB,PATIENT 777 XXXX O 10/09/14 TEST 2 P BLUE CROSS/BS N N

11 ?IB,PATIENT 2 XXXX O 10/14/14 TEST 1 P AETNA US HEALT Y Y

12 IB,PATIENT 2 XXXX O 10/14/14 TEST 1 S NEW YORK LIFE

13 IB,PATIENT 98 XXXX I 10/16/14 C SURGERY P CIGNA

14 #IB,PATIENT 37 XXXX I 10/17/14 C SURGERY P BLUE CROSS/BS N N

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

DE Remove Entry AC Add Comment SP Set 'In Progress' Mark

EE Expand Entry ST Sort List RP Remove 'In Progress' Mark

AE Add Entry ***NR Next Review Date*** PR HCSR Response WL

RL Refresh EX Exit

Select Action: Next Screen// NR Next Review Date

Select Event Entry(s): (1-14): 2

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

Entry a future date or 'D' to delay until discharge. A 'D' will remove the

selected entries from the worklist until the patients have been discharged.

Entering a Date will remove the selected entries from the worklist until the

selected date.

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

**Sample Add Comment Screen**

HCSR Worklist Oct 30, 2014@14:04:13 Page: 1 of 3

Filtered By: Both CPAC and CHAMPVA/TRICARE, Selected Outpt, Selected Inpt

Sorted By: Oldest Entries First

 Patient Name S Apt Date Ward/Clnc COB Insurance Comp U/P SC Re

1 \*IB,PATIENT 2 XXXX O 08/29/14 TEST P AETNA US HEALT Y Y

2 ?IB,PATIENT 2 XXXX O 08/29/14 TEST S NEW YORK LIFE

3 \*IB,PATIENT 37 XXXX O 09/02/14 TEST P CIGNA Y Y

4 \*IB,PATIENT 6 XXXX O 09/15/14 TEST P BCBS SERVICE B

5 ?IB,PATIENT 37 XXXX O 09/15/14 TEST P CIGNA HEALTHCA Y

6 ?IB,PATIENT 37 XXXX O 09/15/14 TEST S CHAMPVA

7 ?IB,PATIENT 44 XXXX O 09/18/14 TEST 2 S AETNA US HEALT Y Y

8 ?IB,PATIENT 44 XXXX O 10/07/14 TEST P AETNA N A

9 IB,PATIENT 2 XXXX O 10/09/14 TEST 1 S NEW YORK LIFE

10 ?IB,PATIENT 777 XXXX O 10/09/14 TEST 2 P BLUE CROSS/BS N N

11 ?IB,PATIENT 2 XXXX O 10/14/14 TEST 1 P AETNA US HEALT Y Y

12 IB,PATIENT 2 XXXX O 10/14/14 TEST 1 S NEW YORK LIFE

13 IB,PATIENT 98 XXXX I 10/16/14 C SURGERY P CIGNA

14 #IB,PATIENT 37 XXXX I 10/17/14 C SURGERY P BLUE CROSS/BS N N + ?Await #In-Prog -RespErr !Unable +Pend \*NextRev

DE Remove Entry ***AC Add Comment*** SP Set 'In Progress' Mark

EE Expand Entry ST Sort List RP Remove 'In Progress' Mark

AE Add Entry NR Next Review Date PR HCSR Response WL

RL Refresh EX Exit

Select Action: Next Screen// AC Add Comment

Select Event Entry(s): (1-14): 1

COMMENT:

 No existing text

 Edit? NO// y YES

==[ WRAP ]==[ INSERT ]===============< COMMENT >=============[ <PF1>H=Help ]====

This is a test comment for an entry on the HCSR WL.

<=======T=======T=======T=======T=======T=======T=======T=======T=======T>======

**Sample HCSR Response WL**

HCSR Response Worklist Nov 17, 2014@16:08:46 Page: 1 of 2

Filtered By: Both CPAC and CHAMPVA/TRICARE, All Outpt, All Inpt

Sorted By: Oldest Entries First

 Patient Name S Apt Date Ward/Clnc COB Insurance Comp CertAct

1 IB,PATIENT 2 XXXX I 08/27/14 C MEDICINE S NEW YORK LIFE A2

2 IB,PATIENT 56 XXXX I 09/15/14 O&E SURGIC P CIGNA A1

3 IB,PATIENT 203 XXXX O 09/15/14 TEST P CIGNA HEALTHCA A1

4 IB,PATIENT 66 XXXX O 09/22/14 C MEDICINE S BLUE CROSS/BS A1

5 IB,PATIENT 543 XXXX O 10/02/14 TESTIB S BLUE CROSS CA A3

6 IB,PATIENT 11 XXXX O 10/09/14 TEST 1 S NEW YORK LIFE A3

7 IB,PATIENT 92 XXXX O 10/22/14 TEST S BLUE CROSS/BS A1

8 IB,PATIENT 123 XXXX O 10/30/14 TEST P AETNA C

9 IB,PATIENT 6 XXXX O 10/30/14 TEST 1 S AETNA HEALTH P A3

10 IB,PATIENT 44 XXXX O 10/30/14 TEST 1 S AETNA HEALTH P NA

11 IB,PATIENT 129 XXXX O 10/31/14 TEST P AETNA GROUP IN C

12 IB,PATIENT 377 XXXX I 11/01/14 O&E MEDICA P CIGNA A1

13 IB,PATIENT 10 XXXX O 11/03/14 TEST P AETNA A1

14 IB,PATIENT 76 XXXX O 11/04/14 TEST 2 P AETNA GROUP IN C

15 IB,PATIENT 3 XXXX O 11/10/14 TEST 1 P AETNA US HEALT A1

+ Enter ?? for more actions

DE Remove Entry ST Sort RP Remove 'In Progress'

EE Expand Entry RL Refresh EX Exit

NR Next Review Date SP Set 'In Progress'

Select Action: Next Screen//

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

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

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

 Insurance Company Information

 Name: CIGNA Reimburse?: WILL REIMBURSE

 Phone: 800/525-9999 Billing Phone: 800/525-9999

 Precert Phone: 800/111-1209

 Address: POD 9358, ANYCITY, TX 99999

 Group/Plan Information

 Type Of Plan: COMPREHENSIVE MAJOR MEDICAL Require UR: YES

 Group?: YES Require Amb Cert:

 Group Name: CIGNA Require Pre-Cert: YES

 Group Number: WXXXXX Exclude Pre-Cond:

 BIN: Benefits Assignable: YES

 PCN:

Plan Comments:

+ Enter ?? for more actions

SR (Send 278 Request) RP Remove 'In Progress'

SP Set 'In Progress' VR View Sent Request EX Exit

Select Action: Next Screen//

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

HCSR Worklist Oct 30, 2014@14:21:51 Page: 2 of 3

Filtered By: Both CPAC and CHAMPVA/TRICARE, Selected Outpt, Selected Inpt

Sorted By: Oldest Entries First

+ Patient Name S Apt Date Ward/Clnc COB Insurance Comp U/P SC Re

1 \*IB,PATIENT 2 XXXX O 08/29/14 TEST P AETNA US HEALT Y Y

2 ?IB,PATIENT 2 XXXX O 08/29/14 TEST S NEW YORK LIFE

3 \*IB,PATIENT 37 XXXX O 09/02/14 TEST P CIGNA Y Y

4 \*IB,PATIENT 6 XXXX O 09/15/14 TEST P BCBS SERVICE B

5 ?IB,PATIENT 37 XXXX O 09/15/14 TEST P CIGNA HEALTHCA Y

6 ?IB,PATIENT 37 XXXX O 09/15/14 TEST S CHAMPVA

7 ?IB,PATIENT 44 XXXX O 09/18/14 TEST 2 S AETNA US HEALT Y Y

8 ?IB,PATIENT 44 XXXX O 10/07/14 TEST P AETNA N A

9 IB,PATIENT 2 XXXX O 10/09/14 TEST 1 S NEW YORK LIFE

10 ?IB,PATIENT 777 XXXX O 10/09/14 TEST 2 P BLUE CROSS/BS N N

11 ?IB,PATIENT 2 XXXX O 10/14/14 TEST 1 P AETNA US HEALT Y Y

12 #IB,PATIENT 2 XXXX O 10/14/14 TEST 1 S NEW YORK LIFE

13 IB,PATIENT 98 XXXX I 10/16/14 C SURGERY P CIGNA

14 #IB,PATIENT 37 XXXX I 10/17/14 C SURGERY P BLUE CROSS/BS N N

+ ?Await #In-Prog -RespErr !Unable +Pend \*NextRev DE Remove Entry AC Add Comment ***SP Set 'In Progress' Mark***

EE Expand Entry ST Sort List RP Remove 'In Progress' Mark

AE Add Entry NR Next Review Date PR HCSR Response

RL Refresh EX Exit

Select Action: Next Screen// sp Set 'In Progress' Mark

Select Event Entry(s): (15-28): 13

**Sample Remove ‘In Progress” Mark Screen**

HCSR Worklist Oct 30, 2014@14:47:22 Page: 2 of 3

Filtered By: Both CPAC and CHAMPVA/TRICARE, Selected Outpt, Selected Inpt

Sorted By: Newest Entries First

+ Patient Name S Apt Date Ward/Clnc COB Insurance Comp U/P SC Re

1 \*IB,PATIENT 2 XXXX O 08/29/14 TEST P AETNA US HEALT Y Y

2 ?IB,PATIENT 2 XXXX O 08/29/14 TEST S NEW YORK LIFE

3 \*IB,PATIENT 37 XXXX O 09/02/14 TEST P CIGNA Y Y

4 \*IB,PATIENT 6 XXXX O 09/15/14 TEST P BCBS SERVICE B

5 ?IB,PATIENT 37 XXXX O 09/15/14 TEST P CIGNA HEALTHCA Y

6 ?IB,PATIENT 37 XXXX O 09/15/14 TEST S CHAMPVA

7 ?IB,PATIENT 44 XXXX O 09/18/14 TEST 2 S AETNA US HEALT Y Y

8 ?IB,PATIENT 44 XXXX O 10/07/14 TEST P AETNA N A

9 IB,PATIENT 2 XXXX O 10/09/14 TEST 1 S NEW YORK LIFE

10 ?IB,PATIENT 777 XXXX O 10/09/14 TEST 2 P BLUE CROSS/BS N N

11 ?IB,PATIENT 2 XXXX O 10/14/14 TEST 1 P AETNA US HEALT Y Y

12 #IB,PATIENT 2 XXXX O 10/14/14 TEST 1 S NEW YORK LIFE

13 IB,PATIENT 98 XXXX I 10/16/14 C SURGERY P CIGNA

14 #IB,PATIENT 37 XXXX I 10/17/14 C SURGERY P BLUE CROSS/BS N N

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

DE Remove Entry AC Add Comment SP Set 'In Progress' Mark

EE Expand Entry ST Sort List ***RP Remove 'In Progress' Mark***

AE Add Entry NR Next Review Date PR HCSR Response WL

RL Refresh EX Exit

Select Action: Next Screen// rp Remove 'In Progress' Mark

Select Event Entry(s): (15-28): 12

### HCSR Expanded Entry

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

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

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

* Inquiry can be Triggered for Appointment: 2//
* Inquiry can be Triggered for Admission: 1//

**Sample HCSR Expanded Entry Screens**

HCSR Expanded Entry Oct 30, 2014@14:59:32 Page: 1 of 3

IB,PATIENT M XX-XX-XXXX DOB: XX-XX-XXXX AGE: XX

 Insurance Company Information

 Name: BLUE CROSS CA (65-WY) Reimburse?: WILL REIMBURSE

 Phone: Billing Phone: 111/737-7776

 Precert Phone:

 Address: POD 60007, LOS ANGELES, CA 90060

 Group/Plan Information

 Type Of Plan: PREFERRED PROVIDER ORGANIZATION (PPO)Require UR:

 Group?: YES Require Amb Cert:

 Group Name: GRP NAME 10 Require Pre-Cert:

 Group Number: GRP NUM 10794 Exclude Pre-Cond:

 BIN: Benefits Assignable: YES

 PCN:

+ Enter ?? for more actions

SR (Send 278 Req Full) DP View Pending Resp SP Set 'In Progress'

SS Send 278 Req Brief AC Add Comment RP Remove 'In Progress'

CR (Copy 278 Request) SI Send 278 Inquiry VR View Sent Request

EX Exit

Select Action: Next Screen//

HCSR Expanded Entry Oct 30, 2014@15:05:19 Page: 2 of 3

IB,PATIENT M XX-XX-XXXX DOB: XX-XX-XXXX AGE: XX

+

Plan Comments:

 THIS GROUP NAME "CALPERS" STANDS FOR CALIFORNIA PUBLIC EMPLOYEES'

 RETIREMENT SYSTEM.

 Policy/Subscriber Information

 Insured's Name: IB,PATIENT M Effective: 3/2/2014

 Subscriber Id: RXXXXXXX Expiration:

 Relationship: SELF Coord of Benefits: SECONDARY

 Insured's DOB: X/X/XXXX

 Employer Sponsored Group Health Plan?:

 User Added Comments for This Entry

User's Name: UR,NURSE 2 Date Comment Entered: 10/30/2014@15:03:38

 Comment:

 This is a Test comment.

+ Enter ?? for more actions

SR (Send 278 Req Full) DP View Pending Resp SP Set 'In Progress'

SS Send 278 Req Brief AC Add Comment RP Remove 'In Progress'

CR (Copy 278 Request) SI Send 278 Inquiry VR View Sent Request

EX Exit

Select Action: Next Screen//

HCSR Expanded Entry Oct 30, 2014@15:07:25 Page: 3 of 3

IB,PATIENT M XX-XX-XXXX DOB: XX-XX-XXXX AGE: XX

+

User's Name: UR,NURSE 2 Date Comment Entered: 10/30/2014@15:04:17

 Comment:

 This is a follow-up Test comment.

 Enter ?? for more actions

SR (Send 278 Req Full) DP View Pending Resp SP Set 'In Progress'

SS Send 278 Req Brief AC Add Comment RP Remove 'In Progress'

CR (Copy 278 Request) SI Send 278 Inquiry VR View Sent Request

EX Exit

Select Action: Quit//

The following actions are available from the HCSR Expanded Entry screen:

* **Send 278 Request Full** – This action allows you to send an initial X12N Health Care Services Review – Request for Review and Response (278) request to the UMO.

This action also allows you to edit a 278 request for resubmission when the original results in an error condition.

Note: This action is currently disabled

* **Send 278 Request Brief –** This action allows you to send an initial X12N Health Care Services Review – Request for Review and Response (278) request to the UMO by selecting one of the following brief request formats:
* Admission (Initial)
* Appointment (Initial)
* **Copy 278 Request** – This action allows you to enter the data for a X12N Health Care Services Review – Request for Review and Response (278) request to a primary payer and then to copy that data to a new request for a secondary and/or tertiary payer.

Note: This action is currently disabled

* **View Pending Response** – This actions allows you to view a Pending response from the UMO.
* **Add Comment** - This action allows you to enter a free text comment. The comments can be viewed in Expanded Entry. The user’s name and the date and time are added to the comment automatically.
* **Send 278 Inquiry** – This action allows you to send a X12N Health Care Services Review – Inquiry and Response for a 278 request or inquiry with a Pending status. It also allows you to send a X12N Health Care Services Review – Inquiry and Response to cancel a 278 request or inquiry with a Pending status.
* **Set ‘In Progress’ Mark** – This action allows you to mark an entry as being worked by you. The software places a pound sign (#) before the patient’s name.
* **Remove “In Progress’ Mark** – This action allows you to remove the ‘In Progress’ indicator.
* **View Sent Request** – This action allows you to view the request or inquiry that was sent to payer in X12 format

**Sample Send 278 Request Screens – Outpatient Brief**

HCSR 278 Appointment - Brief Nov 04, 2014@15:29:07 Page: 1 of 5

IB,PATIENT 543 XX-XX-XXXX DOB: XXX XX,XXXX AGE: XX

 UM Organization Requester

 Name\*: Aetna Name\*: ANYSITE VAMC

 National Payer ID\*: XXXXXXXXXX NPI\*: XXXXXXXXXX

 HPID: XXXXXX Tax ID\*: XXXXXXXXXX

 Taxonomy Code: XXXXXXXXXX

 Subscriber Address\*: 1234 Test Blvd

 Name\*: IB,SPOUSE City: ANYSITE

 Primary ID\*: WXXXXXXXXXX State/ZIP\*: WY 82005

 Address:123 TEST BLVD Contact Name\*: UR,NURSE 34

 City/State/ZIP: FORT COLLINS WY 82007 Contact Phone/Ext.:

 Contact Fax:

+ Enter ?? for more actions

SR Send 278 Request AD Add Data EX Exit

Select Action: Next Screen//

HCSR 278 Appointment - Brief Nov 04, 2014@15:29:07 Page: 2 of 5

IB,PATIENT 543 XX-XX-XXXX DOB: XXX XX,XXXX AGE: XX

 Dependent Diagnosis

 Name: IB,PATIENT 543 Diagnosis Qualifier:

 Diagnosis:

 Health Care Service Review Provider Information

 Category\*: Health Services Review Provider Type:

 Certification Type\*: Initial Provider Name:

 Service Type\*: Medical Provider NPI:

 Facility Type\*: ON CAMPUS-OUTPATIENT HOSPITAL

+ Enter ?? for more actions

SR Send 278 Request AD Add Data EX Exit

Select Action: Next Screen//

HCSR 278 Appointment - Brief Nov 04, 2014@15:29:07 Page: 3 of 5

IB,PATIENT 543 XX-XX-XXXX DOB: XXX XX,XXXX AGE: XX

 Service Line Paperwork Attachments

 Service Line #: Report Type:

 Date of Service: Appointment Date Transmission Method:

 Procedure Code\*: Attachment Control Number:

 Request Comments

 Message:

+ Enter ?? for more actions

SR Send 278 Request AD Add Data EX Exit

Select Action: Next Screen//AD Add data

 PATIENT EVENT DETAIL

Patient Event Service Type: Medical Care// 1 Medical Care

 Diagnosis Qualifier: ABF ICD-10 Diagnosis

 Patient Event Diagnosis: M25.539

 Searching for a ICD-10 Diagnosis

 One match found

 M25.539 Pain in unspecified wrist

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

The following Diagnoses are currently on file.

# Type Diagnosis

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

1 ABF M25.539

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

Selection #:

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

 Procedure: 73100

 Searching for a HCPCS (CPT) Procedure Codes

 73100 X-RAY EXAM OF WRIST

 ...OK? Yes// (Yes)

The following Service Lines are currently on file.

# Proc Code

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

1 73100

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

Selection #:

Patient Event Provider Data

 Provider Type: DK Ordering Physician

 Provider: IB,DOCTOR R

 Searching for a VA providers

 IB,DOCTOR R VMS 111 PHYSICIAN

 ...OK? Yes// (Yes)

The following Provider Data Information is currently on file.

# Provider Type Provider

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

1 Ordering Physician IB,DOCTOR R

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

Selection #:

No Additional Patient Information is currently on file.

Add Additional Patient Information? NO// YES

 Report Type: RADIOLOGY REPORTS RR Radiology reports

 Report Transmission: AVAI Available on request at provider site

 Attachment Control #:

The following Additional Patient Information is currently on file.

# Report Type Delivery Method Attachment Control #

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

1 Radiology reports Available on request

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

Selection #:

Message Text:

 1>

Requester Contact Name: UR,STAFF 1//

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

Requester Contact Number #1: 1112223333

Type of Requester Contact Number #2: FX Facsimile

Requester Contact Number #2: 444555666

Type of Requester Contact Number #3:

HCSR 278 Appointment - Brief Nov 04, 2014@15:29:07 Page: 4 of 5

IB,PATIENT 543 XX-XX-XXXX DOB: XXX XX,XXXX AGE: XX

 Dependent Diagnoses

 Name: IB,PATIENT 543 Diagnosis Qualifier: ICD-10 Diag

 Diagnosis: M25.539

 Health Care Service Review Provider Information

 Category\*: Health Services Review Provider Type:Ordering Physician

 Certification Type\*: Initial Provider Name: IB,DOCTOR R

 Service Type\*: Diagnostic X-Ray NPI: XXXXXXXXXX

 Facility Type\*: ON CAMPUS-OUTPATIENT HOSPITAL

+ Enter ?? for more actions

SR Send 278 Request AD Add Data EX Exit

Select Action: Next Screen//

HCSR 278 Appointment - Brief Nov 04, 2014@15:29:07 Page: 5 of 5

IB,PATIENT 543 XX-XX-XXXX DOB: XXX XX,XXXX AGE: XX

 Service Line Paperwork Attachments

 Service Line #: 1 Report Type: Radiology Report

 Date of Service: Appointment Date Transmission Method: Available on Request

 Procedure Code\*: 73100 Attachment Control Number:

 Request Comments

 Message:

+ Enter ?? for more actions

SR Send 278 Request AD Add Data EX Exit

Select Action: Next Screen// Send 278 Request

# MCCR Site Parameters

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

**Sample Screen**

MCCR Site Parameters Oct 28, 2014@12:39 Page: 1 of 1

Display/Edit MCCR Site Parameters.

Only authorized persons may edit this data.

 ***IB Site Parameters*** ***Claims Tracking Parameters***

 Facility Definition General Parameters

 Mail Groups Tracking Parameters

 Patient Billing Random Sampling

 Third Party Billing HCSR Parameters

 Provider Id

 EDI Transmission

 ***Third Party Auto Billing Parameters*** ***Insurance Verification***

 General Parameters General Parameters

 Inpatient Admission Batch Extracts Parameters

 Outpatient Visit Service Type Codes

 Prescription Refill

 Enter ?? for more actions

IB Site Parameter AB Automated Billing EX Exit

CT Claims Tracking IV Ins. Verification

Select Action: Quit//

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

## The MCCR Site Parameter Display/Edit

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

* Tracking Parameters
* Track Inpatient:
	+ - OFF
		- INSURED AND UR ONLY
		- ALL PATIENTS
* Track Outpatient
	+ - OFF
		- INSURED ONLY
		- ALL PATIENTS
* Track Rx
	+ - OFF
		- INSURED ONLY
		- ALL PATIENTS
* Track Prosthetics
	+ - OFF
		- INSURED ONLY
		- ALL PATIENTS
* General Parameters
* Extended Help
	+ - OFF
		- ON
* Initialization Date
	+ - Date
* Use Admission Sheet
	+ - NO
		- YES
* Header Line 1
	+ - Free text
* Header Line 2
	+ - Free text
* Header Line 3
	+ - Free text
* Random Sample Parameters
* Medicine Sample
	+ - Number
* Medicine Admissions
	+ - Number
* Surgery Sample
	+ - Number
* Surgery Admissions
	+ - Number
* Psych Sample
	+ - Number
* Psych Admissions
	+ - Number

The sample number and the admissions number are used by the system to compute a random number.

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

**Sample Screens**

Claims Tracking Parameters Oct 28, 2014@13:09:50 Page: 1 of 2

Only authorized persons may edit this data.

 ***Tracking Parameters Random Sample Parameters***

 Track Inpatient: INSURED AND UR ONLY Medicine Sample: 5

 Track Outpatient: INSURED ONLY Medicine Admissions: 5

 Track Rx: INSURED ONLY Surgery Sample: 5

 Track Prosthetics: INSURED ONLY Surgery Admissions: 5

 Reports Can Add CT: YES Psych Sample: 1

 Psych Admissions: 5

 ***General Parameters***

 Initialization Date: 01/01/94

 Use Admission Sheet: NO

 Header Line 1: ANYSITE VAMC

 Header Line 2: 2360 E. ANYSTREET

 Header Line 3: ANYSITE, WY

+ Enter ?? for more actions

TP Tracking RS Random Sample GP General

EA Edit All HS HCSR EX Exit

Select Action: Next Screen//

HCSR Parameters Oct 28, 2014@14:20:48 Page: 1 of 1

Only authorized persons may edit this data.

 ***Health Care Services Review (HCSR) Parameters***

 CPAC Future Appointments Search: 30 days

 CPAC Future Admissions Search: 30 days

 CPAC Past Appointments Search: 14 days

 CPAC Past Admissions Search: 14 days

 TRICARE/CHAMPVA Future Appointments Search: 30 days

 TRICARE/CHAMPVA Future Admissions Search: 30 days

 TRICARE/CHAMPVA Past Appointments Search: 14 days

 TRICARE/CHAMPVA Past Admissions Search: 14 days

 Inquiry can be Triggered for Appointment: 2 days

 Inquiry can be Triggered for Admission: 1 days

 Days to wait to purge entry on HCSR Response: 20 days

 Clinics Included In the Search: 3

 Wards Included In the Search: 0

 Insurance Companies Included In Appointments Search: 6

 Insurance Companies Included In Admissions Search: 8

 Enter ?? for more actions

HC Clinics HW Wards OP Other

HA Adm Ins HI Appt Ins EX Exit

Select Action: Quit//

###  Clinics Included In the Search

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

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

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

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

Only authorized persons may edit this data.

 Health Care Services Review (HCSR) Parameters

 CPAC Future Appointments Search: 14 days

 CPAC Future Admissions Search: 14 days

 CPAC Past Appointments Search: 7 days

 CPAC Past Admissions Search: 7 days

 TRICARE/CHAMPVA Future Appointments Search: 14 days

 TRICARE/CHAMPVA Future Admissions Search: 14 days

 TRICARE/CHAMPVA Past Appointments Search: 7 days

 TRICARE/CHAMPVA Past Admissions Search: 7 days

 Inquiry can be Triggered for Appointment: 0 days

 Inquiry can be Triggered for Admission: 0 days

 Days to wait to purge entry on HCSR Response: 20 days

 ***Clinics Included In the Search: 3***

 Wards Included In the Search: 0

 Insurance Companies Included In Appointments Search: 6

 Insurance Companies Included In Admissions Search: 9

 Enter ?? for more actions

***HC Clinics*** HW Wards OP Other

HA Adm Ins HI Appt Ins EX Exit

Select Action: Quit// HC

HCSR Clinic Inclusions Nov 19, 2014@10:51:39 Page: 1 of 1

Only authorized persons may edit this data.

Clinics Included in the Search:

 1 CHY CARDIOLOGY -for all payers

 2 TEST -for 2 payers

 3 TEST 1 -for all payers

 4 TEST 2 -for all payers

 5 TESTIB -for all payers

 Enter ?? for more actions

AC Add Clinic AP Add Payer to Clinic EX Exit

DL Delete Clinic DP Delete Payer from Clinic

Select Action: Quit// ac Add Clinic

\*\*Warning\*\*

Changing the value in CPAC/TRICARE/CHAMPVA parameters will affect the Health

Care Services Review Worklist.

Select a Clinic to be added: FTC DIABETIC IB,DOCTOR L

Clinic is currently included in the list for no payers

INCLUDE FOR ALL PAYERS?: NO// y YES

Select a Clinic to be added:

Select Action: Quit// ap Add Payer to Clinic

Select HCSR Clinic(s): (1-5): 2

Clinic is currently included in the list for the following 2 payers:

AETNA

CIGNA

INCLUDE FOR ALL PAYERS?: NO//

Select Payer: BCBS KANSAS CITY

Payer added to the list.

Select Payer:

### Wards Included in the Search

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

***Note:*** If circumstances change, a ward can be deleted from this inclusion list or a payer can be deleted from the ward.

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

**Sample Screens**

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

Only authorized persons may edit this data.

 Health Care Services Review (HCSR) Parameters

 CPAC Future Appointments Search: 14 days

 CPAC Future Admissions Search: 14 days

 CPAC Past Appointments Search: 7 days

 CPAC Past Admissions Search: 7 days

 TRICARE/CHAMPVA Future Appointments Search: 14 days

 TRICARE/CHAMPVA Future Admissions Search: 14 days

 TRICARE/CHAMPVA Past Appointments Search: 7 days

 TRICARE/CHAMPVA Past Admissions Search: 7 days

 Inquiry can be Triggered for Appointment: 0 days

 Inquiry can be Triggered for Admission: 0 days

 Days to wait to purge entry on HCSR Response: 20 days

 Clinics Included In the Search: 3

 ***Wards Included In the Search: 0***

 Insurance Companies Included In Appointments Search: 6

 Insurance Companies Included In Admissions Search: 9

 Enter ?? for more actions

HC Clinics ***HW Wards*** OP Other

HA Adm Ins HI Appt Ins EX Exit

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

Only authorized persons may edit this data.

Wards Included In the Search:

1 O&E MEDICAL - for 2 payers

2 TRANSITIONAL - for all payers

 Enter ?? for more actions

AW Add Ward AP Add Payer to Ward EX Exit

DW Delete Ward DP Delete Payer from Ward

Select Action: Quit// AW Add Ward

\*\*Warning\*\*

Changing the value in CPAC/TRICARE/CHAMPVA parameters will affect the Health

Care Services Review Worklist.

Select a Ward to be added: C MEDICINE

INCLUDE FOR ALL PAYERS?: NO// Y

Select a Ward to be added:

Select Action: Quit// AP Add Payer to Ward

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

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

CIGNA NATIONAL

CIGNA

INCLUDE FOR ALL PAYERS?: NO//

Select Payer: bcbs of Kansas

Payer added to the list.

Select Payer:

### Insurance Companies Included In Appointment Search

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

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

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

**Sample Screens**

HCSR Parameters Oct 28, 2014@14:20:48 Page: 1 of 1

Only authorized persons may edit this data.

 Health Care Services Review (HCSR) Parameters

 CPAC Future Appointments Search: 14 days

 CPAC Future Admissions Search: 14 days

 CPAC Past Appointments Search: 7 days

 CPAC Past Admissions Search: 7 days

 TRICARE/CHAMPVA Future Appointments Search: 14 days

 TRICARE/CHAMPVA Future Admissions Search: 14 days

 TRICARE/CHAMPVA Past Appointments Search: 7 days

 TRICARE/CHAMPVA Past Admissions Search: 7 days

 Inquiry can be Triggered for Appointment: 0 days

 Inquiry can be Triggered for Admission: 0 days

 Days to wait to purge entry on HCSR Response: 20 days

 Clinics Included In the Search: 3

 Wards Included From the Search: 0

 ***Insurance Companies Included From Appointments Search: 6***

 Insurance Companies Included From Admissions Search: 8

 Enter ?? for more actions

HC Clinics HW Wards OP Other

HA Adm Ins ***HI Appt Ins*** EX Exit

Select Action: Quit// HI Appt Ins

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

Only authorized persons may edit this data.

Insurance Companies Included In the Appointment Search:

 Insurance Company Name Address Line 1 ST

 1 AETNA POD 2600 CA

 2 CIGNA POD 9999 KY

AI Add Ins DI Delete Ins EX Exit

Select Action: Quit// AI Add Ins

\*\*Warning\*\*

Changing the value in CPAC/TRICARE/CHAMPVA parameters will affect the Health

Care Services Review Worklist.

Select an Insurance Company to be added: AETNA US HEALTHCARE POD 2559 ANYTOWN INDIANA Y

Include all payers with the same electronic Payer ID?? NO// y YES

Select an Insurance Company to be added:

### Insurance Companies Included In Admissions Search

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

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

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

**Sample Screens**

HCSR Parameters Oct 28, 2014@14:20:48 Page: 1 of 1

Only authorized persons may edit this data.

 Health Care Services Review (HCSR) Parameters

 CPAC Future Appointments Search: 14 days

 CPAC Future Admissions Search: 14 days

 CPAC Past Appointments Search: 7 days

 CPAC Past Admissions Search: 7 days

 TRICARE/CHAMPVA Future Appointments Search: 14 days

 TRICARE/CHAMPVA Future Admissions Search: 14 days

 TRICARE/CHAMPVA Past Appointments Search: 7 days

 TRICARE/CHAMPVA Past Admissions Search: 7 days

 Inquiry can be Triggered for Appointment: 0 days

 Inquiry can be Triggered for Admission: 0 days

 Days to wait to purge entry on HCSR Response: 20 days

 Clinics Included In the Search: 3

 Wards Included In the Search: 0

 Insurance Companies Included In Appointments Search: 6

 ***Insurance Companies Included In Admissions Search: 8***

 Enter ?? for more actions

HC Clinics HW Wards OP Other

***HA Adm Ins*** HI Appt Ins EX Exit

Select Action: Quit//

HCSR Insurance Inclusions Nov 19, 2014@11:07:56 Page: 1 of 1

Only authorized persons may edit this data.

Insurance Companies Included In the Admissions Search:

 Insurance Company Name Address Line 1 ST

 1 AETNA POD 2344 CA

 2 CIGNA POD 99999 KY

AI Add Ins DI Delete Ins EX Exit

Select Action: Quit// AI Add Ins

\*\*Warning\*\*

Changing the value in CPAC/TRICARE/CHAMPVA parameters will affect the Health

Care Services Review Worklist.

Select an Insurance Company to be added: UNITED HEALTHCARE POD 30555 MYTOWN UTAH Y

Include all payers with the same electronic Payer ID?? NO// y YES

Select an Insurance Company to be added:

# Appendix A – Follow-up Actions Codes

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Loop | Valid Request  | Segment Name | Reject Reason Codes | Follow-up Action Codes |
| 2000A | Yes or No | AAA – Request Validation | Authorization Quantity Exceeded Authorization/Access RestrictionsUnable to Respond at Current TimeInvalid Participant Identification | Please Correct and ResubmitResubmission Not AllowedPlease Resubmit Original TransactionDo Not Resubmit; We Will Hold Your Request and Respond Shortly |
| 2010A | Always No | AAA – UMO Request Validation | Unable to Respond at Current TimeInvalid Participant IdentificationNo Response received – Transaction TerminatedPayer Name or Identifier Missing | Resubmission Not AllowedPlease Resubmit Original TransactionDo Not Resubmit; We Will Hold Your Request and Respond Shortly |
| 2010B | Always No | AAA – Requester Request Validation | Required application data missingOut of NetworkAuthorization/Access RestrictionsInvalid/Missing Provider IdentificationInvalid/Missing Provider NameInvalid/Missing Provider SpecialtyInvalid/Missing Provider Phone NumberInvalid/Missing Provider StateProvider is Not Primary Care PhysicianProvider Not on FileInvalid Participant IdentificationInvalid or Missing Provider Address | Please Correct and ResubmitResubmission Not AllowedResubmission Allowed |
| 2010C | Always No | AAA – Subscriber Request Validation | Invalid/Missing Date-of-BirthInvalid/Missing Patient IDInvalid/Missing Patient NameInvalid/Missing Patient Gender CodePatient Not FoundDuplicate Patient ID NumberPatient Birth Date Does Not Match That for the Patient on the DatabaseInvalid/Missing Subscriber/Insured IDInvalid/Missing Subscriber/Insured NameInvalid/Missing Subscriber/Insured Gender CodeSubscriber/Insured Not FoundDuplicate Subscriber/Insured ID NumberSubscriber Found/Patient Not FoundInvalid Participant IdentificationPatient Not Eligible | Please Correct and ResubmitResubmission Not Allowed |
| 2010D | Always No | AAA – Dependent Request Validation | Required application data missingInput ErrorsInvalid/Missing Date-of-BirthInvalid/Missing Patient IDInvalid/Missing Patient NameInvalid/Missing Patient Gender CodePatient Not FoundDuplicate Patient ID NumberPatient Birth Date Does Not Match That for the Patient on the DatabaseSubscriber Found/Patient Not FoundPatient Not Eligible | Please Correct and ResubmitResubmission Not Allowed |
| 2000E | Always No | AAA – Patient Event Request Validation | Required application data missingInput ErrorsService Date Not Within Provider Plan EnrollmentInappropriate DateInvalid/Missing Date(s) of ServiceDate of Birth Follows Date(s) of ServiceDate of Death Precedes Date(s) of ServiceDate of Service Not Within Allowable Inquiry PeriodAuthorization Number Not FoundInvalid/Missing Diagnosis Code(s)Invalid/Missing Onset of Current Condition or Illness DateInvalid/Missing Accident DateInvalid/Missing Last menstrual Period DateInvalid/Missing Expected dat4e of BirthInvalid/Missing Admission DateInvalid/Missing Discharge DateCertification Information Missing | Please Correct and ResubmitResubmission Not Allowed |
| 2010EA | Always No | AAA – Patient Event Provider Request Validation | Required application data missingInput ErrorsOut of NetworkAuthorization/Access RestrictionsInvalid/Missing Provider IdentificationInvalid/Missing Provider NameInvalid/Missing Provider SpecialtyInvalid/Missing Provider Phone NumberInvalid/Missing Provider StateProvider is Not Primary Care PhysicianProvider Not on FileService Dates Not Within Provider Plan EnrollmentInvalid Participant IdentificationInvalid or Missing Provider AddressInappropriate Provider Role | Please Correct and ResubmitResubmission Not Allowed |
| 2010EC | Always No | AAA – Patient Event Transport Location Request Validation | Required application data missingInput ErrorsInvalid/Missing Provider StateInvalid or Missing Provider Address | Please Correct and ResubmitResubmission Not Allowed |
| 2000F | Always No | AAA – Service Request Validation | Required application data missingInput ErrorsService Dates Not Within Provider Plan EnrollmentInvalid/Missing Date(s) of ServiceDate of Birth Follows Date(s) of ServiceDate of Death Procedes Date(s) of ServiceDate of Service Not Within Allowable Inquiry PeriodAuthorization Number Not FoundInvalid/Missing Procedure Code(s)Certification Information Missing | Please Correct and ResubmitResubmission Not Allowed |
| 2010FA | Always No | AAA – Service Provider Request Validation | Required application data missingInput ErrorsOut of NetworkAuthorization/Access RestrictionsInvalid/Missing Provider IdentificationInvalid/Missing Provider NameInvalid/Missing Provider SpecialtyInvalid/Missing Provider Phone NumberInvalid/Missing Provider StateProvider is Not Primary Care PhysicianProvider Not on FileService Dates Not Within Provider Plan EnrollmentInvalid Participant IdentificationInvalid or Missing Provider AddressInappropriate Provider Role | Please Correct and ResubmitResubmission Not Allowed |