Automated Billing System (ABS)

Business Requirements Document v0.9

February 2014

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Revision History

NOTE: *The revision history cycle begins at initial document draft and continues as changes or enhancements are requested. Pre-final versions are numbered 0.1, 0.2, etc. Once the final draft is approved, the revision history should be truncated to track changes made to approved version only. The first approved version is 1.0 and amended as updates occur.*

Date	Version	Description	Author
10/30/2013	0.1	SME Reviewed, Input Incorporated	ABS IPT
11/13/2013	0.2	Updated Appendices and Non-Functional Reqs	ABS IPT
11/15/2013	0.3	Updated Appendices and VistA requirements	Kathy Jurrus
11/18/2013	0.4	Updated Acronym and Assumptions section	Kathy Jurrus
12/02/2013	0.5	Updated Wording of Scope and Requirements	ABS Requirements Team
01/15/2014	0.6	Updated requirements and scope section for RFI	ABS Requirements Team
01/30/2014	0.7	Updated BRD based on recent discussions re: conceptual architecture.	ABS Requirements Team
2/10/2014	0.8	Changed Automated Billing "Solution" to "System; Added 1.16: "The ABS shall determine the Revenue code for Inpatient claims based on bed type in the PTF"; Modified 1.29, adding "uploaded" before "Claims Tracking"; In 1.31, replaced "claims payment data uploaded from VistA" with "835 transactions," whether the 835 transactions come from VistA , clearinghouse or FSC is TBD; Removed "The inclusion of this component is dependent upon design" from several section headings to minimize any confusion or speculation by ABS companies; Added 12.2 per Cari Hutchison; Deleted 14.1 pertaining to the interface with an external workflow system, assuming that interfaces will be in a future phase; Modified NF-2.0 to allow for some growth in # of users; Added the following to NF-3.0: The Contractor shall provide notification to users of scheduled and unscheduled outages. These requirements shall be defined in the Service Level Agreement; Added NF-14.0: The ABS shall have the ability to process $1,510,853 bills / month.	ABS IPT
2/19/2014	0.9	Edited 1.15 and 1.16 to indicate the revenue code on the claims would be based on business rules; Edited non-functional requirements 13.0 and 14.0; Added non-functional requirements 15.0 and 16.0.	RSM Requirements and Testing Team

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Business Requirements Document

1. Purpose

This Business Requirements Document (BRD) describes provider billing system requirements for the Department of Veterans Affairs (VA) Chief Business Office (CBO) for Revenue Operations, Consolidated Patient Account Centers (CPAC). These business requirements address the CPAC process for submitting claims to third party insurance carriers for reimbursement of medical care or services provided. The BRD is for the purpose of automating the billing process.

2. Overview

The CPAC program uses innovative business processes to deliver consistent, efficient, and accountable revenue services to enhance Veterans' healthcare. CPAC provides direct support to Veterans Health Administration (VHA) providing Third Party Payer (TPP) reimbursement services. Third party reimbursements provide Veterans with copayment offset and reduced per diem obligations and are a significant revenue generating activity through which the VA collected over $1.9 billion in FY13.

The current third party billing process is comprised of highly manual and labor intensive procedures. The high level of human interaction is required to ensure low error-rates while simultaneously ensuring timely collection. Much of the manual intervention is driven by limited capabilities of the legacy system, Veterans Health Information and Systems Architecture (VistA).

The goal to implement a standardized automated solution is driven by a commitment to improve the current billing process and aligns with the core values and mission of the VA. Billing solution improvements typically generate immediate short-term benefits by increasing operational efficiency and propagate long-term return on investment by capitalizing on reduced processing expenses and error-rates. A mere 1% improvement in the collections process can be expected to result in increased revenue of approximately $19 million annually for the VA.

The ABS will provide the VA with a modern rules-driven billing solution that delivers required functionality and applies insurance industry standards along with carrier-specific guidelines. Implementation of ABS will result in a "touch-by-exception" claims production environment in which the majority of third-party claims are automatically generated and submitted for payment. An improved billing process will facilitate prompt third party reimbursement, thus offsetting the Veterans' copayments within the 90 day grace period. This will result in improved customer satisfaction.

3. Scope

To improve third party payer efficiency, an Automated Billing System (ABS) is necessary. An ABS will provide enhanced billing capability built on business rules.

The implementation of the ABS has four objectives:

1. Maximize private health care industry best practices while continuing to meet the special needs of the VHA (e.g. federal regulations, directives).
2. Improve the efficiency and cost effectiveness of third-party billing
3. Improve billing accuracy and data integrity
4. Improve claims processing turn-around time

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To meet these objectives, the ABS will provide new or enhanced features and functions that will be integrated within the current third party billing methodology and processes. This scope provides a high level summary of the features and functions needed in an ABS. Features are product requirements that describe the characteristics of the automated billing system. Functions are process requirements that describe how users will interact with the automated billing system, as well as how external systems will interface with the ABS.

Scope of the ABS project:

- Provide automated billing, i.e., "touch by exception" bill processing
    - Automated Claims Generation and Processing
    - Exception / Error-based workflow
    - Increased Claims Accuracy and Quality Control
- Enable Business Rules Driven Claims Processing
    - Built-in Industry Standard Rules
    - Built-in Claims Scrubbing
    - User Managed customer-unique business rules
- Maintain detailed insurance carrier information to include benefit-level business rules
- Upload and maintain a Charge Description Master
- Upload and maintain a Provider File
- Upload and maintain other reference data needed for claims processing
- Provide comprehensive Electronic Data Interchange (EDI) Capability
- Store Claim Images and Attachments associated with claims
- Provide enhanced reporting
    - Pre-packaged Industry Standard Reports
    - User Defined Ad Hoc Reports

Not included in scope:

1. Scheduling, Registration, and Accounts Management functions
2. Billing of First-Party Charges
3. Processing of Pharmacy claims

4. Requirements

4.1. ABS Business and Functional Requirements

Requirement Number	Requirement Statement	Priority
AUTOMATICALLY GENERATE & PROCESS CLAIMS		
1.0	The ABS shall have the ability to automatically generate claims.	High
1.1	The ABS shall provide the ability to automatically generate a professional claim (CMS 1500) for each provider based upon outpatient encounter data.	High
1.2	The ABS shall provide the ability to automatically generate an institutional claim (UB-04) for each inpatient stay.	High
1.3	The ABS shall provide the ability to automatically combine encounters to generate a single institutional claim (UB-04) daily based on business rules.	High

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1.4	The ABS shall provide the ability to generate a single claim for multiple dates of service for a given provider for repetitive services based on business rules, (e.g., procedures, services or time period such as every 30 days).	High
1.5	The ABS shall determine which claim form to use based on business rules (currently rules are based on the Facility File and payer business rules).	High
1.6	The ABS shall determine the bill type based on the Facility File in VistA. The designations are: VA Medical Center – 1, Provider Based Facility – 2, Non-Provider Based Facility – 3. The 1 allows for inpatient charges, outpatient institutional and professional charges. The 2 allows for outpatient institutional and professional. The 3 allows for global charges (a derivative of institutional and professional charges).	High
1.7	The ABS shall have the ability to automatically process claims.	High
1.8	The ABS shall automatically apply VA-unique business rules when processing claims.	High
1.9	The ABS shall automatically apply payer business rules when processing claims.	High
1.10	The ABS shall prevent re-use of cancelled claim numbers.	High
1.11	The ABS shall prevent the generation of duplicate claims.	High
1.12	The ABS shall determine if the provider is billable based on the payer business rules.	High
1.13	The ABS shall determine if the provider is billable based on the provider type.	High
1.14	The ABS shall suspend the claim if the provider is not billable.	High
1.15	The ABS shall determine the Revenue code for Outpatient claims based on business rules (table mapping or default).	High
1.16	The ABS shall determine the Revenue code for Inpatient claims based on business rules (currently 0101- All Inclusive R&B and 0201- All Inclusive Ancillary).	High
1.17	The ABS shall provide the ability to automatically combine encounters on one claim.	High
1.18	The ABS shall perform an automatic crosswalk from CPT/HCPCS to alternative CPT when the patient's primary insurance is Medicare which requires a change in code (e.g. between consult code and E&M code).	High
1.19	The ABS shall determine if any diagnosis on the claim is determined to be a sensitive diagnosis.	High
1.20	The ABS shall determine if a valid, active patient's Release of Information for any identified sensitive diagnosis on the claim is on file to automatically process the claim.	High
1.21	The ABS shall automatically suspend the claim if a Release of Information for identified sensitive diagnosis does not exist.	High
1.22	The ABS shall auto-populate the value code on the institutional claim based on business rules/mapping tables in the ABS.	High
1.23	The ABS shall auto-populate the condition code on the institutional claim based on business rules/mapping tables in the ABS.	High

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1.24	The ABS shall auto-populate the occurrence code on the institutional claim based on business rules/mapping tables in the ABS.	High
1.25	The ABS shall have the ability to identify claims by type of bill to include: Admit-through-Discharge; interim (first, continuing, and last claim); late charges only; replacement of a prior claim; void/cancel of a prior claim; adjustment claim; nonpayment/zero claims.	High
1.26	The ABS shall have the ability to identify claims by status to include: Transmitted, Adjusted, Cancelled, Suspended, Authorized, and Printed/Mailed/Submitted.	High
1.27	The ABS shall have the ability to identify claims sent to Medicare for adjudication.	High
1.28	The ABS shall auto-populate the authorization number from the pre-certification/authorization that matches the claim.	High
1.29	The ABS shall match prospective pre-certs (uploaded from Claims Tracking) to outpatient encounters.	High
1.30	The ABS shall provide an exceptions report for pre-certs that do not have a matching ABS claim.	High
1.31	The ABS shall provide the ability to automatically process a claim for coordination of benefits based on 835 transactions.	High
1.32	The ABS shall provide the ability to automatically process a claim for a secondary payer based on receipt of an electronic Medicare Remittance Advice (eMRA).	High
1.33	The ABS will calculate the total charges for each claim based on the VA CDM and VA business rules.	High
1.34	The ABS shall suspend claims with the appropriate exception code when the claim fails a business rule.	High
1.35	The ABS shall suspend claims with the appropriate exception code when the claim fails an edit.	High
1.36	The ABS shall provide the ability to cancel line items on suspended/exception claims.	High
MANUALLY PROCESSING CLAIMS		
2.0	The ABS shall provide the ability to manually generate a claim.	High
2.1	The ABS shall provide the ability to delete line items during the creation of a claim.	High
2.2	The ABS shall provide the ability for the user to edit the claim.	High
2.3	The ABS shall provide the ability to manually cancel claims.	High
2.4	The ABS shall require entry of a Reason Not Billable (RNB) for each cancelled line item of a claim.	High
2.5	The ABS shall display the RNB code and description of the RNB associated with the claim.	High
2.6	The ABS shall require a bill cancellation reason code (aligned to RNB).	High
2.7	The ABS shall have the ability to manually produce interim (split) claims.	High

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2.8	The ABS shall provide the ability to manually put a claim on hold.	High
2.9	The ABS shall provide a work queue for Claims placed on hold by the user.	High
2.10	The ABS shall have the ability to store images and attachments associated to a claim, for example insurance carrier refund request and e-MRA exemption letter.	High
2.11	The ABS shall be International Classification of Diseases (Healthcare) (ICD-10) Tenth Revision compliant.	High
BUSINESS RULES		
3.0	The ABS shall provide the ability for a super user to add business rules.	High
3.1	The ABS shall provide the ability for a super user to modify business rules.	High
3.2	The ABS shall provide the ability for a super user to associate begin and end dates with business rules.	High
3.3	The ABS shall provide the ability for a super user to deactivate business rules by adding an end date.	High
3.4	The ABS shall allow the configuration of business rules by payer.	High
3.6	The ABS shall have the ability to determine the transmission method, EDI or paper, based on payer business rules.	High
3.7	The ABS shall process claims for services provided by nurse based clinics, based on business rules.	High
EDI TRANSACTIONS/TRANSMISSIONS		
4.0	The ABS shall have the ability to send Health Insurance Portability and Accountability Act of 1996 (HIPAA) standard EDI transactions.	High
4.1	The ABS shall have the ability to receive HIPAA standard EDI transactions.	High
4.2	The ABS shall have the ability to process HIPAA standard EDI transactions.	High
4.3	The ABS shall provide the ability to transmit claims attachments when required.	High
4.4	The ABS shall provide the ability to automatically process an electronic Medicare Remittance Advice (e-MRA).	High
4.5	The ABS shall have the ability to receive electronic remittance advices (ERAs) with line item details.	High
4.6	The ABS shall have the ability to automatically process electronic remittance advices with line item details.	High
ABS AR		
5.0	The ABS shall update accounts receivable (within ABS) when the claim is authorized/transmitted.	High
5.1	The ABS shall update accounts receivable (within ABS) when a claim is modified.	High
5.2	The ABS shall update accounts receivable (within ABS) when a claim is cancelled.	High

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5.3	The ABS shall aggregate accounts receivable data to a claim (K#) level for the VistA AR system.	High
PRINTING		
6.0	The ABS shall have the ability to print claims to send to the payer.	High
6.1	The ABS shall have the ability to define print parameters.	High
CLAIMS SCRUBBER		
7.0	The ABS shall utilize claims scrubbing software.	High
7.1	The ABS shall automatically process claims using the claims scrubber rules/edits.	High
7.2	The ABS shall route scrubber errors or warnings to role based work queues for manual processing.	High
7.3	The ABS shall allow the user to override specified claims scrubber edits (based on configuration).	High
EXTRACTS/LOADS		
Data Extracts to be loaded in ABS		
8.0	The ABS shall upload data extracts from VistA to include encounters, Claims Tracking notes, SC/SA determinations, and Release of Information data.	High
8.1	The ABS shall upload Claims Tracking data to create precertifications/authorizations.	High
8.2	The ABS shall upload Non-VA Care claims data from the Purchased Care system to generate a claim for the third party payer associated with the Veteran.	High
Data Files to be generated and sent to VistA (Daily batch process)		
8.6	The ABS shall automatically send updates to VistA when the claim is ready to transmit.	High
8.7	The ABS shall create a file of claims not billable (with RNB information) to be uploaded into VistA IB (Claims Tracking).	High
8.8	The ABS shall create a file of insurance table updates to be sent to VistA.	High
8.9	The ABS shall provide a report of any data upload errors.	High
TABLES		
9.0	The ABS shall maintain reference tables required for claims processing.	High
9.1	The ABS shall create a table of Release of Information (ROI) determination data extracted from VistA. (Read only)	High
9.2	The ABS shall upload ROI data updates from VistA.	High
9.3	The ABS shall create a table of Facility data extracted from VistA. (Read only)	High
9.4	The ABS shall upload Facility data updates from VistA.	High
9.5	The ABS shall create a table of Provider information extracted from VistA (e.g., Name, NPI, and Specialty). (Read only)	High
9.6	The ABS shall upload Provider data updates from VistA.	High

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9.7	The ABS shall create a Charge Description Master (CDM) extracted from VistA. (Read only)	High
9.8	The ABS shall upload CDM updates from VistA.	High
9.9	The ABS shall create tables of Insurance data extracted from VistA.	High
9.10	The ABS shall upload Insurance data updates from VistA.	High
9.11	The ABS shall create a table of Reasons Not Billable (RNB) data extracted from VistA. (Read only)	High
9.12	The ABS shall upload RNB data updates from VistA.	High
REPORTING		
10.0	The ABS shall provide the ability for the user to run standard reports.	High
10.1	The ABS shall provide the ability for the user to run ad hoc reports on ABS data based on user-specified parameters.	High
10.2	The ABS shall allow the user to view a list of claims by user-specified parameters (e.g. patient, bill status, bill type).	High
10.3	The ABS shall allow the user to view a list of patients who require insurance verification by user-specified parameters.	High
WORKFLOW		
11.0	The ABS shall provide workflow functionality for claims exceptions processing.	High
11.1	The ABS shall provide the ability to route claims based on specific edits to role based work queues.	High
11.2	The ABS shall automatically assign claims workload based on business rules.	High
UR DETERMINATIONS		
12.0	The ABS shall store UR determinations related to pre-certification/pre-authorization information. (Claims Tracking data may be used for this purpose.)	High
12.1	The ABS shall store UR determinations related to SC/SA validation information. (Claims Tracking data may be used for this purpose.)	High
12.2	The ABS shall store other UR comments that have been entered into Claims Tracking (e.g. encounter's relationship to an active worker's comp, tort feasor, no fault insurance)	High
INSURANCE		
13.0	The ABS shall have the ability to maintain third party insurance information to include payer /insurance company name, address, phone number, HPID, EDI information, etc.	High
13.1	The ABS shall allow the Insurance Verification (IV) user to enter insurance policy information.	High
13.2	The ABS shall allow the IV user to identify insurance carriers by type: Local; Regional or National.	High
13.3	The ABS shall associate Veterans with insurance policies and benefits information.	High
13.4	The ABS shall identify insurance carriers as primary, secondary, or tertiary payer by Veteran.	High

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13.5	The ABS shall allow configuration of claim transmission methods by payer.	High

4.2. VistA Functional Requirements

VistA will continue to be the authoritative data source.

Requirement Number	Requirement Statement	Priority
15.0	The ABS data extract routines shall extract encounter, inpatient stay, precertification, and reference table data from VistA.	High
15.1	VistA shall upload claims data extracted from ABS.	High

4.3. Non-Functional Requirements

Requirement Number	Non-Functional Requirements
NF-1.0	The system shall meet all VHA Security, Privacy and Identity Management requirements including VA Handbook 6500.
NF-2.0	The ABS shall support up to 1000 concurrent users.
NF-3.0	The Contractor shall provide Service Availability of 99.9% for the operational hours of 6:00 a.m. and Midnight Eastern Time Monday through Friday. Service Availability is defined as all services and applications in the Federal private cloud environment are available, whether it is during abnormal system operation or software upgrade regardless of hardware, software or user fault. The Contractor shall provide notification to users of scheduled and unscheduled outages. These requirements shall be defined in the Service Level Agreement.
NF-4.0	The ABS shall be Section 508 compliant.
NF-5.0	The ABS shall ensure that new versions of the ABS or updates do not overwrite custom configuration rules/files.
NF-6.0	The ABS shall provide access to view up to four years of archived data in real time.
NF-7.0	The ABS shall provide an audit trail to include username for data additions, changes, and deletions.
NF-8.0	The ABS shall provide ability for the user to view audit trail information.
NF-9.0	The ABS shall provide ability to transmit data using IPv6 and IPv4 protocols.
NF-10.0	The ABS shall ensure backup operations are performed daily in a manner and timeframe that minimizes impact on operations.
NF-11.0	The ABS shall archive data on closed claims older than three (3) fiscal years.
NF-12.0	The ABS shall provide the ability to support multiple users at multiple locations simultaneously.
NF-13.0	The ABS shall allow for user access based on use of PIV card technology.
NF-14.0	The ABS shall have the ability to process 1.6 million bills / month. Number of claims expected to increase at a rate of 1% /year.
NF-15.0	The ABS shall provide validation edits for information accuracy.
NF-16.0	The ABS shall provide functionality for administering user access.

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4.4. Related Projects or Work Efforts

- National Insurance File
    - The National Insurance File (NIF) is a web based centralized VA payer repository that is being developed to serve as the trusted and authoritative source for insurance payer data at the VA.
    - The NIF has the ability to import and maintain both the Health Plan Identifiers and Other Entity Identifiers from a downloadable file created by the U.S. Department of Health and Human Services' Health Plan and Other Entity Enumeration System (HPOES) for future use in electronic health care transactions.
    - The NIF has the ability for additional payers to be manually input.
- Pending Third Party Billing Work Reporting
    - Procurement of vendor contract services to provide CPAC PMO with an analysis and feasibility assessment report related to pending third party billing work from multiple known sources and produces standard and ad hoc reporting capabilities.

5. Other Considerations

5.1. Assumptions

Assumption Number	Process/System Assumption Statement	Notes
1.0	If VistA encounter data is extracted for the same date used to create the Code Me Report on the previous day (encounters T-7 days), the encounters were already scrubbed by the Facility Revenue Technician, reviewed by UR and validated by coding.	
2.0	CPAC will evaluate the pre-loaded insurance file that comes with the ABS for potential use.	
3.0	VistA shall continue to store Reason Not Billable (RNB) codes for all encounters.	
4.0	UR reviews every potentially billable inpatient stay in VistA.	
5.0	UR reviews outpatient encounters and inpatient stays to determine the requirements for pre-authorization/pre-certification (encounter examples include: MRI, physical therapy) in VistA and creates applicable Claims Tracking entries.	
6.0	FRM/FRT enters ROI in VistA and ROI is used by facility staff as well as CPAC staff, thus VistA must remain the authoritative source for ROI.	
7.0	TRICARE and CHAMPVA claims will continue to be processed in VistA IB.	

5.2. Dependencies

Subject Matter Experts (SMEs): SMEs in the area of Billing, Revenue Utilization Review, Insurance Verification and Accounts Receivable will be needed for every phase of the project to ensure effective functional processes, as well as regulatory compliance. This includes both business and technical SMEs.

Testing Platforms and Processes: Adequate test systems and the ability to test using "test data" from VistA to its final destination at third party payer will be necessary (end to end testing). There are five systems involved: (1) VHA VistA systems, (2) ABS, (3) FSC, (4) AITC, (5) and the Clearinghouse.

5.3. Constraints

Technical (programmer) SME shortage: Due to the complexity of the existing software, the participation of experienced VistA IB and AR application developers is essential to the successful design and development of the system.

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Appendix A. References

Integrated Billing Documentation:

http://www.va.gov/vdl/application.asp?appid=45

Billing Guidebook:

https://vaww.cpac.portal.va.gov/SAT%20Approved%20Guidebooks/CPAC%20Billing%20Guidebook%20v2.0.pdf

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Appendix B: VHA Revenue Operations Overview

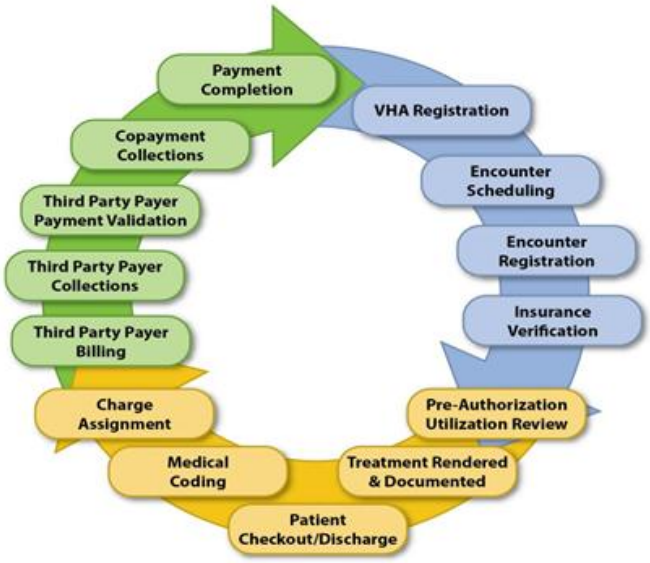
VHA Revenue Operations Overview

VA Medical Centers (VAMCs) encompass:

- Insurance capture
- Documentation
- Coding
- Charge capture

Consolidated Patient Accounts Center (CPAC) encompasses:

- Payer Relations
- Insurance verification
- Revenue Utilization Review
- Facility Revenue
- Billing
- Accounts management/Follow-up
- Payment Validation
- Denials Management
- Collections/Cash Management



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Appendix C: CPAC FY13 Annual Billing Volume

FY 2013	# Bills FYTD	
	Outpatient	Inpatient
National	**10,334,024**	**462,448**
Central Plains	1,471,181	50,970
Florida Caribbean	987,760	53,519
Mid Atlantic	1,643,245	67,880
Mid South	1,851,957	85,061
North Central	1,280,169	60,586
North East	1,788,338	81,395
West	1,311,374	63,037

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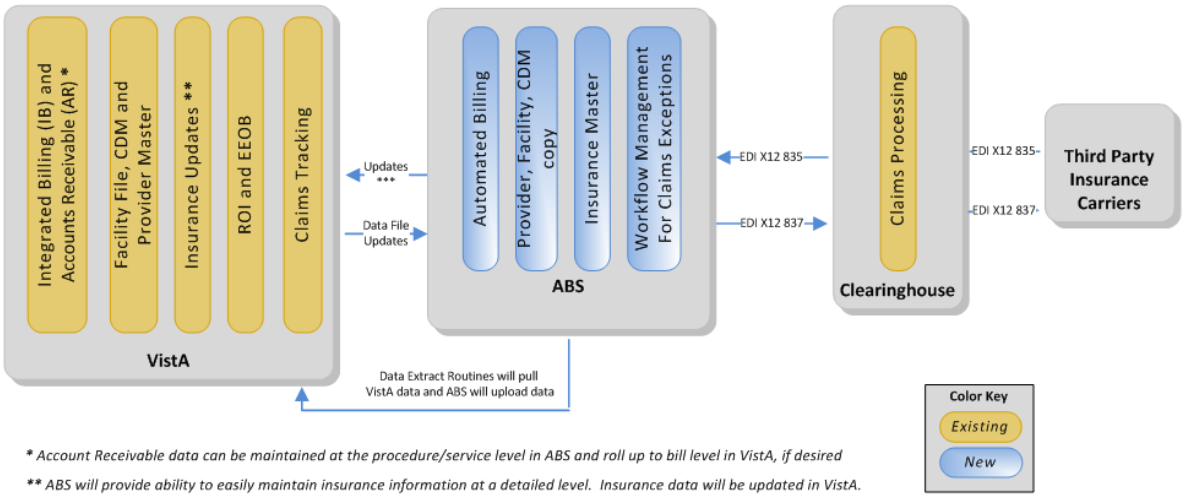
Appendix D: ABS Conceptual Architecture



** Account Receivable data can be maintained at the procedure/service level in ABS and roll up to bill level in VistA, if desired*

*** ABS will provide ability to easily maintain insurance information at a detailed level. Insurance data will be updated in VistA.*

**** ABS will provide a nightly file of claims data for uploading in VistA.*

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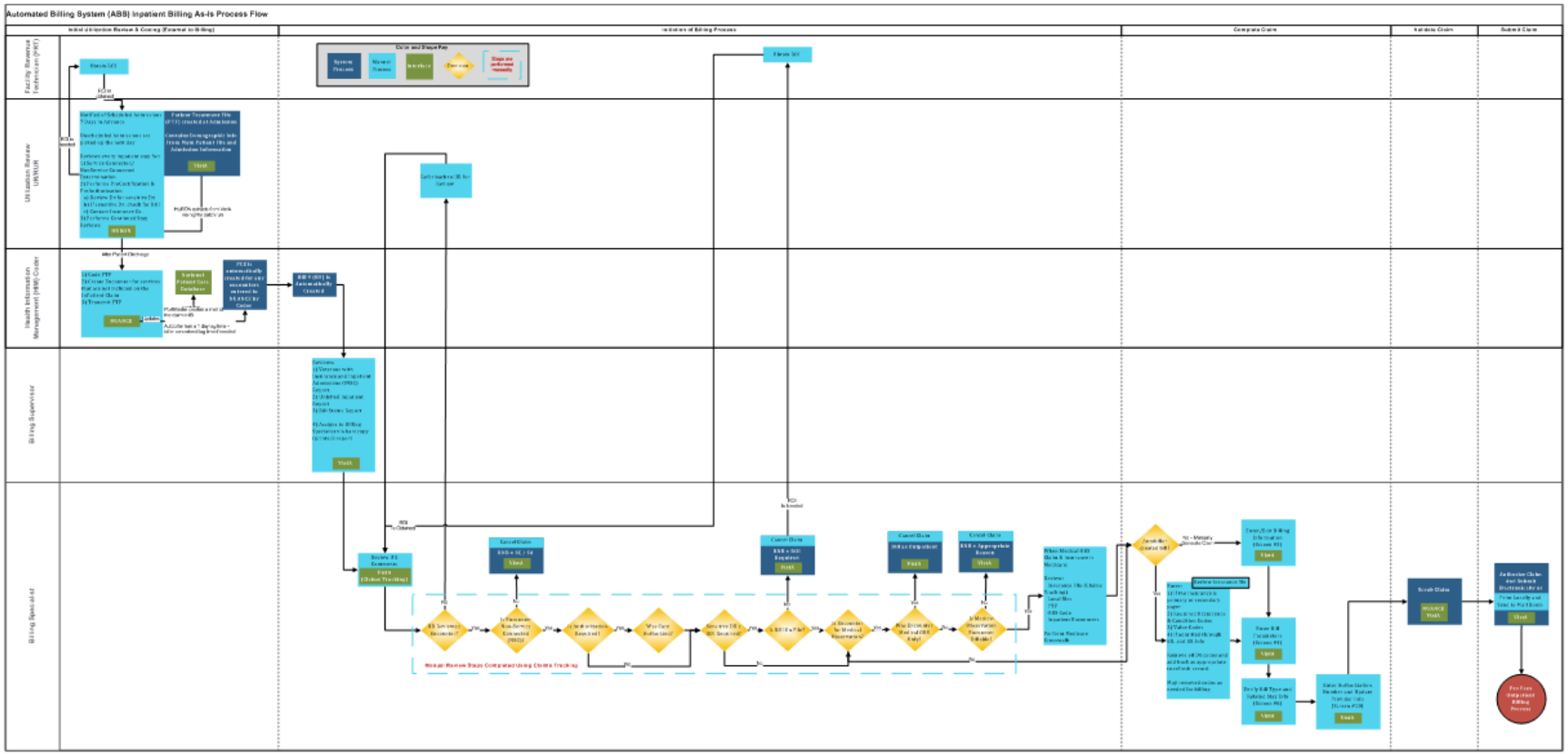
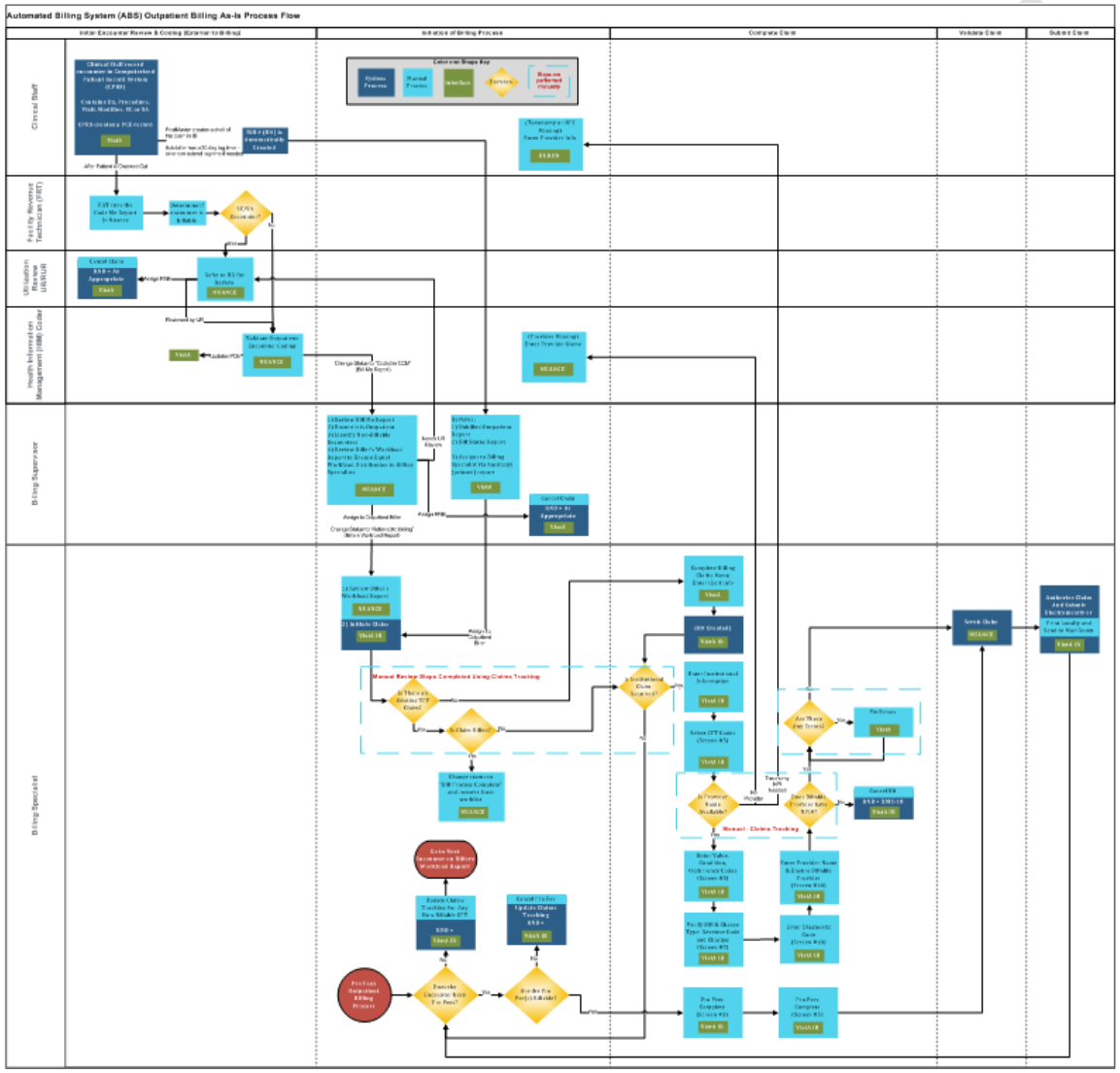
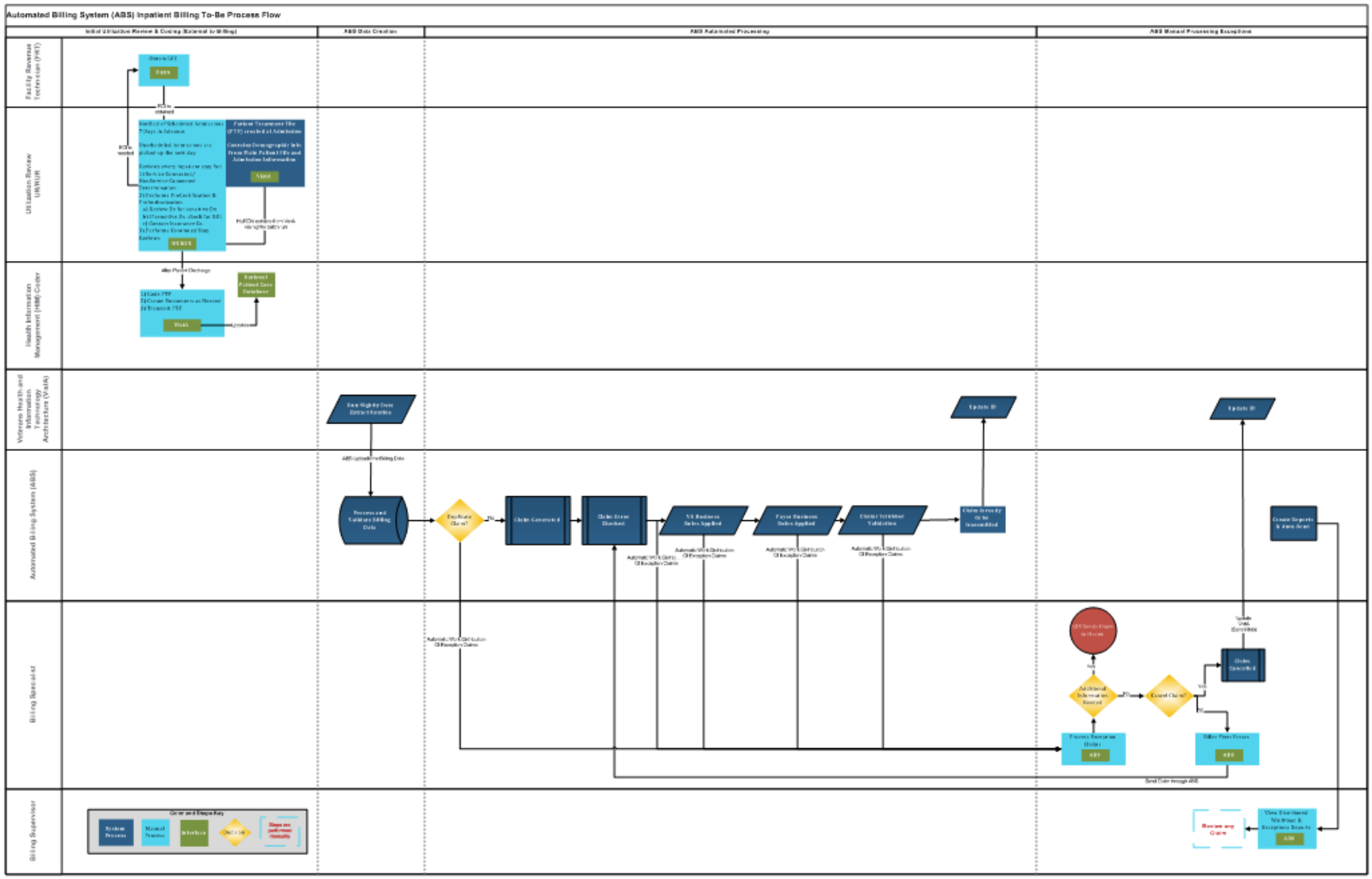
Appendix E: “As-Is” Inpatient Billing Process Flow



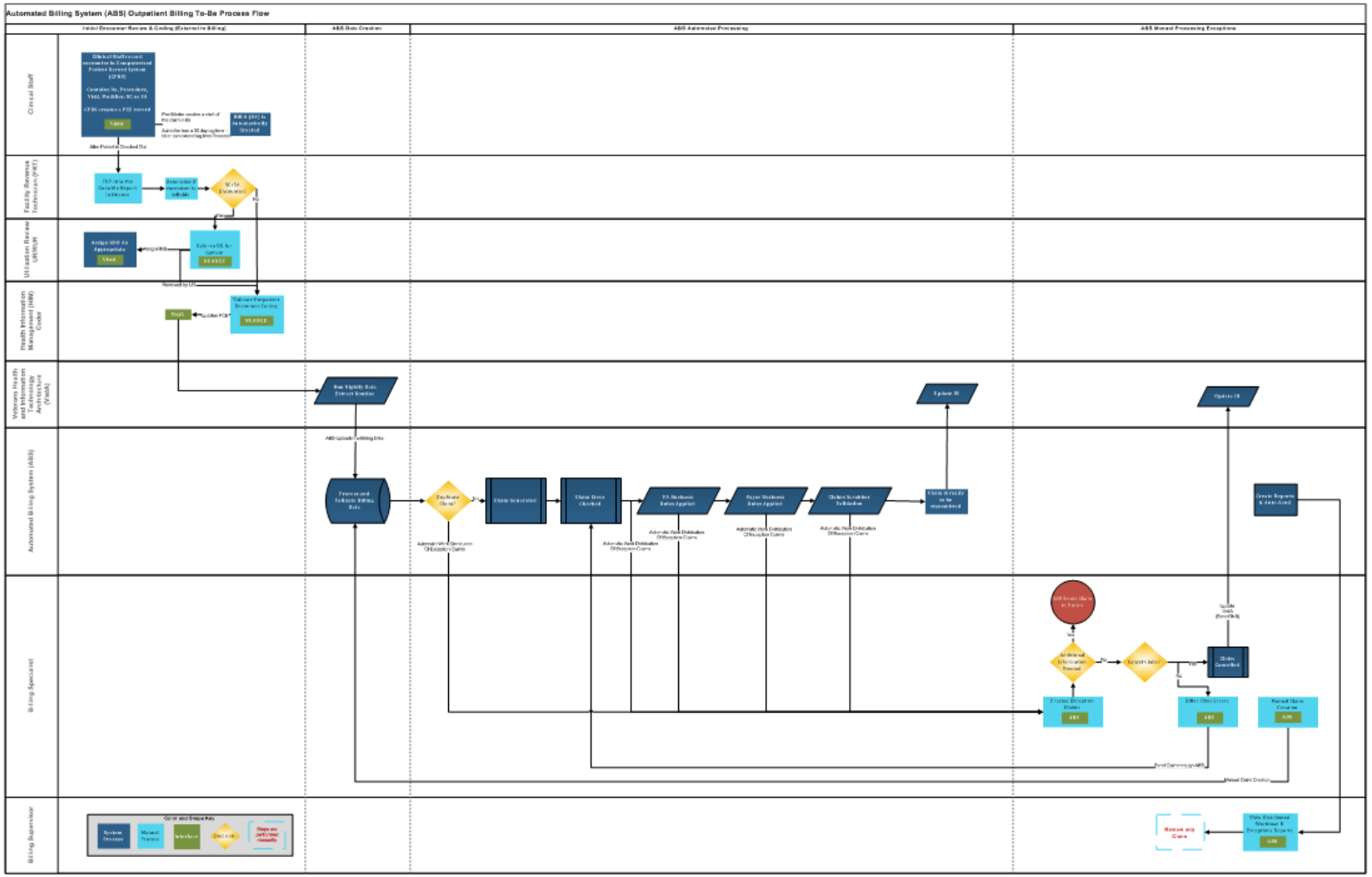
Appendix F: “As-Is” Outpatient Billing Process Flow



Appendix G: “To-Be” Inpatient Billing Process Flow



Appendix H: “To-Be” Outpatient Billing Process Flow



Appendix I: ABS User Roles

Type of User	ABS Role
Facility Revenue Manager (FRM)	Enters Release of Information (ROI) information.
Revenue Utilization Review (RUR)	Addresses RUR exceptions (pre-certification/pre-authorization, SC/SA, ROI information) in order to maximize reimbursement from third party payers.
Insurance Verification (IV)	Maintains insurance information.
Billing Supervisor	Distributes exception claims. Views reports.
Billing Specialist	Processes exception claims. Generates non-automated claims.

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Appendix J. Acronyms and Abbreviations

Term	Definition
ABS	Automated Billing System
AITC	Austin Information Technology Center
AR	Accounts Receivable
BRD	Business Requirements Document
CBO	Chief Business Office
CDM	Charge Description Master
CMS	Centers for Medicare and Medicaid Services
COTS	Commercial Off-The-Shelf
CPAC	Consolidated Patient Account Center
CPT	Current Procedural Terminology
E&M	Evaluation & Management
EDI	Electronic Data Interchange
EEOB	Electronic Explanation of Benefits
e-MRA	Electronic Medicare Remittance Advice
FBCS	Fee Basis Claims System
FRM	Facility Review Manager
FRT	Facility Review Technology
FSC	Financial Services Center
FYTD	Fiscal Year To Date
HCP	Healthcare Claims Processing
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
HL7	Health Level Seven International
HPID	Health Plan Identifier
HPOES	Health Plan and Other Entity Enumeration System
IB	Integrated Billing
ICB	Insurance Capture Buffer
ICD	International Classification of Diseases
IT	Information Technology
IV	Insurance Verification
IPv	Internet Protocol version
MRI	Magnetic Resonance Imaging
NIF	National Insurance File
NSR	New Service Request
OIT	Office of Information and Technology
PCE	Patient Care Encounter

Term	Definition
PIV	Personal Identification Verification
PMAS	Project Management Accountability System
PTF	Patient Treatment File
RA	Remittance Advice
RNB	Reason Not Billable
ROI	Release of Information
RUR	Resource Utilization Review
SA	Special Authority
SC	Service Connected
SME	Subject Matter Expert
TPJI	Third Party Joint Inquiries
TPP	Third Party Payer
UB-04	Uniform Billing
UR	Utilization Review
VA	Department of Veterans Affairs
VAMC	Veterans Administration Medical Center
VHA	Veterans Health Administration
VistA	Veterans Health Information Systems and Technology Architecture

DRAFT