VETERANS HEALTH ADMINISTRATION

- CHIEF BUSINESS OFFICE -

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CONSOLIDATED PATIENT ACCOUNT CENTERS (CPAC)

BILLING GUIDEBOOK

FRAMEWORK, PROCESSES, PROCEDURES, AND INTERNAL CONTROLS

VERSION 1.9

BILLING GUIDEBOOK

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Document Information 1: Version History

Version	Date	Version Description
1.1	1-27-2010	Draft developed and delivered to CPAC for review/approval
1.2	10-01-2010	SAT Approved
1.3	3-11-2011	Entity-level Controls & Revisions to Existing SOPs added (SAT Approved on 3/4/11)
1.4	9-27-2011	Internal Controls updated
1.5	10-28-2011	SOP 3.7.1 Added
1.6	6-11-2012	Updates added (SAT approved on 6/25/12)
1.7	8-29-2012	Added Internal Controls 4.2.1-A and 4.2.1-B
1.8	1-14-2013	Added revised Entity-level controls (SAT approved 12/19/2012)
1.9	2-28-2013	Updated SOPs during annual re-certification; added new "Reference" for CPAC-approved curriculum, student guides, and job aids to each SOP; added revised Internal Controls + revised Internal Controls (SAT approved on 2/20/13)

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Executive Summary

This Billing Guidebook (BI) is intended to serve as a primary reference and training resource for billing business operations. The Guidebook provides a framework of high-level descriptions for major processes with specific procedural descriptions of Standard Operating Procedures (SOPs) by activity. Included in the SOPs are Activity-Based Controls (ABCs), which are critically important to provide checks and balances to reduce risk related to error, waste, and abuse.

Guidebook Layout and Design

The Guidebook is organized into four distinct tiers of information, each providing a differing level of understanding and perspective of the overall Billing framework. These Functions, Processes, SOPs and Internal Controls help the reader to better understand the organization of labor and easily locate specific procedures.

1) **Function Sections:** Each initial section of the Guidebook begins with a description of a major Function. There are five function-level sections to the guidebook, each describing a distinct segment of the overall Billing Framework (Figure 1). These sections provide a high-level view of a particular Billing function, offering purpose and context to subsequent levels of information contained within.

2) **Process Section:** The second tier of information within the guidebook describes distinct processes within a particular function. There are a total of fourteen process-level sections within the guidebook, each offering an illustrative graphic of the process to provide context. These sections provide an intermediate-level view of the overall Billing framework while also introducing the subsequent SOPs contained within.

3) **SOP Sections:** The third and lowest tier of information within the guidebook, SOPs, provide an activity level description of a distinct procedure. SOPs comprise the bulk of this Guidebook, and are intended to provide activity-specific procedural guidelines for specific tasks. The SOPs do not provide a key-stroke level of detail. Instead, they are designed to provide descriptions of tasks. Each SOP description is also accompanied by a graphical representation of the procedures, which serves to better articulate the linear flow of procedural steps.

4) **Internal Controls:** There are four different types of internal controls found throughout the guidebook. They are Entity-level, Managerial Controls, Automated/Information Technology Controls and Manual Controls. Internal Controls form an effective shield to protect the integrity of the data and resources entrusted to the Consolidated Patient Accounts Center (CPAC).

Guidebook Numbering Convention

A standard numbering convention is used within the document to quickly identify specific Frameworks, Processes, and SOPs. These follow the same numbering sequence as the table of contents. This is critical to efficiently recognizing an SOP, for instance, and also retaining the overall structure of the Billing Framework. The numbering convention for an SOP also describes the associated processes and where it aligns within the framework.

1) **Function Numbering Convention (1):** Function levels of the document are denoted with a single integer (ex. 1). For instance, "BI 1" refers to Billing Function 1: Inpatient.

2) **Process Number Convention (1.1):** Process levels of the document are denoted with a single integer followed by a single decimal integer (ex. 1.1). For instance, "BI 1.1" refers to Billing Process 1.1: Inpatient Facility Charge.

3) **SOP Numbering Convention (1.1.1):** SOP levels of the document are denoted with a single integer followed by two decimal integers (ex. 1.1.1). For instance, "BI 1.1.1" refers to Billing Procedure 1.1.1: Submitting Inpatient UB-04 Claims.

4) **Internal Control Numbering Convention:** The internal controls found throughout the Guidebook have a specific numbering convention. All Managerial, Automated/IT, and Manual controls follow the same numbering as outlined above. Internal Controls that are aligned to the Department/Function/Process/SOP are marked by both the Department/Function/Process/SOP number, as well as an additional letter, in order of occurrence beginning with A. For instance, the first internal control for BI 1.1.1 would be coded as "BI 1.1.1.-A." This gives reference to both the SOP alignment as well as the sequence of internal controls.

> Department = (BI-A, BI-B, BI-C)
> Function = (BI 1-A, BI 1-B, BI 2-A, BI 2-B, etc)
> Process = (BI 1.1-A, BI 2.1-A, BI 2.1-B, etc)
> SOP= (BI 1.1.1-A, BI 1.1.2-A, BI 1.1.2-B, etc)

Getting to Know your Internal Controls

Internal controls serve as the first line of defense to safeguard assets and prevent and detect errors and deficiencies. By implementing effective internal controls, we are promoting effective stewardship of public resources. Lack of, or inadequate, internal controls create opportunities for fraud, waste, and abuse.

They are designed to identify, detect, avoid, and where necessary, mitigate risks before damage occurs. Standardized internal control procedures reduce process variation, which can lead to more predictable outcomes.

1 - Internal Control Standards

In November 1999, The General Accounting Office issued its revised "Standards for Internal Control in the Federal Government" (GAO/AIMD-00-21.3.1). This publication updates and replaces the previous standards first issued in 1983 in accordance with the Federal Managers' Financial Integrity Act of 1982.

The standards update was performed primarily in response to: (1) the effect upon internal control as a result of rapid advances in information technology management, (2) a greater recognition of the role of human capital management as an important factor in internal control, and (3) the need to implement updates of the standards used in the private sector where useful in the federal government environment. The new standards also reflect the increased emphasis on internal control inherent in important legislation, such as the Chief Financial Officers Act of 1990, the Government Performance and Results Act of 1993, and the Federal Financial Management Improvement Act of 1996. These standards provide the overall framework for federal agencies to establish and maintain internal control and to identify and address major performance and management challenges and areas at greatest risk for fraud, waste, abuse and mismanagement.

The following definitions, objectives, and concepts taken from the "Standards for Internal Control in the Federal Government" report provide the foundation for the internal control standards.

Definition and Objectives

Internal control is a major part of managing an organization. It includes the methods and procedures used to meet goals and objectives and, in doing so, support performance-based management. Internal control also serves as the first line of defense in safeguarding assets and preventing and detecting errors and fraud. In short, internal control, which is synonymous with management control, helps government program managers achieve desired results through effective stewardship of public resources.

Internal control should provide reasonable assurance that the objectives of the agency are being achieved in the following categories:

- Effectiveness and efficiency of operations including the use of the entity's resources.
- Reliability of financial reporting, including reports on budget execution, financial statements, and other reports for internal and external use.
- Compliance with applicable laws and regulations.

A subset of these objectives is the safeguarding of assets. Internal control should be designed to provide reasonable assurance regarding prevention of or prompt detection of unauthorized acquisition, use, or disposition of an agency's assets.

The Five Standards Internal Control Standards
- Control Environment
- Risk Assessment
- Control Activities
- Information and Communications
- Monitoring

These standards define the minimum level of quality acceptable for internal control in government and provide the basis against which internal control is to be evaluated. These standards apply to all aspects of an agency's operations: programmatic, financial, and compliance. These standards provide a general framework. In implementing these standards, management is responsible for developing the detailed policies, procedures, and practices to fit their agency's operations and to ensure that they are built into and an integral part of operations.

Control Environment

Management and employees should establish and maintain an environment throughout the organization that sets a positive and supportive attitude toward internal control and conscientious management.

Risk Assessment

Internal Control should provide for an assessment of the risks the agency faces from both external and internal sources.

Control Activities

Internal control activities help ensure that management's directives are carried out. They help ensure that actions are taken to address risks. The control activities should be effective and efficient in accomplishing the agency's control objectives.

Categories of control activities that are common to all agencies include the following:
- Top level reviews of actual performance,
- Reviews by management at the functional or activity level,
- Management of human capital,
- Controls over information processing,
- Physical control over vulnerable assets,
- Establishment and review of performance measures and indicators,
- Segregation of duties,
- Proper execution of transactions and events,
- Accurate and timely recording of transactions and events,
- Access restrictions to and accountability for resources and records, and
- Appropriate documentation of transactions and internal control.

Information and Communication

Information should be recorded and communicated to management and others within the entity who need it and in a form and within a time frame that enables them to carry out their internal control and other responsibilities.

Monitoring

Internal control monitoring should assess the quality of performance over time and ensure that the findings of audits and other reviews are promptly resolved.

2 - Types of Internal Controls

In this section, there are four types of internal controls throughout the guidebook – Entity-Level (E), Managerial Controls (MGR), Automated/Information Technology Controls (IT), and Manual Controls (MAN).

Managerial, Automated/IT, and Manual Controls have been identified throughout the Guidebook using a top-down approach in the following sequence:
1. **Department** – Controls that pertain to the entire Department (i.e. First Party, Accounts Management, IV)
2. **Function** – Controls that pertain to the entire Function in the Guidebook
3. **Process** – Controls that pertain to the entire Process in the Guidebook
4. **SOP** – Controls that pertain to the entire SOP in the Guidebook

Entity-Level Controls pertain to the overall CPAC operation. They are related to the confidentiality, integrity and availability of data to the business enterprise, including controls to ensure proper access is granted and/or limited to authorized programs, applications and data.
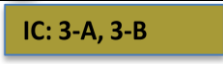
Managerial Controls are used to ensure that proper supervision of employees is occurring through the chain of command, guide the performance and compliance of a person or group and provide overarching governance to support adherence to Standard Operating Procedures.

Automated/IT Controls are specific activities performed by persons or systems designed to ensure that CPAC objectives are met. This includes automatic system controls and reports that prevent and/or detect incorrect transactions, key strokes and other potential human errors.

Manual Controls relate to the Functions/Processes/Procedures throughout the Guidebook. Manual controls are actions, supported by VHA policies and procedures that, when enforced, manage or reduce risks.

3 - Risks and Internal Controls Key

Risks and Internal Controls are represented throughout the Guidebook using the following symbols:

Risk Symbols	Internal Control Symbols	
🟢 - Low Risk	🟡 (gold ring)	A gold ring placed around a risk indicates an Internal Control was developed to mitigate the risk
🟡 - Moderate Risk	IC: 3-A, 3-B	The gold box placed next to the gold ring contains the Internal Control #
🔴 - Serious Risk		

For example: The following represents a moderate risk that has been mitigated by Internal Control 2.2-A:

IC: 2.2-A 🟡
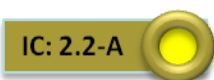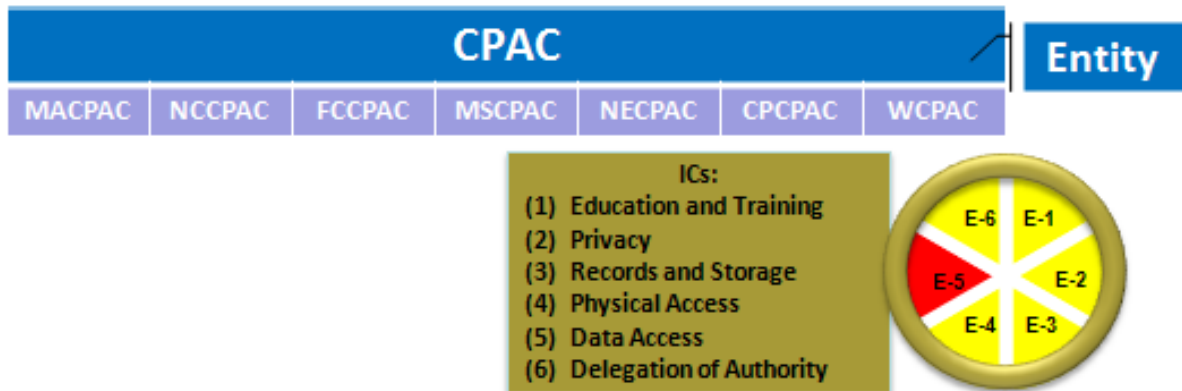
The CPAC Internal Controls Work Group (ICWG) developed twenty-three (23) Entity Level Internal Controls to mitigate the Eleven (11) identified Entity Level Risks. Entity level Risks were identified and segmented into six (6) overarching risk categories:

- E-1   Education and Training
- E-2   Privacy
- E-3   Records and Storage
- E-4   Physical Access
- E-5   Data Access
- E-6   Delegation of Authority

E-1 – Education and Training

Risk: If Employees are not properly trained, then:
  a) Operational activities may not be accurate, valid, complete, and efficient,
  b) Personally Identifiable Information (PII) or other sensitive information may be disclosed; and
  c) Abuse and fraud could occur and not be detected or reported.

Risk Score: 6

E-1.1: Automated Control
- **Who:** Talent Management System (TMS)
- **What it does:** TMS automatically e-mails reminders to personnel and their supervisors that upcoming training is due. TMS also lists assigned training for personnel. At a minimum, this assigned training should include all mandatory training for that person, which is shown in http://vaww.ees.lrn.va.gov/Training/mandatory/2465/.
- **How it does it**: E-mail reminders and VA training requirements are established VA-wide, by personnel outside of the CPACs, in TMS.
- **When:** As requirements change.
- **Where the evidence is:** TMS can produce a report of required training not completed before the due date. Also, TMS lists training assigned to each user which should align with mandatory training shown in http://vaww.ees.lrn.va.gov/Training/mandatory/2465/.

E-1.2: Manual Control
- **Who:** CPAC personnel
- **What they do:** Complete all assigned training on time.
- **How they do it:** At their own pace.
- **When:** By training due date.
- **Where the evidence is:** TMS can produce a report of required training not completed before the due date.

E-1.3: Manual Control
- **Who:** CPAC PMO Education and Training Department
- **What they do:** Provide standardized Departmental Training to be used at all CPACs.
- **How they do it:** Prepare and communicate standardized Departmental Training material.
- **When:** Ongoing
- **Where the evidence is:** CPAC PMO Education and Training SharePoint and training materials provided at the CPACs

E-2 - Privacy

Risk: If local privacy policies are not established, staff will be less aware of their responsibilities to protect veteran privacy, resulting in higher incidents of privacy violations.
Risk Score: 8

E-2.1: Manual Control
- **Who:** CPAC Privacy Officers
- **What they do:** Implement CPAC PMO privacy policy at their local CPAC. The local CPAC may have additional privacy policies or procedures.
- **How they do it:** Publish any additional policies and procedures to Share Point site and make sure all privacy policies are covered in training.
- **When:** Communicate policy changes as CPAC PMO (and local, if applicable) policies changes and update Share Point.
- **Where the evidence is:** Share Point, emails to all staff, and/or meeting minutes
  - **Ref:** VHA Handbook 1605.03, pp. 12-13

Risk: If personnel are not made aware of their Privacy Officer(s) contact information, they will not know the individual to report privacy incidents to and privacy violations might be under-reported or unreported.
Risk Score: 8

E-2.2: Manual Control
- **Who:** CPAC Privacy Officers
- **What they do:** Ensure all personnel are aware of their respective Privacy Officer's name, telephone number, and e-mail addresses.

- **How they do it:** Through continuous personnel privacy awareness activities such as strategically posting flyers with the Privacy Officer's contact information.
- **When:** Ongoing
- **Where the evidence is:** Flyers posted for maximum visibility, e-mails to all staff, and/or meeting minutes
  - o **Ref:** VHA Handbook 1605.03, p. 8

Risk: If sensitive information clauses are not documented in contracts with disposal or recycling vendors, these vendors will not be aware of their responsibilities to protect information they are disposing of, increasing the likelihood of privacy violations.
Risk Score: 8

E-2.3: Manual Control

- **Who:** CPAC Privacy Officers, as Contracting Officer Representatives (CORs) of their CPAC's shredding contracts
- **What they do:** Coordinate with Contracting Officers to ensure contracts with disposal or recycling vendors have all the clauses needed to safeguard sensitive information being disposed of.
- **How they do it:** Present privacy requirements to the Contracting Officer. Obtain written assurance from the Contracting Officer that the contract language meets these privacy requirements.
- **When:** Anytime there is a new or modified contract awarded
- **Where the evidence is:** Contract language, and the Contracting Officer's written assurance that the contract language meets the privacy requirements
  - o **Ref:** VHA Handbook 1605.03, p. 8

Risk: If sensitive information disposal contract clauses are not enforced, the likelihood of privacy violations increases.
Risk Score: 16

E-2.4: Manual Control

- **Who:** CPAC Privacy Officers, as CORs of their CPAC's shredding contracts
- **What they do:** Ensure all contract clauses addressing sensitive information safeguarding are strictly complied with.
- **How they do it:** Ensure a disinterested (with no financial or other interests in the contractor) CPAC employee who understands the contract's privacy requirements is observing and certifying compliance with these requirements.
- **When:** Ongoing (whenever sensitive information is being disposed of)
- **Where the evidence is:** Disinterested CPAC employee's signature and date
  - o **Ref:** VHA Handbook 1605.03, p. 8

Risk: If the CPAC Privacy Officer doesn't monitor privacy compliance, he/she will have no assurance the CPAC's privacy program is working properly, increasing the likelihood of undetected privacy violations.
Risk Score: 8

E-2.5: Manual Control

- **Who:** CPAC Privacy Officers, alternate Privacy Officers, or designees
- **What they do:** Conduct monthly walk-throughs to observe for privacy compliance, taking notes from discussions with employees and dating these notes.
- **How they do it:**
    1. Ask employees with various job functions about their understanding, training and actions concerning VHA privacy practices and procedures.
    2. Focus on all aspects of privacy and the observation of daily business practices.
- **When:** Monthly
- **Where the evidence is:** Dated hard copy or electronic notes from discussions with employees during monthly walk-throughs
    - **Ref:** VHA Handbook 1605.03, p. 10

Risk: If complaints are not documented, then they can not be resolved in a timely manner.
Risk Score: 8

E-2.6: Manual Control
- **Who:** CPAC Privacy Officers
- **What they do:** Document individual privacy complaints
- **How they do it:** In VA's Network Security Operations Center (VANSOC) website's Privacy Security Event Tracking Center (PSETC), which replaces the Privacy Violation Tracking System (PVTS).
- **When:** Every time a privacy complaint occurs
- **Where the evidence is:** In PSETC
    - **Ref:** VHA Handbook 1605.03, p 21

E-3 – Records and Storage

Risk: If records are not logged and tracked, then delays may occur in responding to requests for information (e.g., congressional inquiries, veterans' requests, etc.) and future claims adjudication might be inaccurate.
Risk Score: 6

E-3.1: Manual Control
- **Who:** CPAC Directors
- **What they do:** Assign a Records Officer (RO) to maintain compliance with RCS 10-1.
- **How they do it:** In writing.
- **When:** As needed.
- **Where the evidence is:** Records Management binder

E-3.2: Manual Control
- **Who:** Records Officers (RO)
- **What they do:** Request NARA records management training in addition to the mandatory TMS training if needed.

- **How they do it:** At a minimum, request NARA training for Records Officers (ROs) or designated Records Liaison and require this training to be provided to other records management professionals.
- **When:** As needed
- **Where the evidence is:** NARA and TMS records training certificates located in the Records Management binder

E-3.3: Manual Control
- **Who:** Records Officers (RO)
- **What they do:** Oversee and monitor the local CPAC records management program.
- **How they do it:**
    1. Identify and document RCS 10-1 recordkeeping requirements for all CPAC records.
    2. Communicate these requirements to all who handle CPAC records, advising them to clearly label their records and noting that no records may be destroyed **without proper authorization as specified in the Federal Records Act.**
    3. **Make sure records and pallets of records are clearly labeled, following-up with** record keepers as needed.
- **When:** Initially, and anytime the CPAC needs to manage a new type (or series) of records.
- **Where the evidence is:** The records and the record pallets

E-3.4: Manual Control
- **Who:** Records Liaisons, with oversight from the Records Officer (RO)
- **What they do:** Maintain a complete and valid log of inventory items.
- **How they do it:** Log all records when they are placed in storage. When records are removed from storage, document their removal and where they are removed to (conversion to electronic format, checked out, transferred out, destroyed, etc.), as well as the timing of these events. Records liaisons will receive written notification of these events.
- **When:** When records are initially placed in temporary storage, and when notice is received that records are removed from storage
- **Where the evidence is:** Electronic or hard copy activities log for records management

E-4 – Physical Access

Risk: If access to buildings, rooms, documents, and systems is not restricted, abuse and fraud could occur and be undetected and unreported, and harm to personnel could occur.
Risk Score: 6

E-4.1: Manual Control
- **Who:** CPAC Director's Secretary
- **What they do:** Establish and execute a process for issuing and recovering electronic and manual keys to exterior doors and secured interior doors which cover new employees, transferred employees, and terminated employees.
- **How they do it:** Keys are signed for on a "key" card or GSA Form 1025, Receipt for Government Property.

- **When:** Ongoing
- **Where the evidence is:** Key Control Officer's Log

E-4.2: Manual Control
- **Who:** CPAC Cash Management Supervisors
- **What they do:** Verify names on a CPAC Access list to ensure the following:
  - Staff does not have unauthorized access to the cash management office, mailroom, Logistics, IT Server rooms or other restricted areas determined by local leadership.
  - Building access is revoked for staff that transfer or terminate employment within five business days after their official transfer or termination date.
- **How they do it:**
  1. Review access to restricted areas monthly and terminate access for those unauthorized.
  2. Ensure departing staff complete the transfer/termination checklist and submit request to terminate building access using local procedures (e.g., e-ticket, email, etc.)
- **Where the evidence is:** Access Control list with a status column. Supervisors and Managers should maintain the following:
  - Electronic or hard copy evidence of monthly access reviews to secure areas
  - Electronic or hard copy evidence demonstrating timely requests to terminate building access (e.g., e-ticket, email, other).

E-4.3: Manual Control
- **Who:** CPAC Administrative Officers
- **What they do:** Establish and implement a Building Security and Access policy that focuses on authorized access (employees and visitors), entry procedures, and employee/visitor identification.
- **How they do it:** In writing, published to Share Point and distributed to all employees and visitors.
- **When:** Ongoing
- **Where the evidence is:** In the Master Policy Binder and/or the CPAC Share Point site

E-5 – Data Access

Risk: If Processes and Data are not protected from improper access, then unauthorized transactions could be processed and abuse and fraud could occur and not be detected or reported.
Risk Score: 16

E-5.1: Manual Control
- **Who:** The CPAC PMO Policy Analysts, the CPAC PMO Financial Internal Controls Manager, and the designated Compliance Point of Contact (POC)
- **What they do:** Review VistA menu and security key requests.
- **How they do it:** Identify Separation of Duties and other conflicts.
- **When:** As needed
- **Where the evidence is:** OI&T's Share Point site

E-5.2: Manual Control

- **Who:** The CPAC PMO Implementation Coordinator and the CPAC PMO Financial Internal Controls Manager
- **What they do:** The Implementation Coordinator prepares an updated CPAC System Access Restriction document. The Financial Internal Controls Manager reviews and comments on each updated document.
- **How they do it:** The Implementation Coordinator incorporates VistA changes and change requests into an updated draft access restrictions change document. The Financial Internal Controls Manager reviews and comments on this document, addressing concerns from an internal controls perspective.
- **When:** As needed
- **Where the evidence is:** OI&T's Share Point site

E-5.3: Manual Control

- **Who:** Managers and Supervisors
- **What they do:** Managers and Supervisors request standard VistA access for the job assignment of new/transferred staff members, identifying and requesting removal of all pre-existing VistA access.
- **How they do it:** To request new access, Managers and Supervisors complete the OI&T Services Request Form (SRF). To identify and request removal of pre-existing access, Managers and Supervisors obtain a list of this new staff member's VistA keys and menus (before new access is granted) and enter a Consolidated Patient Account Center (CPAC) IT Help Desk ticket at the highest priority level, requesting removal.
- **When:** When job duties change
- **Where the evidence is:** SRF

E-5.4: Manual Control

- **Who:** Managers and Supervisors
- **What they do:** Request cancellation of access rights for every computer user leaving their assignment, and make sure the help desk ticket number is entered on the terminated user's clearance form.
- **How they do it:** Create a CPAC IT Help Desk Portal ticket at the highest priority level, and look at the terminated user's clearance form to make sure the help desk ticket number is included.
- **When:** Immediately
- **Where the evidence is:** Help Desk tickets and current personnel lists

E-5.5: Manual Control

- **Who:** CPAC Directors, Managers, Supervisors, and designated Leads
- **What they do:** Managers, Supervisors, and designated leads review each of their employee's VistA menus and keys to identify, document, and request correction of Separation of Duties conflicts and unnecessary access. CPAC Directors submit review certification memos to the CPAC ISO at CPACISO@va.gov. CPAC Directors also submit certification memos to the Chief Compliance and Business Integrity Officer.

- **How they do it:** Managers, Supervisors, and designated Leads follow the VistA Menu Review SOP document on the CPAC Portal. CPAC Directors follow the CPAC Director Steps document they receive by e-mail.
- **When:** By March 1 and September 1 to the CPAC ISO and by March 31 and September 30 to the Chief Compliance and Business Integrity Officer.
- **Where the evidence is:** CPAC tracking spreadsheets and Directors' certification memos

E-5.6: Manual Control
- **Who:** All computer users
- **What they do:** Lock or log off their computer terminals when leaving their desks during the day, and log off their terminals at the end of the day to allow for system updates.
- **How they do it:** To lock screens, they hold down control-alt-delete keys and select the "Lock Computer" button or press the windows key and simultaneously press the "L" key. To log off, they click the "Start" button in the lower left corner of their screens and select the "Log Off" button.
- **When:** Anytime they leave their desks
- **Where the evidence is:** When computer users leave their desks, the terminal should only allow an authorized user to unlock or log into the computer with their User ID and password. No other information should be visible or accessible on this terminal.

E-6 – Delegation of Authority

Risk: If delegated authority is not documented, unauthorized actions might occur.
Risk Score: 8

E-6.1: Manual Control
- **Who:** CPAC CFOs
- **What they do:** Delegate authority to the appropriate fiscal staff.
- **How they do it:** Via a Delegation of Authority memo. Memorandums state the purpose of the Delegation, include employee authorized to delegate authority, and list personnel who are authorized authority.
- **When:** Annual or upon turnover of affected personnel, whichever is sooner.
- **Where the evidence is:** Manager's file of their employees' Delegation of Authority documents

Billing Framework

Billing at the Consolidated Patient Account Center (CPAC) is comprised of operational processes associated with the following five (5) core functions:

1) Inpatient
2) Outpatient
3) Specialty Services
4) Reporting
5) Records Management

These functions are illustrated in Figure 1 provided below:

Figure 1: Billing Framework
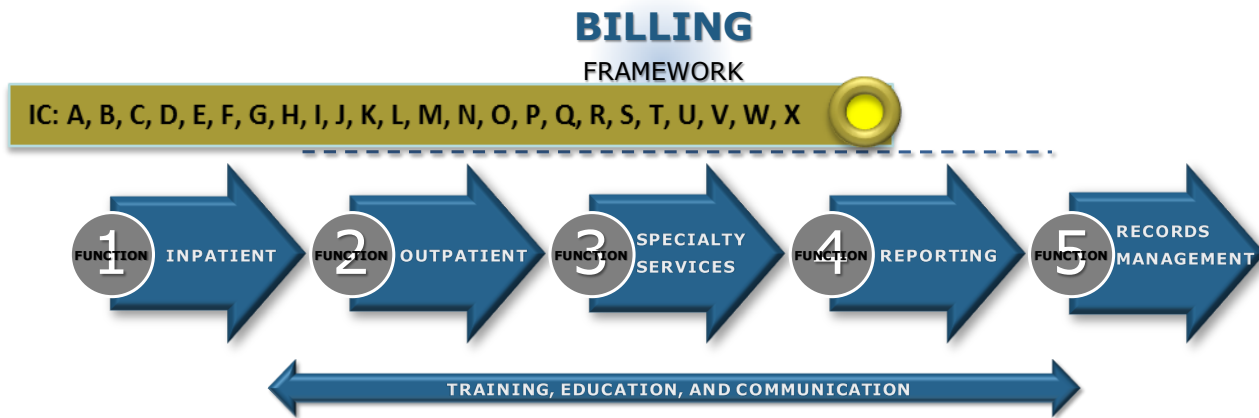
Inpatient: Dedicated inpatient Billing Specialists bill third party payers for all inpatient encounters. They receive bills and encounter information for services provided by external (non-VA) vendors and providers and generate bills for each encounter or service rendered. Finally, billing staff are responsible for generating facility and provider bills for Veteran care provided within skilled nursing facilities.

Outpatient: Billing Specialists bill third party payers for all outpatient encounters. They receive bills and encounter information for services provided by external (non-VA) vendors and providers and generate bills for each encounter. Similarly, for specialty billing, billing staff receive bills and encounter information from VAMCs and generate bills for the services rendered.

Specialty Services: Specialty services include ambulance, dental ineligibles, DME/Prosthetics, Fee Basis, humanitarian, tort feasor, and worker's compensation claims. Billing specialists receive encounter information for these types of services from facility revenue staff and generate individual claims for each encounter.

Reporting: Billing staff generate a variety of operational reports (daily, weekly, monthly) that are distributed to employees, supervisors and managers to effectively manage work lists and ensure all billable encounters are captured and claim rejections are processed timely.

Records Management: On a daily basis, billing staff are responsible for assisting with the maintenance of a variety of paper-based, hardcopy records in order to generate accurate bills in a timely manner. For certain types of bills that cannot be submitted electronically, Billing Specialists print hard copy bills directly to the mailroom for distribution to the appropriate third party payer or program. For patients with sensitive diagnoses, Billing Specialists must verify that a Release of Information (ROI) has been obtained from the Veteran for each sensitive diagnosis listed on the bill. Additionally, Billing Specialists are responsible for following up with Facility Revenue Managers (FRMs) in the event that an NPI or PPN number is not listed for a provider within VistA.

INTERNAL CONTROLS (DEPARTMENT LEVEL)				
ID	**CONTROL DESCRIPTION**	**TYPE**	**RISK**	**SCORE**
BI-A	Type of Control: Automated Control Who: Power Plus System What: Calculates Days to Bill (calculation methodology is in Power Plus) compared to goal. How: Extracts data from FMS and other systems. Calculates the Days to bill. When: Updated weekly Where: Power Plus website	Automated	If the Billing Manager does not provide managerial oversight then Revenue may be impacted.	10
BI-B	Type of Control: Managerial Control Who: Billing Manager (and IV Manager for Rx billing) What: Is responsible for meeting Days to Bill Goal How: Reviews Power Plus, Quadramed and other information to identify root cause. When: When Days to Bill goal is not met. Where: billing Manager keeps a copy of the Action Plan, if appropriate to document future plans to improve Days To Bill metric.	Managerial	Same	10
BI-C	Type of Control: Automated Control Who: Power Plus System What: Reports Third Party Billings $ compared to goal How: Extracts data from FMS and other systems. Calculates the third Party Billings $ When: Updated Weekly Where: Power Plus website	Automated	Same	10

ID	CONTROL DESCRIPTION	TYPE	RISK	SCORE
INTERNAL CONTROLS (DEPARTMENT LEVEL)				
BI-D	Type of Control: Managerial Control Who: Billing Manager What: Is responsible for meeting Third Party Billings $ goal How: Reviews Power Plus, Quadramed and other information to identify root cause. When: Third Party Billings $ goal is not met. Where: Billing Manager keeps a copy of the Action Plan, if appropriate to document future plans to increase billed revenue amounts.	Managerial	Same	10
BI-E	Type of Control: Automated Control Who: Quadramed System What: Tracks all changes to Encounters after Medical Center appointment. How: Extracts Encounters from VistA and tracks all changes to the Bill by: i. Facility Revenue Technician (FRT) ii. Coding iii. Billing When: Continuous Where: Encounters remain in data base and all changes to Encounters are tracked.	Automated	Same	10
BI-F	Type of Control: Automated Control Who: Quadramed System What: Creates Bill Me Report How: The Encounters that the FRT refers to Coding (via the Code Me Report) flow to the coders. After Coding, Encounters flow to the Bill Me report. When: Daily, when requested by Billing personnel Where: Creates Bill Me Reports used by Billing personnel to process claims and track backlog.	Automated	Same	10

INTERNAL CONTROLS (DEPARTMENT LEVEL)				
ID	CONTROL DESCRIPTION	TYPE	RISK	SCORE
BI-G	Type of Control: Managerial Control Who: The Billing Manager/Supervisor/or designee What: Will run the Unbilled from the default date (beginning of time in VistA) to T-365 to ensure unbilled is not aging past timely filing guidelines within payer agreements and to bill for services outside of payer agreements that fall within the CFR 38 Part 17.106 that allows for VA to bill for services up to 6 years from services rendered that do not fall under any other VA agreement based on the return the CPACs return on investment. How: Using Vista When: Quarterly Where: Unbilled report can be run to include historical data back to 7/25/11, which is the effective date of CFR 38, Part 17.106. If the date of service is older than 7/25/11 and the TPP's timely filing limit or the terms of a specific payer agreement does not allow for a timely filing limit back to 7/25/11, the terms of this CFR don't provide VA with the authority to back-bill prior to 7/25/11.	Managerial	Same	10
BI-H	Type of Control: Automated Who: Huron TRAC Report What do they do : Identifies Billing Work In Progress (WIP): How do they do it: 1. Tracks the WIP trend for the last 7 weeks; 2. Compares the Current Week WIP against the Goal; 3. Identifies the WIP and action taken for each Medical Center and Technician/Specialist; and 4. Tracks Delinquent QUICs. When: Weekly Where is the evidence: Hardcopies maintained by Billing Manager/Supervisor for at least 2 months	Automated	Same	10

INTERNAL CONTROLS (DEPARTMENT LEVEL)				
ID	CONTROL DESCRIPTION	TYPE	RISK	SCORE
BI-I	Type of Control: Managerial Who: CPAC COO What do they do : Holds a Revenue Meeting each week. How do they do it: The Billing Manager or designee addresses TRAC WIP and Delinquent QUIC trends and variances from Goal. When: Weekly Where is the evidence: Outlook Calendar invites (may be unique to each CPAC)	Managerial	Same	10
BI-J	Type of Control: Managerial Who: Billing Supervisors What do they do : Perform a Quality Review of each Technician's transactions How do they do it: Conduct and document a review of at least 5 transactions When: Monthly Where is the evidence: Billing Quality Review Tracker is maintained on the SharePoint. Billing Supervisors keep copies of each employee's QR audit sheet (form)	Managerial	Same	10
BI-K	Type of Control: Managerial Who: Billing Manager or designee What do they do : Determine CPAC and individual facility Billed Revenue How do they do it: Reviews the Clerk Productivity report from (VistA) When: Daily Where is the evidence: Maintains the Billed Revenue spreadsheet (tracker) on the CPAC SharePoint.	Managerial	Same	10

INTERNAL CONTROLS (DEPARTMENT LEVEL)				
ID	CONTROL DESCRIPTION	TYPE	RISK	SCORE
BI-L	Type of Control: Managerial Who: Billing Manager or designee What do they do : Ensure that claims on CSA > 5 business days reflect appropriate billing action, as indicated by asterisk (*). Some examples include: referred to Coding for _____ (device code, modifier, pharm. drug code, HCPCS code, referring provider, etc.); QUIC to IV to verify insurance; QUIC to IV for spouse's DOB; pending VistA patch to add occ code 55. How do they do it: Review the CSA Work List in VistA, sort by "Number of Days Pending" When: Daily Where is the evidence: CSA report in VistA	Managerial	Same	10
BI-M	Type of Control: Managerial Who: Billing Manager or designee What do they do : Identify MRA rejects not received at Novitas. How do they do it: Reviews the Bill Status-Request MRA . VistA reports and weekly TRAC reports assist to identify billing errors through MRA before CSA. When: Monthly Where is the evidence: TRAC reports are uploaded to the SharePoint on a recurring basis.	Managerial	Same	10
BI-N	Type of Control: Managerial Who: Billing Manager or designee What do they do : Identify claims in a Entered/Not Reviewed status How do they do it: Reviews the Bill Status report When: Weekly Where is the evidence: TRAC reports are uploaded to the SharePoint weekly.	Managerial	Same	10

INTERNAL CONTROLS (DEPARTMENT LEVEL)				
ID	**CONTROL DESCRIPTION**	**TYPE**	**RISK**	**SCORE**
BI-O	Type of Control: Manual Who: Inpatient Biller What do they do : Identify billable admissions not found on the Unbilled or Bill Status report. How do they do it: Generates the INSC report from VistA for date range of T-365. Any billable admissions found not to be worked would be identified on a monthly basis when Billing Manager or designee reviews control BI-J. When: Weekly Where is the evidence: Unbilled admissions found on the monthly review could be an indication that the INSC is not being worked weekly.	Manual	Same	10
BI-P	Type of Control: Managerial Who: Billing Manager or designee What do they do : Identify billable admissions not identified on an Unbilled or Bill Status report and reviews admissions with RNBs assigned. How do they do it: Generate the Unbilled report from VistA for date range of T-365 . Once inpatient billers have completed the report, the Billing Manager or designee will review for accuracy. When: Monthly Where is the evidence: Unbilled Reports can be compared month to month, historical data is available in VistA.	Managerial	Same	10

INTERNAL CONTROLS (DEPARTMENT LEVEL)				
ID	**CONTROL DESCRIPTION**	**TYPE**	**RISK**	**SCORE**
BI-Q	Type of Control: Managerial Who: Billing Manager or designee What do they do : identify unbilled amounts. These unbilled amounts are reported to CPAC, VISN, and facility leadership on VA dashboards. How do they do it: Review the "Re-generate Unbilled Amounts report" generated in VistA When: Monthly Where is the evidence: Monthly Unbilled Amounts are reported on the Monthly Dashboards	Managerial	Same	10
BI-R	Type of Control: Managerial Who: Billing Manager or designee What do they do : Monitor the Day to Bill (currently DtB should be less than 38 days) How do they do it: Review the Days to Bill (DtB) fileman report from VistA **IF** DtB in POWER PLUS > 38 Days. The VistA report will assist Billing Manager in identifying where delays are occurring that impact this metric (i.e. encounter close out, coding, billing, etc.) When: Monthly Where is the evidence: Tracked on POWER PLUS	Managerial	Same	10
BI-S	Type of Control: Managerial Who: Billing Manager or designee What do they do : Ensure billers are scrubbing the claims (goal is 95% for the first scrub). How do they do it: Review the Claim Scrubber Usage Report (Quadramed) When: At least monthly Where is the evidence: Scrubber Usage Report in QM stores historical data	Managerial	Same	10

INTERNAL CONTROLS (DEPARTMENT LEVEL)				
ID	CONTROL DESCRIPTION	TYPE	RISK	SCORE
BI-T	Type of Control: Managerial Who: Billing Manager or designee What do they do : Ensure that delinquent amounts do not exceed 5% of the total amount. How do they do it: Review the MRW Work List from VistA and/or the daily TRAC WIP report When: Daily Where is the evidence: TRAC reports are uploaded to the SharePoint weekly.	Managerial	Same	10
BI-U	Type of Control: Managerial Control Who: Quality Assurance (QA) Department What: Independently verifies the accuracy of a random sample of Third Party authorized claims submitted to third party payers. In addition to confirmation of VHA billing integrity, this review also identifies timely verification of third party policies in correlation to authorized date of claims. How: See QA SharePoint - Reference Material When: Monthly Where: Review reports and Quality Improvement Plans (QIP) are on QA SharePoint.	Managerial	If Quality Assurance Department monitoring is not completed and Quality Improvement plans (QIP) are not prepared, then Billing deficiencies may go undetected and revenue may be lost.	10
BI-V	Type of Control: Managerial Control Who: Quality Assurance (QA) Department What: Reviews encounters assigned a Reason Not Billable, for accuracy. How: See QA SharePoint - Reference Material When: Monthly Where: Review Reports and Quality Improvement Plans (QIP) are on QA SharePoint.	Managerial	Same	10

| INTERNAL CONTROLS (DEPARTMENT LEVEL)				
ID	CONTROL DESCRIPTION	TYPE	RISK	SCORE
BI-W	Type of Control: Managerial Control Who: Quality Assurance (QA) Department What: Assess the accuracy of the Third Party billing process for FEE/Non-VA Care Billing and identify any opportunities for missed revenue as a result of this review. How: See QA SharePoint - Reference Material When: Monthly Where: Review Reports and Quality Improvement Plans (QIP) are on QA SharePoint	Managerial	Same	10
BI-X	Type of Control: Managerial Control Who: Quality Assurance (QA) Department What: Identify possible unbilled revenue occurring from inpatient stays. This review focuses on integral inpatient services by determining if Veterans are being seen at least once per day by a billable provider while admitted, whether there is appropriate documentation and coding, and whether the service is billable. How: See QA SharePoint - Reference Material When: Monthly Where: Review Reports and Quality Improvement Plans (QIP) are on QA SharePoint.	Managerial	Same	10

1 - INPATIENT FUNCTION

Figure 2: Inpatient Section Map
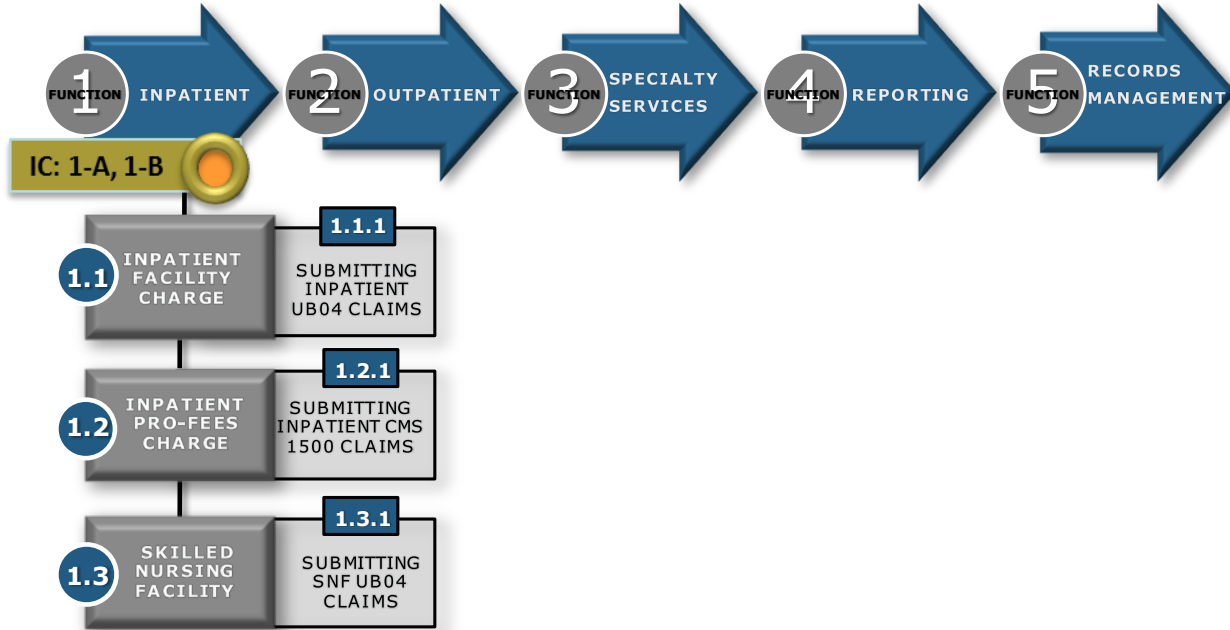
Medical services provided to a patient who has been admitted to a hospital or other health facility, including diagnostic treatment, room, board, and general nursing care are classified and billed as inpatient services. Institutional (facility) charges and professional fees (clinicians' work) are billed separately on different claim forms.

Dedicated inpatient Billing Specialists (assigned by facility), manage the *INSC Report* to bill third party payers for all inpatient encounters. Moreover, billing staff receive bills and encounter information for services provided by external (non-VA) vendors and providers and generate bills for each encounter or service rendered (in contrast to salary, per capita or prepayment). Additionally, billing staff are responsible for generating facility and provider bills for Veteran care provided within skilled nursing facilities (SNFs).

Figure 2 above provides a map of all the processes and SOPs associated with the Inpatient function.

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INTERNAL CONTROLS				
ID	**CONTROL DESCRIPTION**	**TYPE**	**RISK**	**SCORE**
BI 1-A	Type of Control: Managerial Who: Billing Manager or designee What do they do : Identify coded PTF records and/or inpatient professional fees that can be submitted as interim claims for patients hospitalized for 180 days or longer. not found on the INSC or Bill Status report. How do they do it: Ensure the Inpatient Biller generates the Inpatient Unbilled report from VistA for the date range of T-365. When: Monthly Where is the evidence: Unbilled admissions found on the monthly review could be an indication that the Inpatient Unbilled is not being worked weekly. Compare Inpatient Unbilled Report month to month.	Managerial	If inpatient bills are not generated accurately and timely, then Revenue may be delayed or lost.	12
BI 1-B	Type of Control: Managerial Who: Billing Manager or designee What do they do : Identify billable admissions not found on the Unbilled or Bill Status report. How do they do it: Ensure the Inpatient Biller generates the INSC report from VistA on a weekly basis for date range of T-365. Any billable admissions found not to be worked would be identified on a monthly basis when Billing Manager or designee review via control BI-J. When: Monthly Where is the evidence: Unbilled admissions found on the monthly review could be an indication that the INSC is not being worked weekly.	Managerial	Same	12

1.1 - Inpatient Facility Charge Process

Figure 3: Inpatient Facility Charge Process

Institutional (facility) services are captured directly within the patient treatment file (PTF). Billing Specialists manage the *INSC, Unbilled and Bill Status Reports* to ensure all billable inpatient encounters have been captured. Billing Specialists input patient information provided by HIMS and the PTF into VistA on a UB-04 claim form, including demographics, diagnoses/procedural codes, insurance policies, revenue codes and other billing parameters. UB-04 claim forms are standard claim forms used for both inpatient and outpatient facility charges.

Billing staff perform the following procedures daily:

1) **Submitting Inpatient UB-04 Claims (BI 1.1.1)** – Create and transmit bills for reimbursement from third party payers for inpatient institutional VA services.

1.1.1 - Submitting Inpatient UB-04 Claims

SOP DETAIL	
Title: Submitting Inpatient UB-04 Claims	
Purpose: Create and transmit bills for reimbursement from third party payers for inpatient institutional VA services.	
Responsible Party: Billing Specialist, Billing Supervisor	
Issued By:	**Approved By:**
Effective Date:	**Last Revised:** 12-28

SOP PROCESS FLOW

Updated process flow to be added

PROCEDURES
GENERAL CONSIDERATIONS: • Billing staff are notified of any changes to billing procedures during bi-weekly meetings and via email.   • For patients diagnosed with sensitive diagnoses, Billing Specialists must verify that a Release of Information (ROI) has been obtained from the Veteran for each sensitive diagnosis listed on the bill.

STEP	ACTIVITY

1	**Run Bill Status, Unbilled and INSC Reports:** At least twice weekly, the Billing Specialist runs the *Bill Status Report.* After completion of the Bill Status Report, the Billing Specialist runs the *Unbilled Report* (for inpatient only) and compares these encounters to the Patient Treatment File (PTF) to determine whether the admission is released or transmitted. On a monthly basis, Billing Specialist runs a detailed version of the *Veterans w/Insurance and Inpatient Admissions (INSC) Report* to identify unbilled hospitalization greater than 30 days that may require interim billing.
	    a. Date Range: T-365 thru today
	
	    b. **NOTE**: Interim billing is only appropriate for patients that do not have primary Medicare coverage and for long-term admissions. In these situations, interim bills are created every 30 days.

2	*Review INSC, Unbilled and Bill Status Summary Reports* At least on a weekly basis, the Billing Supervisor reviews the *INSC, Unbilled and Bill Status Summary Reports* in VistA for the assigned facilities: a. Medicare timely filing limit T-365 thru today

PROCEDURES	

3	**Establish Billing Record:** The Billing Specialist establishes a new billing record for each encounter listed on the *above Reports*:
	    a. At the Billing Clerk menu, select "Enter/Edit Billing Information".
	    b. Establish billing record:
	        i. Enter "yes".
	        ii. Enter the selected bill number (or patient identifier,, if a bill number has not been generated)
	        iii. Review bill demographic information:
	            1. Bill location of care
	            2. Billing event information source
	            3. Billing time frame
	            4. Billing rate type
	            5. Select admission date (MM/DD/YY format)
	
	NOTE: Enter "?" at any time during the billing process for options applicable to that prompt.

PROCEDURES	

4	***Enter Bill Parameters:*** *The Billing Specialist enters the appropriate information into VistA, guided by screen prompts:*
	
	a. Screen <2>: Review patient employment information
	b. Screen <1>: Review patient address and date of birth
	c. Screen <1>: Check to see if any SC conditions
	    i. At any screen: "?SC" will show if patient has any SC conditions
	    ii. If any SC conditions, check Claims Tracking for RUR comments (SC or NSC)
	d. Screen <2>: Review patient employment information
	d. At any Billing Screen: "?INX" to verify COB and view individual and group comments:
	    i. Determine primary, secondrary and tertiary coordination of benefits (COB) and Coverage Limitations for each payer
	    ii. Patient Policy Comments – includes policy-specific notes such as when (or IF) an ROI form for alcoholism was sent to patient for completion
	    iii. Group Policy Comments identify coverage limitations for this policy – for example, only 50 physcial therapy visits allowed per year
	e. Screen <3>: Enter insurance information:
	    i. Select Option [1].
	    ii. Enter primary, secondary and tertiary insurance policies as appropriate.
	f. Screen <4>: Evaluate encounter information (if available):
	    i. Admission date
	    ii. Time
	    iii. Accident hour (if applicable)
	    iv. [For worker's compensation or tort information see section **3.7**]
	    v. Type of admit
	    vi. Source of admit
	    vii. Skilled nursing care (SNF Care) , if applicable
	    viii. Admitting diagnosis
	    ix. Procedure codes (ICD-9)

PROCEDURES	
5	**Select and Review Bill Type:** The Billing Specialist determines whether an institutional bill can be generated.
	a. If an institutional bill cannot be generated:
	i. Proceed to Screen <6>.
	ii. Select Option [1] to change the form type to CMS 1500 and proceed to section 1.2 for guidance specific to creating a CMS 1500 bill for inpatient professional fees. If this is a DOM or Residential Treatment program where an inpatient bill is set up but cannot be billed no IP charges will drop), only Outpatient Charges are billable with place of service 22.
	b. If an institutional bill can be generated:
	i. Proceed to Screen <4>.
	ii. Select Option [3] to add dischargediagnosis codes from PTF FILE.
	iii. Select Option [4] to add procedure codes from PTF FILE and verify ICD-9 Coding method is selected.
	iv. Select Option [6] to enter the appropriate occurrence code and admission date.
	v. Use Option [8] to enter the Value Code.
	1. The Value Code will always be "semi" for semi-private.
	vi. Enter the daily room and board (R/B). (This auto populates based on MS-DRG
	1. The daily rate can be found using "?CHG"
6	**DECISION: Does the Patient Have Primary MEDICARE PART A Coverage?**
	a. If Yes, **PROCEED TO STEP 7**
	b. If No, **PROCEED TO STEP 8**

PROCEDURES	
7	**Submit Claim through eMRA Process**: Select Medicare Part A as the primary payer and include the secondary (and tertiary payer if one exists) on Screen <3>

a. On Screen <4>, enter covered days of the inpatient stay

    i.   HIPAA value code for covered days is "80", but VistA will not bring up "Covered days" if 80. Enter "??" to find "Covered days   80" and select the number next to the correct VistA entry or type "covered days" at the value code prompt

    ii.   Value amount = the # of covered days for the admission

b. On Screen <4>, enter the co-insurance days for the inpatient stay (if applicable)

    i.   HIPAA value code for co-insurance days is "81" – refer to #1 under covered days to select the appropriate code for co-insurance days

        1.   Value amount = the number of inpatient Medicare days occurring after the 60th day and before the 91st day or inpatient SNF/Swing Bed days occurring after the 20th and before the 101st day in a single spell of illness. For Medicare claims, multiply the number of co-insurance days by the Part A hospital co-insurance amount (refer to NOTE 2 below)

c. On Screen <4>, enter the non-covered days for the inpatient stay (if applicable)

    i.   HIPAA value code for non-covered days is "82" – refer to #1 under covered days to select the appropriate code for non-covered days

    ii.   Value = the number of days that are not covered for the admission

    iii.   If non-covered days are indicated, also enter occurrence code "76" for "Patient Liability" and include the non-covered dates of care (enter the first to the last non-covered dates of the hospitalization)

    iv.   For non-covered days, also include value code "31" for the "Patient Liability Amount", which is equal to the total dollar amount for the non-covered days

        1.   The amount for value code 31 is manually calculated by adding the daily rate on Screen <6> for Room and Board and Ancillary charges and multiplying this amount by the number of non-covered days

NOTE 1: Medicare requires covered days to be reported on every inpatient claim. However, **it is only necessary to include non-covered days if the number of non-covered days is greater than zero**. For example, if the patient was admitted for more days than they have available as Medicare full benefit and/or co-insurance days, those days are considered "non-covered" for the MRA process and would be reported on the claim.

NOTE 2: Co-insurance days are required on Medicare claims ONLY if co-ins. days apply to the hospitalization. Medicare Part A Deductible and Coinsurance amounts are located at: http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html https://www.novitas-solutions.com/

PROCEDURES	

8	**DECISION: Was a leave of absence (LOA) reported during the admission?**
	   a. If yes, **PROCEED TO STEP 9**
	   b. If no, **PROCEED TO STEP 10**

9	**Document Leave of Absence:** The Billing Specialist will document the leave of absence (LOA) by entering the following:
	   a. At Screen <4>:
	      i. Enter occurrence code 74
	         1. Enter the date range (to and from dates) for leave of absence
	   b. At Screen <6>:
	      i. Enter revenue code 180
	         1. Enter $0.00 for the covered charges amount, 0 for the number of units, and $0.00 for the non-covered charges

10	**Review Covered Days of Admission:** The Billing Specialist reviews the number of covered days of admission and reconciles the DRG number of days with the length of stay (LOS) and covered days:
	   a. At Screen <6>:
	      i. If the DRG number of days matches the length of stay and covered days, then proceed to Screen <8>.
	      ii. If the DRG number of days does not match the length of stay and covered days:
	         1. Research and resolve why DRG days do not reconcile with LOS and covered days.
	         2. Select Option [5] to group DRGs together.
	         3. Proceed to Screen <8>.

11	**Enter Pre-Authorization Number:** The Billing Specialist enters the appropriate pre-authorization number, as needed.
	   a. At Screen <8>:
	      i. Select Option [1] and enter pre-authorization number.

12	**Enter or Update Provider Information:** The Billing Specialist enters the appropriate provider information associated with the claim.
	   a. At Screen <10>:
	      i. Select Option [3]
	      ii. Update name of attending provider and provider ID number(s), if required
	      iii. If appropriate, add name and identification number(s) of operating provider
	      iv. **PROCEED TO STEP 14**
	   b. If the NPI or other provider information is missing, **PROCEED TO STEP 13**

PROCEDURES	

13	**Cancel the claim:** If provider information is missing, Billing Specialist will cancel the claim and assign a Reason Not Billable (RNB) in Claims Tracking.
	   a. Assign cancellation code of XMC18
	      i. Add additional comments to assist FRM or designee in resolving this provider issue
	      ii. The following day, FRM automatically receives notification via communication tool that claim has been canceled due to missing provider information & initiates steps to obtain required data
	   b. Enter RNB and comment in Claims Tracking to specify the provider information that is missing (i.e. NPI, taxonomy code, PIN, Tax ID, etc.)
	   c. If missing information has not been obtained after 30 days, FRM will notify Billing Specialist via communication tool that cancellation was appropriate
	      i. **END OF PROCEDURE**
	   d. If provider information is updated in VistA, FRM will notify Billing Specialist via communication tool to re-bill previously canceled claim
	      i. **PROCEED TO STEP 3**

14	**Send claim through scrubber:** The Billing Specialist sends the claim through the Claims Scrubber.
	   a. If valid insurance verification (VistA) edits appear:
	      i. Forward error to Insurance Verification for correction.
	      ii. After error is corrected and returned to Billing, send bill through the Claims Scrubber.
	   b. After VistA edits, send claim to the Claims Scrubber.
	      i. If valid non-coding edits exist, review and correct error
	      ii. If valid coding edits exists return to coding for resolution via Recode/Reject process.
	      i. If edits that appear are not valid, bypass scrubber.

15	**Submit Claim:** The Billing Specialist submits the claim through the appropriate process, depending on primary payer eligibility.
	   a. If the patient has Medicare, submit the bill through the MRA process. If patient does not have Medicare, submit through EDI.
	   b. If patient has primary Medicare Part A coverage and the claim cannot be submitted through the MRA process (for example, admission for an inpatient rehabilitation or a skilled nursing facility stay), claim should be locally printed with Medicare Payer Exclusion letter.
	
	NOTE: A CMS 1500 Form will then be generated if there are professional charges associated with the claim**.**

PROCEDURES	
16	**Print Bill Locally (If Necessary):** If the bill cannot be submitted electronically, the Billing Specialist prints the bill locally: a. At Screen <10>: i. Select Option [3] to force local print. ii. Authorize bill. iii. Send printed bill to Mail Room. NOTE: Claims should be submitted electronically; however, Denial Management analyses, technical limitations or other special circumstances may warrant paper bills to be printed locally. **END OF PROCEDURE**

REFERENCE DOCUMENTS
RELATED HANDBOOKS AND OTHER REFERENCES

– Central Business Office Procedures Guide Series 1601C.03, Billing
  – Ch. 1 Sec. C, No. 3: Facility Versus Professional Services
  – Ch. 1 Sec. C, No. 4: Billable Inpatient Services
  – Ch. 1 Sec. E, No. 3: UB-04 Billing Claim Form
  – Ch. 1 Sec. E, No. 4: Exhibit 1: UB-04 and CMS 1500 Matrix
  – Ch. 1 Sec. G: General Billing Procedures
– Electronic Data Interchange (EDI) Billing Users Guide
– Inegrated Billing (IB), Version 2.0 User Manual, March 1994
– CPAC Utilization Review Guidebook, *SOP 1.1.2 - Performing Admission Certification Review Procedures*
– CPAC Insurance Verification Guidebook, *SOP 2.1.1 Checking Inpatient Buffer Entries in the ICB System, SOP 2.2.1 - Checking for Inpatient Buffer Entries in the VistA System*
– Mid-Atlantic Consolidated Patient Account Center Guidebook, October 31, 2006
– QuadraMed Encoder Suite Process Guide
– Reasonable Charges Desk Reference, Version 2.0
– Uniform Billing Editor
– Bill Cancellation Review Request Procedure

On-line access to additional current guidance:
– CBO Intranet web site: http://vaww1.va.gov/cbo

PROCEDURAL DOCUMENTATION EXAMPLES

CPAC Education and Training Curriculum Billing Level I
– *Common Billing Reports (Bill Status Report)*
– *Common Billing Reports (Unbilled Report)*
– *Inpatient Basics (INSC Report)*

VERSION HISTORY				
VERSION	**DATE**	**CHANGE DESCRIPTION**	**AFFECTED SECT.**	**APPROVED**
1.9	1-24-13	Updated guidance	All	C. Hutchison
1.8	12-28-12	Updated guidance	All	C. Hutchison
1.6	6-11-12	Updated process	All	C. Hutchison
1.3	2-28-11	Process change	All	C. Hutchison
0.1	05-28-10	N/A (new draft version developed)	N/A	
	01-26-09	Added detailed steps	All	Jean Shaw
	11-01-05	N/A	N/A	Victor Cruz

1.2 - Inpatient Professional Fees Charge Process

Figure 4: Inpatient Professional Fees Charge Process

Professional fees constitute the performance or interpretive portion of a diagnostic or therapeutic procedure and are a representation of a physician/provider's work. Inpatient professional charges are billed independently of the facility charge and are typically billed on a CMS 1500 claim form. Billing Specialists manage the *Bill Me Report* to ensure that all inpatient professional services to be billed have been captured. The integrated billing package in VistA automatically generates a CMS 1500 claim form for applicable professional charges and pre-populates patient information from the associated UB-04 claim form. Billing Specialists, however, must then modify the appropriate fields, including diagnosis/CPT codes and other billing parameters.

Billing staff perform the following procedures daily:

1) **Submitting Inpatient CMS 1500 Claims (BI 1.2.1)** – Create and transmit bills for reimbursement from third party payers for inpatient professional VA services.

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1.2.1 - *Submitting Inpatient CMS 1500 Claims*

SOP DETAIL	
Title: Submitting Inpatient CMS 1500 Claims	
Purpose: Create and transmit bills for reimbursement from third party payers for inpatient professional VA services.	
Responsible Party: Billing Specialist, Billing Lead	
Issued By:	**Approved By:**
Effective Date:	**Last Revised:** 12-282012

SOP PROCESS FLOW

Updated process flow to be added

PROCEDURES
GENERAL CONSIDERATIONS: • Billing staff are notified of any changes to billing procedures during bi-weekly meetings and via email. • For patients diagnosed with sensitive diagnoses, Billing Specialists must verify that a Release of Information (ROI) has been obtained from the Veteran for each sensitive diagnosis listed on the bill.

STEP	ACTIVITY

1	**Review Professional Charges:** Based on the type of stay and services provided, VistA prompts the Billing Specialist to determine whether professional charges are applicable.
	  a. If professional charges are not applicable, then cancel the bill.
	  b. If professional charges are applicable, proceed to Screen <3> and select appropriate payer.
	  c. If professional services are not coded the Billing Specialist will send request to FRM to have services coded.
	  d. Inpatient professional claim will be canceled after 14 days if not coded.

2	**Run *Bill Me Report*:** On a daily basis, the Billing Lead runs a *Bill Me Report* for the assigned facilities and distributes it to assigned Billing Specialists. a. The Billing Lead sorts the report to contain only inpatient encounters.

3	**Enter Bill Parameters:** The Billing Specialist enters the appropriate information into VistA, guided by screen prompts:
	  a. Screen <1>: Review patient address and date of birth
	  b. Screen <1>: Check to see if any SC conditions
	     i. At any screen: "?SC" will show if patient has any SC conditions
	     ii. If any SC conditions, check Claims Tracking for RUR comments (SC or NSC)
	  c. Screen <2>: Review patient employment information

PROCEDURES	

	d. At any Billing Screen: "?INX" to verify COB and view individual and group comments:
	  i. Determine primary, secondrary and tertiary coordination of benefits (COB) and Coverage Limitations for each payer
	  ii. Patient Policy Comments – includes policy-specific notes such as when (or IF) an ROI form for alcoholism was sent to patient for completion
	  iii. Group Policy Comments identify coverage limitations for this policy – for example, only 50 physcial therapy visits allowed per year
	 e. Screen <3>: Enter insurance information:
	  i. Select Option [1].
	  ii. Enter primary, secondary and tertiary insurance policies as appropriate.

4	**Enter Diagnosis Codes:** The Billing Specialist selects the appropriate diagnosis codes related to the CPT, ensuring the link between the two occurs.
	 a. At Screen <4>:
	  i. Select Option [3].
	  ii. Delete all diagnosis codes.
	  iii. Select Option [4].
	  iv. Enter dates and procedure codes listed on the 801 screen or equivalent.
	  v. If necessary, correct modifiers, billable providers, and billable codes.
	 b. Determine whether the link between diagnosis and CPT is completed:
	  i. If the diagnosis did not link, the Billing Specialist sends a message to the HIMS designee via the Recode/Reject function requesting a review and then discontinues the process until the issue has been resolved.
	  ii. If the diagnosis linked, proceed to Screen <6>
	
	NOTE: The communication stream between Billing and HIMS when diagnoses are not linked to the CPT is being revised.

5	**Review Charges**: The Billing Specialist determines whether the charges accurately populated the record.
	 a. At Screen <6>:
	  i. If charges did not populate, See Billing Lead or Billing Supervisor to determine the reason why charges did not populate (the most common reasons are no charges were entered in the system, or the provider incorrectly checked out the patient).
	   1. Discontinue the process if necessary.
	  iii. If charges populate, proceed to Screen <10>:
	   1. Select Option [3].
	   2. Change the name of the rendering provider; include referring physician and provider identification number if required by current billing guidelines.
	   3. Check warnings and edits.

PROCEDURES	

6	**Enter or Update Provider Information:** The Billing Specialist enters the appropriate provider information associated with the claim.
	   a. At Screen <10>:
	      v. Select Option [3]
	      vi. Update name of rendering provider and provider ID number(s), if required
	      vii. If appropriate, add name and identification number(s) of referring provider
	      viii. **PROCEED TO STEP 7**
	   b. If the NPI or other provider information is missing, **PROCEED TO STEP 6.1**

6.1	**Cancel the claim:** If provider information is missing, Billing Specialist will cancel the claim and assign a Reason Not Billable (RNB) in Claims Training.
	   a. Assign cancellation code of XMC18
	      iii. Add additional comments to assist FRM or designee in resolving this provider issue
	      iv. The following day, FRM automatically receives notification via communication tool that claim has been canceled due to missing provider information & initiates steps to obtain required data
	   b. Enter RNB and comment in Claims Tracking to specify the provider information that is missing (i.e. NPI, taxonomy code, PIN, Tax ID, etc.)
	   c. If missing information has not been obtained after 30 days, FRM will notify Billing Specialist via communication tool that cancellation was appropriate
	      i. **END OF PROCEDURE**
	   d. If provider information is updated in VistA, FRM will notify Billing Specialist via communication tool to re-bill previously canceled claim
	      i. Establish billing record and **PROCEED TO STEP 3**

7	**Send claim through scrubber:** The Billing Specialist sends the claim through the Claims Scrubber.
	   a. If valid insurance verification (VistA) edits appear:
	      i. Forward error to Insurance Verification for correction.
	      ii. After error is corrected and returned to Billing, send bill through the Claims Scrubber.
	   b. After VistA edits, send claim to the Claims Scrubber.
	      i. If valid non-coding edits exist, review and correct error
	      ii. If valid coding edits exists return to coding for resolution via Recode/Reject process.
	      i. If edits that appear are not valid, bypass scrubber.

8	**Submit Claim:** The Billing Specialist submits the claim through the appropriate process, depending on primary payer eligibility. a. If the patient has Medicare, submit the bill the MRA process. If patient does not have Medicare, submit through EDI.

PROCEDURES	
	b. Answer "yes" or "no", accordingly, when asked if this bill should be copied to create another professional bill for this date.

9	**Print Bill Locally (If Necessary):** If the bill cannot be submitted electronically, the Billing Specialist prints the bill locally:
	   a. At Screen <10>:
	     i. Select Option [3] to force local print.
	     ii. Authorize bill.
	     iii. Send printed bill to Mail Room.
	 NOTE: Claims should be submitted electronically; however, Denial Management analyses, technical limitations or other special circumstances may warrant paper bills to be printed locally.
	
	 END OF PROCEDURE

REFERENCE DOCUMENTS
RELATED HANDBOOKS AND OTHER REFERENCES

– Central Business Office Procedures Guide Series 1601C.03, Billing
- – Ch. 1 Sec. C, No. 3: Facility Versus Professional Services
- – Ch. 1 Sec. C, No. 4: Billable Inpatient Services
- – Ch. 1 Sec. E, No. 2: CMS 1500 Billing Claim Form
- – Ch. 1 Sec. E, No. 4: Exhibit 1: UB-04 and CMS 1500 Matrix
- – Ch. 1 Sec. G: General Billing Procedures

– Electronic Data Interchange (EDI) Billing Users Guide
– Integrated Billing (IB), Version 2.0 User Manual, March 1994
– CPAC Utilization Review Guidebook, *SOP 1.1.2 - Performing Admission Certification Review Procedures*
– CPAC Insurance Verification Guidebook, *SOP 2.2.1 - Checking for Inpatient Buffer Entries in the VistA System*
– Medicare Claims Processing Manual, Chapter 12 - Physician and Non-Physician Practitioner, Sec. 30.6.12
– Mid-Atlantic Consolidated Patient Account Center Guidebook, October 31, 2006
– QuadraMed Encoder Suite Process Guide
– Reasonable Charges Desk Reference, Version 2.0
– Uniform Billing Editor
– Bill Cancellation Review Request Procedure

On-line access to additional current guidance:
– CBO Intranet web site: http://vaww1.va.gov/cbo

PROCEDURAL DOCUMENTATION EXAMPLES

REFERENCE DOCUMENTS

CPAC Education Curriculum, Billing Level I/II
- *Inpatient Basics*
- *Billing Research Menu Options (Claims Tracking, PCE)*
- *Bill Cancellation and Reasons Not Billable Codes*
- *Bill Me Report*

VERSION HISTORY

VERSION	DATE	CHANGE DESCRIPTION	AFFECTED SECT.	APPROVED
1.9	1-24-2013	Updated guidance	All	C. Hutchison
1.8	12-28-12	Updated guidance	All	C. Hutchison
1.6	6-11-2012	Updated guidance	All	C. Hutchison
1.3	02-28-11	Process change	Steps 5 & 5.1	C. Hutchison
0.1	05-28-10	N/A (new draft version developed)	N/A	
	01-26-09	Added detailed steps	All	Jean Shaw
	11-01-05	N/A	N/A	Victor Cruz

1.3 - Skilled Nursing Facility Process

Figure 5: Skilled Nursing Facility Process

Veteran care provided within skilled nursing facilities (SNFs) must be ordered by a physician, performed by appropriate technical personnel, required on a daily basis, not be acute and be provided on an inpatient basis. Additional conditions may be applicable in order for services to be billable as SNF care. Billing staff are responsible for generating bills to third party payers for both facility and provider charges.

Billing staff perform the following procedures daily:

1) **Submitting Skilled Nursing Care Facility Claims (BI 1.3.1.) –** Create and transmit bills for reimbursement from third party payers for skilled nursing VA services.

1.3.1 - *Submitting Skilled Nursing Facility UB-04 Claims*

SOP DETAIL	
Title: Submitting Skilled Nursing Facility UB-04 Claims	
Purpose: To create and transmit bills for reimbursement from third party payers for skilled nursing VA services	
Responsible Party: Billing Specialist and Billing Supervisor	
Issued By:	**Approved By:**
Effective Date:	**Last Revised:** 12-28-2012

SOP PROCESS FLOW

Updated process flow to be added

PROCEDURES
GENERAL CONSIDERATIONS:

- Care in a skilled nursing facility (SNF) is billable on both the UB-04 and the CMS 1500 under specific conditions, which are listed in the *CBO Procedures Guide Series, Billing*, Ch. 8 Sec. C.
- Certification and recertification of the need for services is required, but no specific procedures or forms are required for this purpose. The statements may be entered on forms, notes or records, as long as they are based on the patient's chart and the presenting condition. Re-certifications are required every 30 days.
- For patients diagnosed with sensitive diagnoses, Billing Specialists must verify that a Release of Information (ROI) has been obtained from the Veteran for each sensitive diagnosis listed on the bill.

STEP	ACTIVITY
1	**Run *INSC, Unbilled and Bill Status Reports*:** On a daily basis, the Billing Specialist runs the *INSC, Unbilled and Bill Status Reports* and compares encounters to the PTF file to determine whether the *a*dmission was released or transmitted. **NOTE**: If admission is long term care interim billing will be completed and tracked via Excel spreadsheet.
2	***Review INSC, Unbilled and Bill Status Summary Reports*** At least on a weekly basis, the Billing Supervisor reviews the *INSC, Unbilled and Bill Status Summary Reports* in VistA for the assigned facilities: a. Medicare timely filing limit is T-365 through Today

PROCEDURES	
3	**Establish Billing Record:** The Billing Specialist establishes a new billing record for each encounter listed on the above reports

a. At the Billing Clerk menu, select "Enter/Edit Billing Information".
b. Establish billing record:
    i. Enter "yes".
    ii. Enter the selected bill number (or patient identifier, if a bill number has not been generated).
    iii. Review bill demographic information:
        1. Bill location of care
        2. Billing event information source
        3. Billing time frame
        4. Billing rate type
        5. Select admission date (MM/DD/YY format)

NOTE: Enter "?" at any time during the billing process for options applicable to that prompt.

PROCEDURES	
4	**Enter Bill Parameters:** The Billing Specialist reviews and enters the appropriate information into VistA, guided by screen prompts.

a. Screen <1>: Review patient address and date of birth

b. Screen <1>: Check to see if any SC conditions

    i. At any screen: "?SC" will show if patient has any SC conditions

    ii. If any SC conditions, check Claims Tracking for RUR comments (SC or NSC)

c. Screen <2>: Review patient employment information

d. At any Billing Screen: "?INX" to verify COB and view individual and group comments:

    i. Determine primary, secondrary and tertiary coordination of benefits (COB) and Coverage Limitations for each payer

    ii. Patient Policy Comments – includes policy-specific notes such as when (or IF) an ROI form for alcoholism was sent to patient for completion

    iii. Group Policy Comments identify coverage limitations for this policy – for example, only 50 physcial therapy visits allowed per year

e. Screen <3>: Enter insurance information:

    i. Select Option [1].

    ii. Enter primary, secondary and tertiary insurance policies as appropriate.

f. Screen <4>: Designate SNF/sub acute care:

    i. Admission dates

    ii. Time

    iii. Type of admit

    iv. Source of admit

    v. Skilled nursing care (SNF Care)

    vi. Admitting diagnosis

    vii. Procedure codes (ICD-9)

g. At Screen <4>:

    i. Select Option [3] to add diagnosis codes

    ii. Select Option [4] to add procedure codes and verify ICD-9 Coding method is selected

    iii. Select Option [6] to enter the appropriate occurrence code and admission date

    iv. Use Option [8] to enter the Value Code

        1. The Value Code will always be "semi" for semi-private.

    v. Enter the daily room and board (R/B)

        1. The daily rate can be found using "?CHG"

Note: Medicare covers a maximum of 90 days when there is a three day qualifying stay.

PROCEDURES	
5	**Enter Bill Type:** The Billing Specialist changes the bill type to Skilled Nursing. a. In Screen <6>, change the bill type to 21X Skilled Nursing **NOTE**: Screen 6 will no longer display the DRG-related charges.

6	**Enter Pre-Authorization Number:** The Billing Specialist enters the appropriate pre-authorization number as needed.
	    a. At Screen <10>:
	          i. Select Option [1] and enter pre-authorization number.

7	**Enter or Update Provider Information:** The Billing Specialist enters the appropriate provider information associated with the claim.
	    a. At Screen <10>:
	          i. Select Option [3]
	          ii. Update name of rendering provider and provider ID number(s), if required
	          iii. If appropriate, add name and identification number(s) of referring provider
	          iv. **PROCEED TO STEP 8**
	    b. If the NPI or other provider information is missing, **PROCEED TO STEP 7.1**

7.1	**Cancel the claim:** If provider information is missing, Billing Specialist will cancel the claim and assign a Reason Not Billable (RNB) in Claims Training.
	    e. Assign cancellation code of XMC18
	          i. Add additional comments to assist FRM or designee in resolving this provider issue
	          ii. The following day, FRM automatically receives notification via communication tool that claim has been canceled due to missing provider information & initiates steps to obtain required data
	    f. Enter RNB and comment in Claims Tracking to specify the provider information that is missing (i.e. NPI, taxonomy code, PIN, Tax ID, etc.)
	    g. If missing information has not been obtained after 30 days, FRM will notify Billing Specialist via communication tool that cancellation was appropriate
	          i. **END OF PROCEDURE**
	    h. If provider information is updated in VistA, FRM will notify Billing Specialist via communication tool to re-bill previously canceled claim
	          i. **PROCEED TO STEP 3**

PROCEDURES	

8	**Send claim through scrubber:** The Billing Specialist sends the claim through the Claims Scrubber.
	    a. If valid insurance verification (VistA) edits appear:
	          i. Forward error to Insurance Verification for correction.
	         ii. After error is corrected and returned to Billing, send bill through the Claims Scrubber.
	    b. After VistA edits, send claim to the Claims Scrubber.
	          i. If valid non-coding edits exist, review and correct error
	         ii. If valid coding edits exist return to coding for resolution via Recode/Reject process.
	    c. If edits that appear are not valid, bypass scrubber.

9	**Submit Claim:** The Billing Specialist submits the claim through the appropriate process, depending on primary payer eligibility. a. If the patient has Medicare, payer sequencing is changed to secondary and claim is printed locally with Payer Exclusion letter. **NOTE**: A CMS 1500 will then be generated if there are professional charges associated with the claim. Follow inpatient professional fees charge process. Professional SNF charges are billable through the MRA process.

10	**Print Bill Locally (If Necessary):** If the bill cannot be submitted electronically, the Billing Specialist prints the bill locally:
	    a. At Screen <10>:
	          i. Select Option [3] to force local print.
	         ii. Authorize bill.
	         iii. Send printed bill to Mail Room.
	
	NOTE: Claims should be submitted electronically; however, Denial Management analyses, technical limitations or other special circumstances may warrant paper bills to be printed locally.
	
	END OF PROCEDURE

REFERENCE DOCUMENTS

RELATED HANDBOOKS AND OTHER REFERENCES

– Central Business Office Procedures Guide Series 1601C.03, Billing
  – Ch. 1 Sec. C: No. 3: Facility Versus Professional Services
  – Ch. 1 Sec. C: No. 4: Billable Inpatient Services
  – Ch. 1 Sec. E: No. 3: UB-04 Billing Claim Form
  – Ch. 1 Sec. E: No. 4: Exhibit 1: UB-04 and CMS 1500 Matrix
  – Ch. 1 Sec. G: General Billing Procedures
  – Ch. 8 Sec. C: Skilled Nursing and Sub-Acute Care Reasonable Charges and Billing
– Electronic Data Interchange (EDI) Billing Users Guide
– Integrated Billing (IB), Version 2.0 User Manual, March 1994
– Mid-Atlantic Consolidated Patient Account Center Guidebook, October 31, 2006
– QuadraMed Encoder Suite Process Guide
– Reasonable Charges Desk Reference, Version 2.0
– Uniform Billing Editor
– Bill Cancellation Review Request Procedure
– CPAC Utilization Review Guidebook, *SOP 1.1.5 – Performing Skilled Nursing Facility LTC Certification*
On-line access to additional current guidance:
– CBO Intranet web site: http://vaww1.va.gov/cbo

PROCEDURAL DOCUMENTATION EXAMPLES

CPAC Education Curriculum, Billing Level I
  – *Skilled Nursing Facility Care*
  – *Common Billing Reports (Bill Status Report)*
  – *Common Billing Reports (Unbilled Report)*
  – *Inpatient Basics (INSC Report)*

VERSION HISTORY

VERSION	DATE	CHANGE DESCRIPTION	AFFECTED SECT.	APPROVED
1.9	1-24-13	Updated guidance	All	C.Hutchison
1.8	12-28-12	Updated guidance	All	C. Hutchison
1.6	6-11-2012	Updated guidance	All	C. Hutchison
0.3	02-28-2011	Process change	Steps 7 & 7.1	C. Hutchison
0.1	05-28-10	N/A (new draft version developed)	N/A	

Figure 6: Outpatient Section Map
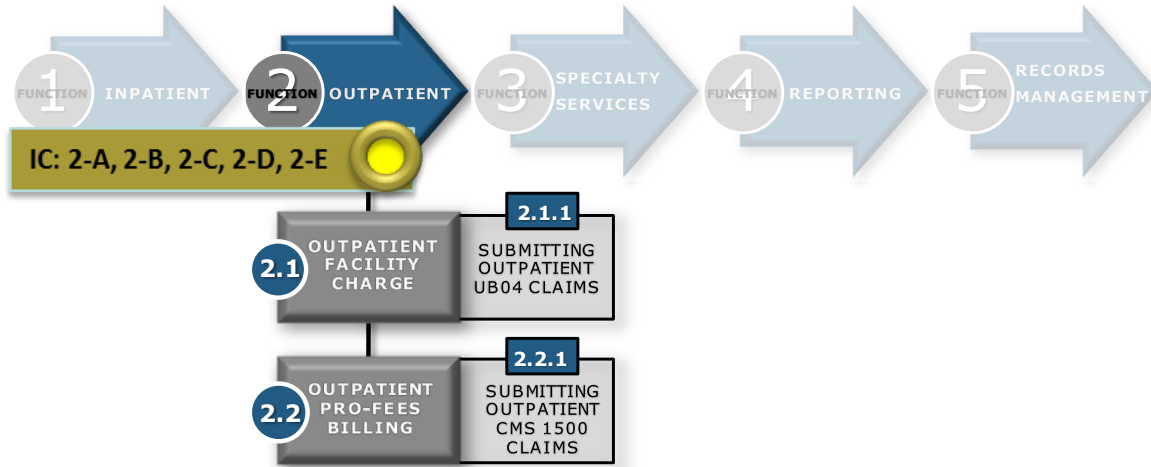
Medical service encounters that last less than 24 (twenty four) hours are classified and billed as outpatient services. Institutional (facility) charges and professional fees (provider work) are billed separately on different claim forms.

Billing Specialists, assigned by facility, manage the Bill Me, *Bill Status Reports* and Unbilled *Reports* to bill third party payers for all billable outpatient encounters.

Figure 6 above provides a map of all the processes and SOPs associated with the outpatient function.

INTERNAL CONTROLS (FUNCTION LEVEL)				
ID	**CONTROL DESCRIPTION**	**TYPE**	**RISK**	**SCORE**
BI 2-A	Type of Control: Managerial Who: Billing Supervisor or designee What do they do : Identify any missed billing opportunities How do they do it: Generate the Bill Status report for Entered/Not Reviewed (by entry date) in Quadramed - Billing Compliance Module. Report is assigned to billing staff to identify any missed billing opportunities. This report can be re-generated at any time by date range to ensure completion. When: Weekly Where is the evidence: Review on delinquent BSTP's on the weekly TRAC report (high volume of delinquents would indicate that this is not being done)	Managerial	If outpatient bills are not generated accurately and timely, then Revenue may be delayed or lost.	9

INTERNAL CONTROLS (FUNCTION LEVEL)				
ID	**CONTROL DESCRIPTION**	**TYPE**	**RISK**	**SCORE**
BI 2-B	Type of Control: Managerial Who: Billing Supervisor or designee What do they do : Ensure coded encounters are assigned to billing staff for completion. How do they do it: Generate the Bill Me report weekly via Quadramed When: Weekly Where is the evidence: CCM Status in Quadramed would indicate encounters that have been referred to billing, completed by billing, etc.	Managerial	Same	9
BI 2-C	Type of Control: Managerial Who: Billing Supervisor or designee What do they do : Review number of encounters each biller has pending from previous day. How do they do it: Generate the PCE Compliance Report daily via Quadramed. This report can be re-generated at any time by date range to ensure completion, but if generated for T-5 will show the number of encounters each biller has pending from the previous day (when encounters are assigned to a biller, the status changes to "Referred to Billing") When: Daily Where is the evidence: Quadramed reports can be pulled at any time to see the amount of workload assigned to any biller. If a biller had an extreme number of encounters assigned to them, this would be an indication that this is not being done.	Managerial	Same	9

INTERNAL CONTROLS (FUNCTION LEVEL)				
ID	CONTROL DESCRIPTION	TYPE	RISK	SCORE
BI 2-D	Type of Control: Managerial Who: Billing Supervisor or designee What do they do : Identify the number of encounters pending billing How do they do it: Generate the PCE Compliance Report (by date assigned) via Quadramed. When: At least weekly Where is the evidence: Bill Me volumes are reported on the weekly TRAC report.	Managerial	Same	9
BI 2-E	Type of Control: Managerial Who: Billing Supervisor or designee What do they do : Identify billable encounters or non-billable encounters that need appropriate RNBs assigned. How do they do it: Generate the Outpatient Unbilled report via VistA. The report can be re-generated at any time to ensure completion and/or identify any missed billing opportunities. When: Monthly Where is the evidence: Unbilled outpatient episodes can be identified on the Unbilled Report at any time and historical data is available.	Managerial		9

2.1 - Outpatient Facility Billing Process

Figure 7: Outpatient Facility Billing Process

Billing Specialists manage the *Bill Me*, *Bill Status and Unbilled Reports*, assigned by facility, to bill for outpatient facility encounters. Billing Specialists enter and verify patient information into VistA. This information is provided by HIMS and includes demographics, diagnoses and procedural codes. The UB-04 claim form is used for both inpatient and outpatient facility charges.

Dialysis, physical, occupational, speech and kinesio-therapies are often administered and billed as repetitive service. On a monthly basis, the Billing Leads and Billing Supervisors provide Billing Specialists with a spreadsheet that lists repetitive therapy encounters. Billing Specialists utilize the information provided within the spreadsheets to establish billing records, select the appropriate revenue codes/modifiers for the type of therapy rendered and generate a bill on a UB-04 form for each encounter listed.

Billing staff perform the following procedures daily:

1) **Submitting Outpatient UB-04 Claims (BI 2.1.1)** – Create and transmit bills for reimbursement from third party payers for outpatient institutional VA services.

2.1.1 - *Submitting Outpatient UB-04 Claims*

SOP DETAIL	
Title: Submitting Outpatient UB-04 Claims	
Purpose: Create and transmit bills for reimbursement from third party payers for outpatient institutional VA services	
Responsible Party: Billing Specialist	
Issued By:	**Approved By:**
Effective Date:	**Last Revised:** 12-28-2012

SOP PROCESS FLOW

Updated process flow to be added

PROCEDURES	
GENERAL CONSIDERATIONS: • Billing staff are notified of any changes to billing procedures during bi-weekly meetings and via email. • For patients diagnosed with sensitive diagnoses, Billing Specialists must verify that a Release of Information (ROI) has been obtained from the Veteran for each sensitive diagnosis listed on the bill.	

STEP	ACTIVITY

1	**Run *Bill Me, Bill Status and Unbilled Reports*:** The Billing Lead or designee:
	   a. Runs the *Bill Me, Bill Status and Unbilled Reports*,
	   b. Sorts the data to filter any out any non-billable encounters,
	   c. Distributes encounters to the appropriate Billing Specialist.
	      NOTE: Date range for Bill Status and Unbilled reports will be based on Medicare timely filing (T-365 thru T-14)

2	**Establish Billing Record:** The Billing Specialist establishes a new billing record for each encounter listed on the report.
	   a. At the Billing Clerk menu, select "Enter/Edit Billing Information".
	      i. Enter "?" at any time during the billing process for options applicable to that prompt.
	   b. Establish billing record:
	      i. Enter "yes".
	      ii. Enter the selected bill number (or patient identifier, if a bill number has not been generated).
	      iii. Enter bill demographic information:
	         1. Bill location of care
	         2. Billing event information source - Outpatient

PROCEDURES	
	3. Billing time frame – Admit to Discharge 4. Billing rate type – Reimbursable 5. Billing outpatient event date (MM/DD/YY format) **NOTE**: Enter "?" at any time during the billing process for options applicable to that prompt.

3	**Enter Bill Parameters:** The Billing Specialist enters the appropriate information into VistA, guided by screen prompts:
	  a. Screen<1>: Review patient address and date of birth
	  b. Screen<1>: Check to see if any SC conditions
	     i. At any screen: "?SC" will show if patient has any SC conditions
	     ii. If any SC conditions, check Claims Tracking for RUR comments (SC or NSC)
	  c. Screen <2>: Review patient employment information.
	  d. At any Billing Screen: "?INX" to verify COB and view individual and group comments:
	     i. Determine primary, secondrary and tertiary coordination of benefits (COB) and Coverage Limitations for each payer
	     ii. Patient Policy Comments – includes policy-specific notes such as when (or IF) an ROI form for alcoholism was sent to patient for completion
	     iii. Group Policy Comments identify coverage limitations for this policy – for example, only 50 physcial therapy visits allowed per year
	  e. Screen <3>: Enter insurance information:
	     i. Select Option [1].
	     ii. Select primary, secondary and tertiary insurance policies as appropriate.
	  f. Screen <5>: Complete required billing fields from provided documentation:
	     i. Option [4]: Select appropriate CPT codes ensuring diagnosis linkage.
	     ii. Add appropriate modifiers.
	     iii. Review case comments.
	     iv. Enter appropriate value, condition and occurrence codes as required by current billing and MRA guidelines.
	     v. Change coding method to ICD-9 coding.

4	**Review Revenue Codes:** The Billing Specialist selects appropriate discharge status and revenue codes. a. At Screen <7>, select Option [5] to correct revenue codes, if necessary.

5	**Enter or Update Provider Information:** The Billing Specialist enters the appropriate provider information associated with the claim.
	  a. At Screen <10>:
	     i. Select Option [3]
	     ii. Add the attending provider and provider ID number(s), if required by the payer listed on Screen<3>
	     iii. Update name of rendering provider and provider ID number(s), if required

PROCEDURES	
	iv. If appropriate, add name and identification number(s) of referring provider v. **PROCEED TO STEP 6** b. If the NPI or other provider information is missing, **PROCEED TO STEP 5.1**

5.1	**Cancel the claim:** If provider information is missing, Billing Specialist will cancel the claim and assign a Reason Not Billable (RNB) in Claims Training.
	a. Assign cancellation code of XMC18
	     i. Add additional comments to assist FRM or designee in resolving this provider issue
	     ii. The following day, FRM automatically receives notification via communication tool that claim has been canceled due to missing provider information & initiates steps to obtain required data
	b. Enter RNB and comment in Claims Tracking to specify the provider information that is missing (i.e. NPI, taxonomy code, PIN, Tax ID, etc.)
	c. If missing information has not been obtained after 30 days, FRM will notify Billing Specialist via communication tool that cancellation was appropriate
	     i. **END OF PROCEDURE**
	d. If provider information is updated in VistA, FRM will notify Billing Specialist via communication tool to re-bill previously canceled claim
	     i. **PROCEED TO STEP 3**

6	**Send claim through scrubber:** The Billing Specialist sends the claim through the Claims Scrubber.
	a. If valid insurance verification (VistA) edits appear:
	     i. Forward error to Insurance Verification for correction.
	     ii. After error is corrected and returned to Billing, send bill through the Claims Scrubber.
	b. After VistA edits, send claim to the Claims Scrubber.
	     i. If valid non-coding edits exist, review and correct error
	     ii. If valid coding edits exists return to coding for resolution via Recode/Reject process.
	     iii. If edits that appear are not valid, bypass scrubber.

7	**Submit Claim:** The Billing Specialist submits the claim through the appropriate process, depending on primary payer eligibility. a. If the patient has Medicare, submit the bill through the MRA process. If patient does not have Medicare, submit through EDI. b. If the claim cannot go thru the MRA process, claim should be locally printed with Medicare Payer Exclusion letter. **NOTE 1**: A CMS 1500 Form will then be generated if there are professional charges associated with the claim.

PROCEDURES		
		NOTE 2: MRA Excluded services are referenced on the most current version of the Medicare Payer Exclusion letter. As more services are added to the MRA process, the list of excluded services will change, so please ensure that you're using the correct version of the Payer Exclusion letter.

8		**Print Bill Locally (If Necessary):** If the bill cannot be submitted electronically, the Billing Specialist prints the bill locally:
		
		 a. At Screen <10>:
		
		      i. Select Option [3] to force local print.
		
		      ii. Authorize bill.
		
		      iii. Send printed bill to Mail Room.
		
		 NOTE: Claims should be submitted electronically; however, Denial Management analyses, technical limitations or other special circumstances may warrant paper bills to be printed locally.
		
		 END OF PROCEDURE

REFERENCE DOCUMENTS
RELATED HANDBOOKS AND OTHER REFERENCES

– Central Business Office Procedures Guide Series 1601C.03, Billing
- – Ch. 1 Sec. C, No. 3: Facility Versus Professional Services
- – Ch. 1 Sec. C, No. 5: Billable Outpatient Services
- – Ch. 1 Sec. E, No. 3: UB-04 Billing Claim Form
- – Ch. 1 Sec. E, No. 4: Exhibit 1: UB-04 and CMS 1500 Matrix
- – Ch. 1, Sec. G: General Billing Procedures

– Electronic Data Interchange (EDI) Billing Users Guide
– Integrated Billing (IB), Version 2.0 User Manual, March 1994
– CPAC Utilization Review Guidebook, SOP 3.1.1 – *Validating Outpatient Encounters*
– Mid-Atlantic Consolidated Patient Account Center Guidebook, October 31, 2006
– QuadraMed Encoder Suite Process Guide
– Reasonable Charges Desk Reference, Version 2.0
– Uniform Billing Editor
– Bill Cancellation Review Request Procedure

On-line access to additional current guidance:
- – CBO Intranet web site: http://vaww1.va.gov/cbo/
- – https://www.novitas-solutions.com/

PROCEDURAL DOCUMENTATION EXAMPLES

REFERENCE DOCUMENTS

CPAC Education, Billing Level I/II
- *Billing Basics*
- *Bill Me Report*
- *Common Billing Reports - Bill Status Report*
- *Common Billing Reports - Unbilled Report*

VERSION HISTORY

VERSION	DATE	CHANGE DESCRIPTION	AFFECTED SECT.	APPROVED
1.9	1-24-13	Updated guidance	All	C.
1.8	12-28-12	Updated guidance	All	C. Hutchison
1.6	6-11-2012	Updated guidance	All	C. Hutchison
1.3	2-28-11	Process change	Steps 5 & 5.1	C. Hutchison
0.1	05-28-10	N/A (new draft version developed)	N/A	
	01-26-09	Added detailed steps	All	Jean Shaw
	11-01-05	N/A	N/A	Victor Cruz

2.2 - Outpatient Professional Fees Billing Process

Figure 8: Outpatient Professional Fees Billing Process

Professional fees constitute the performance or interpretive portion of a diagnostic or therapeutic procedure, and are a representation of a clinician's work. Outpatient professional charges are billed independently of the facility charge and are typically billed on a CMS 1500 claim form. Billing Specialists manage the *Bill Me, Bill Status and Unbilled Reports* to ensure that all outpatient professional services to be billed have been captured. The integrated billing package in VistA automatically generates a CMS 1500 claim form for applicable professional charges and pre-populates patient information from the associated UB-04 claim form; however, Billing Specialists must then modify the appropriate fields, including diagnosis/CPT codes and other billing parameters.

Billing staff perform the following procedures on a daily basis:

1) **Submitting Outpatient CMS 1500 Claims (BI 2.2.1)** – Create and transmit bills for reimbursement from third party payers for outpatient professional VA services.

2.2.1 - Submitting Outpatient CMS 1500 Claims

SOP DETAIL	
Title: Submitting Outpatient CMS 1500 Claims	
Purpose: Create and transmit bills for reimbursement from third party payers for outpatient professional VA services	
Responsible Party: Billing Specialist	
Issued By:	**Approved By:**
Effective Date:	**Last Revised:** 12-28-2012

SOP PROCESS FLOW

Updated process flow to be added

PROCEDURES	
GENERAL CONSIDERATIONS:	

- If professional fees are applicable, CMS 1500 Claim forms are automatically generated by VistA upon completion of UB-04 Claim forms.
- For patients diagnosed with sensitive diagnoses, Billing Specialists must verify that a Release of Information (ROI) has been obtained from the Veteran for each sensitive diagnosis listed on the bill.

STEP	ACTIVITY
1	***Run Bill Me, Bill Status and Unbilled Reports***: The Billing Lead or designee: a. Runs the *Bill Me, Bill Status and Unbilled Reports*, b. Sorts the data to filter any out any non-billable encounters, c. Distributes encounters to the appropriate Billing Specialist. **NOTE**: Date range for Bill Status and Unbilled reports will be based on Medicare timely filing (T-365 thru T-14)
2	**Review Professional Charges:** Billing Specialist determines whether professional charges are applicable. a. If professional charges are not billable, then cancel the bill. b. If professional charges can be billed, then proceed to Screen <3> and select appropriate payer, as required.

3	**Enter Bill Parameters:** The Billing Specialist enters the appropriate information into VistA, guided by screen prompts:
	 a. Screen <1>: Review patient address and date of birth
	 b. Screen <1>: Check to see if any SC conditions
	      i. At any screen: "?SC" will show if patient has any SC conditions
	      ii. If any SC conditions, check Claims Tracking for RUR comments (SC or NSC)
	 c. Screen <2>: Review patient employment information.

PROCEDURES	

	d. At any Billing Screen: "?INX" to verify COB and view individual and group comments:
	    i. Determine primary, secondary and tertiary coordination of benefits (COB) and Coverage Limitations for each payer
	    ii. Patient Policy Comments – includes policy-specific notes such as when (or IF) an ROI form for alcoholism was sent to patient for completion
	    iii. Group Policy Comments identify coverage limitations for this policy – for example, only 50 physcial therapy visits allowed per year
	e. Screen <3>: Enter insurance information:
	    i. Select Option [1].
	    ii. Select primary, secondary and tertiary insurance policies as appropriate.

4	**Enter CPT Codes:** The Billing Specialist selects the appropriate CPT codes related to the encounter, and the associated diagnosis codes will populate. At Screen <5>: a. Select Option [4] b. Delete all procedure codes from the bill c. Select Option [2] d. Delete all diagnosis codes e. Select Option [4] f. Pull in the appropriate procedure codes g. Review case comments h. Add appropriate modifiers, place of service, and type of service i. Enter occurrence code and date

5	**Enter or Update Provider Information:** The Billing Specialist enters the appropriate provider information associated with the claim.
	a. At Screen <10>:
	    i. Select Option [3]
	    ii. Update name of rendering provider and provider ID number(s), if required
	    iii. If appropriate, add name and identification number(s) of referring provider
	    iv. **PROCEED TO STEP 6**
	b. If the NPI or other provider information is missing, **PROCEED TO STEP 5.1**

5.1	**Cancel the claim:** If provider information is missing, Billing Specialist will cancel the claim and assign a Reason Not Billable (RNB) in Claims Training.
	a. Assign cancellation code of XMC18
	    i. Add additional comments to assist FRM or designee in resolving this provider issue
	    ii. The following day, FRM automatically receives notification via communication tool that claim has been canceled due to missing

PROCEDURES	
	provider information & initiates steps to obtain required data
	b. Enter RNB and comment in Claims Tracking to specify the provider information that is missing (i.e. NPI, taxonomy code, PIN, Tax ID, etc.)
	a. If missing information has not been obtained after 30 days, FRM will notify Billing Specialist via communication tool that cancellation was appropriate
	i. **END OF PROCEDURE**
	c. If provider information is updated in VistA, FRM will notify Billing Specialist via communication tool to re-bill previously canceled claim
	i. Establish new billing record and **PROCEED TO STEP 3**

6	**Send claim through scrubber:** The Billing Specialist sends the claim through the Claims Scrubber.
	
	a. If valid insurance verification (VistA) edits appear:
	    i. Forward error to Insurance Verification for correction.
	    ii. After error is corrected and returned to Billing, send bill through the Claims Scrubber.
	b. After VistA edits, send claim to the Claims Scrubber.
	    i. If valid non-coding edits exist, review and correct error
	    ii. If valid coding edits exists return to coding for resolution via Recode/Reject process.
	    iii. If edits that appear are not valid, bypass scrubber.

7	**Submit Claim:** The Billing Specialist submits the claim through the appropriate process, depending on primary payer eligibility. a. If the patient has Medicare, submit the bill through the MRA process. If patient does not have Medicare, submit through EDI. b. If the claim cannot go thru the MRA process, claim should be locally printed with Medicare Payer Exclusion letter. **NOTE**: A CMS 1500 Form will then be generated if there are professional charges associated with the claim.

8	**Print bill locally (If Necessary):** If the bill cannot be submitted electronically, the Billing Specialist prints the bill locally:
	
	a. At Screen <10>:
	    i. Select Option [3] to force local print.
	    ii. Authorize bill.
	    iii. Send printed bill to Mail Room.
	
	NOTE: Claims should be submitted electronically; however, Denial Management analyses, technical limitations or other special circumstances may warrant paper bills to be printed locally.
	
	END OF PROCEDURE

REFERENCE DOCUMENTS

RELATED HANDBOOKS AND OTHER REFERENCES

– Central Business Office Procedures Guide Series 1601C.03, Billing
- Ch. 1 Sec. C, No. 3: Facility Versus Professional Services
- Ch. 1 Sec. C, No. 5: Billable Outpatient Services
- Ch. 1 Sec. E, No. 3: UB-04 Billing Claim Form
- Ch. 1 Sec. E, No. 4: Exhibit 1: UB-04 and CMS 1500 Matrix
- Ch. 1, Sec. G: General Billing Procedures

– Electronic Data Interchange (EDI) Billing Users Guide
– Integrated Billing (IB), Version 2.0 User Manual, March 1994
– CPAC Utilization Review Guidebook, SOP 3.1.1 – Validating Outpatient Encounters
– Mid-Atlantic Consolidated Patient Account Center Guidebook, October 31, 2006
– QuadraMed Encoder Suite Process Guide
– Reasonable Charges Desk Reference, Version 2.0
– Uniform Billing Editor
– Bill Cancellation Review Request Procedure

On-line access to additional current guidance:
– CBO Intranet web site: http://vaww1.va.gov/cbo/

PROCEDURAL DOCUMENTATION EXAMPLES

CPAC Education Billing Level I/II
- *Bill Me Report*
- *Billing ResearchMenu Options*
- *Bill Cancellation and Reasons Not Billable Codes*
- *Common Billing Reports - Bill Status Report*
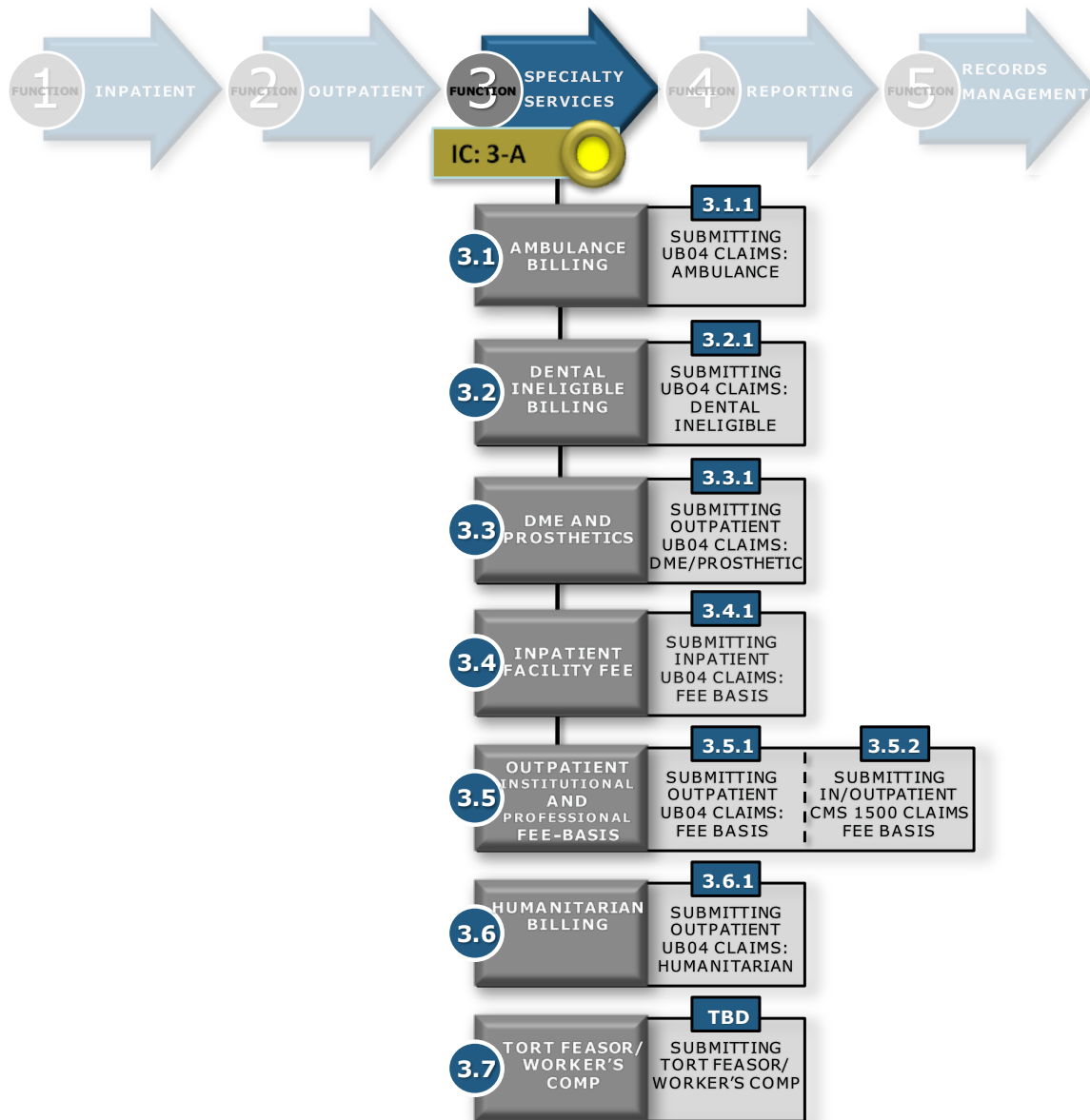- *Common Billing Reports - Unbilled Report*

VERSION HISTORY				
VERSION	**DATE**	**CHANGE DESCRIPTION**	**AFFECTED SECT.**	**APPROVED**
1.9	1-24-13	Updated guidance	All	C. Hutchison
1.8	12-28-12	Updated guidance	All	C. Hutchison
1.6	6-11-2012	Updated guidance	All	C. Hutchison
1.3	2-28-11	Process change	Steps 4 & 4.1	C. Hutchison
0.1	05-28-10	N/A (new draft version developed)	N/A	
	01-26-09	Added detailed steps	All	Jean Shaw
	11-01-05	N/A	N/A	Victor Cruz

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Figure 9: Specialty Services Section Map

Specialty services include ambulance, dental ineligibles, DME/Prosthetics, Fee Basis, humanitarian, tort feasor and worker's compensation claims.

Billing Specialists receive encounter information for these types of services from facility revenue staff and generate individual claims for each encounter.

NOTE: Non-MCCF billing is performed at the medical facilities and includes the following: Allied Beneficiary, CHAMPVA, fugitive felon, Peace Corps, sharing agreements and Tricare.

INTERNAL CONTROLS (FUNCTION LEVEL)

ID	CONTROL DESCRIPTION	TYPE	RISK	SCORE
BI 3-A	Type of Control: Managerial Who: Billing Manager or designee What do they do : Ensure all billable prosthetic encounters are billed. How do they do it: Generate the Bill Me report to identify encounters that have been validated by Coding by entry into a non-count Prosthetics Clinic at least monthly via Quadramed. This report can be re-generated at any time by date range to ensure completion by assigned specialty biller. When: Monthly Where is the evidence: Quadramed reports can be pulled at any time to see the amount of prosthetic encounters that have been assigned to any specialty biller. If a specialty biller had an extreme number of prosthetic encounters assigned to them for > 30 days, this would be an indication that this is not being done timely.	Managerial	If Specialty Services bills are not generated accurately and timely, then Revenue may be delayed or lost.	9

3.1 - Ambulance Billing Process

Figure 10: Ambulance Billing Process
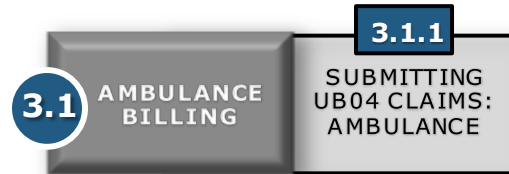
Coverage of ambulance services is based on medical necessity established when the patient's medical condition warrants ambulance transport and any other method is contraindicated. Medical necessity *must* be supported by documentation from the ambulance company and requires a Physician Certification Statement (PCS) for non-emergent ambulance transport. The PCS must be retained on file and be available upon request to the payer.

Billing staff perform the following procedures on an ad hoc basis:

1) **Submitting UB-04 Claims: Ambulance (BILL 3.1.1)** – Create and transmit bills for reimbursement from third party payers for ambulance services.

3.1.1 - Submitting UB-04 Claims: Ambulance

SOP DETAIL	
Title: Submitting UB-04 Claims: Ambulance	
Purpose: Create and transmit bills for reimbursement from third party payers for ambulance services.	
Responsible Party: Billing Lead and Billing Specialist	
Issued By:	**Approved By:**
Effective Date:	**Last Revised:** 12-28-2012

SOP PROCESS FLOW

**Updated process flow to be added

PROCEDURES
GENERAL CONSIDERATIONS: • Billing staff are notified of any changes to billing procedures during bi-weekly meetings and via email. • The Facility Revenue Manager (FRM) provides information needed to complete ambulance billing. NOTE: Ambulance information is usually obtained through a variety of different sources at each VAMC including, but not limited to: Travel, Fee Basis, Contracting Office, and Fiscal Service • Third party claims are submitted using Reasonable Charges. • For patients diagnosed with sensitive diagnosis. Billing Specialists must verify that a Release of Information (ROI) has been obtained from the Veteran for each sensitive duanosis listed on the bill. **NOTE:** Ambulance charges are most commonly reported on a UB-04 claim form, however if an individual third party payer require s these services to be submitted on a CMS-1500 claim form, it is appropriate to do so.

STEP	ACTIVITY
1	**Receive Bill:** On an ad hoc basis, the Billing Specialist receives the ambulance billing information from the facility revenue team to be submitted on the UB-04 form.

PROCEDURES	

2	**Establish Billing Record:** The Billing Specialist establishes a new billing record for each encounter listed on the provided documentation (i.e., CMS 1500, UB-04, or MS Excel spreadsheets).
	
	a. At the Billing Clerk menu, select "Enter/Edit Billing Information".
	b. Establish billing record
	  i. Enter "yes"
	  ii. Enter the selected bill number (or patient identifier, if a bill number has not been generated)
	  iii. Review bill demographic information:
	    1. Bill location of care
	    2. Billing event information source
	    3. Billing time frame
	    4. Billing rate type
	    5. Billing outpatient event date (MM/DD/YY format)
	NOTE: Enter "?" at any time during the billing process for options applicable to that prompt.

3	**Enter Bill Parameters:** The Billing Specialist enters the appropriate information into VistA, guided by screen prompts:
	
	a. Screen <1>: Review patient address and date of birth
	b. Screen <1>: Check to see if any SC conditions
	  iii. At any screen: "?SC" will show if patient has any SC conditions
	  iv. If any SC conditions, coordinate review of ambulance charges with RUR for SC/SA and medical necessity determination(s)
	c. Screen <2>: Review patient employment information.
	d. At any Billing Screen: "?INX" to verify COB and view individual and group comments:
	  iv. Determine primary, secondrary and tertiary coordination of benefits (COB) and Coverage Limitations for each payer
	  v. Patient Policy Comments – includes policy-specific notes such as when (or IF) an ROI form for alcoholism was sent to patient for completion
	  vi. Group Policy Comments identify coverage limitations for this policy – for example, only 50 physcial therapy visits allowed per year
	e. Screen <3>: Enter insurance information:
	  iii. Select Option [1].
	  iv. Select primary, secondary and tertiary insurance policies as appropriate.

PROCEDURES	

4	**Enter Diagnosis Codes:** The Billing Specialist enters the appropriate diagnosis codes related to the HCPCS.
	At Screen <5> for Outpatient;
	   a. Select Option [2]for Outpatient;
	      i. Enter diagnosis codes from copy of the bill
	   b. Select Option [4]
	      i. Enter HCPCS codes from the copy of the bill
	     ii. Add appropriate modifiers, mileage and zip code
	         1. NOTE: If ambulance modifier is not available for selection within VistA, claim must be printed to manually add the modifier to the paper claim

5	**Review Charges**: The Billing Specialist determines whether the charges accurately populated the record.
	   a. At Screen <7> for Outpatient;
	   b. If a reasonable charge amount is not available refer claim to Billing Lead.
	   c. Select Option [5] to update revenue code if applicable
	   d. Proceed to Screen <8>:
	      i. Select Option [3].
	     ii. Enter the name of the attending provider; include provider identification number if required by current billing guidelines.
	    iii. Check warnings and edits.

6	**Enter Ambulance Information:** The Billing Specialist may enter ambulance transport transport information (i.e. origin and destination locations), transport reason and distance, and ambulance certification data on Billing Screen <9>.

7	**Enter or Update Provider Information:** The Billing Specialist enters the appropriate provider information associated with the claim.
	   c. At Screen <8>:
	      v. Select Option [3]
	     vi. Update name of rendering provider and provider ID number(s), if required
	    vii. If appropriate, add name and identification number(s) of referring provider
	   viii. **PROCEED TO STEP 8**
	      i. If the NPI or other provider information is missing, **PROCEED TO STEP 7.1**

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