VETERANS HEALTH ADMINISTRATION

- CHIEF BUSINESS OFFICE -

FEBRUARY 28, 2013

CONSOLIDATED PATIENT ACCOUNT CENTERS (CPAC)

BILLING GUIDEBOOK

FRAMEWORK, PROCESSES, PROCEDURES, AND INTERNAL CONTROLS

VERSION 1.9

BILLING GUIDEBOOK

BILLING GUIDEBOOK

- TABLE OF FIGURES -

PROCEDURES	

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.
	    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.)
	    b. 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. **PROCEED TO STEP 2**

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 exists return to coding for resolution via Recode/Reject process.
	        i. 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.

PROCEDURES	

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. G: General Billing Procedures
  – Ch. 2 Sec. B: Ambulance Reasonable Charges and Billing Procedures
  – Ch. 5 Sec. D: Fellow Services and Fee Basis (Purchased Care) Reasonable Charges and Billing Procedures
– Electronic Data Interchange (EDI) Billing Users Guide
– Integrated Billing (IB), Version 2.0 User Manual, March 1994
– M-1, Part I, Chapter 21 Operations, Part I, Medical Administration Activities, Chapter 21, Authorized Non-VA Hospitalization in the U.S.
– M-1, Part I, Chapter 22 Operations, Part I, Medical Administration Activities, Chapter 22, Unauthorized Medical Services
– QuadraMed Encoder Suite Process Guide
– Reasonable Charges Desk Reference, Version 2.0
– Uniform Billing Editor
– Bill Cancellation Review Request Procedure
– CPAC Facility Revenue Guidebook, SOP 5.1.1, Preparing Ambulance Services

On-line access to additional current guidance:
  – CBO Intranet web site: http://vaww1.va.gov/cbo
  – http://vaww1.va.gov/CBO/rcbilling/presentations/ambulance.asp
  – Fee Program (Purchased Care for Veterans) web site: http://www.nonvacare.va.gov/
  – https://www.novitas-solutions.com
  – Ambulance reasonable charges and billing process
  – Medicare Claims processing Manual – Chapter 15 – Ambulance
  – Payer Exclusion Letter
  – Complete the Ambulance UB-04 Form
  – Medicare Benefit Policy Manual, Chapter 10 – Ambulance Service
  –

PROCEDURAL DOCUMENTATION EXAMPLES

CPAC Education Billing Level I/II
  – *Ambulance Services*
  – *Billing Research Menu Options*
  – *Billing Cancellation and Reasons Not Billable Codes*

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 5 & 5.1	C. Hutchison
0.1	04-15-10	N/A (new draft version developed)		

3.2 - Dental Ineligible Billing Process

Figure 11: Dental Ineligible Billing Process
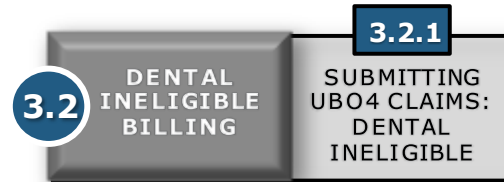
Dental benefits are provided by the Department of Veterans Affairs according to very limited eligibility criteria, as established by law. There are only six dental categories or "benefit classes". Some allow extensive dental care, while other classes only proved for limited treatment. Most veterans do not meet the eligibility criteria to receive cost-free dental treatment at a VA facility. Those veterans who are ineligible for dental care may elect to pay for dental treatment at a VA facility according to the applicable cost-based rate for the type of care provided: emergent outpatient dental treatment or non-emergent outpatient dental treatment.

On an ad hoc basis, Billing Specialists receive from facilities a list of dental ineligible encounters to be billed. Billing Specialists utilize the spreadsheet to establish billing records and generate bills on a UB-04 claim form for each encounter.

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

1) **Submitting UB-04 Claims: Dental Ineligible (BILL 3.2.1)** – Create and transmit bills to patients for reimbursement for dental ineligible services.

FEBRUARY 28, 2013   **DEPARTMENT OF VETERANS AFFAIRS**
CONSOLIDATED PATIENT ACCOUNT CENTER (CPAC)   PAGE | 78
- BILLING GUIDEBOOK -

3.2.1 - Submitting UB-04 Claims: Dental Ineligible

SOP DETAIL	
Title: Submitting UB-04 Claims: Dental Ineligible	
Purpose: Create and submit bills to patient for reimbursement for dental ineligible 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 dental ineligible billing.
- Dental Ineligibles are submitted using cost-based rates.

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

2	**Establish Billing Record:** The Billing Specialist establishes a new billing record for each encounter based on the provided documentation from the FRM.
	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 (dental)
	      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 Date of Service:** The Billing Specialist enters date of service at Screen <5>, under Option [3].

PROCEDURES	
4	**Review Charges**: The Billing Specialist determines whether the charges accurately populate on Screen <7>.

5	**Print bill locally**
	    a. Authorize bill
	    b. Send printed bill to Mail Room

REFERENCE DOCUMENTS
RELATED HANDBOOKS AND OTHER REFERENCES
– Central Business Office Procedures Guide Series 1601C.03, Billing   –   Ch. 4, No. 1: Dental Services Reasonable Charges and Billing – VHA Directive 2005, Cost-Based and Inter-Agency Billing Rates (expires 12/31/2010) – CPAC Facility Revenue Guidebook, SOP 5.1.5 Preparing Humanitarian and Dental Billing – Integrated Billing (IB), Version 2.0 User Manual, March 1994 – Reasonable Charges Desk Reference, Version 2.0 – Uniform Billing Editor On-line access to additional current guidance: – CBO Intranet web site: http://vaww1.va.gov/cbo
PROCEDURAL DOCUMENTATION EXAMPLES
CPAC Education, Billing Level II   –   *Ineligible Dental Care*

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
0.1	04-15-10	N/A (new draft version developed)		

3.3 - DME and Prosthetics Process

Figure 12: DME and Prosthetics Process

Durable medical equipment consists of medical equipment used on an outpatient basis to aid in a better quality of living. Home oxygen and equipment, CPAP's, nebulizers and wheelchairs often qualify as durable medical equipment. Prosthetics are artificial body parts which are used to replace body parts which have been lost due to disease, injury, or birth defect.

On an ad hoc basis, Billing Specialists receive a spreadsheet from facilities detailing DME/Prosthetic encounters to be billed on an outpatient basis. Billing Specialists utilize the spreadsheet to establish billing records and generate bills on a UB-04 claim form for each encounter.

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

1) **Submitting Outpatient UB-04 Claims: DME and Prosthetics (BILL 3.3.1)** – Create and transmit bills for reimbursement from third party payers for outpatient DME and prosthetics VA services.

NOTE: Certain payers may require the service to be billed on a CMS 1500.

FEBRUARY 28, 2013   **DEPARTMENT OF VETERANS AFFAIRS**
CONSOLIDATED PATIENT ACCOUNT CENTER (CPAC)   PAGE | 81
- BILLING GUIDEBOOK -

3.3.1 - *Submitting Outpatient UB-04 Claims: DME and Prosthetics*

SOP DETAIL	
Title: Submitting Outpatient UB-04 Claims: DME and Prosthetics	
Purpose: To create and transmit bills for reimbursement from third party payers for outpatient DME and prosthetics 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:	
- DME and prosthetic items may often require letter of medical necessity substantiated by a physician order. - Certain types of DME services (such as oxygen) are billed on a monthly basis, with the first day of the month listed as the beginning date of service and the last day of the month as the ending date of service on the claim. - 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	**Receive DME/Prosthetic Encounters on Bill Me:** On a daily basis, the Billing Supervisor or designee identifies coded DME/prosthetics encounters on the Bill Me, by clinic name/type, that are ready to be billed and assigns these to the appropriate Biller.

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".
	    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
	            3. Billing time frame
	            4. Billing rate type

PROCEDURES

	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. 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
	 d. Group Policy Comments identify coverage limitations for this policy – for example, only 50 physcial therapy visits allowed per year Screen <2>: Review patient employment information.
	 e. Screen <3>: Enter insurance information.
	      i. Select Option [1]
	          a. Enter primary, secondary and tertiary insurance policies as appropriate
	          b. f the patient has Medicare, payer sequencing is change to secondary
	 f. Screen <5>: Enter the following items:
	      i. Option [6]: Select HCPCS codes
	      ii. Option [2]: Enter appropriate diagnosis codes
	      iii. Option [4]: Select HCPCPS Coding Method and enter appropriate HCPCS codes with modifiers , if applicable
	      iv. In some cases, Billing Specialist must assign the appropriate modifier, based on the item dispensed and the third party payer's billing requirements (see table below):
	
	 (table below)

Billing Modifier	Description	When to Use
NU	New Equipment	New equipment or supply item was purchased by VA (i.e. CPAC supplies)
RR	Rental	Wound vacs, oxygen, hospital beds, wheelchairs **NOTE:** Unless the local facility purchases the oxygen equipment, ALL oxygen HCPCS codes should be billed

PROCEDURES

			with the rental (RR) modifier
	UE	Used Equipment	BILLABLE used prosthetic equipment appears in VistA Prosthetics *Display 2319* as "VA Source" and will generate Claims Tracking entries, but these items do not always create a line item in the Prosthetics GUI Package
	--	Repairs	Currently, there is no modifier for repaired prosthetic/DME items

4	**Review Revenue Codes:** The Billing Specialist selects revenue codes and number of units as necessary.
	    a. At Screen <7>:
	        i. If necessary, select Option [5] to correct revenue codes.
	        ii. Bill using Reasonable Charges.
	
	IC: IT controls should be implemented to limit options to the specific codes for the function and to list the options in a drop-down menu.
	
	IC: The Billing Supervisor reviews and approves corrections to the revenue codes.

5	**Enter or Update Provider Information:** The Billing Specialist enters the appropriate provider information associated with the claim.
	    a. At Screen <10>:
	        i. If Medicare is primary payer, select Option [1] and enter for Remark "DME/Prosthetic – Need Exclusion Letter"
	        ii. Select Option [2]: Enter Primary Reason For Visit (PRV) = Primary Dx code
	        iii. Select Option [3]
	        iv. Update name of attending or rendering provider and provider ID number(s), if required
	        v. If appropriate, add name and identification number(s) of referring provider
	        vi. **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

PROCEDURES	
	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 2**
6	**Submit Claim:** The Billing Specialist submits the claim through the appropriate process, depending on primary payer eligibility. a. If the patient has Medicare, the claim must be printed locally with Payer Exclusion letter.

7	**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
    – Ch. 7 Sec. H: Prosthetics Reasonable Charges and Billing
    – Ch. 4 No. 7: Durable Medical Equipment (DME) Reasonable Charges and Billing Procedures
– Electronic Data Interchange (EDI) Billing Users Guide
– Integrated Billing (IB), Version 2.0 User Manual, March 1994
CPAC Facility Revenue Guidebook, SOP 3.3.1– Identifying Billable Prosthetics and Durable Medical Equipment
– 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 http://vaww1.va.gov/cbo,
    – https://www.novitas-solutions.com/

PROCEDURAL DOCUMENTATION EXAMPLES
CPAC Education Billing Level II   – *Prosthetics and Durable Medical Equipment*

VERSION HISTORY				
VERSION	**DATE**	**CHANGE DESCRIPTION**	**AFFECTED SECT.**	**APPROVED**
1.9	1-24-2013	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

3.4 - Inpatient Facility Fee Basis Claim Process

Figure 13: Inpatient Facility Fee Basis Claim Process

Fee Basis inpatient institutional (facility) services are captured by Fee Basis staff and sent to coding staff for entry into the Patient Treatment File (PTF). On an ad hoc basis, the Billing Specialist receives the non-VA (fee basis) billing information from the facility revenue team.   Billing Specialists validate that a non-PTF record has been transmitted for the fee basis admission and enter the appropriate billing information on the institutional/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 on an ad hoc basis:

1) **Submitting Inpatient UB-04 Fee Basis Claims (BI 3.4.1)** – Create and transmit bills for reimbursement from third party payers for inpatient institutional services rendered by non-VA providers.

Submitting Inpatient UB-04 Claims: Fee Basis

SOP DETAIL
Title: Submitting Inpatient UB-04 Claims: Fee Basis
Purpose: Create and transmit bills for reimbursement from third party payers for inpatient institutional services rendered by non-VA providers.
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:

- Billing staff are notified of any changes to billing procedures during bi-weekly meetings and via email.
- The Facility Revenue Technician (FRT) provides information needed to complete non-VA care billing.
- Third party claims are submitted using Reasonable Charges on the appropriate form type.
- 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	**Receive Notification of Non-VA Admission:** Twice per month, the Billing Specialist receives a spreadsheet from the FRT , regarding paid non-VA/Fee services . If the spreadsheet includes inpatient treatment at a non-VA facility, Billing Specialist generates an inpatient claim to third party payer, if appropriate. a. Verify that non-VA PTF has been transmitted.

2	**Establish Billing Record:** The Billing Specialist establishes a new billing record for each encounter :
	    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

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

- i. Screen <1>: Review patient address and date of birth
- ii. 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)
- iii. 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
- iv. Group Policy Comments identify coverage limitations for this policy – for example, only 50 physcial therapy visits allowed per year
- v. Screen <2>: Review patient employment information.
- vi. Screen <3>: Enter insurance information:
    - i. Select Option [1].
    - ii. Enter primary, secondary and tertiary insurance policies as appropriate.
- vii. Screen <4>: Evaluate encounter information (if available):
    - i. Admission date
    - ii. Time
    - iii. Accident hour (if applicable)
    - iv. Type of admit
    - v. Source of admit
    - vi. Skilled Nursing Facility Care (SNF Care)
    - vii. Discharge date and time
    - viii. Discharge status
    - ix. Admitting diagnosis
    - x. Procedure codes (ICD-9)

PROCEDURES	

4	**Select and Review Bill Type:** The Billing Specialist determines whether an institutional bill can be generated.
	    a. If an institutional bill cannot be generated, no claim is created
	    b. If an institutional bill can be generated:
	          i. Select Option [3] to add diagnosis codes from PTF FILE.
	         ii. Select Option [4] to add procedure codes from PTF FILE and verify ICD-9 Coding method is selected.
	        iii. Select Option [6] to enter occurrence code "11" for onset of illness/symptoms and the 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) rate.
	              1. The daily rate can be found using "?CHG".

5	**DECISION: Does the Patient Have Primary MEDICARE PART A Coverage?**
	    a. If Yes, **PROCEED TO STEP 6**
	    b. If No, **PROCEED TO STEP 7**

PROCEDURES	
6	**Submit Claim Through eMRA Process**: Select Medicare Part A as the primary payer and the 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 #1under 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: 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	

7	**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 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 <10>.
	        ii. If the DRG number of days do 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. Change the bed section associated with each revenue code to "Non-VA Care".
	             4. Proceed to Screen <10>.

8	**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.
	        ii. Select Option [2] and add the operating and attending provider to the claim with identification numbers.

9	**Enter Provider Information:** The Billing Specialist enters the appropriate provider information associated with the claim.
	    a. At Screen <10>:
	         i. Select Option [3]
	             1. Update name of attending provider and provider ID number(s), if required
	             2. If appropriate, add name and identification number(s) of operating and/or referring provider(s)
	        ii. Select Option [4]
	             1. Enter Non-VA Facility Information

PROCEDURES	

10	**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.

11	**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 claim electronically 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 (i.e. admission to skilled nursing facility (SNF) or admit for inpatient rehabilitation stay), claim should be locally printed with the Medicare Payer Exclusion letter.

12	**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.
	        iv. If secondary claim, ensure MRA/EOB is also printed.
	
	NOTE: Claims should be submitted electronically; however, Denial Management analyses, technical limitations or other special circumstances may warrant paper bills to be printed locally.

13	**Notate Billing Action Taken on Spreadsheet:** If inpatient claim for non-VA admission is created, enter claim number in last column of spreadsheet. If inpatient claim cannot be created, enter the appropriate reason that non-VA admission could not be submitted to third party payer (i.e. payer does not cover inpatient care, policy was not in effect at time of admission, timely filing exceeded, ROI not obtained for sensitive dx of XXXX, etc.)
14	**Save Completed Spreadsheet:** Save spreadsheet to appropriate folder on SharePoint or shared drive. **END OF PROCEDURE**

REFERENCE DOCUMENTS

RELATED HANDBOOKS AND OTHER REFERENCES

– Central Business Office Procedures Guide Series 1601C.03, 1601D.3,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. 6 Sec. F: Non-Covered Services Billing Procedures
- – Ch. 5 Sec. D: Fellow Services and Fee Basis (Purchased Care) Reasonable Charges and Billing Procedures

– Electronic Data Interchange (EDI) Billing Users Guide

– Integrated Billing (IB), Version 2.0 User Manual, March 1994

– M-1, Part I, Chapter 21 Operations, Part I, Medical Administration Activities, Chapter 21, Authorized Non-VA Hospitalization in the U.S.

– M-1, Part I, Chapter 22 Operations, Part I, Medical Administration Activities, Chapter 22, Unauthorized Medical Services

– CPAC Facility Revenue Guidebook, SOP 5.1.2, 5.1.3 Preparing Fee/Non –VA Care Billing Third Party CPAC Utilization Review, SOP 5.1.1 – Purchased Care (Fee Basis) Review Process, SOP 5.1.2 – Purchased Care Cont. Stay Review

– 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

– VHA Directive 2007-010, Timeliness Standards for Processing Non-VA Provider Claims, February 16, 2007

– Bill Cancellation Review Request Procedure

– CPAC Facility Revenue Guidebook; SOP 5.1.2 – *Preparing Fee/Non-VA Care Billing – Third Party (FBCS only)*

On-line access to additional current guidance
- – CBO Intranet web site: http://vaww1.va.gov/cbo
- – Fee Program (Purchased Care for Veterans) web site: http://www.nonvacare.va.gov/
- – https://www.novitas-solutionscom/

PROCEDURAL DOCUMENTATION EXAMPLES

CPAC Education, Billing Level II
- – *Fee Basis*
- – *Inpatient Basics*

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	02-28-11	Process changes	Steps 5,7 & 7.1	C. Hutchison
0.1	04-15-10	N/A (new draft version developed)	N/A	

3.5 - Outpatient Institutional and Professional Fee Basis Claim Process

Figure 14: Outpatient Institutional and Professional Fee Basis Claim Process
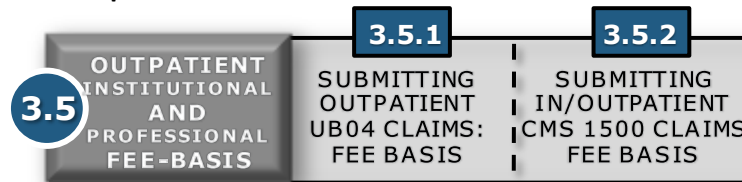
Non-VA (fee basis) outpatient institutional and professional services are captured by Fee Basis staff. Facility revenue teams identify fee basis outpatient services that are potentially billable to a third party payer. On an ad hoc basis, the Billing Specialist receives the non-VA (fee basis) billing information from the facility revenue team.   Billing Specialists use the fee basis claim information provided by the facility revenue team to create the institutional (UB-04) or professional (CMS-1500) claim form as appropriate, including demographics, diagnoses/procedural codes, insurance policies, revenue codes and other required billing parameters. UB-04 claim forms are standard claim forms used for both inpatient and outpatient facility charges.

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

1) **Submitting Outpatient Institutional UB-04 Claims: Fee Basis (BI 3.5.1)** – Create and transmit bills for reimbursement from third party payers for outpatient institutional services rendered by non-VA providers.

2) **Submitting Inpatient/Outpatient CMS-1500 Claims: Fee Basis (BI 3.5.2)** – Create and transmit bills for reimbursement from third party payers for inpatient and outpatient professional services rendered by non-VA providers.

FEBRUARY 28, 2013   **DEPARTMENT OF VETERANS AFFAIRS**
CONSOLIDATED PATIENT ACCOUNT CENTER (CPAC)   PAGE | 96
- BILLING GUIDEBOOK -

3.5.1 - *Submitting Outpatient UB-04 Claims: Fee Basis*

SOP DETAIL	
Title: Submitting Outpatient UB-04 Claims: Fee Basis	
Purpose: Create and transmit bills for reimbursement from third party payers for outpatient institutional services rendered by non-VA providers.	
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.
- The Facility Revenue Technician (FRT) provides information needed to complete non-VA care billing.
- Dialysis, chemotherapy and other services are often outsourced to vendors to provide greater patient access or due to limited services provided within certain geographical areas.
- Third party claims are submitted using Reasonable Charges on the appropriate form type.
- 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	**Receive Spreadsheet from Facility Revenue**: Billing Specialist receives non-VA billing information from the FRT via spreadsheet that is posted to SharePoint twice per month. NOTE: Fee claims are processed on a first-in, first-out basis.

2	**Establish Billing Record:** The Billing Specialist establishes a new billing record for each encounter listed on the vendor 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:

PROCEDURES	
	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
	    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. 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
	d. Group Policy Comments identify coverage limitations for this policy – for example, only 50 physcial therapy visits allowed per year
	e. Screen <2>: Review patient employment information.
	f. Screen <3>: Enter insurance information:
	    i. Select Option [1].
	    ii. Enter primary, secondary and tertiary insurance policies as appropriate.
	        1. Change payer sequence as necessary.
	g. Screen <5>: Enter the following items:
	    i. Based on carrier requirements
	    ii. Providers listed
	    iii. Option [2]: Enter appropriate diagnosis
	    iv. Option [4]: Enter appropriate CPT codes
	    v. Add appropriate modifiers
	    vi. Enter appropriate value, condition and occurrence codes as required by current billing and MRA guidelines
	    vii. Change coding method to ICD-9 coding

4	**Review Revenue Codes:** The Billing Specialist selects appropriate revenue codes
	a. At Screen <7>:
	    i. Select Option [5] to correct revenue codes and number of units as necessary.
	    ii. Change the bed section to non-VA care.

PROCEDURES	

5	**Enter 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 and/orreferring provider

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, payer sequencing is changed to secondary and claim is printed locally with 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.
	          iv. If secondary claim, ensure MRA/EOB is also printed.
	
	NOTE: Claims should be submitted electronically; however, Denial Management analyses, technical limitations or other special circumstances may warrant paper bills to be printed locally.

9	**Notate Billing Action Taken on Spreadsheet:** If inpatient claim for non-VA admission is created, enter claim number in last column of spreadsheet. If inpatient claim cannot be created, enter the appropriate reason that non-VA admission could not be submitted to third party payer (i.e. payer does not cover inpatient care, policy was not in effect at time of admission, timely filing exceeded, ROI not obtained for sensitive dx of XXXX, etc.)

PROCEDURES		
10	**Save Completed Spreadsheet:** Save spreadsheet to appropriate folder on SharePoint or shared drive. **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
- – Ch. 6 Sec. F Non-Covered Services Billing Procedures
- – Ch. 5 Sec. D: Fellow Services and Fee Basis (Purchased Care) Reasonable Charges and Billing Procedures

– Electronic Data Interchange (EDI) Billing Users Guide

– Integrated Billing (IB), Version 2.0 User Manual, March 1994

– CPAC Facility Revenue Guidebook*, SOP 5.1.2, 5.1.3 Preparing Fee/Non-VA Care Billing-Third Party (fbcs only)*

– M-1, Part I, Chapter 21 Operations, Part I, Medical Administration Activities, Chapter 21, Authorized Non-VA Hospitalization in the U.S.

– M-1, Part I, Chapter 22 Operations, Part I, Medical Administration Activities, Chapter 22, Unauthorized Medical Services

– 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

– VHA Directive 2007-010, Timeliness Standards for Processing Non-VA Provider Claims, February 16, 2007

– Bill Cancellation Review Request Procedure

– On-line access to additional current guidance:
  - – CBO Intranet web site: http://vaww1.va.gov/cbo
  - – Fee Program (Purchased Care for Veterans) web site: http://www.nonvacare.va.gov/

PROCEDURAL DOCUMENTATION EXAMPLES
CPAC Education, Billing Level II

- – *Fee Basis*

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 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

3.5.2 - Submitting Inpatient and Outpatient CMS 1500 Claims: Fee Basis

SOP DETAIL	
Title: Submitting Inpatient and Outpatient CMS 1500 Claims: Fee Basis	
Purpose: Create and transmit bills for reimbursement from third party payers for inpatient and outpatient professional services rendered by non-VA providers.	
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

GENERAL CONSIDERATIONS:
- Billing staff are notified of any changes to billing procedures during bi-weekly meetings and via email.
- The Facility Revenue Technician (FRT) provides information needed to complete non-VA care billing.
- Dialysis, chemotherapy and other services are often outsourced to vendors to provide greater patient access or due to limited services provided within certain geographical areas.
- Third party claims are submitted using Reasonable Charges on the appropriate form type.
- 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	**Receive Spreadsheet from Facility Revenue**: Billing Specialist receives non-VA billing information from the FRT via spreadsheet that is posted to SharePoint twice per month. NOTE: Fee claims are processed on a first-in, first-out basis.

2	**Establish Billing Record:** The Billing Specialist establishes a new billing record for each encounter listed on the vendor 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
	       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

4	**Enter Diagnosis Codes:** The Billing Specialist selects the appropriate diagnosis codes related to the CPT.
	 At Screen <5> for Outpatient; Screen <4> for Inpatient:
	    a. Select Option [2]for Outpatient; Option [3] for Inpatient
	        i. Enter diagnosis codes from copy of the bill
	    b. Select Option [4]
	        i. Enter CPT codes from the spreadsheet or copy of the bill
	       ii. Associate diagnosis and CPT codes
	      iii. Add appropriate modifiers, place of service, type of service and diagnosis by number
	    c. Enter purchased cost of care from the non-VA provider's claim

5	**Review Charges**: The Billing Specialist determines whether the charges accurately populated the record.
	    a. At Screen <7> for Outpatient; Screen <6> for Inpatient:
	        i. If charges did not populate, manually enter them from the bill provided.
	       ii. Select Option [5] to update bed section to non-VA care
	      iii. Proceed to Screen <8>:
	          1. Select Option [3].
	          2. Enter the name of the rendering provider; include referring physician and provider identification number if required by current billing guidelines.
	          3. Select Option [4]and enter name of facility where the fee basis services were performed
	          4. Check warnings and edits.

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

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, payer sequencing is changed to secondary and claim is printed locally with 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.
	        iv. If secondary claim, ensure MRA/EOB is also printed.
	
	NOTE: Claims should be submitted electronically; however, Denial Management analyses, technical limitations or other special circumstances may warrant paper bills to be printed locally.

9	**Notate Billing Action Taken on Spreadsheet:** If inpatient claim for non-VA admission is created, enter claim number in last column of spreadsheet. If inpatient claim cannot be created, enter the appropriate reason that non-VA admission could not be submitted to third party payer (i.e. payer does not cover inpatient care, policy was not in effect at time of admission, timely filing exceeded, ROI not obtained for sensitive dx of XXXX, etc.)
10	**Save Completed Spreadsheet:** Save spreadsheet to appropriate folder on SharePoint or shared drive. **END OF PROCEDURE**

REFERENCE DOCUMENTS	
RELATED HANDBOOKS AND OTHER REFERENCES	

– Central Business Office Procedures Guide Series 1601C.03, Billing
  – Ch. 1 Sec. C, No. 4: Billable Inpatient Services
  – Ch. 1 Sec. C, No. 3: Facility Versus Professional 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
  – Ch. 5 Sec. D: Fellow Services and Fee Basis (Purchased Care) Reasonable Charges and Billing Procedures
  – Ch 6 Sec. F: Non-Covered Services Billing Procedures
– Electronic Data Interchange (EDI) Billing Users Guide
– Integrated Billing (IB), Version 2.0 User Manual, March 1994
– M-1, Part I, Chapter 21 Operations, Part I, Medical Administration Activities, Chapter 21, Authorized Non-VA Hospitalization in the U.S.
– M-1, Part I, Chapter 22 Operations, Part I, Medical Administration Activities, Chapter 22, Unauthorized Medical Services
– 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
– VHA Directive 2007-010, Timeliness Standards for Processing Non-VA Provider Claims, February 16, 2007
– Bill Cancellation Review Request Procedure
– CPAC Utilization Review, SOP 5.1.1 – *Purchased Care (Fee Basis) Review Process*, SOP 5.1.2 *Purchased Care Cont. Stay Review*
– CPAC Facility Revenue Guidebook, *SOP 5.1.2 – Preparing Fee/Non-VA Care Billing – Third Party (FBCS only)*
On-line access to additional current guidance:
  – CBO Intranet web site: http://vaww1.va.gov/cbo
  – Fee Program (Purchased Care for Veterans) web site: http://www.nonvacare.va.gov/

PROCEDURAL DOCUMENTATION EXAMPLES	

CPAC Education, Billing Level II
  – *Fee Basis*
  – *Billing Basics*
  – *Inpatient Basics*

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 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

3.6 - Humanitarian Billing Process

Figure 15: Humanitarian Billing Process
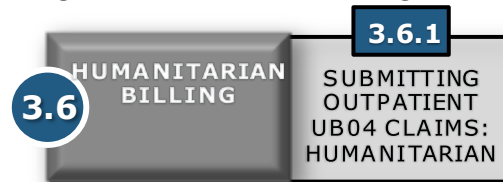
VHA Policy, in compliance with *Public Law (P. L.) 104-262*, the Veterans Health Care Eligibility Reform Act of 1996 and VHA Directive 2012-006 states Under Title 38 United States Code (U.S.C.) 1784 and Title 38 Code of Federal regulations (CFR) Section 17.43 (Emergency Humanitarian Care authority), VHA may provide hospital care or treatment as a humanitarian service to persons having no eligibility and in need of emergency care while at the VAMC. When VA medical care or service is furnished to an ineligible person (i.e. a non-veteran), the patient is charged the appropriate cost-based rate, as determined by VHA Directive.

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

1) **Submitting Outpatient UB-04 Claims: Humanitarian (BILL 3.6.1)** – Create and transmit bills to patients for reimbursement of Humanitarian services.

FEBRUARY 28, 2013   **DEPARTMENT OF VETERANS AFFAIRS**
CONSOLIDATED PATIENT ACCOUNT CENTER (CPAC)   PAGE | 108
- BILLING GUIDEBOOK -

3.6.1 - Submitting UB-04 Claims: Humanitarian

SOP DETAIL	
Title: Submitting UB-04 Claims: Humanitarian	
Purpose: Create and submit bills to patient for reimbursement for Humanitarian 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 Humanitarian billing.	
• Humanitarian are submitted using cost-based rates.	

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

2	**Establish Billing Record:** The Billing Specialist establishes a new billing record for each encounter based on the provided documentation from the FRM.
	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 (Humanitarian)
	      5. Billing outpatient event date (MM/DD/YY format)
	NOTE: Enter "?" at any time during the billing process for options applicable to that prompt.

PROCEDURES		
3	**Enter Date of Service:** The Billing Specialist enters date of service at Screen <5>, under Option [3] **Note**: Diagnosis and CPT codes are not required but if available, should be added.	
4	**Review Charges**: The Billing Specialist determines whether the charges accurately populate on Screen <7>.	

5	**Print bill locally**
	   a. Authorize bill
	   b. Send printed bill to Mail Room
	
	NOTE 1: Until VistA enhancement is implemented to allow for the creation of a humanitarian bill to a third party payer using the Humanitarian rate type, a manual process must be used to send Humanitarian bills to third party payers.
	
	NOTE 2: If patient receives humanitarian care and is covered by a billable third party payer, the Billing Specialist may place a label with the third party payer's name/address over the patient's name/address on the printed bill. If payment is received from third party payer, the patient will be responsible for any remaining balance due.
	
	END OF PROCEDURE	

REFERENCE DOCUMENTS
RELATED HANDBOOKS AND OTHER REFERENCES
– M-1, Part I, Chapter 15, Charges and Payments for Medical Care – VHA Directive 2007-012, Eligibility Verification Process for VA Health Care Benefits – Integrated Billing (IB), Version 2.0 User Manual, March 1994 – Volume XII – Debt Management, Chapter 5 – CPAC Facility Revenue Guidebook, SOP 5.1.5 – Preparing Humanitarian and Dental Billing On-line access to additional current guidance: – CBO Intranet web site: http://vaww1.va.gov/cbo
PROCEDURAL DOCUMENTATION EXAMPLES
CPAC Education Billing Level II   –   *Humanitarian Care*

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
0.1	04-15-10	N/A (new draft version developed)	N/A	

FEBRUARY 28, 2013   **DEPARTMENT OF VETERANS AFFAIRS**
CONSOLIDATED PATIENT ACCOUNT CENTER (CPAC)   PAGE | 111
- BILLING GUIDEBOOK -

3.7 - Tort Feasor and Worker's Compensation Cases

Figure 16: Tort Feasor and Worker's Compensation Cases
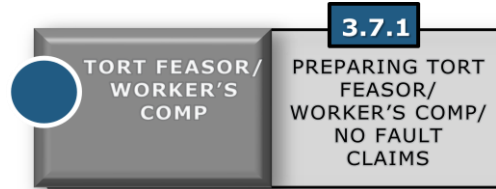
Tort feasor, worker's compensation and no fault cases are specific to accidents and injuries incurred outside of VA by Veterans. A "tort feasor" case involves incidents where a Veteran has suffered an injury that may be a result of another party's negligence. A "worker's compensation" case is related to an on-the-job injury or illness entitling a person to compensation from a state or Federal agency as a result of that incident. A "no fault" case typically involves a motor vehicle accident in which the injured party was a driver, passenger, pedestrian, or bicyclist.

CPAC is only responsible for those claims that are posted to the MCCF/CPAC General Ledger. This does not include federal employees with active worker's comp cases, which are processed by the Office of Worker's Compensation Program (OWCP) within the U.S. Department of Labor. All tort, non-federal worker's comp and no fault claims should be created with the appropriate rate type (Tort Feasor, Worker's Compensation or No Fault) and using Reasonable Charges.

Accurate and timely billing of these cases must be coordinated between CPAC Facility Revenue and Billing staff. Many worker's comp policies require pre-authorization of inpatient and/or outpatient services to consider any claims for reimbursement. Additionally, all claims related to tort, worker's comp and no-fault cases must be generated in a timely manner to allow sufficient time for Regional Counsel to review, submit, and negotiate reimbursement of these claims with third party payers.

FEBRUARY 28, 2013   **DEPARTMENT OF VETERANS AFFAIRS**
CONSOLIDATED PATIENT ACCOUNT CENTER (CPAC)   PAGE | 112
- BILLING GUIDEBOOK -

3.7.1 - *Preparing Tort Feasor, Worker's Compensation and No-Fault Claims*

SOP DETAIL	
Title: Preparing Tort Feasor, Worker's Compensation and No-Fault Claims	
Purpose: Prepare claims for services related to tort feasor, worker's compensation and no fault cases.	
Responsible Party: Billing Specialist	
Issued By:	**Approved By:**
Effective Date:	**Last Revised:** 12-28-2011

SOP PROCESS FLOW

3.7.1 PREPARING TORT FEASOR, WORKER'S COMPENSATION AND NO-FAULT CLAIMS

Manual — **VistA**

1. Receive Notification of Billable Services Related to Legal Cases
2. Establish Billing Record
3. Review Spreadsheet to Determine Type of Service
4. Is Inpatient Facility? — YES
5. Refer to SOP 1.1.1 / NO
6. Is Inpatient Professional? — YES
7. Refer to SOP 1.2.1 / NO
8. Is Outpatient Facility? — YES
9. Refer to SOP 2.1.1 / NO
10. Is Outpatient Professional? — YES
11. Refer to SOP 2.2.1 / NO
12. Is DME/Prosthetics? — YES
13. Refer to SOP 3.3.1 / NO
14. Is Inpatient Facility Fee Basis? — YES
15. Refer to SOP 3.4.1 / NO
16. Is Outpatient Facility Fee Basis? — YES
17. Refer to SOP 3.5.1 / NO
18. Is Inpatient Prof./Outpatient Fee? — YES
19. Refer to SOP 3.5.2 / NO
20. Is Prescription? — YES
21. Validate Charges
22. Add Comment
23. Send Printed Claims to FRT (A)

NO

FRT

Notification of Billable Services Related to Legal Cases

Comments → Billing
Claims → FRT, Regional Counsel

Supplier(s)
- Facility Revenue Technician

Input(s)
- Notification of Billable Services Related to Legal Cases (Spreadsheet)

Procedure Objective(s)
- Prepare claims for services related to tort feasor, worker's compensation and no fault cases.
- Determine the type of service and refer to appropriate SOP's to generate claims

(A) **Key Handoff:** All claims are sent to the FRT

Output(s)
- Comments
- Printed Claims

Customer(s)
- Billing
- Facility Revenue Technician
- Regional Counsel

PROCEDURES

GENERAL CONSIDERATIONS:
- Facility Revenue Technician (FRT) is responsible for obtaining all paperwork required by their Regional Counsel Office for each tort, worker's compensation and no-fault claim.
- FRT will provide tort feasor, worker's compensation and no-fault policy information to Insurance Verification for entry into VistA; this includes the patient's condition(s) that are related to the tort feasor or worker's compensation case for entry into the Patient Policy Comments section of the Patient Insurance entry.
- Prior to providing information to Billing, FRTs will coordinate with Utilization Review (UR) to validate whether patient received case-related treatment.
- Once coding has been completed, FRT will update the Legal Cases spreadsheet and post to SharePoint for billing action.
- If treatment is determined to be non-billable and patient has no other insurance coverage, FRT will assign the appropriate RNB in Claims Tracking.
- Tort feasor, worker's compensation and no fault claims are created using reasonable charges.

STEP	ACTIVITY
1	**Receive Notification of Billable Services Related to Legal Cases:** On a ad hoc basis, FRTs will post updated spreadsheets to CPAC SharePoint, identifying billable inpatient, outpatient, prosthetics, fee, and prescription services related to legal cases. All items listed on the spreadsheet will be validated by UR and Coding prior to posting on SharePoint site. *NOTE: To activate automatic e-mail notification each time information within a SharePoint folder has been updated, access the appropriate SharePoint folder, click on "Actions" and then select "Alert Me".*
2	**Establish Billing Record:** The Billing Specialist establishes a new billing record for each item on the spreadsheet. a. When creating the billing record, choose one of the following billing rate types: Tort Feasor, Worker's Comp or No Fault

3	**Decision:** Review spreadsheet to determine the type of service to be billed (i.e. inpatient, outpatient, durable medical equipment (DME)/prosthetic item, Fee Basis, medication).
	
	a. If inpatient facility service, **refer to SOP 1.1.1**
	   1. Then **PROCEED TO STEP 5**
	b. If inpatient professional service, **refer to SOP 1.2.1**
	   1. Then **PROCEED TO STEP 5**
	c. If outpatient facility claim, **refer to SOP 2.1.1**
	   1. Then **PROCEED TO STEP 5**
	d. If outpatient professional claim, **refer to SOP 2.2.1**
	   1. Then **PROCEED TO STEP 5**
	e. If DME/prosthetic item, **refer to SOP 3.3.1**
	   1. Then **PROCEED TO STEP 5**
	f. If inpatient facility Fee Basis service, **refer to SOP 3.4.1**
	   1. Then **PROCEED TO STEP 5**
	g. If outpatient facility Fee Basis service, **refer to SOP 3.5.1**
	   1. Then **PROCEED TO STEP 5**
	h. If inpatient professional or outpatient Fee Basis service, **refer to SOP 3.5.2**
	   1. Then **PROCEED TO STEP 5**
	i. If prescription, **PROCEED TO STEP 4**

4	**Validate Charges:** Validate that charges populate for each prescription on the claim. a. Screen <5>: Select Option [5] and select the appropriate prescriptions to be included on the claim. b. Screen <7>: If charges are not listed, Select Option [1] and remove bill charge type (institutional/professional) and validate that charges appear on Screen <7> for each prescription listed on Screen <5> . c. Screen <8>: Select Option [2] to add the attending provider. d. **PROCEED TO STEP 5** **NOTE 1**: Diagnosis code is populated under Option [2] on Screen <5>; certain carriers may require specific diagnosis code. **NOTE 2**: For additional guidance related to prescription billing, refer to CPAC OPECC Guidebook, SOP 1.2.1 entitled "Submitting Paper Outpatient Pharmacy Claims".

FEBRUARY 28, 2013   **DEPARTMENT OF VETERANS AFFAIRS**
CONSOLIDATED PATIENT ACCOUNT CENTER (CPAC)   PAGE | 116
- BILLING GUIDEBOOK -

5	**Add Comment:** All non-Federal worker's comp, tort feasor and no fault claims must include a statement which specifies that the total charge on the claim includes Veteran's copayments. a. Screen <8>: Select Option [1] and enter the comment "Gross amount includes the copayment" *NOTE*: Per Medical Care Debts Financial Policies and Procedures, Volume XII - Chapter 5, if the Veteran pays the copayment and all or a portion of the copayment is recovered from the third party payer, a refund to the Veteran is to be made promptly.
6	**Notate action taken on spreadsheet:** The Billing Specialist will enter their initiails next to each line item that has been billed (in the last column) to ensure each legal case on the spreadsheet has been processed.
7	**Save Completed Spreadsheet:** Save spreadsheet to appropriate folder on SharePoint or shared drive.
8	**Send Printed Claims to Facility Revenue Technician (FRT).** Mail a copy of the spreadsheet and all corresponding claims to FRT for submission to Regional Counsel. **END OF PROCEDURE**

REFERENCE DOCUMENTS

RELATED HANDBOOKS AND OTHER REFERENCES

– Central Business Office Procedures Guide Series 1601C.03, Billing
  – Ch. 8 Sec. H, Worker's Compensation and Reasonable Charges and Billing
  – Ch. 6 Sec G, No Fault Billing Procedures
  – 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
  – Ch. 7 Sec. H: Prosthetics Reasonable Charges and Billing
  – Ch. 4 No. 7: Durable Medical Equipment (DME) Reasonable Charges and Billing Procedures
  – Ch. 7 Sec. B: Pharmacy Reasonable Charges and Billing
  – Ch. 7 Sec. G: Prescriptions Reasonable Charges and Billing
  – Ch. 5 Sec. D: Fellow Services and Fee Basis (Purchased Care) and Reasonable Charges and Billing Procedures
– Integrated Billing (IB), Version 2.0 User Manual, March 1994
– Reasonable Charges Desk Reference, Version 2.0
– Uniform Billing Editor
– CPAC Facility Revenue Guidebook*, SOP 5.1.4: Preparing Documentation for Legal Cases*
– CPAC Insurance Verification Guidebook, SOP 2.2.10: Entering Tort Feasor, Worker's Compensation and No Fault Policies
– CPAC Accounts Management Guidebook*, SOP 4.1.2 - Preparation of Regional Counsel Third Party Referrals, SOP 5.1.1- Workers' Compensation/Tort Feasor/No Fault Accounts Management Procedures*
– Medical Care Debts Financial Policies and Procedures, Volume XII - Chapter 5
On-line access to additional current guidance:
  – CBO Intranet web site: http://vaww1.va.gov/cbo

PROCEDURAL DOCUMENTATION EXAMPLES

CPAC Education, Billing Level II
  – *Legal Cases*

VERSION HISTORY				
VERSION	**DATE**	**CHANGE DESCRIPTION**	**AFFECTED SECT.**	**APPROVED**
1.9	1-24-13	Update guidance	All	C. Hutchison
1.8	12-28-12	Updated guidance	All	C. Hutchison
1.4	10-28-2011	N/A (new draft version developed)	3.7	C.Hutchison

Figure 17: Reporting Section Map

Daily, weekly, and monthly, the billing staff generates a variety of operational reports that are distributed to employees, supervisors and managers to effectively manage work lists and ensure all billable encounters are captured.

Health Information Management (HIM) staff also perform retrospective coding audits that may result in changes to the diagnosis and/or procedure code(s) assigned to the encounter. When these cases are identified, HIM communicates these retrospective reviews back to Billing via spreadsheet to take appropriate corrective action. If the encounters were previously billed to a third party payer Billing staff use the communication tool to notify Accounts Management, cancel the original claim, and submit a corrected claim when appropriate.

Figure 17 above provides a map of all processes and SOPs associated with Reporting function:

INTERNAL CONTROLS (FUNCTION LEVEL)				
ID	CONTROL DESCRIPTION	TYPE	RISK	SCORE
N/A	Covered at the department level	N/A	If the Billing Manager does not review and analyze relevant billing reports, then Revenue may be delayed or lost.	12

4.1 - Claim Status Awaiting Resolution (CSA) and MRA Worklist (MRW) Reports

Figure 18: CSA and MRA Worklist Reports
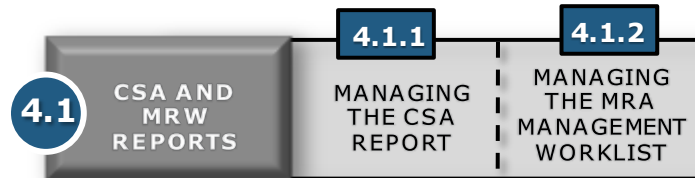
The Claim Status Awaiting Resolution (CSA) report includes error (rejection) messages for electronic claims. Rejected claims on the CSA report have not been accepted by the payer and require follow-up action to resolve. Billing staff should work this report daily and take appropriate corrective action within 5 business days. Billing Specialists should resolve their own rejects to facilitate learning and improve their first pass "clean claim" rate. Failure to work claim rejections in timely manner may negatively impact the AR > 90 Days and GDRO performance metrics.

The MRA Worklist (MRW) includes processed, rejected, and denied MRAs from Novitas(Medicare) Part A and Part B. Claims on the MRW have not been converted to secondary claims for submission to the secondary payers. Billing Specialists should also review their own claims on the MRW and take appropriate corrective action within 5 business days. Failure to work claims on the MRA Worklist in a timely manner may result in a negative impact to the Collections performance metric.

Billing staff perform the following procedures daily:

1) **Managing the Claim Status Awaiting Resolution (CSA) Report (BI 4.1.1)** - Identify and implement corrective actions for rejected claims within 5 business days

2) **Managing the MRA Management Work List (MRW) (BI 4.2.1)** - Identify and resolve processed, rejected and denied Medicare Remittance Advices (MRAs) returned by Novitas Part A and Part B.

FEBRUARY 28, 2013   **DEPARTMENT OF VETERANS AFFAIRS**
CONSOLIDATED PATIENT ACCOUNT CENTER (CPAC)   PAGE | 120
- BILLING GUIDEBOOK -

4.1.1 - *Managing the Claims Status Awaiting Resolution (CSA) Report*

SOP DETAIL	
Title: Managing the Claim Status Awaiting Resolution (CSA) Report	
Purpose: Identify and implement corrective actions for rejected claims within 5 business days	
Responsible Party: Billing Specialist, Billing Lead	
Issued By:	**Approved By:**
Effective Date:	**Last Revised:** 12-28-2012

SOP PROCESS FLOW

Updated process flow to be added

PROCEDURES	
GENERAL CONSIDERATIONS:	
• Electronic claim rejections occur at various sources external to VistA: the HIPAA Validator (VALD) at Austin's Financial Services Center (FSC), Emdeon Clearinghouse (EMDEON), or a Payer. • Failure to work rejected claims timely may result in a negative impact to the following POWER Performance Metrics: AR > 90 Days and GDRO (Gross Days Revenue Outstanding)	

STEP	ACTIVITY

1	**Run Claim Status Awaiting Resolution (CSA) Report**: On a daily basis, the Billing Specialist runs the CSA Report in VistA using the following sort criteria:
	   a. Authorizing Biller = ALL
	     Primary Sort = **N**umber of Days Pending
	     Secondary Sort = **A**uthorizing Biller
	     Tertiary Sort = **P**ayer
	   b. In addition to the sort above, the following alternate sort criteria options could be helpful in the error resolution process:
	     i. Authorizing Biller = ALL; Primary Sort = Bill Number (identifies all error messages associated to one claim)
	     ii. Authorizing Biller = ALL; Primary Sort = Patient Name (identifies all rejected claims for the same patient)
	     iii. Authorizing Biller = ALL; Primary Sort = Payer; Secondary Sort = Error Code Text (identifies payer trends)

2	**Identify the source of the rejection/error**: Each CSA rejection message includes one of the following sources:
	   a. **RTP** indicates a Return to Provider rejection from Novitas Part A
	   b. **VALD** indicates a Validator rejection from the Financial Services Center (FSC)
	   c. **Emdeon** identifies a claim rejection from Emdeon
	     i. Certain Emdeon errors are implemented at the request of specific payers and must be resolved by contacting the payer
	   d. **Payer** represents a rejection from a Payer (including Novitas Part A/Part B)

3	**Take corrective action**: The Billing Specialist reviews each rejected claim and performs

PROCEDURES		
		the appropriate corrective action within 5 business days using one of the following options:
		a. Cancel bill
		b. Copy/Cancel Bill
		c. Retransmit Bill
		d. Resubmit by Print
		e. Review Status
		i. If claim rejections cannot be resolved within 5 business days, change the review status to "Review in Process"
		ii. For all claims in a Review in Process status, use the "Enter/Edit Comments" option to indicate all action(s) taken
4		**Review CSA Report:** At least bi-weekly, Billing Lead reviews the CSA report to ensure rejected claims are consistently worked within 5 business days
		a. Unresolved CSA rejections greater than 5 working days must be monitored to ensure corrective action is completed
		END OF PROCEDURE

REFERENCE DOCUMENTS
RELATED HANDBOOKS AND OTHER REFERENCES
Central Business Office Procedures Guide Series 1601C.03, Billing
–   Ch. 1 Sec. G, No.7: Correcting Billing Errors
–   Electronic Data Interchange (EDI) Billing Users Guide
On-line access to additional current guidance:
–   CBO Intranet web site: http://vaww1.va.gov/cbo
–   e-MRA (electronic Medicare Remittance Advice) and e-Claims (electronic Claims) web sites: http://vaww.vistau.med.va.gov/vistau-ebp/default.htm
PROCEDURAL DOCUMENTATION EXAMPLES
CPAC Education, Billing Level I/II
–   *Common Billing Reports*
–   *Claims Status Awaiting Report(CSA)*

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 process flow	All	C. Hutchison
0.1	05-28-10	N/A (new draft version developed)	N/A	

4.1.2 - *Managing the MRA Management Worklist (MRW)*

SOP DETAIL	
Title: Managing the MRA Management Work List (MRW)	
Purpose: Identify and resolve processed, rejected and denied Medicare Remittance Advices (MRAs) returned by Novitas Part A and Part B	
Responsible Party: Billing Specialist, Billing Lead	
Issued By:	**Approved By:**
Effective Date:	**Last Revised:** 12-28-2012

SOP PROCESS FLOW

Updated process flow to be added

PROCEDURES	
GENERAL CONSIDERATIONS:	
• Claims on the MRW are always from Novitas and include processed, rejected and denied MRA requests	
• Failure to work claims on the MRW report in a timely manner may result in a negative impact to the following POWER Performance Metric: Collections	
STEP	**ACTIVITY**

1	**Run the MRA Management Work List (MRW)**: On a daily basis, the Billing Specialist runs the MRW Report in VistA using the following sort criteria:
	    a. Authorizing Biller = <Enter Last Name>
	       Sort By = **L** Date Last MRA Received
	       Include Denied MRAs for Duplicate Claim/Service?/ **Y**es (to see duplicate rejects)
	    b. Alternate sort criteria are available to identify trends and effective resolution strategies:
	       i. **M**RA Status – separates the Processed and Denied MRAs
	       ii. **P**atient Name – groups all claims for the same patient together
	       iii. **S**ervice Date – lists claims according to the oldest date of service
	       iv. **P**atient Responsibility – lists claims according to the highest remaining balance to be billed to a secondary payer

2	**Review each claim:** The Billing Specialist uses the following options to research claims on the MRW:
	    a. SU – Summary MRA information
	    b. VE – View an EOB (provides more detailed MRA information)
	    c. VB – View Bill (shows data in same format as the Print Bill (GEN) option)
	    d. TP – Third Party Joint Inquiry
	    e. PM – Print MRA

3	**Take corrective action**: Once the Billing Specialist reviews each claim on the MRW and performs the appropriate corrective action within 5 business days using one of the following options:

PROCEDURES	

	a. PC (Process COB) is used to manually convert a Processed MRA on the MRW to a secondary claim
	    i. To use this option, the MRA status must = Processed and the Patient Responsibility amount must be > $0.00
	b. CB (Cancel bill) is the most appropriate option if the MRA status = Denied and no corrective action exists to obtain a Processed MRA (for example, the patient has a Medicare Replacement policy rather than traditional Medicare)
	    i. If using the Cancel Bill option, make sure to also enter an appropriate reason not billable
	c. CC (Cancel/Clone a Bill) is appropriate if the MRA Request claim was Denied, but a Processed MRA could be obtained if the correct data is resubmitted (for example, the original claim was denied due to missing/incorrect/invalid information)

4	**Review MRA Management Work List:** At least bi-weekly, Billing Lead reviews the MRA Management Work List (MRW) to ensure these claims are consistently worked within 5 business days a. Unresolved claims on the MRW greater than 5 working days must be monitored to ensure corrective action is completed

REFERENCE DOCUMENTS
RELATED HANDBOOKS AND OTHER REFERENCES

– Central Business Office Procedures Guide Series 1601C.03, Billing Ch. 1 Sec. G, No.7: Correcting Billing Errors
– Electronic Data Interchange (EDI) Billing Users Guide
On-line access to additional current guidance:
    – CBO Intranet web site: http://vaww1.va.gov/cbo
    – e-MRA (electronic Medicare Remittance Advice) and e-Claims (electronic Claims) web sites: http://vaww.vistau.med.va.gov/vistau-ebp/default.htm
    – https://www.novitas-solutions.com

PROCEDURAL DOCUMENTATION EXAMPLES

CPAC Education, Billing Levels I/II
    – *Common Billing Reports*
    – *Medicare Remittance Advice Work list (MRW)*

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
0.1	05-28-10	N/A (new draft version developed)	N/A	

4.2 - Processing Retrospective Coding Reviews

Insert new flow diagram

Health Information Management (HIM) staff perform retrospective coding audits that may result in changes to the diagnosis and/or procedure code(s) assigned to the encounter. When coding changes occur during these audits, HIM communicates retrospective reviews back to Billing via spreadsheet so that corrective action can be taken. If the encounters were previously billed to a third party payer Billing staff notify Accounts Management using the communication tool, cancel the original claim, and submit a corrected claim when deemed appropriate.

4.2.1 - *Processing Retrospective Reviews from Coding*

SOP DETAIL	
Title: Processing Retrospective Reviews from Coding	
Purpose: To standardize the procedure that Billing Specialist, designated by Billing Manager or Supervisor, will utilize to process retrospective reviews sent from facility Health Information Management (HIM) departments to CPAC Billing	
Responsible Party: Billing Specialist	
Issued By:	**Approved By:**
Effective Date: 5-1-2012	**Last Revised:** 12-28-2012

IC: 4.2.1-A, 4.2.1-B — **4.2.1 PROCESSING RETROSPECTIVE REVIEWS FROM CODING**

Supplier(s)
- Facility Health Information Management Department

Input(s)
- Retrospective Review

Procedure Objective(s)
- To standardize the procedure that Billing Specialist, designated by Billing Manager or Supervisor, will utilize to process retrospective reviews sent from facility Health Information Management (HIM) departments to CPAC Billing

(A) **Key Handoffs**: If quarterly uploads are not available, esclate issue to Billing Manager

(B) **Key Handoff**: Send communication to Accounts Management

(C) **Key Handoff**: Save changes to spreadhseet and document on SharePoint

Output(s)
- Escalated Issue
- Claim Notification
- Updated Spreadsheet

Customer(s)
- Billing Manager
- Accounts Management
- Billing Department
- HIM Department

PROCEDURES

GENERAL CONSIDERATIONS:

- Each HIM Department is mandated by VHA Directive 2010-013 Monitoring "Reasons Not Billable" and VHA Handbook 1907.03, Health Information Management Clinical Coding Program Procedures, to notify Billing when a code has been changed based on retrospective review via an Excel spreadsheet containing the errors identified

- To comply with this Directive, GAO findings and OIG audits, Billing is required to document the subsequent billing action taken for each retrospective review listed on the spreadsheet and save all spreadsheets to a centralized location (i.e. SharePoint)

- Retrospective coding reviews occur as the result of Compliance and Business Integrity (CBI) audits, external coding audits and HIM supervisors auditing work completed by their Coding staff

    o CBI and supervisory audits are usually performed quarterly, however it is possible that Billing would not receive a spreadsheet for every retrospective review performed, as only those with errors would be captured on this document

    o External coding audits are received on an ad hoc basis

- **NOTE**: Every retrospective review WILL NOT result in identified coding errors. In many cases, the retro review demonstrates no errors found, which means no spreadsheet had to be communicated to Billing

STEP	ACTIVITY
1	**Billing Retrieves Spreadsheet:** At least once per month, Billing Specialist will access the designated SharePoint to identify any new Retrospective Review cases added by HIM. *NOTE*: CPAC Billing Manager will coordinate establishment of "Retrospective Review" folder(s) on SharePoint and collaborate with HIM Manager from each facility to ensure appropriate staff from each department have access to this folder.

2	**Decision: Did HIM upload a spreadsheet to folder for each quarter?**
	    a. If no, **PROCEED TO STEP 3**
	    b. If yes, **PROCEED TO STEP 4**

PROCEDURES	
3	**Escalate to Billing Manager:** Billing Specialist will escalate to Billing Manager, who will contact HIM Manager to communicate that no retrospective review spreadsheets were posted for the quarter. If any coding discrepancies were identified during one of the three types of retrospective reviews, HIM must communicate these to Billing via the Retrospective Review Spreadsheet. **NOTE 1**: If HIM Manager reports that the facility does not capture retrospective reviews on a spreadsheet as mandated by VHA Policy, Billing Manager will escalate issue through CPAC HIM Liaison to National HIM to facilitate resolution. Billing Manager will include the steps they've taken to resolve with facility HIM Manager in their communication and send notification to the national mail group **VHA CBO CPAC HIM**. **NOTE 2**: If no retro review spreadsheet was communicated from HIM for an entire quarter, Billing Manager needs to contact HIM Manager to verify that no coding errors were identified for the entire quarter during any retrospective review process. If verified by HIM via e-mail, save the e-mail to SharePoint to confirm no reviews for the quarter.
4	**Add Column to Spreadsheet:** Billing Specialist will add one column at the end of spreadsheet for the Biller's Initials.

5	**Review Recoded Encounter:** Billing Specialist will review the encounter on the spreadsheet that has been re-coded to determine if corrective action is required.
	     a. Decision: Was encounter previously billed?
	        i. If yes **PROCEED TO STEP 6**
	       ii. If encounter was not previously billed to TPP, follow standard billing procedure and then **PROCEED TO STEP 7**

PROCEDURES	

6	**Take Appropriate Corrective Action**. Billing Specialist will take appropriate action to submit a corrected claim to third party payer, cancel claim, or document no action required.
	   a. Identify which item(s) were changed on the spreadsheet
	      i. If procedure code changed:
	         1. A corrected claim must be submitted to the third party payer (TPP)
	         2. When using the VistA option "Correct Rejected/Denied Bill" or "**CRD**", to correct the original claim, the "Billing Timeframe" located on Screen ,<7>, #1 for an outpatient claim or Screen <6>, #1 for inpatient claim must be changed to **7** to reflect that this is a "Replacement Prior Claim" and ensure that the correct procedure code(s) are included on Screen <5> for outpatient or Screen <4> for inpatient
	      ii. If the primary diagnosis code changed:
	         1. Check the policy comments to determine if coverage limitations support submitting a corrected claim, canceling this claim, or no further action
	           • For example, if primary diagnosis of diabetes mellitus, Type II was re-coded to obesity, if policy group comments state that obesity is not a covered diagnosis, claim must be canceled with RNB of "MED NEC-DX NOT COVERED"
	         2. Look for UR notes under the option ^PRINT CT to determine if prior authorization information was obtained by UR Nurse. If a change to the diagnosis affects medical necessity requirements of the payer, the claim will need to be re-billed.
	         3. If no policy limitations or pre-cert requirements for medical necessity are found, then no corrected billing action is required

7	**Document Billing Action Taken on Spreadsheet:** Billing Specialist will document action taken regarding each encounter on the Retrospective Review spreadsheet. In some instances, no corrective action is required, which must also be noted on this document. Several examples of corrective action and no action requires are provided below:
	   a. Examples of corrective billing actions include:
	      i. Re-billed with corrected procedure code
	      ii. Canceled claim# K------ for non-covered treatment of obesity (new primary dx) and entered RNB
	         • When canceling claim VistA, copy the reason for cancellation from the spreadsheet and paste as the "reason canceled"
	   b. Billing Specialist will enter their initials in the last column of the spreadsheet

8	**Decision: Was Cancelled Claim Entered/Not Reviewed?**
	   a. IF yes, the canceled claim was entered/not reviewed (unauthorized) status, **PROCEED TO STEP 10**; or
	   b. IF No, the cancelled or re-billed claim was previously printed or transmitted, **PROCEED TO STEP 9**.

PROCEDURES	
9	**Send Communication to Accounts Management:** Billing Specialist will send a communication request to Accounts Management to advise each instance that a printed or transmitted claim has been re-billed or canceled. a. Communication will include the claim number and reason for cancellation or corrected billing. **PROCEED TO STEP 11**

10	**Document No Billing Action Required (if appropriate).** If no corrective action is required, that must also be noted on this spreadsheet under the column entitled "Billing Action Taken".
	    a. Examples of scenarios that do not require corrective action
	        i. Prior claim not authorized (Billing Specialist will ensure that the correct codes appear on the encounter before authorizing the claim for printing/transmission to TPP)
	        ii. No action req, policy term'd for d.o.s.
	        iii. No action req, trmt for SC condition
	        iv. No action req, re-sequenced dx codes only
	    b. Billing Specialist will enter their initials in the last column of the spreadsheet

11	**Enter Comment in TPJI:** Billing Specialist will copy the comments from the "billing action taken" column for the re-coded encounter from spreadsheet and paste as a comment in TPJI under the active claim number, if one exists. Billing Specialist's initials will be entered at the end of the TPJI comment.
12	**Save Changes to Document on SharePoint:** Billing Specialist will save the completed spreadsheet to SharePoint. **END OF PROCEDURE**

INTERNAL CONTROLS				
ID	**CONTROL DESCRIPTION**	**TYPE**	**RISK**	**SCORE**
BI 4.2.1-A	Type of Control: Manual Who: Billing Specialist What do they do : Document action taken regarding each encounter How do they do it: Document action taken regarding each encounter on the Retrospective Review spreadsheet (located on SharePoint). In some instances, no corrective action is required, which must also be noted on this document. When: Within 30 days from the date received from Coding (*__NOTE__: Retro reviews are not expected to be done more frequently than quarterly, and not every audit will result in Coding errors that must be communicated to Billing) Where is the evidence: Retrospective Review Spreadsheet on Share Point	Manual	If timely billing corrective action does not occur when encounters have been re-coded by HIM after submission to a third party payer, VA may be at risk of accepting inappropriate reimbursement	12

INTERNAL CONTROLS				
ID	**CONTROL DESCRIPTION**	**TYPE**	**RISK**	**SCORE**
BI 4.2.1-B	Type of Control: Manual Who: Billing Supervisor What do they do : Ensure that Billing Specialist has documented action taken regarding each encounter How do they do it: Initial the Retrospective Review spreadsheet (located on SharePoint) to validate that Billing Specialist has completed review of each line item on the spreadsheet. Billing Specialist is expected to document the billing action/non-action that has been completed for each line item on the spreadsheet within 30 days from the date received from Coding. (***NOTE**: Retro reviews are not expected to be done more frequently than quarterly, and not every audit will result in Coding errors that must be communicated to Billing) When: Within 45 days from the date the spreadsheet was received from Coding Where is the evidence: Retrospective Review Spreadsheet on Share Point - OR - **IF Billing has not received any retro review spreadsheets from Coding for > 90 days**, Billing Manager will request confirmation from HIM Manager that there were no coding errors identified via retro review spreadsheet for that quarter (i.e. Outlook e-mail)	Manual	Same	12

REFERENCE DOCUMENTS
RELATED HANDBOOKS AND OTHER REFERENCES
– VHA Directive 2010-013 Monitoring "Reasons Not Billable" – VHA Handbook 1907.03, Health Information Management Clinical Coding Program Procedures
PROCEDURAL DOCUMENTATION EXAMPLES
Copy of Retrospective Coding

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	4-13-12	New Process	All	C. Hutchison

Figure 19: Records Management Section map
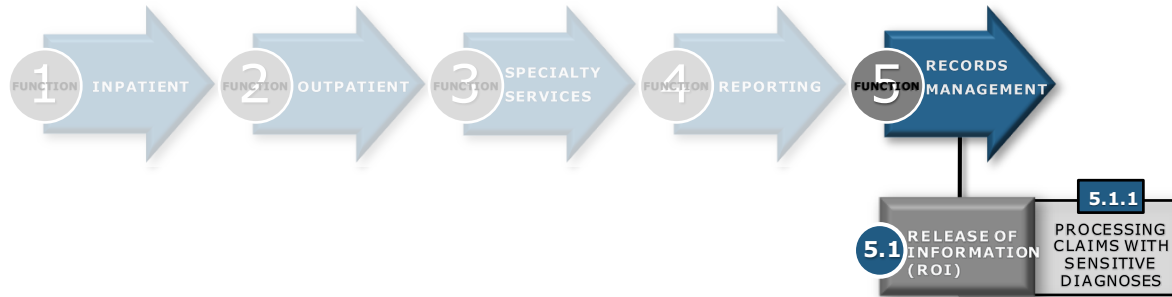
On a daily basis, billing staff are responsible for assisting with the maintenance of a variety of paper-based, hardcopy records in order to generate accurate bills in a timely manner. For certain types of bills that cannot be submitted electronically, Billing Specialists print hard copy bills directly 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.

5.1 - Release of Information (ROI) Process

Figure 20: Release of Information (ROI) Process

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. If a signed ROI has been obtained from the Veteran, the Billing Specialist proceeds with generating the bill. If an ROI has not been obtained, the Billing Specialist cancels the claim using a standard cancellation code.   Assignment of this cancellation code triggers an automatic notification to be sent to a Facility Revenue work list the following day. Facility Revenue staff will reach out to the Veteran to submit an ROI. Upon receipt of the ROI, the Billing Specialist completes the claim.

Billing staff perform the following procedures daily:

1) **Processing Claims with Sensitive Diagnoses (BILL 5.1.1)** – Ensures proper authorization has been obtained from the patient to release medical information involving sensitive diagnoses, which is required before billing.

Processing Claims with Sensitive Diagnoses

SOP DETAIL	
Title: Processing Claims with Sensitive Diagnoses	
Purpose: To verify patients' authorization to release medical information involving sensitive diagnosis has been obtained.	
Responsible Party: Billing Specialist, Facility Staff	
Issued By:	**Approved By:**
Effective Date:	**Last Revised:** 12-28-2012

SOP PROCESS FLOW
IC: 5.1.1-A

FEBRUARY 28, 2013   **DEPARTMENT OF VETERANS AFFAIRS**
CONSOLIDATED PATIENT ACCOUNT CENTER (CPAC)   PAGE | 136
- BILLING GUIDEBOOK -

Updated process flow to be added

PROCEDURES
GENERAL CONSIDERATIONS: • 38 US Code § 7332 was enacted by Congress on October 21, 1976 and provides confidentiality for sensitive diagnoses as they pertain to drug abuse, alcoholism and alcohol abuse, human immunodeficiency virus infection (HIV) or sickle cell anemia. This is protected information, which means the individual's signed written authorization must be obtained, whether inpatient or outpatient care is provided, prior to disclosing any information of medical care or testing to any third party insurer or any Federal agency or government-wide third party insurer for payment purposes.

STEP	ACTIVITY
1	**Identify Encounter:** The facility staff identifies encounters that require a sensitive consent from the *Code Me Report and RNB Report.*,
2	**Review Claims Tracking and Review VA Form 10-5345:** When submitting a claim form, the Billing Specialist reviews Claims Tracking to determine whether a valid sensitive consent has been obtained for the encounter and is on file at the medical center. **NOTE**: Sensitive Consents are valid for 12 months for a specific condition unless otherwise specified.

PROCEDURES	

3	**Complete or Cancel Bill:** The Billing Specialist determines whether the bill can be completed or should be canceled:
	
	 a. If Release of Information (ROI) is annotated as OBTAINED:
	
	  i. Complete billing functions
	
	 b. If ROI is REQUIRED:
	
	  i. Cancel only the claims tracking entry related to the sensitive diagnosis code and/or CPT code(s). Assign cancellation code XMC12
	
	   1. Include additional comments of sensitive diagnosis (e.g. Drug, Alcohol, HIV/AIDS, Sickle Cell Anemia) and dates of service requiring ROI
	
	  i. Mark encounter as non-billable in Claims Tracking using RNB - RELEASE OF INFORMATION NOT OBTAINED.
	
	  ii. If Patient Policy Comment indicates that the ROI has been sent to/requested from the patient:
	
	   1. Under "Review Information (RI)" within the Claims Tracking Edit option, enter "REQUIRED"
	
	  iii. If ROI has not been obtained after 30 days, FRM will notify Billing Specialist that cancellation was appropriate
	
	  iv. If ROI is obtained, FRM will notify Billing Specialist to re-bill previously canceled claim
	
	 c. If ROI is annotated as REFUSED:
	
	  i. Cancel bill
	
	  ii. Mark encounter as non-billable using RNB – REFUSES TO SIGN RELEASE (ROI) while in Claims Tracking

4	**Review Scrubber Edits:** If the Billing Specialist does not check Claims Tracking, the Scrubber will generate an edit notifying the biller that an ROI consent is needed (only applicable if diagnosis is sensitive).
	
	 a. Review for consent on file in Claims Tracking:
	
	  i. If consent is on file, bypass scrubber and complete bill.
	
	  ii. If no consent is on file, see Step 3 above for corrective actions.
	
	  iii. Check with Billing Lead or Billing Supervisor for any unknown errors.
	
	 END OF PROCEDURE

INTERNAL CONTROLS (SOP LEVEL)				
ID	**CONTROL DESCRIPTION**	**TYPE**	**RISK**	**SCORE**
BI 5.1.1-A	Type of Control: Manual Who: Billing Specialist What do they do : Ensure that patient has completed VA Form 10-5345 and verify a valid Release of Information (ROI) is on file How do they do it: Billing Specialist must collaborate with Facility Revenue to ensure that patient has completed VA Form 10-5345. Facility Revenue will either maintain a spreadsheet on the SharePoint/shared drive or the scanned VA Form 10-5345 will actually be uploaded to the SharePoint or a shared drive. Billing Specialist will verify a validate ROI is on file by either viewing the spreadsheet or the scanned document on the SharePoint/shared drive prior to submitting claim with sensitive diagnosis. When: Monthly Where is the evidence: spreadsheet or the scanned document on the SharePoint or shared drive	MAN	If Claims with Sensitive Diagnoses are not processed accurately, then Revenue may be delayed or lost.	9

REFERENCE DOCUMENTS				
RELATED HANDBOOKS AND OTHER REFERENCES				

– 38 US Code § 7332, Confidentiality of Certain Medical Records
– Central Business Office Procedures Guide Series 1601C.03, Billing
  – Ch. 1, Sec. G: General Billing Procedures
  – Ch. 1 Sec. H: Release of Information (ROI) Billing Procedures
– Electronic Data Interchange (EDI) Billing Users Guide
– Integrated Billing (IB), Version 2.0 User Manual, March 1994
– CPAC Facility Revenue Guidebook, SOP 4.1.1 – Release of Information Authorization
– CPAC Utilzation Review Guidebook, SOP 1.1.1 – Performing Pre-Admission (Pre-Certification) Review Procedures, SOP 1.1.3 – Performing Continued Stay Certification Review Procedures, SOP 1.2.1 – Performing Outpatient Mental Health/Substance Abuse Authorization Review Procedures.
– 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 ROI Policy for Sensitive Diagnoses P009-02-02

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 Cancellation and Reasons Not Billable Codes*
  – *Bill Me Report*
  – *Common Billing Reports - Bill Status Report*
  – *Common Billing Reports - Unbilled Report*
  – *Release of Information - VA Form 10-5345*

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 process flow and references	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	
	07-19-07	N/A	N/A	Deborah Miller

ID	ACRONYM	DEFINITION
	ACRONYM LIST	
1	A/R or AR	Accounts receivable
2	ABC	Activity based controls
3	ACRD	A report that details CHAMPVA encounters and generate bills on a UB-04 claim form
4	BCBS	Blue Cross Blue Shield
5	CBI	Compliance and Business Integrity
6	CBOC	Community Based Outpatient Clinic
7	CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
8	CMS 1500	Standard form used for physician claims
9	CPAC	Consolidated Patient Account Centers
10	CPT	Current Procedural Terminology
11	CSA	Claim Status Awaiting Resolution
12	DRG	Diagnosis Related Group
13	*e.g.*	For example
14	ECME	Electronic Claims Management Engine
15	e-Gov	Electronic Government Initiative
16	e-MRA	Electronic Medicare Remittance Advice
17	EOB	Explanation of benefits
18	FBCS	Fee Basis Claim System
19	FMS	Financial Management System
20	FRM	Facility Revenue Manager
21	GAO	Government Accountability Office (formerly the General Accounting Office)
22	HIMS	Health Information Management Services (coding at the facility level)
23	HIPAA	Health Insurance Portability and Accountability Act
24	IB	Integrated billing
25	IC	Internal control
26	ICD-9	International Classification of Diseases, 9th Revision, Clinical Modification
27	ID	Identification
28	INSC	Veterans with Reimbursable Insurance and Inpatient Admissions (a CPAC billing report)
29	IT	Information Technology
30	KT	Kinesiotherapy
31	LOS	Length of stay
32	MCCF	Medical Care Collection Fund
33	MCCR	Medical Care Cost Recovery
34	MRW	MRA Work List
35	MS-DRG	Medicare Severity Diagnosis Related Group

ACRONYM LIST		
ID	ACRONYM	DEFINITION
36	MS	Microsoft
37	NCPDP	National Council for Prescription Drug Program
38	NPI	National Provider Identifier
39	OMB	Office of Management and Budget
40	OT	Occupational therapy
41	PCRR	Potential Claim Recovery Report
42	PMA	President's Management Initiative
43	PPN	Preferred Provider Number
44	PT	Physical therapy
45	PTF	Patient treatment file
46	QUIC	Quality Improvement Checklist
47	R/B	Room and board
48	RNB	Reason not billed
49	ROI	Release of Information
50	RUG	Resource Utilization Group
51	RX	Prescription
52	SNF	Skilled Nursing Facility
53	SOP	Standard operating procedure
54	SSN	Social Security Number
55	ST	Speech therapy
56	TPJI	Third Party Joint Inquiry
57	TRAC	Total Record Archive Communication Systems
58	UB-04	Uniform Billing Form 04
59	VA	Veterans Affairs
60	VAMC	Veterans Affairs Medical Center
61	VHA	Veterans Health Administration
62	VISN	Veterans Integrated Service Network
63	VistA	Veterans Health Information Systems and Technology Architecture

APPENDIX B: Management Reporting

MANAGEMENT REPORTING DASHBOARD				
REPORT	**DESCRIPTION**	**PROCEDURE**	**OWNER**	**FREQUENCY**
Bill Accuracy Report	Utilized to monitor authorized bills sent to insurance with unresolved edits	• Open Billing Compliance Module • Audit IB Claims • By Authorized Date (default) <date range> • Claim Status Filters: Authorized, Printed, Request MRA • Right Click and select "Audit Records" • Add Report Name: Billing Accuracy Report <date range> • Sort by flag • Double click on bills with flag other than OK to view the edit on the audit report (bottom)	Billing Supervisor	Daily
Bill Me Report	Provides billing staff with a listing of all encounters that have been coded by the coding staff. The *Bill Me Report* helps Billing Specialists monitor professional fees because it captures encounters in which institutional (UB-04) charges were available but professional fees were not coded at the time.	• Select Bill Me Report in PCE Compliance Module • Date Range: Last Date Coded Date Range • Select filters: Reviewed/Accepted, Coded by CCM, Bypass CCM, Coding and Recoded/Not Reviewed • Right click in the "Flag Filters" area and select all flags except "Suspend" • View Bill Me Report Records	Billing Lead	Daily

FEBRUARY 28, 2013   **DEPARTMENT OF VETERANS AFFAIRS**
CONSOLIDATED PATIENT ACCOUNT CENTER (CPAC)   PAGE | 143
- BILLING GUIDEBOOK -

MANAGEMENT REPORTING DASHBOARD				
REPORT	**DESCRIPTION**	**PROCEDURE**	**OWNER**	**FREQUENCY**

Bill Status Report	Utilized to monitor incomplete bills. This report will display all claims in IB that have not been authorized.	• Open Billing Compliance Module
		• Audit IB Claims
		• Event Date Range: As far back as there are bills (min 2 years)
		• Claim Status Filters: Check only Entered (leave all others unchecked/blank)
		• Right click in white area and select Audit records
		• Title report: BSR <date range>
		• Sort CCM History
		   o Complete all bills with Coded by CCM History
		   o Review all: Not coded by CCM and No Entry on File
			Billing Supervisor	Weekly

Claim Status Awaiting Resolution (CSA) Report	Utilized to monitor error messages/rejections of electronic claims that require billing action to resolve.	Refer to VistA guidelines	Billing Lead	Bi-Weekly

MANAGEMENT REPORTING DASHBOARD				
REPORT	**DESCRIPTION**	**PROCEDURE**	**OWNER**	**FREQUENCY**
Duplicate Bill Audit Report	Utilized to see if there was more than one CMS-1500 for an encounter	• Open Billing Compliance Module • Audit IB Claims • Set "Event" Date • Leave all statuses checked • Right Click and uncheck "Include UB-04 Claim Form Types" option. • Right Click and "Audit Records" and name the report. • From Audit Results – drag the "Patient Name" column header into dark grey area to sort • If any count for a patient is showing more than 1, then click on plus sign to check the statuses	Billing Lead	Weekly
INSC Report (Veterans with Reimbursable Insurance and Inpatient Admissions)	Utilized to capture all billable inpatient encounters and serve as a work list for Billing Specialists.	• Select Option 2 within VistA (include unbilled episodes, episodes with RNB, patient's rated disabilities) • Select Run	Billing Specialist	Weekly
Single Claim Scrubber Usage Report	Utilized to monitor the usage of the claim scrubber by biller (user).	• Open Specialized Reports • Select date range • Select user or right click and select all users • Click the Generate Report icon	Billing Supervisor	Daily or Weekly
Unbilled Report	To check for individual CPT codes that have not been billed	Refer to VistA guidelines	Billing Supervisor	Weekly
MRA Worklist (MRW)	Utilized to monitor process, rejected and denied MRA Requests that require billing action to resolve.	Refer to VistA guidelines	Billing Lead	Bi-Weekly

Appendix C: List of Directives and Handbooks

ID	RELATED DOCUMENT	RELATED SECTION	RELATED SOP
**RELATED HANDBOOKS AND OTHER REFERENCES**		

| **VHA Directives and Handbooks** (available at http://www1.va.gov/vhapublications/)
 VA Directives and Handbooks (available at http://www.va.gov/publ/direc/finance/finance.htm)
 Up-to-date revenue cycle guides, policies, and the Questions and Answers Database are available on the CBO Intranet web site <http://vaww1.va.gov/cbo> under the "Important Tools" menu. | | | |
| **The references used in this guidebook are current as of the date it was prepared. Users should use the most current iteration of these documents.** | | | |

ID	RELATED DOCUMENT	RELATED SECTION	RELATED SOP
1	CBO Intranet web site http://vaww1.va.gov/cbo		All
2	Fee Program (Purchased Care for Veterans) web site: http://www.nonvacare.va.gov/		3.4.1: Submitting Inpatient UB-04 Claims: Fee Basis 3.5.1: Submitting Outpatient UB-04 Claims: Fee Basis 3.5.2: Submitting Inpatient and Outpatient CMS 1500 Claims: Fee Basis
3	*Central Business Office Procedures Guide Series 1601C.03, Billing:* http://vaww1.va.gov/CBO/apps/policyguides/contents.asp?address=VHA_PG_1601C	Ch. 1 Sec. C, No. 3: Facility versus Professional Services	All
4		Ch. 1 Sec. C, No. 4: Billable Inpatient Services	1.1.1: Submitting Inpatient UB-04 Claims 1.2.1: Submitting Inpatient CMS 1500 Claims 3.4.1: Submitting Inpatient UB-04 Claims: Fee Basis 3.5.2: Submitting Inpatient and Outpatient CMS 1500 Claims: Fee Basis
5		Ch. 1, No.1: Dental Services Reasonable Charges and Billing	3.2.1: Submitting UB-04: Dental Ineligible

RELATED HANDBOOKS AND OTHER REFERENCES			
ID	**RELATED DOCUMENT**	**RELATED SECTION**	**RELATED SOP**
6		Ch. 1 Sec. C, No. 5: Billable Outpatient Services	2.1.1: Submitting Outpatient UB-04 Claims 2.2.1: Submitting Outpatient CMS 1500 Claims 3.3.1 Submitting Outpatient UB-04 Claims: DME and Prosthetics 3.5.1: Submitting Outpatient UB-04 Claims: Fee Basis 3.5.2: Submitting Inpatient and Outpatient CMS 1500 Claims
7		Ch. 1 Sec. E, No. 2: CMS 1500 Billing Claim Form	1.2.1: Submitting Inpatient CMS 1500 Claims 2.2.1: Submitting Outpatient CMS 1500 Claims 3.5.2: Submitting Inpatient and Outpatient CMS 1500 Claims
8		Ch. 1 Sec. E, No. 3: UB-04 Billing Claim Form	1.1.1: Submitting Inpatient UB-04 Claims 1.2.1: Submitting Inpatient UB-04 Claims: Fee Basis 1.3.1: Submitting Skilled Nursing Facility UB-04 Claims 2.1.1: Submitting Outpatient UB-04 Claims 3.3.1 Submitting Outpatient UB-04 Claims: DME and Prosthetics 3.5.1: Submitting Outpatient UB-04 Claims: Fee Basis

ID	RELATED DOCUMENT	RELATED SECTION	RELATED SOP
9		Ch. 1 Sec. E, No. 4: Exhibit 1: UB-04 and CMS 1500 Matrix	1.1.1: Submitting Inpatient UB-04 Claims 1.2.1: Submitting Inpatient CMS 1500 Claims 1.3.1: Submitting Skilled Nursing Facility UB-04 Claims 2.1.1: Submitting Outpatient UB-04 Claims 2.2.1: Submitting Outpatient CMS 1500 Claims 3.3.1 Submitting Outpatient UB-04 Claims: DME and Prosthetics 3.4.1: Submitting Inpatient UB-04 Claims: Fee Basis 3.5.1: Submitting Outpatient UB-04 Claims: Fee Basis 3.5.2: Submitting Inpatient and Outpatient CMS 1500 Claims: Fee Basis
10		Ch. 1 Sec. G: General Billing Procedures	All
11		Ch. 1 Sec. G, No. 7: Correcting Billing Errors	4.1.1: Managing the Claim Status Awaiting Resolution (CSA) Report 4.2.1: Managing the MRA Work List (MRW)
12		Ch. 1 Sec. H: Release of Information (ROI) Billing Procedures	All
13		Ch. 2, Sec. B: Ambulance Reasonable Charges and Billing Procedures	3.1.1: Submitting UB-04: Ambulance
14		Ch. 4, No. 1: Dental Services and Reasonable Charges Billing	3.2.1: Submitting UB-04: Dental Ineligible
15		Ch. 4 No. 7: Durable Medical Equipment (DME) Reasonable Charges and Billing Procedures	3.3.1 Submitting Outpatient UB-04 Claims: DME and Prosthetics

RELATED HANDBOOKS AND OTHER REFERENCES			
ID	**RELATED DOCUMENT**	**RELATED SECTION**	**RELATED SOP**
16		Ch. 5 Sec. D: Fellow Services and Fee Basis (Purchased Care) Reasonable Charges and Billing Procedures	3.4.1: Submitting Inpatient UB-04 Claims: Fee Basis 3.5.1: Submitting Outpatient UB-04 Claims: Fee Basis 3.5.2: Submitting Inpatient and Outpatient CMS 1500 Claims: Fee Basis
17		Ch. 6 Sec. F: Non-Covered Services Billing Procedures	1.1.2: Submitting Inpatient UB-04 Claims: Fee Basis 1.2.2: Submitting Inpatient CMS 1500 Claims: Fee Basis 2.1.2: Submitting Outpatient UB-04 Claims: Fee Basis 2.3.2: Submitting Outpatient CMS 1500 Claims: Fee Basis
18		Ch. 7 Sec. H: Prosthetics Reasonable Charges and Billing	3.3.1 Submitting Outpatient UB-04 Claims: DME and Prosthetics
19		Ch. 8 Sec. C: Skilled Nursing an Sub-Acute Care Reasonable Charges and Billing	1.3.1: Submitting Skilled Nursing Facility UB-04 Claims
20	*Electronic Data Interchange (EDI) Billing Users Guide*		All
21	*Integrated Billing (IB), Version 2.0 User Manual,* March 1994		All
22	M-1, Part I, Chapter 15, Charges and Payments for Medical Care		3.6.1: Submitting UB-04 Claims: Humanitarian
23	M-1, Part I, Chapter 21 Operations, Part I, Medical Administration Activities, Chapter 21, Authorized Non-VA Hospitalization in the U.S.		3.4.1: Submitting Inpatient UB-04 Claims: Fee Basis 3.5.1: Submitting Outpatient UB-04 Claims: Fee Basis 3.5.2: Submitting Inpatient and Outpatient CMS 1500 Claims: Fee Basis
24	M-1, Part I, Chapter 22 Operations, Part I, Medical Administration Activities, Chapter 22, Unauthorized Medical Services		3.4.1: Submitting Inpatient UB-04 Claims: Fee Basis 3.5.1: Submitting Outpatient UB-04 Claims: Fee Basis 3.5.2: Submitting Inpatient and Outpatient CMS 1500 Claims: Fee Basis

RELATED HANDBOOKS AND OTHER REFERENCES			
ID	RELATED DOCUMENT	RELATED SECTION	RELATED SOP
25	VHA Directive 2007-010, Timeliness Standards for Processing Non-VA Provider Claims, February 16, 2007		3.4.1: Submitting Inpatient UB-04 Claims: Fee Basis 3.5.1: Submitting Outpatient UB-04 Claims: Fee Basis 3.5.2: Submitting Inpatient and Outpatient CMS 1500 Claims: Fee Basis
26	VHA Directive 2005-058, Cost-Based and Inter-Agency Billing Rates		3.2.1: Submitting UB-04 Claims: Dental Ineligible 3.6.1: Submitting UB-04 Claims: Humanitarian
27	*Mid-Atlantic Consolidated Patient Account Center Guidebook,* October 31, 2006		All
28	*QuadraMed Encoder Suite Process Guide*		All
29	*Reasonable Charges Desk Reference, Version 2.0*		All
30	*Uniform Billing Editor*		All
31	38 US Code § 7332, *Confidentiality of Certain Medical Records*		5.1.1: Processing Claims with Sensitive Diagnoses
32	*Electronic Data Interchange (EDI) Billing Users Guide*		All
33	*Integrated Billing (IB), Version 2.0 User Manual,* March 1994		All

Appendix D: List of Procedural Document Examples

ID	DOCUMENT	DOCUMENT FORMAT
	PROCEDURAL DOCUMENT EXAMPLES	
1	*ACRD Ad Hoc Report*	MS Excel (Hardcopy)
2	*Billing Accuracy Report*	Electronic
3	*Bill Me Report*	Electronic
4	*Bill Status Report*	Electronic
5	*Duplicate Bill Audit Report*	Electronic
6	*INSC Report*	Electronic
7	*Plan Matching List*	Electronic
8	*Single Claim Scrubber Usage Report*	Electronic
9	*Unbilled Report*	VistA
10	*VA Form 10-5345*	MS Word
11	*CPAC Education Billing Level I/II*	Electronic