Veterans Medical Benefits

(IHS)

User Manual

Version 3.0
October, 2018

Office of Resource, Access and Partnership
Division of Business Office Enhancement

Table of Contents

Preface

This document is intended to be used to help the Indian Health Service and Tribal Health facilities with guidance on enrollment, billing and collections pertaining to the Veterans Administration Reimbursement Agreement.

Version Control

The following table identifies all versions of this document:

Date	Author	Description
	Adrian Lujan	General Updates

1.0 Introduction

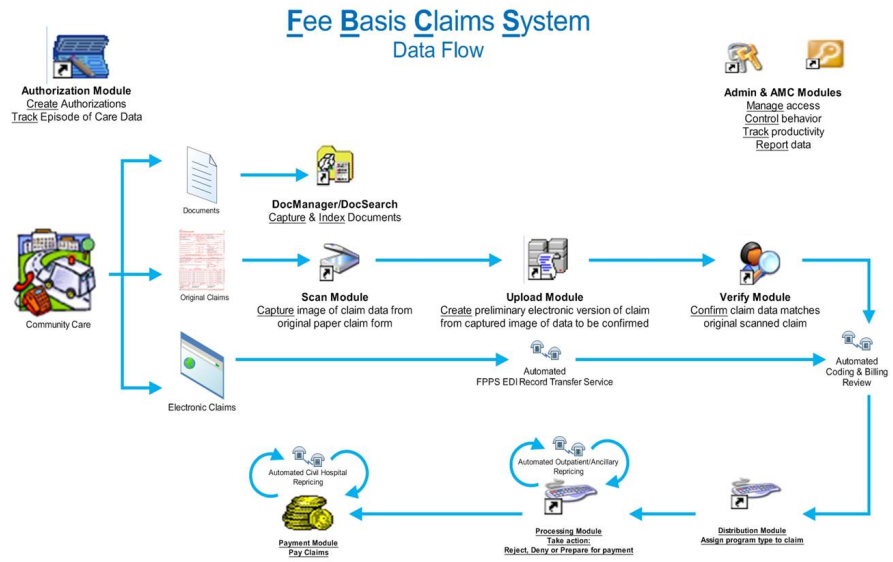
The Department of Veteran Affairs (VA) has been working with tribal governments by partnering with the Indian Health Service (IHS) to provide reimbursement for direct care services provided to eligible American Indian/Alaskan Native (AI/AN) Veterans at non-urban IHS facilities.

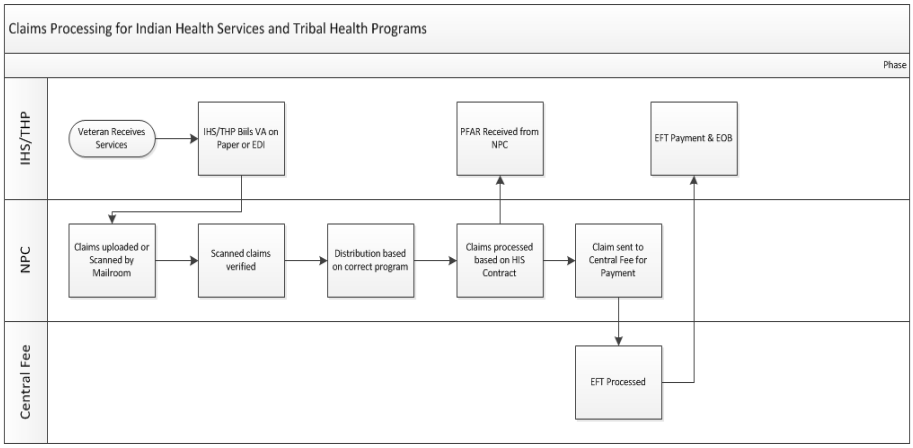
On December 5, 2012, VA and IHS signed the national agreement which sets the guidelines of this reimbursement agreement. The agreement marks an important partnering achievement for VA and the IHS and is consistent with mutual goals to increase access to care for Veterans. The agreement does not pertain to Tribal Health Programs. THPs can follow these guidelines but must put their Agreement in place with the VA.

1.1 Process Flow

The claims processing flow is outlined in the following diagram:

Commented [C1]: Have we ever included the diagram?


Fee Basis Claims System
Data Flow
Authorization Module
Create Authorizations
Track Episode of Care Data
Admin & AMC Modules
Manage access
Control behavior
Track productivity
Report data
Documents
DocManager/DocSearch
Capture & Index Documents
Community Care
Original Claims
Scan Module
Capture image of claim data from original paper claim form
Upload Module
Create preliminary electronic version of claim from captured image of data to be confirmed
Verify Module
Confirm claim data matches original scanned claim
Automated Coding & Billing Review
Automated FPPS EDI Record Transfer Service
Electronic Claims
Automated Civil Hospital Repricing
Automated Outpatient/Ancillary Repricing
Payment Module
Pay Claims
Processing Module
Take action:
Reject, Deny or Prepare for payment
Distribution Module
Assign program type to claim


Claims Processing for Indian Health Services and Tribal Health Programs
Phase
IHS/THP
NPC
Central Fee
Veteran Receives Services
IHS/THP Bills VA on Paper or EDI
PFAR Received from NPC
EFT Payment & EOB
Claims uploaded or Scanned by Mailroom
Scanned claims verified
Distribution based on correct program
Claims processed based on HIS Contract
Claim sent to Central Fee for Payment
EFT Processed

2.0 Completing the Local Implementation Plan

The Department of Veterans Affairs (VA) requires a Local Implementation Plan prior to veteran enrollment or billing. Each Service Unit or billing facility needs to complete an implementation plan. In this case, the Service Unit or billing facility refers to the main billing facility (Parent) along with all child locations (Satellites) as long as each of the billing facilities use the same Tax Identification Number (TIN) on their claims. If a Satellite location utilizes a different Tax ID (from the Parent location) to bill, a separate Implementation Plan for that satellite location will need to be completed.

The Implementation Plan template will be provided by Cynthia Larsen, ORAP.

The completion and signature of the local implementation plan provides for two key elements for billing purposes

- Implementation Date – Identifies the billing date as the visit date of service the Service Unit may begin billing.
- Contract Number – Established the VA/IHS Contract Number. The VA/IHS Contract Number is a data requirement and needs to be submitted on the claim.

2.1 Requirements

This is the list of requirements:

- List of Direct Care services provided at your facility.
- Contact information for the facility and the Area as well as the Local VA Medical Center (VAMC) including Pharmacy
- VA VISN20 Vendor demographic form (to be provided by ORAP)
  - Name = Name as it appears on your IRS document
  - Business Name = Printable Name of Payment Site found in RPMS, 3P Site Parameters
  - Remaining fields are self-explanatory
  - Signature required by either CEO or Business Office Manager.
- W-9
  - Provided by ORAP
  - To be completed by site
  - Name = Name as it appears on your IRS documents
  - Business Name = Printable Name of Payment Site found in RPMS, 3P Site Parameters
  - Tax Classification = Exempt Payee
  - Use Physical Address on form address fields

Commented [C2]: Added

  - EIN = Billing Tax Identification Number
  - Signature not required
- ACH Vendor/Miscellaneous Payment Enrollment Form (SF-3881)
  - Provided by ORAP with VA information completed on form.
  - Name = Name as it appears on your IRS document
  - Under PAYEE/COMPANY INFORMATION NAME field, use the Printable Name of Payment Site found in RPMS, 3P Site Parameters
  - Financial Institution information will need to be completed by PNC Bank.
  - Form will also need to be signed by PNC Bank.
- Copy of Service Unit's most recent JCHAO/AAAHC Accreditation or CMS Certification.
- Critical Access Hospitals must supply copy of the CMS Letter Establishing their current reimbursement rates. This is a yearly requirement to allow the VA to reimburse at the correct CAH reimbursement rates.

The Implementation Plan template and all supporting documents will need to be forwarded to Cynthia Larsen. Do not sign the forms unless indicated in the above list. The forms will be submitted to the VA to finalize. The VA will respond with signatures and the Service Unit will be notified of their Implementation Date.

Please reference Addendum A for copies of the Implementation Plan template and other required forms.

Commented [C3]: Should we still include this as an addendum? The VA will provide them with everything they need for the IP.

2.2 Accreditation

Copies of current accreditation for the following: Joint Commission, AAAHC, or CMS Certification must be on file and submitted along with the initial enrollment application. Proof of Renewal of accreditation must be submitted to the VA to keep on File.

Commented [C4]: Changed Wording.

Expired or revoked accreditation may be subject to immediate suspension of claims processing and payment by the VA until valid accreditation is received.

3.0 Required RPMS Setup

3.1 Adding the VA Insurer into RPMS

The Service Unit will be responsible for ensuring the correct Insurer entry has been entered into the Insurer file in RPMS for use by the Registration staff. The following details the instructions for adding the new Insurer into the system.

Note that in 2017, the VA recently updated their claims mailing address. The Billing Address fields reflect the new address needed to submit claims.

Please insure that you are entering the data exactly as shown. Any differences will result in claims being re-routed or not processed correctly.

Commented [C5]: Added

3PB>TMTP>INTM>EDIN Add/Edit Insurer

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |        THIRD PARTY BILLING SYSTEM - VER 2.6p10                          |
          +                    Add/Edit Insurer                                    +
          |                   BROWNING HOSPITAL                                    |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: LUJAN,ADRIAN M                    14-MAR-2013 11:40 AM

WARNING: Before ADDING a new INSURER you should ensure that it
         does not already exist!

     Select one of the following:

          1         EDIT EXISTING INSURER
          2         ADD NEW INSURER

Select DESIRED ACTION: 1// 2  ADD NEW INSURER

Enter the NAME of the INSURER: VA MEDICAL BENEFIT (VMBP)

Do you want to Add 'VA MEDICAL BENEFIT (VMBP)' as a New INSURER? YES
OK, adding...

<--------------- MAILING ADDRESS --------------->
STREET: PO BOX 1035 MAILSTOP 10N20
City.....: PORTLAND
State....: OREGON
Zip Code.: 97207

<--------------- BILLING ADDRESS --------------->
      (if Different than Mailing Address)
Billing Office.: VA PORTLAND HCS 10N20NPC
        Street.: 1601 E 4TH PLAIN BLVD ATTN:IHS (Or THP for Tribes)
        City...: VANCOUVER
        State..: WASHINGTON
        Zip....: 98661

Phone Number.......: (855)331-5560
```

```
Contact Person.....: KERRY PAPERMAN
Federal Tax ID#....: 931127631
AO Control Number..: 12115

Insurer Status.....: BILLABLE// <enter>
Type of Insurer....: PRIVATE// V (Veterans Administration)
All Inclusive Mode.: <enter>
Backbill Limit (months): 12
Dental Bill Status.: <enter>
Rx Billing Status..: O  OUTPATIENT DRUGS ONLY

Select CLINIC UNBILLABLE:

EMC SUBMITTER ID:
EMC PASSWORD:
EMC TEST INDICATOR:
USE PLAN NAME?:
72 HOUR RULE:
NPI USAGE: NPI ONLY
TRIBAL SELF-INSURED?:
ICD-10 EFFECTIVE DATE: 10/1/2013//   (OCT 01, 2013)

GROUP NUMBER:

PROVIDER PIN#

Select PROVIDER:
```

Add the following visits types into the Insurer file. Depending on the services provided by the facility, additional visit types may need to be added.

- **Start Billing Date** – Equals the date of the last signature on the signed Implementation Plan. Reference your copy of the Implementation Plan for this date.
- **Procedure Coding** – Set to CPT except for Dental which will be set to ADA.
- **Fee Schedule** – Leave blank.

Commented [C6]: Added

Number	Visit Type	Export Mode(s)
131	Outpatient	CMS-1500 or 837P
111	Inpatient	UB-04 or 837I
450	Emergency Room	UB-04 or 837I
831	Ambulatory Surgery	CMS-1500 or 837P
997	Pharmacy	CMS-1500 or 837P
998	Dental	ADA-2006
999	Professional Component	CMS-1500 or 837P

```
Visit                       Mode of     Mult  Fee    ------- Flat Rate --------
Type - Description           Export     Form Sched   Start      Stop       Rate
================================================================================

Select VISIT TYPE..: 131  OUTPATIENT
  Are you adding 'OUTPATIENT' as a new VISIT TYPE (the 1ST for this 3P INSURER)?
 No// Y  (Yes)
Billable (Y/N/E)....: Y  YES
Reporting purposes only:
Do you want to replace with another insurer/visit type?
Start Billing Date (create no claims with visit date before): 3/8/2013  (MAR 08,
2013)
Procedure Coding....: CPT// <Enter>
Fee Schedule........:
Add Zero Fees?...:
Multiple Forms?.....:
Payer Assigned Provider Number.....:
EMC Submitter ID #..:
EMC Reference ID....:
Auto Approve?.......:
Mode of Export......: 837P (HCFA) 5010
Block 24K..........:
Block 29...........:
Block 33 PIN#......:
Contract Code Req'd? NO
Service Facility Location:
SUBPART NPI:
```

3.2 Adding the Default VA Station and Contract Number

Patch 21 for third party billing allows the user to key enter the default VA Station Number and the VA Contract Number into the site parameters for the location being billed.

The numbers must be entered for each division within the RPMS system where VA claims are being generated.

Access to Site Parameters (3PB→TMTP→SITM) is required to complete the entries.

```
VA STATION NUMBER: 999
VA CONTRACT NUMBER: VA-999-IHS-9999
```

3.3 Adding the Group Number into Table Maintenance

The group number will be used in the eligibility page in Registration. The group name of "VMBP" and the group number of "IHS" will be added as an identifier. This identifier is used by the VA to identify IHS claims which will ensure correct routing at the VA claims processing center.

3P>TMTP>GRTM>EDGR Add/Edit Group Insurance Plans

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |        THIRD PARTY BILLING SYSTEM - VER 2.6p10          |
          +             Add/Edit Group Insurance Plans              +
          |                    BROWNING HOSPITAL                    |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: LUJAN,ADRIAN M                    14-MAR-2013 12:02 PM

Select EMPLOYER GROUP INSURANCE GROUP NAME: VMBP
  Are you adding 'VMBP' as a new EMPLOYER GROUP INSURANCE (the 230TH)? No// YES
  (Yes)

     NOTE: Some Insurers assign different Group Numbers based upon the
           particular type of visit (dental, outpatient, etc.) that
           occurred.

Do the Group Numbers vary depending on Visit Type (Y/N)? N// O

[5a] Group Number.....: IHS (THP for Tribes)
```

3.4 Adding a new Application Type in to Patient Registration

A new application type may be added to aide in the enrollment/eligibility verification process to document when an application has been submitted.

REG→TM→APTP Edit/Enter Patient Application types

```
Select PATIENT APPLICATION TYPES: VA MED BENEFITS PROG
  Are you adding 'VA MED BENEFITS PROG' as
    a new PATIENT APPLICATION TYPES (the 8TH)? No// YES  (Yes)
APPLICATION TYPE: VA MED BENEFITS PROG  Replace <Enter>
```

3.5 Electronic Claims Setup

Electronic Data Interchange (EDI) Claims Submission. The VA contracts with Change Healthcare (previously Emdeon), an EDI clearinghouse. Tribal facilities submitting EDI claims will need to register with Change Healthcare by calling 1-800-845- 6592 or visiting the Change Healthcare website at http://www.emdeon.com/payerlists/. If you are currently using a different clearinghouse, that clearinghouse will have to work with Change Healthcare to ensure claims are routed correctly.

The payer IDs are: 12115 for medical claim submissions, 12116 for dental claims, and 00231 for any inquiry transaction. Once registered, billing staff should ensure that "THP" is added to the SBR03 segment of the 837 for proper routing through the VA. This requirement has been incorporated in the RPMS Third Party Billing Package. A clearinghouse should NOT change the structure or data elements of the file sent.

Commented [C7]: Added. Received directly from the VA. Added some additional comments.

4.0 Enrollment/Eligibility for the Veteran

4.1 Training

To prepare for the implementation of Veteran billing, the VA has been conducting online enrollment training. Staff responsible for eligibility and enrollment must attend this training and become familiar with the enrollment and eligibility process. Periodic training announcements are sent to the IHS Business Office Coordinator mailgroup. Contact your Area Business Office Coordinator for additional information.

4.2 Eligible Entities

Patients that meet the following criteria are eligible for the enrollment process:

- American Indian/Alaska Natives (AI/AN)
- Veteran

Non-Indian (Non-Beneficiary) Veterans are eligible to be enrolled but any claims submitted to the VA Medical Benefits Program will not be processed under the IHS-VA signed agreement. Claims for Non-Beneficiary Veterans for direct care services should be submitted to your local VAMC for processing.

Commented [C8]: Added

4.3 Initial Veteran Enrollment Verification

This is a one-time service provided by the VA's Health Eligibility Center (HEC) at initial implementation to allow the IHS and Tribal locations to efficiently verify Veteran enrollment. This process involves providing the HEC with a list of Veterans registered into the RPMS Patient Registration system.

A new report has been released in the RPMS Third Party Billing system, Version 2.6 Patch 11 and allows a list of Veterans to be printed. When printing the list, run the report by service date within the last three years. Currently, the report prints an entry for all Veterans, including deceased and Non-Beneficiary Veterans. The report must be submitted in a standard Excel format.

```
==========================================================================
VET LISTING of VISITS                          MAY 21,2013@08:23:56   Page 1
For VISIT DATES: 02/10/2013 thru 05/21/2013
Billing Location: INDIAN HOSP
==========================================================================
PATIENT NAME                          HRN     DOB        SSN       VISIT CNT
==========================================================================
CASH,OWEN                             111226  02/05/1973 555565648        4
CONDA,ANNA                            111212  05/14/1972 558669665        4
DEMO,JOHN                             123567  01/01/1950 222222222        3
FURR,DOUGLAS                          111235  09/16/1932 558999877        4
HOOD,ROBIN                            111221  07/16/1972 555236588        5
LITTLE FOOT,ED EDD                    123456  08/02/2006 500000008        1
MUNK,CHIP                             111254  02/05/1970 555555558        1
SLEDD,BOB                             111265  07/15/1983 555555555        5

(REPORT COMPLETE):
```

The file must be encrypted prior to sending to the VA since the file will have Patient data. If unfamiliar with encryption, please contact the OIT Helpdesk or your local IT for further assistance. Contact Cynthia Larsen, ORAP/DBOE for further submission details and a copy of the standard spreadsheet template that is used.

The VA and HEC have agreed to work with us to continue this effort. You can submit a file of "need to verify enrollment" Veterans to Cynthia every six months or so. We ask that if you have more than five (5) veterans that need to be verified, please use this process.

All files sent to the HEC must follow this process. All files have to go through DBOE and sent securely to the HEC for Verification. DO NOT fax or send files in the mail directly to HEC. This file has Social Security Number and other PHI and must be protected at ALL times.

The VA will provide DBOE (Cynthia Larsen at this time) with the information who will submit the verified file to the Area/Service Unit with information on the Veteran to identify a Veteran's enrollment status into the VA Medical Benefits program. This information can be entered into the Patient Registration system.

Commented [C9]: Added to

The following list is an example of what will be received from the VA:

NAME	SSN	FIRST ENROLLED DATE	CURRENT ENROLLMENT STATUS	CURRENT PRIORITY GROUP	Comment*
LAST, FIRST	111-22-1111		NOT ENROLLED	N/A	This means the veteran is not enrolled.
LAST, FIRST	222-11-2222	3/12/2013	VERIFIED	2	This means the veteran is enrolled.

NAME	SSN	FIRST ENROLLED DATE	CURRENT ENROLLMENT STATUS	CURRENT PRIORITY GROUP	Comment*
LAST, FIRST	333-11-1324	3/5/2012	Pending; Means Test Required		This means the veteran attempted to enroll and that all requirements have not been met.
LAST, FIRST	111-34-2211	6/7/2007	Rejected; Below Enrollment Group Threshold	8G	Veteran is not eligible, cannot be enrolled
LAST, FIRST	444-11-4444		Rejected; Refused to pay copay		Veteran is not eligible, cannot be enrolled.
LAST, FIRST	222-11-1111		NO RECORD FOUND		Veteran not found in the enrollment database.

4.3.1 Enrollment Changes

Once the Veteran is enrolled, their eligibility may change depending on factors that may affect their eligibility. For example, a Veteran may no longer be eligible if a means test was conducted and the income of the Veteran has changed which may make the Veteran ineligible. Fugitive felons (on the "fugitive felon list") will need to be cleared prior to paying any benefits. If cleared, claim can be resubmitted. The Accounts Receivable Technicians will more than likely see these during the reconciliation process if the claim denies.

4.4 After the Implementation (ongoing enrollment)

The Service Unit needs to enforce the process of asking the patient for their Veteran and/or Veteran Enrollment Status. This is a process that will occur on a daily basis and involves Patient Registration/Benefits Coordinator contact with the Veteran.

Patient Registration staff will check the Veteran Status in Patient Registration. If the status is not indicated, the patient will need to be asked about their Veteran Status. If the status is set to YES, check the Insurer Page (page 4) for VMBP eligibility. If eligibility is found, then no further action is needed. If no eligibility exists, the patient must begin the eligibility enrollment process or verification.

Note:	Prior to contacting the VA's HEC, please check the list provided by the VA during the initial enrollment verification process. The Veteran may have been checked but the status may not have been updated in RPMS. IF the status is Not Enrolled or no status has been found, the patient will need to be referred to the benefits coordinator for enrollment.

Refer the patient to the Benefits coordinator who will begin the enrollment process.

The following methods can be used to obtain enrollment eligibility:

Verification Updates (5 Veterans or less)

- Contact the local VA Medical Center by telephone. Refer to the POC name and number listed on Page 6 of the local implementation plan. If the local VAMC POC's are unable to assist contact the VA HEC Points of Contact by telephone.
- Contact the VA HEC by telephone (1-855-488-8441 national phone number), Monday to Friday, 7:00 AM - 5:30 PM (Eastern Time)

Verification Updates (more than 5 Veterans)

- Use the method (sending excel spreadsheet to Cynthia Larsen) via Secure Transfer Email and it will be forwarded to HEC for Verification.

VA HEC Representative Contacts: Wanda Gaither 404-828-5862 or Debra Ringer 404-828-5346 or Parris Phillips 404-828-5614 or Tiki Whitfield 404-828-5197 (As of 11/01/2018)

Commented [C10]: Added updated information

The process for enrollment must be document on the Benefits Coordinator section, Page 5 of the Registration Editor. Upon successful enrollment, the new eligibility must be entered into Page 4 of the Registration Editor.

5.0 Patient Registration

The RPMS Patient Registration application should be used to update the Veterans record of the activity performed when working with the VA to get the patient eligible for services. The first step would be to document the process in the Benefits Coordinator section of the Registration Editor. Once the veteran has been determined to be eligible for services, an insurance entry would need to be created on the Eligibility Page.

5.1 Benefits Coordination

Documenting the process for establishing eligibility needs to be recorded in the Benefits Coordinator section of the Registration system. When adding the application status, the newly added Application Type of *VA MEDS BENEFIT PROG* may be used.

5.2 Adding Registration Eligibility

Eligibility will be entered on Page 4 in the Patient Registration system. Please ensure that the Insurer Type is set to "V" for VMBP to ensure proper accountability for Eligibility counts and VA Collections.

Commented [C11]: Changed wording.

```
IHS REGISTRATION EDITOR  (page 4)                      INDIAN HEALTH HOSPITAL
================================================================================
DEMO,GARY                  (upd:MAY 09, 2013)          HRN:20493  DIRECT ONLY
================================================================================
                              SUMMARY COVERAGE
--------------------------------------------------------------------------------
SEQ      INSURER                 COVERAGE TYPE          ELIG BEGIN - ELIG END
          SUBSCRIBER              POLICY NUMBER
================================================================================
 1.     MEDICARE                A                      04/17/2007            A
         DEMO,GARY               204930404A
        MEDICARE                B                      04/17/2007            A
         DEMO,GARY               204930404A
--------------------------------------------------------------------------------
================================================================================
Enter S(equence), A(dd) insurer, E(dit) insurer, T(oggle seq category)
V(iew) Historical Sequence Dates  L(ist inactive eligibilities): A
Select INSURER NAME: VA MEDICAL
( MEDICAL VIRGINIA )
Search was unsuccessful.


Since the KEYWORD LOOKUP failed lets try a NON-KEYWORD LOOKUP...

     VA MEDICAL BENEFIT (VMBP)       OREGON     97207
         ...OK? Yes// YES  (Yes)
```

Typing the *VA MEDICAL BENFIT* insurer name will allow the entry to be added.

```
IHS REGISTRATION EDITOR            Private Insurance     INDIAN HEALTH HOSPITAL
================================================================================
DEMO,GARY              (upd:MAY 09, 2013) HRN#:20493    (DIRECT ONLY)
================================================================================
1) Policy Holder.:                                5) Gender (M/F):
2) Policy or SSN.:                                6) Date of Birth:
3) Effective Date:                       7) PCP:
4) Expire Date...:                       8) CD Name.....:
-HOLDER'S EMPLOYER INFO-----------------------------------------------------
9) Status........:                        10) Employer:
-INSURER INFORMATION--------------------------------------------------------
                                          11) Grp Name:
                                              Grp Number:
                                          12) Coverage: Ins. Type: 13) CCopy:
----Policy Members----PC-----Member #------HRN-----Rel----------From/Thru-------
--------------------------------------------------------------------------------
Last edited by: LUJAN,ADRIAN M on May 09, 2013
Entering new PRIVATE INSURANCE ELIGIBILITY record

Enter the NAME of the POLICY HOLDER or the POLICY NUMBER if it already exists.
          (Enter 'SAME' if the PATIENT is the Policy Holder.)

Select POLICY HOLDER: SAME



  (APR 17, 1942)


Name as Stated on Policy..: DEMO,GARY//
HOLDER'S ADDRESS - STREET: PO BOX 1039//
HOLDER'S ADDRESS - CITY: BERNALILLO//
HOLDER'S ADDRESS - STATE: NEW MEXICO//
HOLDER'S ADDRESS - ZIP: 87130//
HOLDER'S TELEPHONE NUMBER: 505 204 2949//
[2] Policy or SSN...: 204930404
[3] Effective Date..: 3/27/2013  (MAR 27, 2013)
[4] Expiration Date:
POLICY HOLDER'S SEX: MALE//
DATE OF BIRTH: APR 17,1942//
HOLDER'S EMPLOYMENT STATUS: UNKNOWN//
EMPLOYER:
[11] Select GROUP NAME: VMBP
[12] Select COVERAGE TYPE:
   Person Code...:
[7] PCP:
   Member Number..:
```

When adding the eligibility, accept the default prompts as they appear with data. The only data that needs to be modified is:

- **Policy or SSN** – Add the Social Security Number of the Veteran
- **Effective Date** – Use effective date from the list (or verified from the VA). If the first enrolled date hasn't been received or is unknown, then use December 5, 2012 as the effective date.

```
IHS REGISTRATION EDITOR             Private Insurance     INDIAN HEALTH HOSPITAL
================================================================================
DEMO,GARY              (upd:MAY 09, 2013) HRN#:20493    (DIRECT ONLY)
================================================================================
1) Policy Holder.: DEMO,GARY                        |5) Gender (M/F): M
2) Policy or SSN.: 204930404                        |6) Date of Birth: 4/17/1942
3) Effective Date: MAR 27, 2013         |7) PCP:
4) Expire Date...:                      |8) CD Name.....:
-HOLDER'S EMPLOYER INFO-----------------------------------------------------
9) Status........: UNKNOWN              |10) Employer:
-INSURER INFORMATION--------------------------------------------------------
VA MEDICAL BENEFIT (VMBP)               |11) Grp Name: VMBP
   PO BOX 1035 MAILSTOP 10N20           |    Grp Number: IHS
   PORTLAND, OREGON 97207               |12) Coverage:
   (855)331-5560       Ins. Type: P     |13) CCopy:
----Policy Members----PC-----Member #------HRN-----Rel----------From/Thru-------
14) DEMO,GARY             204930404       20493   SELF     3/27/2013
--------------------------------------------------------------------------------
***WARNING 017: Coverage Type(s) not defined for the policy (204930404|VA MEDICA
L BENEFIT (VMBP))
Last edited by: LUJAN,ADRIAN M on May 09, 2013
================================================================================
ENTER ACTION (<E>dit Data,<A>dd Member,<D>elete Member,<V>iew/Edit PH Addr):
```

Coverage type is not needed as there is no coverage type associated with the Veteran's eligibility. The Priority Group may be used as a coverage type but at this time will have no effect on how the claim is generated.

```
IHS REGISTRATION EDITOR  (page 4)                      INDIAN HEALTH HOSPITAL
================================================================================
DEMO,GARY                  (upd:MAY 09, 2013)          HRN:20493  DIRECT ONLY
================================================================================
                            SUMMARY COVERAGE
--------------------------------------------------------------------------------
SEQ      INSURER                 COVERAGE TYPE          ELIG BEGIN - ELIG END
         SUBSCRIBER               POLICY NUMBER
================================================================================
 1.     VA MEDICAL BENEFIT (VMBP                        03/27/2013             A
          DEMO,GARY               204930404
 2.     MEDICARE                A                       04/17/2007             A
          DEMO,GARY               204930404A
        MEDICARE                B                       04/17/2007             A
          DEMO,GARY               204930404A
--------------------------------------------------------------------------------
================================================================================
Enter S(equence), A(dd) insurer, E(dit) insurer, T(oggle seq category)
V(iew) Historical Sequence Dates  L(ist inactive eligibilities):
```

6.0 Billing

Timely Filing IHS/THP claims must be submitted to VA for payment within 12 months from the date of service, otherwise the claims will not be reimbursed by VA.

Commented [C12]: Added. Received directly from VA.

6.1 Coordination of Benefits

The VA Medical Benefit Plan (VAMB) is considered the payer of last resort. Currently in the RPMS Third Party Billing system, VAMB will generate before Medicaid and Medicare. Billing staff must ensure all insurance plans have been sequenced correctly to ensure correct Coordination of Benefits.

If a claim is submitted to other insurers where the VAMB insurer is listed as another payer and the insurer denies the claim stating that the VA must be billed first may need for the site to submit a copy of the IHS-VA agreement to indicate that the VA is the payer of last resort.

Secondary Billing is to be done only when Private Insurance has been billed first. You must provide a copy of the Payment/Denial EOB from the Private Insurance Company.

If applicable, the submitted healthcare claims must have an attached Explanation of Benefits (EOB) from the other health insurance. If the healthcare claims are being submitted to the VA via EDI, mail the EOB to VISN 20 NPC at least 4 days prior to expected EDI claim submission.

Commented [C13]: Added. Directly from VA

Secondary Billing (after Private Insurance) will be handled accordingly.

1. Receive and Post EOB from Private Insurance company billed (payment, adjustments, denials)
2. Roll back information from Accounts Receivable to Third Party billing, creating a claim for the VA when appropriate.
    a. If the dollar amount received from the Private Insurer exceed the current All inclusive rate, do not balance bill VA.
    b. If the denial from the private insurance company was for a non-covered service, copay, or deductible, etc., create claim and bill accordingly to the VA.
3. Approve the VA claim according to guidelines.
4. Submit on Paper and attach the EOB.

Commented [C14]: Added

DO NOT secondary bill from Medicaid or Medicare.

6.2 Claim form requirements

The VA Station Number and the Contract Number will need to print on each paper claim form. The entries are added to Site Parameters option for each division within RPMS. Once populated, there is no need to manually add to the Claim Editor.

The VA Station Number is a three-digit number and identifies the VA Medical Center associated to the Indian Health or Tribal Health facility where the patient was seen at.

VA STATION NUMBER					
Export Mode	**Form Locator**	**RPMS Page**	**RPMS Field Description**	**Example**	**VA Facility**
CMS-1500 or 837 Professional	Block 23	3	Prior Authorization Number	568	Fort Mead VA
UB-04 or 837 Institutional	Block 63	3	PRO Approval Number	0568	Fort Mead VA

The Contract Number is the number that the VA assigns to the Indian Health or Tribal Health facility once the Implementation Agreement has been signed. This number will be used to identify the IHS and VA facility and must be sent on the claim.

CONTRACT NUMBER					
Export Mode	**Form Locator**	**RPMS Page**	**RPMS Field Description**	**Example**	**VA Facility**
CMS-1500 or 837 Professional	Block 19	3	HCFA-1500 BLOCK 19	VA-568-IHS-0001	Fort Mead VA
UB-04 or 837 Institutional	Block 80	9F	Remarks	VA-568-IHS-0001	Fort Mead VA

Note: The table references the pages and fields the Station Number and/or Contract Number may be added if manually adding to the claim.

6.3 Itemization of Charges

Although the signed agreement states that the Indian Health Service Federal and Tribal locations shall be reimbursed at the All-Inclusive Rate as published in the Federal Register, all claims must be submitted displaying the itemized charges. The initial set up of the insurer allows the claim to itemize in the Claim Editor.

Note: Do not submit the all-inclusive rate or a default CPT code for services to the VA.

6.4 Outpatient Claims

Outpatient services, as indicated in the Insurer File setup, are to be billed on the CMS-1500 or the 837 Professional export mode. Medications may be billed but the charges would need to be split from the Medical claim. Use the Split Claim option (3P>MGTP>SCMG) to create a new claim.

Every attempt to file Outpatient claims electronically should be pursued. As of the implementation date, if an outpatient claim is submitted on paper, a $15 paper claim fee will be assessed off of every OP paper claim submitted.

Commented [C15]: Added. Should we add more about electronic billing through Emdeon (Change Healthcare)

6.4.1 Ambulatory Surgical Center (Day Surgery)

All services pertaining to Ambulatory Surgeries should be presented (billed) on a CMS-1500 ONLY. Only submit one claim form.

6.4.2 Emergency Room

Emergency Room services are billed on the UB-04 or 837 Institutional claim form. Sites that normally separate the Emergency Room claim to bill the Professional Component separate from the facility charges will need to ensure that all billing is approved on one claim form. This means the Professional Component must be billed with the facility charges on the UB-04 or 837 Institutional claim form.

6.4.3 Inpatient Claims

Inpatient claims are billed on the UB-04 or the 837 Institutional claim form. Charges will be itemized and the Inpatient Professional Component may be split on to a separate claim and billed using the CMS-1500 or the 837 Professional claim form.

Per VISN20, and per the Agreement, Inpatient claims will be reimbursed at the current DRG (Diagnostic Related Grouper) rates. This means that the facility bill will be reimbursed according to length of stay, condition and diagnosis of patient, age of patient, etc. VISN20 is not able to calculate the actual DRG code to use for reimbursement, therefore in order to receive payment, IHS/THPs must include the DRG on the claim. The DRG is to be added to Block #71 of the UB.

Commented [C16]: Need some work

> **Note:** As of date, we have encountered an issue with submitting claims electronically for Inpatient. One, you have to have the DRG present on the UB-04 (837I) for inpatient facility charges. Two, we have found that en route to the clearing house, partial data is being removed from the 837I file, resulting in re-routing the claims to a different location.

As of now, it is recommended that Inpatient claims be submitted on paper. Yes, there will be a $15 paper claims fee on those claims. Until further research is done, IHS/THPs must include the DRG on the paper UB form.

Current development of this process is currently underway.

Commented [C17]: Added

6.4.4 Dental

The VA agreement allows for the billing of dental services. For the enrolled Veteran, dental benefits are very limited. Prior to billing any dental services, please contact the local VA to ensure the services provided will be covered.

Commented [C18]: added

6.4.5 Pharmacy Billing

At this time, medications are not billed using the Pharmacy Point of Sale System (POS). Medications shall be split from the medical claim.

Medications are billed using a HCPCS code that specifically identifies the medication. Use J3490.

Because the VA cannot process Pharmacy claim forms, or accept Point of Sale billing, we are to use the CMS-1500 to bill Pharmacy prescriptions to the VA. The CMS-1500 claim form requires the inclusion of a CPT/HCPCs code for every line billed. We have been instructed to Always use J3490 as the CPT/HCPC code. This should eliminate denials.

At this time, the Pharmacy claims cannot be billed electronically. The VA payment processing system cannot read all pertinent data that is needed for adjudication of these claims. All Pharmacy claims must be billed on paper (CMS-1500). The $15 paper claims fee, DOES NOT apply to pharmacy claims.

Commented [C19]: Added

- The CMS 1500 must contain the following information:
- Date of fill
- Pharmacy name
- Drug name and strength
- Number of day's supply
- Quantity
- Prescription number
- Doctor's name or DEA number
- Amount paid by the other health plan or retail price for the pharmacy

Commented [C20]: Added directly from VA

The summary of pharmacy claims process are as follows:

* Pharmacy claims that are submitted to the VA are scanned in the VA Fee Care Basis System (FBCS) for processing.

* All IHS and THP pharmacy claims are suspended for review by VA claims processor.

* 100% manual pharmacy claims review are done by claims line item for VA Non-Formulary by the VA pharmacy team.

* After the claims review has been completed - the appropriate approval or denial/reject code is assigned. The pharmacy claims are then released to the VA claims processor (at VISN20) for action (either denial/reject or payment)

Commented [C21]: Added. Got from VA via email. Should we include this?

NEW:

As of the end of June, 2018, IHS and VA entered into and signed an addendum to the Agreement that addresses billing for Non-VA Formulary drugs. Per policy, the VA will not reimburse for prescription drugs that fall outside of their Formulary. In order for IHS/THPs to get reimbursed, a Pre-Authorization must be obtained from your local VAMC Pharmacy and the Pre-Authorization must be attached to the hard copy claim upon submission.

Each Area/Facility are working out processes to incorporate this change. Denials may be received "Non-Covered Service" if the PA doesn't accompany the claim.

Commented [C22]: Added. Do you think I need to say more?

From VA: Line items will be rejected with "non-covered charges" if it is non-formulary. If there are multiple lines on a claim and only one is non-formulary the other line items will be paid. If all line items are non-formulary, the entire claim will be rejected. If the one line item is rebilled it should not be rejected as a duplicate. If for some reason it is, please reach out to the call center for assistance

Commented [C23]: Added. Got directly from the VA in an Email

Here is the link to the VA Formulary listing:
http://www.pbm.va.gov/NationalFormulary.asp.

6.4.6 Billing for Supplies:

Here is the guidance received from VISIN20 when asked: Can you provide written guidance on how to bill for Supplies (diabetic, etc). Which form should these be billed on? What code (HCPC) should be used? What else is mandated on the claim form?

DME however is not covered (glasses and hearing aids).

In general the VA does not pay for supplies (they are not in the contract). If these are pharmacy related such as diabetic supplies, they should be billed like all pharmacy with the Jcode.

Commented [C24]: Added. Got directly from the VA in an email

The J code as in J3490? Not all these HCPCs have an NDC. Can some one please provide a mock up claim showing what should be printed on the claim. Because these are treated like pharmacy, do they have to be billed on paper.

Still waiting on response to the above questions.

Commented [C25]: Added. Should I include all of this?

7.0 Accounts Receivable

The following will detail how payments are received and processed in RPMS Accounts Receivable.

7.1 Finance Set-up of CANs

Prior to recording a VA reimbursement into the UFMS, CANS must be set up and created in UFMS with the appropriate VA Budget Activity Program (BAP). Each facility that is currently receiving allowances for PI, MCR, MCD, and OTHER must also have a Common Accounting Number (CAN) for the VA BAP. The following is the procedure for the CAN set up. This should only be done one time. Finance will has established procedures for updating these CANS on an annual basis.

Commented [C26]: Added

See Appendix B: Creating FY2013 CANS for VA-IHS Reimbursement.

7.2 Receiving Reimbursements

7.2.1 Understanding the PFRAR and EFT

The PFRAR is the Preliminary Fee Remittance Advice Report that is mailed by the VA VISN20 National Processing Center. The VISN20 National Processing Center is located in Vancouver, Washington. The PFRAR is used to indicate claims that have been processed. This includes denied claims. This document will be used for account reconciliation in Accounts Receivable. The PFRAR cannot be posted until reconciled with the EFT and EOB from the VA's payment center.

VISN20 sends the "payable" claim file to be processed out of the VA's Austin payment center. There currently is no correlation back to the PFRAR when the payment is submitted to the lockbox. The Business Office will need to work with Finance as the payments will need to be batched.

Summary:

1. Submit claims to VISN20
2. VISN20 adjudicates/processes all claims received. Claims are Paid, Adjusted, or Denied.

NOTE: If a claim is Rejected (didn't get into the processing system), claims are normally returned to the provider and not usually included in the PFRAR.

3. VISN20 creates and sends a PFRAR (Preliminary Advice Report) to facility or Lockbox. The PFRAR includes what VISN20 "said" to pay, adjustments and denials.

4. VISN20 sends “payable” claim file to The Payment Center to confirm and make actual payment.
5. The Payment Center will send the EFT (should not be paper checks) and EOB (actually payments made) to the PNC Lockbox and ACH accounts.
6. Once the EOB/Deposit is confirmed and reconciled, the Item is Batched.
7. Reconcile the EOB and PFRAR with the Batch.
8. Posting of all payments can happen at this time. Remember, the adjustments and denials may only be present on the PFRAR.

Commented [C27]: Added

7.2.2 Batching

Set up a new collection point for Veterans Administration if needed. This can be done in the Manager Menu under Collection Point Edit.

Prior to patch 11 installation for Third Party Billing, batch the payment, post to unallocated and refund using 560 (Transfer) as the Type of refund. Print Refund Letter and submit to Area Finance.

Upon receiving the transfer packet from business office, the area finance will log into UFMS and create an invoice for the amount of the deposit utilizing the CANS that were previously set up for the VA BAP. After completing the UFMS invoice, finance must create and apply a UFMS receipt for the deposit amount with the TDN from the transfer packet. At this point the Treasury Deposit number (TDN) and amount are recorded in UFMS and the funds will be eligible for the allotment/allowance process.

Since the VA payment will be a federal receipt, finance must be careful to record the transaction so that the invoice type and he receipt type are correctly in sync to trigger the allotment/allowance process properly. Proper recording is also necessary so that the transaction does not appear incorrectly on the trial balance. Below is the correct format for creating the VA invoice and VA receipt in UFMS.

See Appendix C: UFMS Manual Invoice/Receipt Example

Commented [C28]: Should we REMOVE

Do not post the payment into RPMS Accounts Receivable until you start using the VA Insurer Type.

7.3 Posting Scenarios

Payment Credit will be posted as long as the Insurer type used is Private Insurance and not VA. Use 20-payment credit and 121 as the adjustment reason.

Once the VA Insurer type is utilized, the transactions (invoice, receipt, and adjustment) will pass to UFMS via the interface. Once this process is implemented, Payments will be posted in RPMS via the Batch/Payment process.

Commented [C29]: Should we remove?

7.3.1 Adjustments

The VA will be charging a processing fee of $15 on outpatient claims for the first two years after the agreement has been signed. Adjustments shall be recorded using Write Off (3) and Processing Fee (140).

This assessment has expired. The VA is no longer adjusting payment for this amount for this reason. If you are still seeing this type of adjustment/fee, please contact Cynthia Larsen with examples via secure transfer as soon as possible

Commented [C30]: Added and reworded

The paper claim adjustment still applies to Medical claims submitted on Paper. The a $15 paper claims adjustment will be entered into AR as a Non-Payment (4) and Statutory Adjustment (686) adjustment reason.

Since the claims will be submitted itemized, the remaining balance will be adjusted using Grouper Allowance (16) with Processed in Excess of Charges (694) to bring the account into balance.

Pharmacy bills totaling under $20. Approve the bills but DO NOT SUBMIT to VA. Adjust the bills accordingly. Use adjustment code Non-Payment (4) and Pymt/Red for Req charges/taxes (141). You can now bill for all Pharmacy services since the $15 doesn't apply anymore.

Commented [C31]: Remove completely since this no longer applies?

7.3.2 Payment Exceeds Billed Amount

Use GROUPER ALLOWANCE, 694 (exception is Inpatient which will use a DRG adjustment type.)

7.3.3 Payment is Within Billed Amount

Use GROUPER ALLOWANCE, 694 (exception is Inpatient which will use a DRG adjustment type).

The following is an example of a claim posted where the billed amount was lower than the payment amount.

```
Transactions for DEMO,WILLIAM  from 05/22/2013 to 05/22/2013     Page: 1

Trans   Type   Amount    Category                Adj. Type
-------------------------------------------------------------------------------
 1.     A      300.00    PAYMENT CREDIT          RECEIVED NO-COL-REGISTER
 2.     A       15.00    WRITE OFF               PROCESSING FEE
 3.     A       15.00    NON PAYMENT             Statutory Adjustment
```

4.	A	-262.00	GROUPER ALLOWANCE	Processed in Excess of Charg

7.3.4 Claims Status Check and Questions By Phone and Online:

VA THP Claims Payment Processing Center contact 1-877-881-7618, Monday through Friday, 6:05 a.m. to 4:45 p.m., Mountain Standard Time (MST), do not enter the zip code.

Please try this Claims Payment Processing Center first. If needed, you can contact one of the POCs listed below. If you feel this is an Agreement, System, or National process issue that may be affecting others, please share with Cynthia Larsen via email.

Claims Payment Center POC's :
:
Lead Voucher Examiner - Melinda VanHoomissen; Melinda.VanHoomissen@va.gov; 360-696-4061 ext. 33314

Supervisor - Tania Redeau; Tania.Redeau@va.gov; 360-696-4061 x 36009

Claims Payment Center Manager - Kerry Paperman; Kerry.Paperman@va.gov; 360-696-4061 ext31673

Online: Vendor Inquiry System (VIS) VIS is an external web application that allows registered IHS/THP providers to research the status of claims received by VA. IHS/THP providers may register in VIS https://www.vis.fsc.va.gov/DesktopDefault.aspx to view the VA Treasury payment information and claim status.

VIS Fact Sheet link: https://www.va.gov/COMMUNITYCARE/docs/providers/VHA-FS_VendorInquiry-System.pdf.

Commented [C32]: Added. Should we keep

Appendix A: VA Eligibility Contact Information

https://www.1010ez.med.va.gov/

OTHER WAYS TO APPLY OR UPDATE YOUR INFORMATION...

By Phone

You can **apply** for enrollment of your benefits or update your information by phone by calling **1-877-222-VETS (8387)**, Monday through Friday, between the hours of 8:00 AM and 8:00 PM (Eastern Time). A VA representative will have your completed form sent to you for verification and signature.

For ***Enrollment Verification***, contact the Health Eligibility Center (HEC): **(855) 488-8441**
Hours of Operation are Monday through Friday, between the hours of 8:00 AM and 5:30 PM (Eastern Time). *We may have to established an approved contact person at each facility that will be allowed to receive information from the HEC.*

Commented [C33]: Changed according to VA

By Mail

Print the 10-10EZ form or 10-10EZR form or call to have the form mailed to you. Complete and sign the application, then mail it to:

Health Eligibility Center
2957 Clairmont Road Suite 200
Atlanta, GA 30329-1647

In Person

Visit a VA Medical Center or clinic nearest you to apply for enrollment or if you are already enrolled, to update your information in person.

Appendix B: Creating FY2013 CANS for VA-IHS Reimbursements

Commented [C34]: Do we want to still include these attachments in this Version.

The Following are the additional parameters to set up the non-project CAN:

Agency: J
Description: <Area Office will determine the CAN specific Description>
Accounting Point: <Area Office Specific>
BACS:
Fund - 0J070020130RA0
BFY - 2013
BAP - 7170AP0000
ORG - <area office ORG>0000000
OC - 00000
SGL - 000000
FUT1 - 0
LOC - <Area Office will determine the Location>
CC - 000
PA - 000000
IHSFUT1 - 0
IHSFUT2 - 0
Start Date: 01-OCT-2012
End Date: 30-SEP-2013
Project Flag: No
Project: <Not Applicable>
Task: <Not Applicable>
Rollforward: Yes
E-Travel: No
PMS: No
AFPS: No

Appendix C: UFMS Manual Invoice/Receipt Example

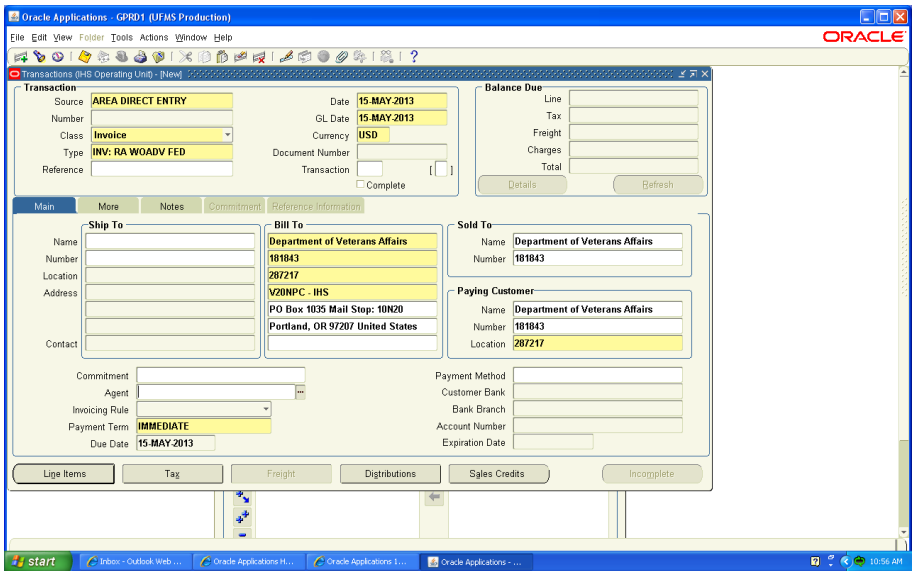
UFMS Invoice

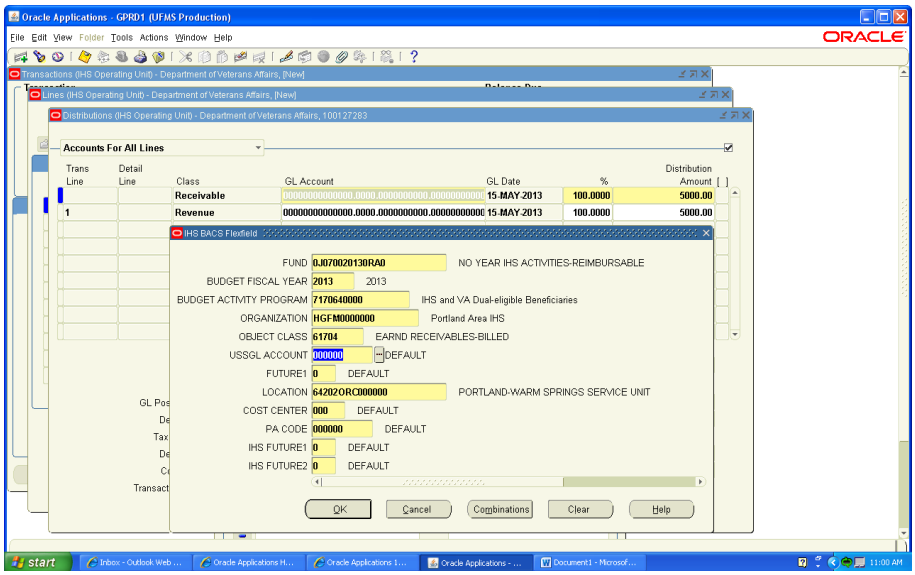
Source	Area Direct Entry
Transaction Type	INV: RA WOADV FED
Description	INVOICE: REIMBURSEABLE AGREEMENT WITHOUT ADVANCE FEDERAL
Customer	Department of Veterans Affairs
HHS T-Code	132
Object Class	61704
UFMS Invoice T-Code	A310A
Receipt T-Code	C186A
Fund	0J070020130RA0
BAP	7170AP0000
note: UFMS customer number is 181843	

UFMS Receipt

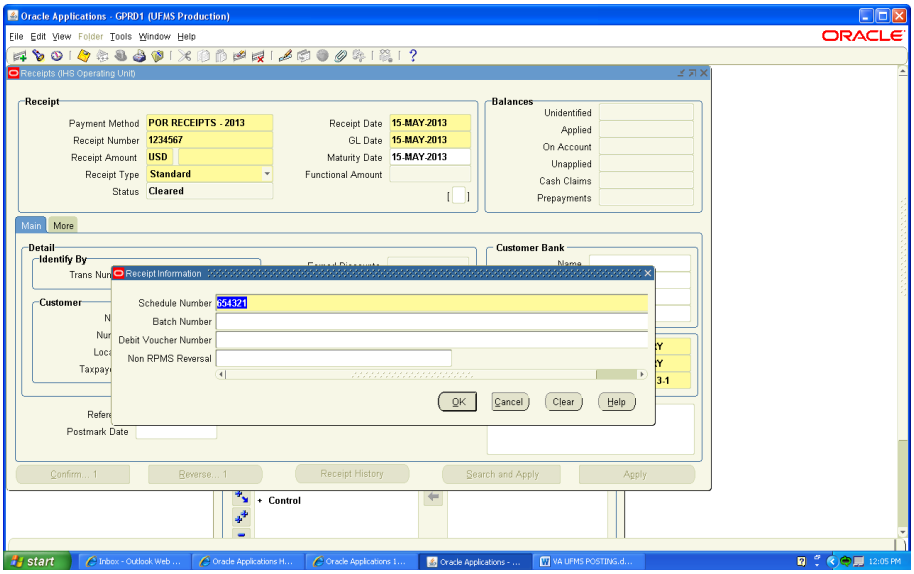
Receipt Method	<Area Office prefix> RECEIPTS-<Fiscal year> (i.e. POR RECEIPTS- 2013)
Schedule Number	SF 215 (TDN)
Customer	Department of Veterans Affairs
note: UFMS customer number is 181843	

It is recommended that there be an invoice created for each facility per deposit.


Oracle Applications - GPRD1 (UFMS Production)
File Edit View Folder Tools Actions Window Help
ORACLE
Transactions (IHS Operating Unit) - [New]
Transaction
Source AREA DIRECT ENTRY
Number
Class Invoice
Type INV: RA WOADV FED
Reference
Date 15-MAY-2013
GL Date 15-MAY-2013
Currency USD
Document Number
Transaction
Complete
Balance Due
Line
Tax
Freight
Charges
Total
Details
Refresh
Main More Notes Commitment Reference Information
Ship To
Name
Number
Location
Address
Contact
Bill To
Department of Veterans Affairs
181843
287217
V20NPC - IHS
PO Box 1035 Mail Stop: 10N20
Portland, OR 97207 United States
Sold To
Name Department of Veterans Affairs
Number 181843
Paying Customer
Name Department of Veterans Affairs
Number 181843
Location 287217
Commitment
Agent
Invoicing Rule
Payment Term IMMEDIATE
Due Date 15-MAY-2013
Payment Method
Customer Bank
Bank Branch
Account Number
Expiration Date
Line Items Tax Freight Distributions Sales Credits Incomplete
start
10:56 AM


Oracle Applications - GPRD1 (UFMS Production)
File Edit View Folder Tools Actions Window Help
ORACLE
Transactions (IHS Operating Unit) - Department of Veterans Affairs, [New]
Lines (IHS Operating Unit) - Department of Veterans Affairs, [New]
Distributions (IHS Operating Unit) - Department of Veterans Affairs, 100127283
Accounts For All Lines
Trans Line
Detail Line
Class
GL Account
GL Date
%
Distribution Amount
Receivable 15-MAY-2013 100.0000 5000.00
1 Revenue 15-MAY-2013 100.0000 5000.00
IHS BACS Flexfield
FUND 0J070020130RA0 NO YEAR IHS ACTIVITIES-REIMBURSABLE
BUDGET FISCAL YEAR 2013 2013
BUDGET ACTIVITY PROGRAM 7170640000 IHS and VA Dual-eligible Beneficiaries
ORGANIZATION HGFM0000000 Portland Area IHS
OBJECT CLASS 61704 EARND RECEIVABLES-BILLED
USSGL ACCOUNT 000000 DEFAULT
FUTURE1 0 DEFAULT
LOCATION 64202ORC000000 PORTLAND-WARM SPRINGS SERVICE UNIT
COST CENTER 000 DEFAULT
PA CODE 000000 DEFAULT
IHS FUTURE1 0 DEFAULT
IHS FUTURE2 0 DEFAULT
OK Cancel Combinations Clear Help
start
11:00 AM

RECEIPT


Oracle Applications - GPRD1 (UFMS Production)
File Edit View Folder Tools Window Help
ORACLE
Receipts (IHS Operating Unit)
Receipt
Payment Method POR RECEIPTS - 2013
Receipt Number 1234567
Receipt Amount USD
Receipt Type Standard
Status Cleared
Receipt Date 15-MAY-2013
GL Date 15-MAY-2013
Maturity Date 15-MAY-2013
Functional Amount
Balances
Unidentified
Applied
On Account
Unapplied
Cash Claims
Prepayments
Main More
Detail
Identify By
Customer
Customer Bank
Receipt Information
Schedule Number 554321
Batch Number
Debit Voucher Number
Non RPMS Reversal
OK Cancel Clear Help
Postmark Date
Confirm... Reverse... Receipt History Search and Apply Apply
Control
start
12:05 PM

Acronym List

BAP	Budget Activity Program
CAN	Common Accounting Number
EFT	Electronic Funds Transfer
EOB	Explanation of Benefits
HEC	Health Eligibility Center
IHS	Indian Health Service
OIT	Office of Information Technology
ORAP	Office of Resource, Access and Partnership
PFRAR	Preliminary Fee Remittance Advice Report
RPMS	Resource and Patient Management System
TDN	Treasury Deposit Number
UFMS	Unified Financial Management Center
VA	Veterans Administration
VISN	Veterans Integrated Service Network

Contact Information

If you have any questions or comments regarding this distribution, please contact the IHS/VA Reimbursement Implementation team in the Office of Resource, Access, and Partnership.

Questions regarding RPMS may be reported to the OIT Helpdesk:

Phone: (505) 248-4371 or (888) 830-7280 (toll free)
Fax: (505) 248-4363
Web: http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm
Email: support@ihs.gov