RESOURCE AND PATIENT MANAGEMENT SYSTEM

Contract Health Management Information System

User Manual

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PREFACE

The Contract Health Services Management Information System (CHS/MIS) User Manual describes the procedures necessary to enter Contract Health Service (CHS) purchase orders, denials for payment of services, and related documents into the local RPMS computer. The purpose of CHS is to provide an effective and reliable means by which eligibility for paid health care is determined. You can also use this manual as a guide to understand how to effectively deal with alternate resources, medical priorities, and payment policy that affects the data in the CHS/MIS software. This manual (Version 3.1) has been revised to enhance your ability to understand the technical aspects of the software. This version of the manual corresponds to Version 3.1 of the software.

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1   INTRODUCTION

This manual describes operation of the Contract Health Management Information System (CHS/MIS). This system is a facility-based automated document and fiscal management system for the Indian Health Service (IHS) Contract Health Service (CHS) Program.

Specific references are included for operation of the CHS/MIS within a compact/contract tribal program, hereafter referred to as "a tribal program."

The CHS/MIS features include:

- Integration with IHS Patient Registration System
- Automated data transfer to the Referred Care Information System (RCIS)
- Name and/or Employee Identification Number (EIN) lookup for Vendor
- Common Accounting Number (CAN) and Object Class Code Edits
- Online Reports by Document, Patient, and Vendor
- Electronic Explanation Of Benefits Report (EOBR) transmission
- Medical data with automated transfer to the Patient Care Component (PCC)
- Multiple Year CANs
- Master Delivery Orders
- Rate Quotation Methodology
- Prompt Payment Methodology

The CHS/MIS is a fully integrated data entry software package in the Resource and Patient Management System (RPMS) and uses shared data files for patients and vendors. (an example of a vendor would be a doctor's office or other health care provider other than IHS). The system that CHS/MIS is involved with generates authorizations for payment for CHS and maintains a current record of all committed CHS funds obligated and/or paid to date.

The CHS/MIS automates the major document preparation functions including:

- Generation of documents
- Printing
- Claim Processing

Information from each authorization is electronically communicated to other offices (e.g., Area Offices, Information Technology Support Services, and the IHS/CHS Fiscal Intermediary (FI)).

The CHS/MIS keeps a running total of the dollars spent by specific categories of care and provides immediate access to the account balances that have been updated. Periodic records of obligation and other reports are produced by the system.

Another major task of the CHS/MIS is to manage a denial system. When the IHS cannot approve CHS payment for care to an individual, a denial must be issued to that individual stating the reasons for denial of payment. The CHS/MIS provides the means for the entry, printing, and filing of individual denials that can be queried either by the patient or the care provider. A request from the patient should be considered as approved, denied, or pending approval upon review.

2 USING THE COMPUTER TERMINAL

This chapter presents basic information about computers. Definitions of basic computer terms and introductory level computing techniques that will be helpful in getting acquainted with the computer and keyboard are included in this chapter. This chapter also helps with the understanding of the management of this data base, security precautions, signing on to the computer terminal, selecting the menu options, maneuvering within the system itself, using the printer, and signing off of the computer terminal. For a more detailed discussion, refer to the Kernel's "User's Guide to Computing" and "VA FileMan" (March 1999), which should be available from the nearest Site Manager.

2.1 COMPUTER TERMINOLOGY

This section covers the most common terms associated with computers.

2.1.1 Hardware

The physical components of a computer or parts of machines that are connected to a computer (e.g. central processing unit, keyboard, monitor, hard drive, printer, CD ROM, floppy disk, mother board, etc).

Central Processing Unit (CPU) - The CPU processes data and compiles it so that the information may be read by all of the connected terminals. For RPMS applications, the CPU is a central unit for a facility. Most computer terminals within the RPMS system are connected to a single computer, which is the Central Processing Unit.

Keyboard – A group of arranged keys by which a machine is operated. The keyboard is the tool used to communicate with the computer.

Monitor (or **Terminal**) – Hardware that monitors the operation of a computer system. The monitor is the piece of hardware that visually displays menus, instructions typed, or messages sent by the computer.

Printer - The printer produces a paper copy of the output (product or turnout) after receiving instructions from the computer. In this case, the printer is a piece of hardware or a machine that produces a printout (sometimes connected physically to the computer).

2.1.2 Software

Allows interaction with the computer. A software program is a set of instructions that control what is seen on the screen, how information is entered, and what the computer does with the information or instructions entered. The CHS/MIS software allows the authorizations for payment to be generated for CHS and maintains a current record of all CHS dollars that are committed or paid.

2.1.3 Interactive Dialogue

Communication between the user and the computer is accomplished through typed words and symbols seen on the monitor. Types of interactive dialogues are as follows:

Cursor – Controllable bright figure (or pointer) on the computer terminal to indicate a position where data is to be entered or a character to be revised. The cursor may be seen as a blinking line and indicates when a response is needed and the position in which it is to be typed.

Prompt - The prompt is an instruction that the computer displays on the screen to indicate to or cue you for the type of information, action, or response the computer requires.

Menu - The menu is a list of different options from which you may select. To choose a specific task, type the given abbreviation at the prompt to select one of the items from the list.

2.1.4 **Fields**
A field is a space in which the same type of information is regularly recorded. Fields on a display screen function like blanks on a form. For each field, a prompt advises the type of data to be entered. There are six basic field types within the CHS/MIS, each allows a different type of information. The fields are as follows:

Computed Field - This field creates a value by performing an operation on other values in other fields (e.g., Payment Adjustment).

Date - This field accepts a variety of formats for entering the date (e.g., Formats: 7/31/96, 073196, T (= Today's date), T+7 (= Today's date + 7 days), T-4 (= Today's date - 4 days)).

Free Text - This field accepts numbers, letters, and most of the symbols on the keyboard. There may be a restriction on the number of characters that may be entered (e.g., Description of Service, and Optional Comments).

Numeric - This field only accepts numbers. There are restrictions that apply to the length of the response (e.g., Estimated Charges).

Pointer to a File - A pointer is a field that directs the computer to another file for information (e.g., Vendor Name).

Set of Codes - This type of field usually accepts one or two characters (e.g., Type of Document (43, 57, or 64), and Y or N (Yes or No responses)).

2.1.5 **Database Management**
A database is a collection of files containing information that may be used for many purposes (e.g., generate reports). Storing information in the computer helps reduce the amount of paperwork and enables quick access to a wealth of information.

Fields – A computer field may be strictly defined as a particular area in which information is regularly recorded. A field is a space in which something is drawn or projected. Fields are represented by the various prompts in the database. A collection of fields makes up a record. See "Interactive Dialogue" for additional information.

Records - A record is a group of fields. All records have names (e.g., a document number). All data associated with a particular name is located within the same record. A record is a collection of related items of information treated as a single unit.

Files - Files are a collection of records with the same type of information stored together (e.g., vendor file).

2.1.6   Keyboard Entry

The keyboard has two main sections. The first section contains a keyboard similar to a ten-key adding machine. This section makes up the right end of the keyboard. The left section of the keyboard resembles a typewriter keyboard with the addition of several special keys and symbols. It is this section and its special keys that you normally use.

When entering numbers, you may either use the numeric keys on the right side of the main keyboard or the numeric keys on the top of the typewriter-like keyboard.

If you enter an incorrect response, the system beeps as an alert to the error. A message following the beep shows the type of error. Another message appears to request the correct information.

2.1.7   Using Capitol Letters

When entering data onto the system, you must be sure to type all letters and words in CAPITAL LETTERS. Set up the terminal to enter only capital letters. Pressing the "Caps Lock" key can do this. This limits all entries to capital letters only. Note that the "Caps Lock" key has no effect on the numeric keys or other special keys. It effects only the letters A-Z.

2.2   SECURITY REQUIREMENTS

When performing basic tasks at the terminal, you are required to enter or review information that may be considered sensitive. Keeping your code(s) secret is the first line of defense against unauthorized users who may seek to defraud or compromise the computer system.

NOTE: Each user is provided security codes, including an access code and a verify code, by the Site Manager responsible for supporting the CHS/MIS at each respective facility. Access is managed per policy and requirements of the Area CHS Program and Service Unit policy.

2.2.1   Guidelines

To protect user security codes, always comply with the following guidelines:

- Do not share your access or verify codes with anyone.

- Do not use obvious codes such as user name, date of birth, or a user's child's name.

- Do not write access or verify codes on slips of paper, tape them under your desk, on a wall, on a computer terminal, or in other obvious hiding places.

- Do not use the computer for personal business.

- Do not leave the computer unattended while online. You should log off each time you leave your computer unattended.

- Do not leave printouts, computer documents, or media containing sensitive data in plain view.

2.2.2 Precautions
Here are some additional precautions:

- Change security codes at regular intervals. Each Site Manager may set the computer system to periodically require users to change their verify codes.

- After gaining access to the computer, you have a limited amount of time to enter data at any prompt. Failure to enter information within an allotted time period causes the computer to return to the "Select Option:" prompt. The computer again waits for information to be entered. Additional failures to respond within the allotted time force the computer to prompt if you wish to HALT. Failure to reply NO at this level causes the computer to log you off the system.

2.3 USING THE RPMS TERMINAL
This section describes some basic functions of the RPMS terminal. You can obtain further information from your Site Manager.

2.3.1 Signing on to the Terminal
Use the access and verify codes to sign onto the computer terminal. After gaining entry to the computer, you can begin working with menus, options, and prompts.

The following are procedures used to gain access to the first menu:

- Enter Access and Verify Codes -- The access and verify codes are unique and are used by the computer to identify you. Codes, when typed, are not visible on the screen. This helps maintain secure access and verify codes. The verify code should be slightly different from the access code.

- Lock-Out Feature -- This precaution within the system is designed to restrict tampering. You have a limited number of opportunities to enter access and verify codes. Should either code be incorrect after the allowed number of attempts, the terminal locks, denying access to anyone for a period of time. The number of attempts allowed and period of lock-out time are determined by the Area Security Officer and/or facility site manager.

- Short-cut to Signing onto the Terminal -- This feature allows you to save time by entering a verify code at the access code prompt. type the access code, a semicolon, and the verify code (e.g. ACCESS CODE: jellybean1;jellybean2).

- Respond to the Terminal "TYPE NAME" prompt -- The "Select Terminal Type Name" prompt may appear on the screen after a successful logon. If the default response identifies the terminal on which you are working, press

<RETURN>; if not, enter the correct terminal (e.g., C-WYSE-75). If you don't know the type of your terminal, contact your Site Manager for assistance.

The following illustration shows the process for accessing the computer:

```
  *********************************************************
                   (YOUR FACILITY NAME)
           RESOURCE AND PATIENT MANAGEMENT SYSTEM


  *********************************************************

Volume set: TRN    UCI: PRD    Device: 5 (5)

ACCESS CODE: (Your entry displays as you type it)
VERIFY CODE: (Your entry is invisible)

Good morning <Your Name> You last signed on yesterday at 16:12
Site set to (Your facility name)
```

2.3.2   Selecting Menu Options
After you sign onto the terminal, type the abbreviation for the specific menu item to select the options from the menu, then press <RETURN>.

Primary Menu - After signing on the system, a prompt for the primary menu is displayed. This menu includes all RPMS and system applications to which you have access. This menu may also be called the CORE menu.

Common Menu – Type double question marks (??) at the primary menu prompt to retrieve the common menu. Under the common menu, you can see the following selections: User's Toolbox, View Alerts, Continue, Halt, Mailman Menu, Restart Session, Time, and Where Am I?. These options are available to everyone.

Sub-Menu – Any application menu or subsequent menu within an application. The various options on the sub-menus are used to perform specific tasks.

You can use the following actions to go back to a previous menu.

- **<RETURN>** key - Press **<RETURN>** without typing a given choice to go back to the previous menu.

- **UP ARROW** key (up-hat) - Press the <6> key (also known as the caret key or the up hat (^)) while holding down the <SHIFT> key to display an up arrow to return to the previous menu. This function is mainly used for the user that decides to escape out of a screen without saving any information that they typed on that screen.

- **DOUBLE ARROW** key (double up-hat) – Enter two up arrows to go directly to the primary menu or main application menu.

- **UP ARROW JUMP** - Press the <6> key while holding down the <SHIFT> key to produce an up arrow (^). Next, type the abbreviation for the option you need to perform. This key combination allows you to jump through menus without passing through the menu hierarchy (e.g., ^REP - takes you directly to the "reprint" option from any point within the CHS/MIS software).

2.3.3 Using the Scrolling Mode
This feature allows information to move up the display screen as you respond to each prompt, step-by-step. The computer stores each response one at a time.

The following are scrolling mode features:

- **<RETURN/ENTER>** Key - Press <RETURN> to show the end on an entry such as a number or a word. Press the <RETURN> key each time you respond to a computer prompt. If you want to return to the previous screen, simply press <RETURN> without entering a response. This takes you back to the previous menu screen. *NOTE*: The <RETURN> key on some keyboards is shown as the <ENTER> key.
- **Keys to Avoid** - The Print, Escape, and Arrow keys may create problems if you use them.

- **Online Help** – Special help displays are available for most menu options and data entry prompts. When you enter a single "?" and press <RETURN>, the computer responds by presenting instructions for entering requested data. Entering two question marks (??) causes the system to display a more complete message. Some prompts display a list of available choices. When choosing from a menu of options, enter three question marks (???) after the prompts to bring up a brief explanation on how to respond to each option. Entry of a single question mark (?) followed by the option number or name causes the system to display a detailed description of that particular option. This occurs if help screens are available for that option.

- **Help Prompts** - If you answer a prompt incorrectly, the computer beeps and automatically presents a "help" prompt. Beneath this, the incorrect response is displayed. At the prompt's second appearance, you have an opportunity to respond correctly.

- **Abbreviated Responses** - An abbreviated response helps you avoid typing complete entries. To use this, enter data by typing only the first letter or series of letters (e.g., type "Out" and the response Outpatient is returned to the prompt).

- **Default Answers** - The computer frequently presents an answer with the prompt. These defaults are identified by the double slash that follows them. If the answer is correct, press <RETURN>; if not, enter the correct information and press <RETURN>.

- **Backspace Key –** The backspace key allows you to move the cursor backward (to the left). It deletes or erases characters as it backspaces.

- **Space Bar –** To use a shortcut during the data entry, use the Space Bar to tell the system to reuse a previous response. For example, when asked to make a selection from a menu of choices, press the Space Bar and <RETURN>. This causes the system to reuse the last selection that was made.

2.3.4   Using the Printer

The following are prompts used for printing:

Home - If you enter **HOME** at the "**Device:**" prompt, the system displays the response (for example, report) to the screen.

Printer Identification - Type the printer identification (e.g., TTB3, 206) at the "Device:" prompt.

Queue - Enter "Q" at the "Device:" prompt to assign the printing job to a specific device at a specific location at a specified time. This allows you to queue a print job while the printer is performing another task.

2.3.5   Signing Off

"Signing off" is the process of terminating a session on the system. If you fail to sign off a system, someone else may use your terminal to perform work using your access code. You will then be held accountable for any entries and actions another user performs while working under your "sign on" status.

To sign off the system, type "**HALT**" and press <RETURN>.

3   CHS/MIS OPERATION

After signing on to the computer, the following CHS/MIS Main Menu is displayed.

```
**************************************************************
                    Indian Health Service
          CONTRACT HEALTH MGMT INFORMATION SYSTEM
               Version 3.1, (distribution date)
**************************************************************
                    (your facility name)

     DOC      Document Generation ...
     PAY      Pay/Edit Documents ...
     PRT      Document Printing ...
     ACC      Account Balances ...
     PT       Patient Data
     VEN      Provider/Vendor Data
     DIS      Display Documents ...
     DCR      Document Control Register
     MGT      Facility Management ...
     DEN      CHS Denial/Deferred Services ...
     XXXX     CHS Programmer Utilities

Select Contract Health System Option:
```

NOTE: CHS staff access to each item shown above is a local Service Unit/Facility decision subject to any applicable Area certification requirements. Access "keys" are assigned to individual users based on their respective job duties. As a result, a user may not have access to all options within the CHS/MIS. Refer to the CHS Specialist or to the local Site Manager for questions regarding access keys.

Use this main menu to select one of the options in the CHS/MIS. To use the item selected from this or any other menu, type the abbreviation of the item and press <RETURN>. If the option title is followed by three periods upon selection, a sub-menu with additional options is available.

4   DOCUMENT GENERATION
Type "DOC" and <RETURN> to display the Document Generation Menu.

```
          CONTRACT HEALTH MGMT INFORMATION SYSTEM
                    (your facility name)
                    Document Generation

     ID     Initial Document
     SUP    Supplemental
     SBO    Special Blanket Obligation
     CAN    Cancel Obligation
     SLO    Special Local Obligations
     REFM   Enter/Edit Referral Medical Data


Select Document Generation Option:
```

To use any of these options, type the abbreviation of the option and press <RETURN>.

Use the six items on this menu to generate or modify CHS documents with supplements and/or cancel transactions. The system generates and processes the following CHS documents:

- HRSA-43 - Purchase Order for Hospital Services
- HRSA-57 - Purchase Order for Dental Services
- HRSA-64 - Purchase Order for Other than Hospital Inpatient or Dental Services
- IHS-T-843 - Purchase Delivery Order for Health Services (Combined purchase order, also referred to as the Universal CHS Purchase Order).

4.1   INITIAL DOCUMENT

To generate a purchase order, type "ID" and press <RETURN>. Next, enter all information necessary to create an initial document. Each prompt is detailed in the following sections.

4.1.1   Fiscal Year
The first prompt queries for the Fiscal Year. The current fiscal year is always shown as the default response. The default response is shown as two (2) slashes "//" following the fiscal year. The fiscal year must be entered with all four digits. For example:

```
ENTER FISCAL YEAR:   (1993-1998):   1998//
```

If selecting a **prior** fiscal year, type a valid fiscal year. After selecting the appropriate fiscal year, press <RETURN>. If a **prior** year is entered, the following message is displayed:

```
Are you sure you want to issue document for a PRIOR
FISCAL YEAR ? NO//
```

WARNING: This is a warning message to ensure that you intend to use prior year funds. You must enter a "Y" if you want a prior year .

4.1.2 Type of Document

After the fiscal year is entered, the system prompts for the Type of Document:

```
Select one of the following:

   43    Hospital Service
   57    Dental Service
   64    Outpatient Service

Type of Document:
```

Enter one of the above listed document types (e.g., 43, 57, or 64) and press <RETURN>.

NOTE: If your location has been converted to use the Universal Purchase Order Form IHS-T-843, you are still prompted to select the type of document as described above. The document types link to a corresponding document reference code (323, 324, or 325) within the Health Accounting System.

4.1.3 Patient Name

The next item of information requested will be the patient's name (Chart Number or Social Security Number).

NOTE: This information is extracted from your location's RPMS Patient Registration System. Therefore, information is only as current and accurate as the most recent entries in the Patient Registration System. Refer questions regarding the Patient Registration System to the location's Business Office Coordinator or Patient Registration Coordinator.

The following prompt is displayed:

```
Select PATIENT NAME:
```

Type one of the following entries:

- Patient's name (Last, First)
- IHS Chart Number
- Social Security Number.

If the patient's name (chart number or social security number) entered is not found, "??" and the prompt "Select PATIENT NAME:" is displayed. If this occurs, type the correct name (correct spelling), chart number or social security number.

To select a patient, type the Chart Number, if known. Only **one** patient is found, avoiding confusion with similar names. View all patient information to be sure this is the proper person, checking date of birth and social security number.

Type several characters of the patient's name. The more characters entered, the fewer number of matches are found. The names that match the entry name are then displayed on the screen, as displayed below.

```
Select PATIENT NAME: ADAMS

  1    ADAMS, AAAAAA    F 07-22-64 494999212   ANY 2963
  2    ADAMS, BBBBBB    M 04-08-75 440704382   ANY 2974
  3    ADAMS, CCCCCC.   F 09-26-62 414806341   ANY 2435
  4    ADAMS, DDDDDD    F 06-19-23 450249559   ANY 2343
  5    ADAMS, EEEEEE    F 09-25-49 421998037   ANY 1942

Enter '^' TO STOP, OR CHOOSE 1-5:
```

WARNING: If duplicate files are listed for the same patient, notify the Patient Registration Coordinator immediately. It is critical to enter CHS information in the correct patient file. Duplicate files must be appropriately corrected prior to entering initial documents, otherwise CHS data will be incorrect.

When working within a multi-facility system, duplicate entries for a patient may be displayed. Verify that the correct patient name and facility location are being selected.

The information on each listed patient includes Name, Sex, Date of Birth, Social Security Number, and Facility Identifier, and Chart Number. Verify all items to ensure the appropriate patient's name has been entered. Now, type the corresponding number on the left side of the screen to select the patient.

NOTE: If the system parameter is set to check CHS eligibility, the patient registration must indicate the patient is eligible for CHS. If the patient's eligibility status is "Direct Only" or "Pending Verification," the system does **not** generate a purchase order for the patient.

As soon as the patient is selected, the screen displays additional information and third party billing information for that particular patient or instructions that the patient is not eligible for Contract Health Services. An example is shown as follows.

```
Type of Coverage  Policy #      Cov. Type  EligDt  TermDt
----------------- ---------     ---------  ------  -------
MEDICARE          345678765A        A      010191
MEDICAID          C-234654-01OK            010193  040794
TRAVELERS INS     445345678               040794
```

The third party information is printed in an abbreviated format on all CHS documents.

Managed Care: Before issuing a purchase order, verify this information with the patient or provider. Perform "Screening of alternate resources information" by asking the patient, patient representative, and/or provider for the current status of

all available alternate resources.

All items of alternate resource information must be verified (including types of insurance, name of insurance, policy number, coverage, and beginning and ending dates). Likewise, this information should always be provided to all providers to ensure they file claims on other alternate resources **prior** to using CHS funds for payment.

To prevent pending claims at the Fiscal Intermediary, you must keep alternate resource information up-to-date, correct, and complete.

If alternate resources information must be updated, notify the Patient Registration Coordinator or Business Office (as appropriate for the user's location) to correct alternate resource information **before** the purchase order is generated.

4.1.4 Estimated Date of Service (DOS)
After selecting the patient name, type the estimated date of service.

An Estimated Date of Service must be typed in a standard date format (e.g., MM-DD-YY). If the year is omitted, the computer uses the Current Year. If six characters are entered in the date of service field (e.g. 012294), it is not necessary to enter dashes or slashes to separate month, day and year entries.

NOTE: The estimated date of service becomes the beginning date for the authorization period.

4.1.5 Provider/Vendor
Type the Vendor at the following prompt and press <RETURN>:

```
Select PROVIDER/VENDOR:
```

Type the name **or** the Employer Identification Number (EIN) of the provider. The most accurate way to identify the provider is to enter the EIN. Type the name in the same format used in entering the vendor file for the location.

If the vendor name entered is not found, "??" and the "Select Provider/Vendor:" prompt are displayed. If this occurs, make sure you have entered the correct vendor name, or use the "?" and <RETURN> to display the following prompt:

```
Answer with VENDOR NAME, or EIN NO., or EIN NO. AND
SUFFIX or CONTRACT NUMBER
Do you want the entire VENDOR List?
```

Type "Y" and press <RETURN> to list all vendors for the facility.

NOTE: If you are using a provider for which you cannot locate the name, check other possible names for the same provider or enter the EIN to search for the appropriate provider. Consult the area supervisor or other CHS staff regarding possible names by which providers have been entered.

If you enter only a few characters or words of the full name, for each match found on the name entered, the screen displays the Name of Provider, EIN, and City of the respective providers. An example is shown as follows:

```
Select PROVIDER/VENDOR: ADAMS

      1   ADAMS MD,WARREN     1234567890    WOODWARD
      2   ADAMS MD,WARREN J   2222222222    OKLAHOMA CITY
      3   ADAMS,STEPHEN       1730456723A1  DEL CITY

Choose 1-3:
```

To select the provider, type the corresponding number at the "Choose 1-__:" prompt and press <RETURN>.

WARNING: If duplicate vendor records exist, notify the CHS Specialist or Site Manager immediately. A purchase order cannot be issued when a duplicate vendor record exists.

After a vendor is selected, the system checks for duplicate purchase orders. If the patient name and vendor name match a previously issued purchase order, a search for similar dates of service are checked. If this combination exists, the following warning displays:

```
  Hold on now pardner!  Whoa Nellie!

  Document 6-ANY-00007 has a Estimated date real close
  to yours.
  (Continue ... if you're sure this isn't a duplicate
  P.O.)

  Press RETURN to Continue ...:
```

Verify that a duplicate purchase order is **not** being created; then, proceed with the data entry. If there is a question, exit the "Initial Document" option and review the patient's record to determine if the purchase order has already been issued. The warning identifies the purchase order that has been issued, and you can view this purchase order through the "Display Document" option. Refer to Section 10 for instructions regarding the "Display Document" option.

4.1.5.1   Vendor Type
If the Vendor file does not contain a Vendor Type, add this information. Refer to Section 9 for further information.

4.1.5.2   Vendor Contracts
If the selected vendor has an **active** contract, Provider Agreement, Blanket Purchase Agreement [BPA], or Rate Quote in the vendor file, a prompt requests this information.

If your location has **no** rate quote agreements, provider agreements or blanket purchase agreements, the following screen is displayed. If only one **active** contract is on file, this contract number becomes the default response to the "Contract Number:" prompt (e.g., Contract Number: 286-93-1001//). Type "?" and additional information about this contract are displayed, as shown below:

```
Contract Number Begin Date    Ending Date    Desc of
                                              Service
--------------- -----------   -----------    -----------
1 286-93-1001   Sep 3, 1993  Sept 1, 1994  Lab Services
2  Open Market

Enter Corresponding CONTRACT, AGREEMENT, or RATE
QUOTE #.
```

If the vendor has more than one active contract, all active contracts are displayed and are selectable. You may also select the "Open Market" response for services that are not included/covered in the contract.

Select the appropriate answer by entering the corresponding number at the left side of the screen and press <RETURN>. The system displays the contract number selected. If this is correct, press <RETURN> to proceed.

If your location participates in the Rate Quote Methodology (RQM) or uses Blanket Purchase Agreements and/or Provider Agreements, the following screen is displayed:

```
#   Type   Number  Eff-Date Exp-Date  MCR  Description
--  ----   ------  -------- --------  ---  ----------------
1  RQ   92-R-0006 09/03/92 09/02/93  YES INP:MEDICARE RATE
                                         OUT:BILLED CHGS-3%

2  RQ   93-R-0006 09/03/93 09/02/94  YES INP:MEDICARE RATE
                                         OUT:BILLED CHGS-3%

Enter Corresponding CONTRACT, AGREEMENT, or RATE QUOTE #.
```

Select from the list provided. The information for the selected agreement or contract is printed on the purchase order. It is important to select the correct agreement.

4.1.6   Description of Service
Type up to 30 characters of information describing and/or limiting the services/ procedures to be performed (e.g., "One office visit").

NOTE: The "Description of Service" allows for entry of "free text"; however, this must be used in accordance with accepted practices in the user's own Service Unit and/or Area. Use standard terms and abbreviations.

4.1.7   Period of Authorization for a HRSA-57 and 64

A beginning and ending "Period of Authorization" is prompted. The beginning date defaults to the estimated date of service and the ending date may be entered per any pre-certification of approved days. If you do not enter an ending date, a date 10 days from the estimated date of service is automatically entered for outpatient purchase orders. An ending date that is 60 days after the estimated date of service is automatically entered for dental authorizations.

4.1.8   Hospital Order Number

When issuing HRSA 64s for costs associated with an inpatient service, type the purchase order number for the related HRSA 43. Type a "?" and press <RETURN> for a list of HRSA 43s for this patient. Type the related inpatient purchase order number.

This feature groups all inpatient services (43s and 64s) for the same episode of care that identifies high cost cases (e.g., catastrophic reimbursements). This information does not print on the Universal PDO; however, the data is collected.

4.1.9   Common Accounting Number

Type the Common Accounting Number (CAN) for the specific document selected (e.g., 43, 57, or 64) as follows:

```
Enter last four digits of the CAN Number:
```

Type the last four digits of the CAN as instructed and press <RETURN>. If unsure of the CAN, type "?" and press <RETURN>. A list of the appropriate CANs will be displayed:

```
ITEM #  FY    CAN NUMBER    DESCRIPTION OF THE CAN NUMBER
------  ---   ----------    -----------------------------
  1     96    J50AJ26         PATIENT & ESCORT TRAVEL
  2     96    J50AJ73         CHS GM & S HOSP
  3     96    J50AJ74         CHS AMBULATORY CARE
  4     96    J50AJ75         CHS ALL OTHER/REHAB

ENTER ITEM # FOR CAN NUMBER :  (1-4):
```

At the "Enter Item # For CAN Number:" prompt, type the corresponding item number and press <RETURN>.

NOTE: The CANs appropriate to the Estimated Date of Service entered is displayed. CHS users have access only to **active** Fiscal Year CANs. Only CHS Supervisors and/or individuals provided the "manager" key have access to CANs for all fiscal years. If an incorrect CAN is typed, one of the following messages is displayed:

```
NOT VALID CAN NUMBER FOR HSA-43

(or)

CAN 'J50AP26' is invalid for FY '1996'
```

Type the CAN again.

4.1.10   Service Class Code

The Service Class Code is the designation for the old object class code system. Type the SCC using the Area/Service Unit instructions for the old object class code table. The Service Class Code automatically "crosswalks" to the new object class codes (effective 10/01/97). The new object class codes are the identified code for all finance and data reporting purposes. The service class code is the internal CHS/MIS structure for report generation. See IHS Headquarters and/or your Area instructions for further information regarding this new structure.

After entering the CAN, type the "Service Class Code:" at the prompt. For certain document types and CANs, a default response is shown (e.g., for an HRSA-43 the default response is 252G//). To use this code, press <RETURN>. Type a "?" and press <RETURN> to view a list of the CHS Service Class Codes that can be used with a particular document type and CAN. An example is shown as follows:

```
    ITEM #          SCC                     DESCRIPTION
   ------          ---            --------------------
     1             252A           MED LAB SRV OUTP NON-IHS
     2             252H           X-RAY SRV OUTP NON-IHS
     3             252L           HOSPITAL OUTPATIENT VISIT
     4             252Q           E.R. SERVICES
     5             252S           PHYSICAL THERAPY SERV.
     6             254D           PHYS OUTP NON-IHS
     7             254J           FEE SPEC. NON MD NON-IHS FAC
     8             4319           INTEREST

SELECT ITEM (1-8):
```

Next, type the corresponding number of the appropriate Service Class Code at the "Select Item:" prompt and press <RETURN>. For each site, internal tables that describe valid Service Class Codes, Cost Centers, and CANs exist. If you cannot enter a particular CAN and Service Class Code, contact the Site Manager or Area Office Support Center for assistance.

4.1.10.1 DCR Account

Each object class code is set to post the obligation to a specific account balance register. The option is also available to allow you to select the destination of an obligation with the account balances register. This must be set in the CHS Site Parameters. If only one destination is linked to an object class code, a message similar to the following displays:

```
DCR ACCOUNT = PHYS OUTPATIENT
```

If an object class code is set for multiple account balance registers, a prompt like the following displays:

```
1  PHYS. OUTPATIENT
2  E.R. ROOM
```

```
SELECT DCR ACCOUNT: (1-2):
```

Managed Care: This mechanism allows flexibility in monitoring CHS expenditures by allowing variations in the type of services being purchased (e.g., radiology services can be costs incurred as a result of an emergency room visit or at a physician's request during the course of an evaluation). This feature allows for the distinction when the funds are allocated to an account balance register.

4.1.10.2 Object Class Code
The automatic "crosswalk" to the new object class code is identified as follows:

```
OBJECT CLASS CODE = 25.6R = MEDICAL HEALTH SERVICES
```

4.1.11 Document Destination
If the document is to be paid by the IHS Fiscal Intermediary (FI), the following prompt is displayed:

```
DOCUMENT DESTINATION:  F//
```

A default response is selected based on the particular Object Class Code previously entered. Press <RETURN> to accept the default response. A message instructing the provider to mail the claim to the FI and the FI address is printed on the document.

If the document is to be paid by IHS, the destination should be "I." No mailing instructions or address is printed on the document.

4.1.12 Referral Type (Dental ONLY)
Type "?" and press <RETURN> to display the following prompt:

```
ENTER G FOR GENERAL REFERRAL, E FOR TYPE E SPECIFIC, B
FOR TYPE B, S FOR TYPE S AND L FOR TYPE L SERVICES

          Choose from:
          G    GENERAL
          E    SPECIFIC, TYPE E
          B    SPECIFIC, TYPE B
          S    SPECIFIC, TYPE S
          L    SPECIFIC, TYPE L

     REFERRAL TYPE (DENTAL ONLY):
```

If a Dental document **and** a Payment Destination being entered are the FI, type the referral type at the "Referral Type:" prompt and press <RETURN>. When selecting a referral type, one of the following messages is printed in the first lines of Part III of form HRSA 57:

General Referral: Before providing services other than examination, radiographs,

or emergency services, this claim must be returned for predetermination.

Specific Referral, Type E: Emergency examination and treatment not to exceed obligation amount. Services limited to Levels I-III of the IHS Schedule of Oral Health Services.

Specific Referral, Type B: Examination and treatment limited to Levels I-III of the IHS Schedule of Oral Health Services. Treatment plans exceeding $200 must be returned for predetermination.

Specific Referral, Type S: Specialty services limited to specifically listed services, not to exceed obligated amount. ADA code(s) should be listed.

Specific Referral, Type L: Authorization for dental laboratory services for a removable or fixed appliance.

4.1.13 Optional Comments

Type up to 10 characters of information for this field. It is an optional, free-text entry. It prints in the Optional Block on HRSA-43s and HRSA-64s. Type an "?" and press <RETURN> to delete a current comment. Press <RETURN> to bypass this field or to accept comments entered. Use this field in accordance with accepted practices in the Area; use standard terms and abbreviations. Standardized use is required for effective use of the Optional Comments Report. There is no "optional comment" block on the Universal IHS-T-843 form; however, the information is stored.

Managed Care: This is a good management report specific for the location depending upon the type of data entered. The report includes both open and paid documents; therefore, it provides current information based on the type of data entered (e.g., review committee date, pending alternate resources information, or the CHS Clerk's initials).

This field is most beneficial when the data is entered consistently and within specific guidelines.

4.1.14 Estimated Inpatient Days

This entry is used only for an HRSA-43. It is an estimate of the number of days the patient is to be hospitalized. Enter an appropriate number based upon the number of pre-certified/approved days or an estimate based upon past hospitalization experience of patients or other appropriate instructions. Enter the LOS (length of stay) indicated on the Disclosure Statement for the admitting or discharge DRG for any provider under Medicare rate contract. The Medicare-designated length of stay may also be used for non-Medicare rate providers/contractors as an estimate. (Obtain Disclosure statements from your Area CHS Office if this Area has Medicare rate hospital contractors.)

4.1.15 Estimated Charges

Type the best estimate of the amount IHS will pay for the service being requested. Consider any third party resources the patient may have. Remember to enter the net amount of the expected IHS payment amount (e.g., Medicare deductible, if

applicable). Use provider estimate, past experience, rate quote tables, and Disclosure Statements as appropriate.

Entry of a decimal point is not necessary if the amount is an even dollar. A zero (0) amount is an acceptable entry. To generate a document for less than one dollar, type (0._ _), a zero, period, and the amount that is less than one dollar. Enter the amount and press <RETURN>.

4.1.16   IHS Referral Medical Priority

Type a "?" and press <RETURN>. The following prompt is displayed:

```
What is the Medical Priority from the Referral Form?

Choose from:
I          I   - EMERGENT/ACUTELY URGENT CARE
II         II  - PREVENTIVE CARE
III        III - PRIMARY AND SECONDARY CARE
IV         IV  - CHRONIC TERTIARY AND EXTENDED CARE


IHS REFERRAL MEDICAL PRIORITY:
```

NOTE: Priority "I" concerns the patient's condition. The other three refer to services provided. "I" is always the highest priority. It is up to the Area to decide on the scope and extent of priorities of II, III, IV.

The referral for which a document is being generated must have been reviewed and assigned an IHS Medical Priority (I, II, III, IV) **and** approved for payment. Type the IHS Medical Priority assigned to this service/episode of care in the location's review process (e.g., CHS Review Committee, Managed Care Committee, Physician Review, etc.).

Type the appropriate code by entering the corresponding number displayed at the left side of the screen and <RETURN>.

The following prompt is displayed:

```
Enter ADDITIONAL REFERRAL DATA NOW?  N//
```

NOTE: The entry of referral medical data must be in accordance with instructions/policy of the Area CHS Program. Training in the use of ICD-9-CM and CPT coding can greatly enhance your ability to use this portion of the "Document Generation" module.

Type "Y" and press <RETURN> to continue entering the referral data listed below.

Managed Care: Data entered in item 4.1.17 through 4.1.24 is pertinent information collected for the "Medical Data Report" that is now available. This information is also used for future reporting through the "Referral Package" that interfaces with PCC. This package is currently being tested for future release.

4.1.17   Referral Physician
Type "?" and press <RETURN> to display the following prompt:

```
Answer with PROVIDER NAME or INITIALS, or DEA#, or CODE, or
IHS LOCAL CODE, or IHS ADC INDEX

Do you want the entire PROVIDER List?
```

NOTE: Type "Y" and press <RETURN> to list all IHS physician providers for a facility. Note that this list is **not** in alphabetical order. The Site Manager can activate and inactivate IHS Providers as needed using FileMan. Type the first few characters of the provider's last name and the system lists all providers with corresponding last names. To select the appropriate provider, type the number indicated and press <RETURN>. Inactivated referral physician names do not display on the screen; however, they are accessible by entering their names at this point.

Managed Care: The consistent entry of the referral physician on all purchase orders allow generating reports of all CHS activity related to specific referring physicians, furnishing specific data on volume, type, and dollar amounts of referrals.

4.1.18   Referral Cause of Injury
Type "?" and press <RETURN> to display the following prompt:

```
Enter the cause of injury from the referral form (ICD Diagnosis
Code beginning with "E8" or "E9".)

CAUSE OF INJURY codes are a subset of ICD DIAGNOSIS codes. They
must begin with an "E".

Answer with ICD DIAGNOSIS CODE NUMBER or DESCRIPTION
Do you want the entire ICD DIAGNOSIS List?
```

The ICD-9-CM Code Lookup Table is available to help you determine the appropriate code to enter if only narrative information is furnished on the referral form. Access to the Lookup Table depends on how a system is configured. Consult the Site Manager for more information.

4.1.19   Referral Alcohol Related
Type "?" and press <RETURN> display the following prompt:

```
Is this Contract Health Referral related to alcohol?

Choose from:
Y     YES
N     NO
U     UNKNOWN

REFERRAL ALCOHOL RELATED?
```

To select the appropriate answer, type the corresponding alpha character displayed

at the left side of the screen and press <RETURN>**.**

4.1.20 Referral DX (Diagnosis)
Type "?" and press <RETURN> to display the following prompt:

```
ENTER THE REFERRAL DIAGNOSIS

Answer with ICD DIAGNOSIS CODE NUMBER or DESCRIPTION
Do you want the entire [#]-ENTRY ICD DIAGNOSIS List?
```

Enter all diagnosis codes from the referral form or the provider HCFA form. The ICD-9-CM Code Lookup Table is available to help you determine the appropriate code to enter if only the narrative information on the referral form is furnished.

4.1.21 Referral DX (Diagnosis) Narrative
Type "?" and press <RETURN> to display the following prompt:

```
Enter the Diagnosis narrative from the referral form (max
245 characters).
```

4.1.22 Referral PX (Procedure)
Type "?" and press <RETURN> to display the following prompt:

```
Enter one of the following:
ICD.EntryName to select a ICD OP/PROC codes, referral.
CPT.EntryName to select a CPT code from referral form.

To see the entries in any particular file type <Prefix.?>
```

Type all procedure codes from the referral form. This field can be either an ICD code or a CPT code. However, the correct prefix (ICD or CPT) **must** be used. The ICD-9-CM Code lookup table is available to help you determine the appropriate code to enter if only narrative information on the referral form is furnished.

4.1.23 Referral PX (Procedure) Narrative
Type "?" and press <RETURN> to display the following prompt:

```
Enter the Procedure narrative from the referral form (max
245 characters).
```

These are all the entries for a particular document. The previously entered data is now be redisplayed, as shown below:

```
Form # 43
Aug 28, 1996        Hospital Service
----------------------------------------------------------------
        Patient                  |Ordering Facility & Provider
Fac:555220 IHS#:999999 111111111 | OCA IHS RPMS TRAINING
DEMO, PATIENT                    | 3625 N.W. 56TH STREET
TULSA, OK  74124                 | OKLAHOMA CITY OK 73112
11-29-56  F  422  002  947-72-40 | 555220
```

```
----------------------------------------------------------------
Est. date-of-svc.: AUG 28,1996   | BAPTIST MEDICAL CTR HOSP
ADMIT - DRG 178                  | 3300 N W EXPRESSWAY
PVT INS                          | OKLAHOMA CITY, OK  73112
Est. Days: 3                     | 1731034824    Open Market
----------------------------------------------------------------
Auth. From AUG 28,1996
DCR Acct. = HOSPITAL CARE        CAN/OBJ: J50AJ73 / 25.2G
 Estimated Charge: $2,855.19     Days: 3
```

After the above screen is displayed, the prompt: "Is This Correct? NO//" is displayed.

Verify all information before entering "Y" and press <RETURN>. This completes generation of the document.

If "NO" is selected, the first entry (Enter Fiscal Year) displays in a scrolling fashion all data for the particular document. Make appropriate changes to data previously entered.

To **not** record or save this document (e.g., if the document is not required), type an "**^**" (up-hat) as a response to the "Enter Fiscal Year" prompt. This cancels all the previous entries for this **one** document and returns to the Document Generation Menu.

After all items have been displayed, the prompt "Is this Correct?" is displayed. If all entries are correct, type "Y" and press <RETURN>. The next sequential number is assigned to this document, as displayed below. Then the document just entered is recorded and can be printed or displayed.

```
Document #  6-ANY-00032    Recorded
```

When generating the next document, press the Space Bar, then press <RETURN>. The system automatically recalls the document type, patient name, and/or provider included in the previous document. This feature expedites issuance of additional documents with similar information.

NOTE: Corrections **cannot** be made after the document number has been recorded as described above. If you have made an error (e.g., incorrect patient, provider, object class code, document type, etc.), the **only** remedy is to cancel the recorded document and to generate another document with correct information.

4.2   SUPPLEMENTAL

This section describes how to increase or "supplement" the dollar amount of a particular document. The supplement has the same number as the "Initial Document" with a suffix appended to the original number (e.g., the initial document number 2-O11-02345 with supplements would be 2-O11-02345S#).

WARNING: If you are supplementing an FI document, follow the applicable threshold instructions. Issuing supplements for amounts less than the designated threshold amounts could result in duplicate obligations if the FI payment transaction is recorded into the accounting system before the supplement. Such obligations remain open as unpaid on the

SHR 424 until Area Finance is instructed to delete.

To issue a Supplemental Document, type "SUP" and press <RETURN> from the Document Generation Menu to display the following prompt:

```
Select Document:
```

Type the document number of the document to be supplemented. The document number format has several options. Type a "?" and press <RETURN> to display the following "help messages."

```
Enter the 'Order Number' for the document
     In the following format:  F-LOC-NUMBER

Where
     F          Is the one-digit fiscal year code
     LOC        Is the three-character financial location code
     NUMBER     Is the five-digit document number

You may omit the first two items if you wish
(Current fiscal year and location code will be assumed).
Also, leading zeros on the document number are OPTIONAL.

Do you wish to see a list of documents? NO//
```

Type "Y" and press <RETURN> to the "Do you wish to see a list of documents?" prompt to display information similar to that shown below:

```
CHOOSE FROM:
     6-ANY-00001      64     OPEN             DEMO,PATIENT
     6-ANY-00002      64     PAID             DEMO,PATINET
     6-ANY-00003      64     OPEN             DEMO,PATIENT
     6-ANY-00004      64     CANCELED         DEMO,PATIENT

Select Document:
```

In most cases, press <RETURN> to accept the default response ("No"), because a long list of documents is generated. In either case, type the document number to supplement and press <RETURN>.

If the document number entered is not found, "??"and the prompt for the document number are displayed. When the correct document is entered and found, the following screen is displayed:

```
Form # 64               REF TYPE                    Order No.
Aug 29, 1996            Outpatient Service    1    6-O17-00009
-----------------------------------------------------------------
          Patient                  | Ordering Facility & Provider
Fac:555220 IHS#:999999 111111111 | OCA IHS RPMS TRAINING
DEMO, PATIENT                      | 3625 N.W. 56TH STREET
TULSA, OK  74124                   | OKLAHOMA CITY OK 73112
11-29-56  F  422  002  947-72-40 | 555220
-----------------------------------------------------------------
date-of-svc.: AUG 22,1996          | OKLAHOMA CITY CLINIC
PHYSICIAN SVCS                     | 701 NORTHEAST 10TH ST
```

```
PVT INS                          | OKLAHOMA CITY, OK  73104
Hosp Ord #: 6-O17-00007          | 1730710161    Open Market
---------------------------------------------------------------
Auth. From AUG 22,1996 to SEP 1,1996
DCR Acct. = PHYS INPATIENT          CAN/OBJ: J50AJ73 / 25.4B
Estimated Charge:   $10,000.00    Hosp Order No: 6-O17-00007
Initial Obligation   10,000.00
                          --------
CURRENT OBLIGATION BALANCE   10,000.00
```

Amount Of Supplement:
Type the supplement amount and press <RETURN>. Entry of a decimal point is not
necessary if the supplement amount is an even dollar. The supplement amount is to be
computed before entering the amount on the computer and should be the payable amount
minus the current obligation balance (including any previous supplements). The amount of
the supplement should not be the payable amount unless the existing obligated balance is
zero.

The prompt "Is everything correct?" is displayed. If the amount entered is correct, type "Y" at
the prompt and press <RETURN>. The following message is displayed:

```
                 ***  Document Updated  ***
Press RETURN...:
```

Press <RETURN> to return to the Document Generation Menu.

4.3   SPECIAL BLANKET OBLIGATIONS

This section discusses how to issue "Special Blanket Obligations." Presently, "blankets" can
be issued for documents to be paid by IHS **and** the Fiscal Intermediary (FI). However,
blankets for the FI is an option that must be set in the site parameters.

WARNING: Special Blanket Obligations are issued **only** in accordance with
instructions/policy of the Area CHS Program. A **disadvantage** of using Special Blanket
Obligations is that NO patient data and/or treatment data can be captured from such
documents. Refer to the CHS Supervisor or to the Area CHS Officer for clarification
regarding policies and use of blanket obligations.

The "Special Blanket Obligation" transaction was designed to allow CHS personnel to issue
one document per month for services provided to various patients (e.g., Ambulance,
Laboratory and Pharmacy Services, and services provided for a fixed fee).

To issue a Special Blanket Obligation, type "SBO" and press <RETURN> from the
Document Generation Menu. The following will be displayed:

```
Blankets may NOT be issued for Object Codes:
  252G, 252R, 254B, or 254P

          ENTER FISCAL YEAR: (1991-1996): 1996//
```

Type the correct fiscal year at the "Enter Fiscal Year: (1991-1996)" prompt and press

<RETURN>. Type the document type (43, 57, or 64). After selecting the document type, the following prompt is displayed:

```
Blanket Description:
```

Type "?" and press <RETURN> to display the following:

```
Enter a Description for this Document.
It Will Be Printed In Place Of The
     Patient Identification Data On The Form.

     The Maximum Length Allowed Is 150 Characters.
Type The Description In A Single Stream Of Characters
     (i.e., Don't Press The RETURN Key Until The End).
```

If the message: "Laboratory Services for September 1996," is typed, the following prompts are displayed:

```
Line 1: LABORATORY SERVICES FOR SEPTEMBER 1996

Edit line #:
```

Edit any of the single lines generated or press <RETURN> to bypass editing.

Type the necessary information to complete the Special Blanket Obligation document as requested at the prompts. This is the same information as previously discussed in "Initial Document" generation. Additional referral data is not required.

The following document is then displayed. Verify that the information shown is correct at the "Is This Correct?" prompt.

```
Form #64
Sep 04, 1996          Outpatient Service
---------------------------------------------------------------
      Description          | Ordering Facility & Provider
LABORATORY SERVICES FOR SEP | OCA IHS RPMS TRAINING 1996
                            | 3625 N.W. 56TH STREET
                            | OKLAHOMA CITY OK 73112
                            | 555220
---------------------------------------------------------------
Date-of-svc.: SEP 1,1996   |OK STATE DEPT OF HEALTH LAB
                            |  EMERGENT DIAGNOSTICS
                            | P.O. BOX 53551
                            | OKLAHOMA CITY, OK  73152
                            | 1736017987W2  Open Market
--------------------------------------------------------------
Auth. From SEP 1,1996 to SEP 30,1996
DCR Acct. = PHYS OUTPATIENT    CAN/OBJ: J50AJ74 / 25.2A
Estimated Charge: $6,000.00    Hosp Order No:
```

Press <RETURN> to accept the default response ("No") and make any necessary corrections, or type a "Y" and press <RETURN> to accept this document if all entries are correct. If

accepted, the next sequential number is assigned to the document.

4.4   CANCEL OBLIGATION

This section describes how to cancel an authorization that has been previously entered. A document may need to be canceled for several reasons. It may have been issued by mistake, or it may contain invalid information (e.g., wrong patient, wrong provider name, CAN and/or object class code, etc.). There are two types of cancellations: a Partial or a Complete Cancellation. These two types discussed in the following sections.

When entering "CAN" and <RETURN> on the Document Generation Menu, the system prompts to select a document. When a valid document number is entered, it is displayed on the screen as follows:

```
Form # 64              REF TYPE   Order No.
Sep 04, 1996           Outpatient Service   1    6-O17-00013
----------------------------------------------------------------
      Patient                    |Ordering Facility/Provider
Fac:555220 IHS#:999999 111111111 | OCA IHS RPMS TRAINING
DEMO, PATIENT                    | 3625 N.W. 56TH STREET
TULSA, OK  74124                 | OKLAHOMA CITY OK 73112
11-29-56  F  422  002  947-72-40 | 555220
----------------------------------------------------------------
Est. date-of-svc.: SEP 4,1996    | OKLAHOMA LITHOTRIPSY CNTR
OUTPATIENT SURGERY               | 5501 N PORTLAND
PVT INS                          | OKLAHOMA CITY, OK  73112
                                 | 1731265799    Open Market
----------------------------------------------------------------
Auth. From SEP 4,1996 to SEP 5,1996
DCR Acct. = HOSPITAL CARE  CAN/OBJ: J50AJ74 / 25.2L  AMB SX
 Estimated Charge: $1510.50    Hosp Order No:

    Initial Obligation         1510.50
                               --------
CURRENT OBLIGATION BALANCE      1510.50

Do You Wish To Cancel The Entire Document? NO//
```

Enter the type of cancellation (partial or complete). Type "No" to indicate a partial cancel transaction. Type "Yes" to perform a complete cancellation. To select the default response ("No"), press <RETURN>. The following prompt is displayed:

```
Amount of Cancellation:
```

Type the amount to be canceled for the document just displayed and press <RETURN>. The amount is displayed along with the following message:

```
Is everything correct? NO//
```

If the cancellation amount entered is correct, type "Y" and press <RETURN>. The following message is displayed:

```
   Why was this document canceled?

   Choose from:
   D    DUPLICATE
   N    NO SHOW
   R    RE-ISSUED
   Z    0 BALANCE
   O    OTHER
   U    UNKNOWN


   CANCELLATION REASON:   UNKNOWN//
```

This completes the "partial cancel" transaction, which means that the document is still "open." The dollar amount of the partial cancel has been taken from the original obligation, thus returning this amount to the unobligated balance. See the CHS Specialist for specific instructions regarding the dollar amount of partial cancels. Note that this is a Service Unit/Area threshold decision. In some instances, it may be more advantageous to cancel the entire document and initiate a new one for the correct amount.

If "Y" has been entered and <RETURN> pressed, the "Do You Wish To Cancel The Entire Document?" prompt is displayed. Also, the system prompts for a reason for the cancellation. Type "?" to list possible reasons for cancellation and press <RETURN>.

The system prompts "Is everything correct? No//." If "Y" is entered and <RETURN> is pressed to reflect that everything is correct, the entire document is canceled and the following message is displayed:

```
                    ***   Document Updated   ***

Press RETURN ...:
```

Press <RETURN> to return to the Document Generation Menu.

4.5   SPECIAL LOCAL OBLIGATIONS

This option should be used **only** in accordance with instructions/policy of the CHS Supervisor or Area CHS Officer.

Managed Care: This entry type allows you to enter an obligation only on the local computer. However, this transaction, any supplements, and/or cancellations are **not** entered into the Health Accounting System (HAS). As a result, you **must** make appropriate considerations for any Special Local Obligations during reconciliation of your local system and DCR with the official HAS Finance reports (e.g., 424, 426, 540E). It is designed to allow the local facility to enter obligations that may originate from sources other than HRSA-43, 57 and 64 sources even though you are still asked for the type of document (43, 57, or 64). This question is asked to categorize the type of services being purchased; in other words, other charges made against the CHS budget at either the local and/or area level. Any Special Local

Obligations must be closed out (canceled or paid) in the system for reconciliation purposes and prior to close of Fiscal Year activities.

> **WARNING:** A restriction of using Special Local Obligations is that NO patient data and/or treatment data can be captured from such documents. Refer to the CHS Supervisor or the Area CHS Officer for any clarification regarding policies and use of the Special Local Obligations.

This "Special Local Obligations" entry is very similar to the Special Blanket Obligations. Instead of a patient's name, the message, "Special Transaction" is automatically inserted in the Description portion of the document. The Optional Comments prompt defaults to "SPEC. TRNS," you can generate the Optional Comments Report based upon this default.

4.6   ENTER/EDIT REFERRAL MEDICAL DATA

This option provides for entry or edit of medical data from the referral form **after** the document has been generated. The fields are the same as the referral fields prompted for during initial document generation.

5 PAY/EDIT DOCUMENTS

When you enter "PAY" and press <RETURN> from the CHS/MIS Master Menu, the Pay/Edit Documents Menu is displayed:

```
            CONTRACT HEALTH MGMT INFORMATION SYSTEM
                    (your facility name)
                     Pay/Edit Documents


         PAY     Pay Documents
         MED     Enter/Edit EOBR Medical Data
         ACTS    Enter a Document Action
         INT     Interest ...
         MISS    Edit Missing Authorization Dates
         REF     Tie Referral to Previous P.O.
         TPCC    Transfer Data to Patient Care Component

     Select Pay/Edit Documents Option:
```

5.1 PAY DOCUMENTS

This section describes the **manual** process for posting payments on CHS purchase orders at the local facility level.

NOTE: If the facility receives EOBR data in an electronic mode, it is necessary to manually "post" payment data only for those documents paid through the AO Finance Branch. The option to manually pay documents is also available in the event of EOBR errors.

To manually process a document for payment, type "PAY" and press <RETURN>.

5.1.1 Select Document

Use "Select Document" to post the manual payment. Type the document number and press <RETURN>. Information about the document (including status, supplements, and cancellations) is displayed on the following page:

```
Form # 64         REF TYPE  Order No.
Sep 04, 1996      Outpatient Service    1   6-O17-00012
---------------------------------------------------------------
      Patient                       |Ordering Facility/Provider
Fac:555220 IHS#:999999 111111111 | OCA IHS RPMS TRAINING
DEMO, PATIENT                     | 3625 N.W. 56TH STREET
TULSA, OK  74124                  | OKLAHOMA CITY OK 73112
11-29-56  F  422  002  947-72-40 | 555220
---------------------------------------------------------------
Est. date-of-svc.: SEP 15,1996   | OKLAHOMA CITY CLINIC
EVALUATION                       | 701 NORTHEAST 10TH ST
PVT INS                          | OKLAHOMA CITY, OK  73104
                                 | 1730710161    Open
Market
---------------------------------------------------------------
Auth. From SEP 15,1996 to SEP 25,1996
DCR Acct. = PHYS OUTPATIENT    CAN/OBJ: J50AJ74 / 25.4D
 Estimated Charge: $0.00          Hosp Order No:

    Initial Obligation            0.00
    Amount Of Supplements        325.00  ( 09-04-96 )
                                 --------
CURRENT OBLIGATION BALANCE       325.00
```
```
Date of Service:
```

NOTE: If you are manually posting the payment from an EOBR that was an error during the electronic posting process, all information for data entry can be found on the EOBR printout.

5.1.2 Date of Service
Type the date the patient first received treatment and press <RETURN>. It is the admission date for an HRSA-43 and the date of the first visit for an HRSA-64 or HRSA-57. If the order date (the date the purchase order was issued) is after the date of service, verify the date of service at the "Are you sure this is correct?" prompt.

```
SERVICE date is before ORDER date.

Are you sure this is correct?  NO//
```

If the purchase order was issued after the date of service, type "Yes" and press <RETURN>.

5.1.3 Workload Units (1-9999)
The "Workload Units" field is what is generally referred to as the "piggyback" information and is collected **only** in the **manual** mode for those documents not processed by the FI. This field is required and accepts a number from 1 to 9999. Workload unit information (number of visits, days in hospital, and/or test(s) performed, etc.) depends on the object class used on the document. See the CHS Manual Issuance for further information. A workload unit of at least one (1) is required. Type the workload unit and press <RETURN>.

This function does not relate to documents processed by the FI; however, if you are

manually entering an EOBR from the FI, you are required to enter this data.

5.1.4 IHS Cost

Type the dollar amount that has been paid by IHS to the provider/vendor and press <RETURN>. This may not be the total amount of the charges for a particular service due to other Third Party Payments made on behalf of an IHS beneficiary.

It is permissible to enter an amount less than and/or greater than the amount of the original (including subsequent supplements and cancels) obligation. However, you may **not** enter an amount greater than a maximum overpayment amount. This is a site parameter and can be changed by appropriate personnel per local requirements. If you are entering an amount greater than the obligation and over the maximum overpayment amount, the following screen displays:

```
Obligated Amount              3,375.00
Current Charge Total          7,375.00
                       ----------------
Exceeded Amount               4,000.00

MAX Overpmt Allowed           3,000,00

You May NOT Exceed This Amount

IHS Cost: 3,375.00//
```

When you are entering an amount different than the amount currently obligated, the difference is automatically added adjusted on the appropriate Account Balance (e.g., if a document is paid for $100.00 less than the obligated amount, that amount is immediately added back to the unobligated balance and is available for new obligation). Likewise, if a document is paid for more than was obligated (within the Maximum Overpayment Amount), the appropriate obligation account balance is updated and the total unobligated balance is decreased.

NOTE: If a payment amount by IHS or the FI is incorrect, **do not** delay entry of payment information and **do not** enter what would be assumed to be the correct amount of IHS responsibility. Enter the **actual amount paid** even though this amount is, or may be, an error. **After** the payment amount has been corrected by the IHS or FI, make a payment adjustment via the Facility Management option. This function is essential for interim reconciliation purposes.

5.1.5 Payment Status

This question pertains to whether a third party has been involved in the payment of the medical bill on behalf of the patient. IHS may have paid only a **partial (P)** amount of the billed charges or may have paid the **full (F)** amount of the bill. Press <RETURN> after selecting "F" for IHS full pay or "P" for an IHS partial payment, as appropriate.

5.1.6 Amount Paid by All Third Parties

This question is asked only if a "P" was entered to the previous question. This would include Medicare, Medicaid, Private Insurance, or any other Alternate Resources payment. Enter the total dollar amount paid by "All Third Parties" and press <RETURN>.

5.1.7 Third Party Source

Next, type the third party source at the "Third Party Source:" prompt and press <RETURN>. Entry of an "?" and <RETURN> at this point displays the following:

```
Who is the source of the 3rd party payment?
ANSWER WITH INSURER NAME, OR CONTROL NUMBER, OR LONG NAME
DO YOU WANT THE ENTIRE (#)-ENTRY INSURER LIST?
```

To list the FileMan insurer file, type "Y" and press <RETURN>. Type the name of the third party source and press <RETURN>.

Managed Care: The Third Party Payment Report, under Facilities Management, collects data only from the primary insurance (the payor who has paid the largest amount of the PDO). It is critical that the first entry is the **largest** Alternate Resource Payor in cases of multiple alternate resource payors.

NOTE: The system does not prompt a tribal program for fields 5.1.8. through 5.1.14.

5.1.8 EOBR Pay Type

Next, select interim or final payment. An interim payment is a partial payment for a claim for which IHS makes additional payment(s). Type "I" for an interim payment or "F" for a final payment and press <RETURN>. The Area Office Finance Branch generally does not make interim payments; therefore, the interim payment selection should only be used when posting FI EOBR errors.

5.1.9 EOBR Date

Type the appropriate date and press <RETURN>. This should be the date the bill was paid by the FI or the date paid by Area Finance. The date paid by Area Finance can be obtained from the 540E (weekly) or 424 (monthly) finance reports.

5.1.10 EOBR Control Number

This is a required field that accepts 1-20 characters. Type the number and press <RETURN>. This is a field specific to FI processing (refer to the Area policy/guidance regarding how to enter data in this field for an Area Finance payment).

5.1.11 EOBR Check Number

This is a required field that accepts a number between 0 and 9999999 with no decimal digits. Enter the number and press <RETURN>. This is a field specific to FI processing (refer to Area policy/guidance regarding how to enter data in this field for an Area Finance payment).

5.1.12 EOBR Remittance Number

This is a required field that accepts a number between 0 and 9999999 with no decimal digits. Type the number and press <RETURN>. This is a field specific to FI processing (refer to Area policy/guidance regarding how to enter data in this field for an Area Finance payment).

5.1.13 EOBR Services Billed

Enter the type of services billed and press <RETURN>. If "?" is typed, a help screen is displayed, as shown below.

```
10   Enter the letter code which indicates the Services Billed:
20   Choose from:
30   A        Professional
40   B        Inpatient
50   C        Outpatient
60   D        Dental
70   U        Unknown
80   EOBR SERVICES BILLED:
```

5.1.14   EOBR Obligation Type

Enter the source from which the obligation was verified. This field is specific to FI processing. Type "?" for help and the following screen is displayed:

```
1.   P.O. Number
2.   SHR 424
```

All payment entries are now completed. The following prompt is displayed:

```
Are All Entries Correct? NO//
```

Type the default response. All the previously entered payment information is redisplayed for review. This allows for making corrections. If all necessary information for a particular document has been entered, but you do not want to "pay" the document, enter an "^" (up-hat) at the "Date of Service:" prompt. This cancels all the payment information previously entered for this document.

After verifying all payment information, type "Y" and press <RETURN>. The account balances are automatically updated and the following message is displayed:

```
            *** Document Paid ***
      *** OBLIGATION REGISTER UPDATED ***
```

Now, type the EOBR Medical Data taken from the FI EOBR, the UB 92, or other statement.

The prompts described in Sections 5.1.13 - 5.1.14 are displayed only for Inpatient Purchase Orders (43s).

NOTE: A tribal program must request HCFA/UB forms from their providers to obtain the following medical data.

5.1.15   Diagnosis Related Group

Type the DRG (Diagnosis Related Group) from treatment information. Answer with the DRG number or a narrative description.

5.1.16   Admission Date

Type the admission date in the standard date format.

5.1.17 Discharge Date
Type the discharge date in the standard date format.

5.1.18 Discharge Type
Enter the type of discharge the patient received. If you type "?" at the prompt, the following is displayed:

```
CHOOSE FROM:
    DEATH AFTER 48 HRS W AUTOPSY          6
    DEATH AFTER 48 HRS W/O AUTOPSY        7
    DEATH W/I 48 HRS W AUTOPSY            4
    DEATH W/I 48 HRS W/O AUTOPSY          5
    IRREGULAR (AMA)                       3
    REGULAR DISCHARGE                     1
    TRANSFERRED                           2
```

5.1.19 Select ICD9 Code
Type the ICD9 diagnosis code. Answer with the ICD-9-CM Diagnosis Code number or a narrative description. This is a multiple field; more than one code may be entered.

5.1.20 Procedure
Type the ICD9 Operation/Procedure code. Answer with the ICD-9 Operation/ Procedure Code number or a narrative description. This is a multiple field; more than one code may be entered.

5.1.21 CPT/REV Code
Answer with the CPT or Revenue Code Information or narrative description. Select a CPT/REV Code until all applicable codes have been entered. If you type "?" at the prompt, the following Help message is displayed:

```
Enter one of the following:
CPT Entry Name to select a Enter the 5-digit CPT code.
REV Entry Name to select a Enter 3-digit REVENUE CODE.
```

To see the entries in any particular file, type the desired prefix: "CPT" or "REV." For each CPT/REV code entered, the system prompts for each prompt in Sections 5.1.19.1 - 5.1.19.6.

5.1.22 DOS From
Type the date the CPT/Revenue Code service began.

5.1.23 DOS To
Type the date the CPT/Revenue Code service ended.

5.1.24 Units
the corresponding number of Units for this CPT/Revenue Code.

5.1.25 Charges Billed
Type the Charges Billed by the vendor for this CPT/Revenue Code.

5.1.26   Charges Allowable
Type the Charges Allowable for this CPT/Revenue Code. The Allowable Charge is based upon calculations determined by applicable contracts, provider agreement, rate quotes, and/or blanket purchase agreements. This also includes third party payment applied against the bill.

5.1.27   MSG Code
Type the processing Message Code accompanying the CPT/Revenue Code (if any) from the FI EOBR. This code is an uppercase letter followed by three digits. This is applicable only to documents paid by the FI.

The prompts described in Sections 5.1.28 - 5.1.30 are asked only for Dental Purchase Orders (57s).

5.1.28   Tooth Number
Type the Tooth Number for this CPT/Revenue Code for Dental documents only.

5.1.29   Tooth Surface
Type the Tooth Surface for this CPT/Revenue Code for Dental documents only.

5.1.30   Message Text
This is a free text field for Dental documents only. A Text Editor is provided for data entry.

Select another document. If you do not need to pay another document at this time, press <RETURN> to return to the previous menu.

NOTE: CHS/MIS has several protective features. One of these is that a document cannot be paid more than once and only one person at a time can process the same document for payment. If you try to pay a previously paid document, a statement that the document was paid on a particular date and the amount paid is displayed. In addition, a "Completely Canceled" document cannot be paid. When you try to pay a canceled document, the date the document was canceled is displayed.

If the facility has activated the link between the CHS/MIS and the Patient Care Component, the following message is displayed after the payment as been posted to the account balances:

```
Transferring Medical data to PATIENT CARE COMPONENT!

...  EXCUSE ME, THIS MAY TAKE A FEW MOMENTS ....  (JUL
15, 1996)
```

The date in this display represents the date of service entered in the payment transaction. This transfer will occur after each document has been paid.

5.2 ENTER/EDIT EOBR MEDICAL DATA

If the EOBR Medical Data was not entered under the "Pay Document" option or if more complete medical data becomes available, this option provides for its entry. The document for which medical data is to be entered must be retrieved using the standard CHS document retrieval process.

5.3 ENTER A DOCUMENT ACTION

Use the "Document Action" option to enter narrative information specific to the action taken for an individual purchase order. The information is entered using a text editor. To use this option, type the purchase order number and the following is displayed:

```
Select Document: 26      7-O17-00026

Entered Sep 22, 1997@12:42:37 by ROGERS,MARJORIE L
WHAT HAPPENED:
  No existing text
  Edit? NO//
```

Type "Y" at the prompt to enter the text editor mode. Next, type a brief narrative regarding the action and edit the editor using the "F1" and "E" combination of keystrokes.
The information entered can be viewed using the "DOCD" option of the "DIS" menu. (The underlining has been added for emphasis.)

```
ORDER NUMBER: 00026                    ORDER DATE: SEP 05, 1997
 DOCUMENT DESTINATION: FISCAL AGENT  CHS CLERK: ROGERS,MARJORIE
  BLANKET ORDER: NO
  TYPE OF SERVICE: 64 (OUTPATIENT SERVICE)
  COMMON ACCOUNTING NUMBER: J50AK74   SERVICE CLASS CODE: 25.4D
  PROVIDER (VENDOR): OKLAHOMA CITY CLINIC
  TOTAL AMOUNT OBLIGATED: 85          OBJECT CLASS CODE: 254D
  STATUS: PAID                        FISCAL YEAR: 7
  DCR ACCOUNT NUMBER: 4
  PATIENT FACILITY: OCA IHS RPMS TRAINING
  CHART NUMBER: 999999                 PATIENT: DEMO,PATIENT
  DESCRIPTION OF SERVICE: EVALUATION  CHECK #: 1
  CHECK PRINT DATE: SEP 05, 1997  CHECK CLEARED DATE:SEP 15, 1997
  VISIT: AUG 01, 1997@12:00        V CHS: OCA IHS RPMS TRAINING
  AUTH BEGINNING DATE:AUG 01, 1997 AUTH ENDING DATE:AUG 11, 1997
  IHS REFERRAL MEDICAL PRIORITY: II - PREVENTIVE CARE
  ESTIMATED DATE OF SERVICE: AUG 01, 1997
WHEN ENTERED:SEP 05, 1997@11:31:07 WHO ENTERED:ROGERS,MARJORIE
 WHAT HAPPENED:   <INITIAL>

WHEN ENTERED: SEP 22, 1997@12:42:37 WHO ENTERED: ROGERS,MARJORIE
 WHAT HAPPENED:   test narrative information
  TOTAL PAYMENT AMOUNT: 90            PAYMENT OBLIG ADJUST: 5
  FINAL PAYMENT DATE: SEP 05, 1997    LAST PAYMENT TYPE: FINAL
  FINAL PAYMENT AMOUNT: 90
TRANSACTION DATE: SEP 05, 1997    TRANSACTION TYPE: INITIAL
  PATIENT: DEMO,PATIENT             IHS PAYMENT AMOUNT: 85.00
  CHS CLERK: ROGERS,MARJORIE L
TRANSACTION DATE: SEP 05, 1997     TRANSACTION TYPE: PAYMENT
  PATIENT: DEMO,PATIENT             IHS PAYMENT AMOUNT: 90
  FULL PAYMENT: FULL PAYMENT            WORKLOAD: 1
```

```
DATE OF SERVICE: AUG 01, 1997    CHS CLERK: ROGERS,MARJORIE L
EOBR DATE: SEP 05, 1997           EOBR CLAIM SEQ NO.: 2
EOBR PAY TYPE: FINAL
```

5.4   INTEREST

To select an option from the Interest Menu, type "INT" and press <RETURN>. The following menu is displayed:

```
        CONTRACT HEALTH MGMT INFORMATION SYSTEM
                 (your facility name)
                       Interest

        CALC Calculate Interest Paid
        DISP Display Interest Data

    Select Interest Option:
```

NOTE: Interest is paid and calculated based upon the requirements of the Prompt Payment Act of 1989. Contact the Area CHS or Finance Office for further information regarding policies and procedures pertaining to the Prompt Payment Act.

5.4.1   Calculate Interest Paid

Use this option to estimate the amount of interest to be paid on a claim. The payment amount, the current interest rate, and the number of days the payment is late must be known before proceeding.

```
         CONTRACT HEALTH MGMT INFORMATION SYSTEM
                  (your facility name)
                 Calculate Interest Paid


   You need to enter Pay amount, Interest rate, and #
   days late.

          Enter Payment Amount:  100
   Enter Interest Rate, e.g., 5.87:  ?
   Response must be with no more than 2 decimal digits.
   Enter Interest Rate, e.g., 5.87:  6.25
   Enter Number of Days Late:  30
   The calculated Interest Amount is $0.52
       ( amt * rate * days / 360 )
       ( 100 * ( 6.25 * .01 ) * 30 / 360 )
Press RETURN To Continue...:
```

5.4.2   Display Interest Data

Type "DISP" and press <RETURN> to select a document, using the standard CHS document lookup, then the transaction. Any information on interest data for the selected transaction is displayed:

```
         CONTRACT HEALTH MGMT INFORMATION SYSTEM
                  (your facility name)
                 Display Interest Data

    Select Document:5-1      5-H11-00001
```

```
--------------------------------------------------------------
        TRANS     TRANS
         NUM     D A T E   TYPE    AMOUNT
--------------------------------------------------------------
           1   Jan 11, 1995   I    22.10 <INITIAL>
           2   Jan 11, 1995  PP    22.10 <PAYMENT>
           3   Jan 20, 1995  ZA     3.20 <ADJUSTMENT>

      Select a transaction:  (1-3): 3
```

```
INTEREST CAN...................... J991011
INTEREST OBJECT CLASS CODE........ 43.19
INTEREST RATE..................... 6.12
INTEREST DAYS ELIGIBLE............ 8
INTEREST PAID..................... 3.20
INTEREST ADDTNL PENALTY PAID.......
INTEREST TOTAL PAID THIS TRANS.....
```

5.5   EDIT MISSING AUTHORIZATION DATES

In posting electronic EOBRs, check to determine if an authorization date exists in the original document records. In CHS software versions prior to 2.0, the entry of a date of service was not a required field and the field did not require that data be in the standard date format. Therefore, some documents may have a missing authorization date. Use this option to enter the authorization date for any document where this data is missing. When this option is selected, the following is displayed:

```
             CONTRACT HEALTH MGMT INFORMATION SYSTEM
                     (your facility name)

Edit Missing Authorization Dates

You  have  the  option  of  [S]earching  for  PDO's  with  missing
beginning   authorization   dates,   or   selecting   a   particular
[D]ocument. In either  case, the document will be displayed, and
you will be given the opportunity to edit both the AUTH BEGINNING
DATE and the AUTH ENDING DATE. The AUTH BEGINNING DATE field is
required. You can skip the document by hatting out ("^"). You
will be given the opportunity of editing the dates, again, before
proceeding to the next document.

     Select one of the following:
             S          Search
             D          Select an Individual Document

      Enter response:
```

If an authorization date exists for the document selected, the following message is displayed:

```
AUTH BEGINNING DATE exists for this document.
```

5.6 TIE REFERRAL TO A PREVIOUS PO

This option links a referral to the Referral Care Information System when the referral was issued prior to the activation of this package within RPMS. Once a facility has activated RCIS, the linking occurs automatically.

5.7 TRANSFER DATA TO PATIENT CARE COMPONENT

If the link between the CHS/MIS and the Patient Care Component has been activated, you may periodically be required to transfer data. Data is automatically transferred via the payment process; however, you may opt to transfer data that was entered prior to establishing the link between the applications.

If this option is selected, the following instructions are displayed:

```
            CONTRACT HEALTH MGMT INFORMATION SYSTEM
                      (your facility name)
            Transfer Data To Patient Care Component

 You'll be asked for a beginning and ending P.O. number.
 The medical data for P.O.s included will be passed to the PCC.
 Press the ESCAPE key to stop.

 Enter RETURN to continue or '^' to exit:
```

To continue, the following prompts are displayed:

```
Select the Beginning P.O. Number ...

Select Document:

Select the Ending P.O. Number...

Select Document:
```

If a document has not been paid, no data is transferred.

6 DOCUMENT PRINTING

Type "PRT" in the CHS/MIS Master Menu and press <RETURN> to display the Document Printing Menu:

```
             CONTRACT HEALTH MGMT INFORMATION SYSTEM
                      (your facility name)
                       DOCUMENT PRINTING

         TOT  Display Document Totals
         PD   Print Documents
         REP  Re-Print Documents
         LAB  Print Vendor Labels
         PATL Patient Labels


    Select Document Printing Option:
```

Use the items on this menu to perform several functions associated with printing the HRSA-43, HRSA-57, and HRSA-64 documents. Each of these functions is detailed in the following sections.

6.1 DISPLAY DOCUMENT TOTALS

Type "TOT" in the Document Printing Menu and press <RETURN> to display the total number of documents waiting to be printed for the first time. A sample display is shown below:

```
                  CONTRACT HEALTH MGMT SYSTEM
                      (your facility name)
                     Display Document Totals

    (your facility name) Hospital Service    1
                            Dental Service     1
                            Outpatient Service 5
                                              -----
                            Total              7

         Press RETURN...:
```

This information helps manage the periodic printing of documents. Normally, a facility does not print documents each day unless a significant number have been generated that day. This is because of the inconvenience and setup time involved in loading forms on the printer.

6.2 PRINT DOCUMENTS

Type "PD" in the Document Printing Menu and press <RETURN> to display "Print Documents." If the facility enters documents for multiple sites, the following is displayed:

```
Print Forms For All Facilities?  NO//

Print Forms On Device:
```

Press <RETURN> to accept the default response. Now, select the printer. This prompt only accepts a device that is a printer. Type the printer name or number and press <RETURN> to

proceed to the following:

```
Print Hospital Service Forms ? YES//

Please Load The Hospital Service
Forms In the Printer.

Press RETURN When Ready:
```

Select the default response "YES," to display the following message:

```
Test Alignment ? YES//
```

Follow the above instructions to ensure that the proper forms are correctly loaded into the printer and that the printer is at the top of form. Do a test alignment.

If you accept the default Test Alignment, test data is printed in several of the boxes of the form. With practice, you can become familiar with how to align the forms. Continue doing the Test Alignment until the forms are correctly aligned.

NOTE: Until you become familiar with the software and the local computer equipment/ hardware, you should enter small batches of documents for printing.

When ready to print the documents, type "N" and press <RETURN>. All the documents of the particular type selected begin printing. When the document type has completed printing, the following prompt is displayed:

```
Put Regular Paper Back In The Printer
And Press RETURN:
```

6.3   RE-PRINT DOCUMENTS

Type "REP" on the Document Printing Menu to reprint an individual and/or a particular batch of documents. When this option is selected, the following information is displayed:

```
1.   Reprint INDIVIDUAL Document(s)
2.   Reprint A Particular 'BATCH' of Documents

Select:  (1-2):  1//
```

If item #1 above is selected, the "Select Document" prompt is displayed. Type the individual document number and press <RETURN>. If item # 2 is selected, information on the print Batches similar to that below is displayed:

```
-----------------------------------------------------------------
ITM     D A T E        FIRST DOC #      LAST DOC #      # DOCS
-----------------------------------------------------------------
 1      NOV 16,1995    6-ANY-00010      6-ANY-00010        1
 2      NOV 12,1995    6-ANY-00004      6-ANY-00009        6
 3      NOV 10,1995    6-ANY-00002      6-ANY-00003        2
```

```
   ENTER ITEM #  :
```

The batches are displayed in reverse date order (most recent is #1). After selection of a batch, printing proceeds in the same manner as the "Print Documents" option. If none of the batches are to be reprinted, press <RETURN>.

6.4 PRINT VENDOR LABELS

The system prompts to print vendor labels for a particular batch of documents. The information is displayed as shown on the next page:

```
            CONTRACT HEALTH MGMT INFORMATION SYSTEM
                      (your facility name)
                    Print CHS Vendor Labels
    ----------------------------------------------------------------
      ITM #    D A T E        FIRST DOC #   LAST DOC #    # DOCS
    ----------------------------------------------------------------
       1       JUN 10,1993    3-Q11-00114   3-Q11-00134    15
       2       JUN  9,1993    3-Q11-00110   3-Q11-00113     4
       3       JUN  9,1993    3-Q11-00100   3-Q11-00112    13

         ENTER ITEM #:  (1-3):
         Print number of copies by [S]election
         or by number of [D]ocuments to be printed?

         (S)el or (D)ocuments   D//
         How many documents per vendor label? (1-100)  30//
```

It is expedient to batch mail PDOs to vendors (e.g., weekly). Batch print vendor labels to affix to your mailing envelopes. You have the option of setting the number of documents per vendor label to be printed based on the number of documents to mail in any one envelope.

If no selection of a batch is needed, the "Want to Select the Vendors? N//" prompt is displayed. Use this option to create labels for special mailings to vendors.

6.5 PRINT PATIENT LABELS

Use this option to print patient labels (for mailing of various CHS information; e.g., denial letters, notices, requests for information, etc.). Add or edit a list and print labels from the lists created.

To add or edit a list, identify the name of the list. Next, select patient names to add to the list. The patient must exist in the Patient Registration system to be included in the list.

To print a list, identify the list to print and proceed as follows:

```
Enter the NAME of the list to Print

NAME:

Do you want to see a list of these names (Y/N)  N//
```

```
Select PATIENT NAME:

Enter the NAME of the list to Print

NAME:

Start with which patient? (RETURN = beginning)
Select PATIENT NAME:

Do you want to print a test label?  (Y/N)  N//

How many copies of each label? (1-5)  1//

DEVICE:
```

A list remains on file until it is deleted or changed.

7 ACCOUNT BALANCES

This section describes how to access information regarding the account balances used in the CHS/MIS.

The CHS/MIS has the capability for each facility to define up to seven accounts that can be used to keep track of funds. The Object Class Code determines which account is to be used by a particular authorization. This is a site parameter and can be modified at each site. Additionally, each facility has the capability to modify the names of the seven accounts.

Type "ACC" in the CHS/MIS Master Menu and press <RETURN> to display the following:

```
                    CONTRACT HEALTH MGMT SYSTEM
                        (your facility name)
                          Account Balances


           VB   View Account Balance
           PB   Print Account Balance

      Select Account Balances Option:
```

To select either of the two options listed below for account balances, type the appropriate alpha characters and press <RETURN>.

7.1 VIEW ACCOUNT BALANCE

Type the fiscal year:

```
The following are Valid Fiscal Years
1991
1992
1993
1994
1995
1996


ENTER FISCAL YEAR:  (1991-1996):  1996//
```

The current fiscal year is always the default. The fiscal year must be entered with all four digits.

The information shown on the next page is then displayed on the screen. This information is reflected if funds have been entered in the "Initial Balance" fields of the register balances.

```
                        (your facility name)
                       CHS REGISTER BALANCES
                       Sep 05, 1996@15:25:28

 Fiscal Year  1996       Register Number  6-001
Last document issued: 6-ANY-00019     Advice of Allow:  250,000.00

 Register         Initial Balance  Obligated Amount  Current Balance
 --------         ---------------  ----------------  ---------------
 HOSPITAL CARE       25,000.00         35,406.44        (10,406.44)
 E.R. ROOM           15,000.00            985.00         14,015.00
 PHYS INPATIENT      20,000.00         11,275.35          8,724.65
 PHYS OUTPATIENT     20,000.00         31,125.00        (11,125.00)
 DENTAL CARE          5,000.00            115.00          4,885.00
 P&E TRAVEL          12,000.00         18,000.00         (6,000.00)
 OTHER                3,000.00              0.0          03,000.00
                   ------------       -----------      ------------
 TOTAL             $250,000.00        $96,906.79       $153,093.21
```

To enter or change the initial balances, press <RETURN>. The following is displayed:

```
Your Initial Balance values don't = your Advice of Allowance (That's OK).

Do you want to update the Initial Balance values?  N//Y  ES

     INITIAL REG-1:  25000//75000
     INITIAL REG-2:  15000//35000
     INITIAL REG-3:  20000//50000
     INITIAL REG-4:  20000//40000
     INITIAL REG-5:  5000//15000
     INITIAL REG-6:  12000//25000
```

The following information is displayed if no funds have been entered in the "Initial Balance" fields of the register balances.

```
                        (your facility name)
                       CHS REGISTER BALANCES
                       Sep 05, 1996@15:25:35

 Fiscal Year  1994               Register Number  4-013
Last document issued: 4-ANY-00025  Advice of Allow: 300,000.00
    Register                       Obligated Amount
    ---------                      ----------------
 HOSPITAL CARE                          4,530.00
 E.R. ROOM                              1,360.00
 PHYS INPATIENT                           222.00
 PHYS OUTPATIENT                        3,392.25
 DENTAL CARE                               0.00
 P&E TRAVEL                                0.00
 OTHER                                     0.00
     Un-Obligated Balance
                                     ----------------
TOTAL                                  9,504.25      290,495.75
```

As can be seen from the above display, each of the seven (7) accounts are listed with the dollar amount obligated and/or paid for that particular category. The current Advice of Allowance and the Current (Unobligated) Balance is also displayed. This provides CHS personnel with an instant picture of their account balances and their unobligated balance.

7.2   PRINT ACCOUNT BALANCE

Use this option to print the account balances on any device.

```
DEVICE:

      The Following are Valid Fiscal Years
            1991
            1992
            1993
            1994
            1995
            1996


      ENTER FISCAL YEAR:  (1991-1996):  1996//
```

8 PATIENT DATA

Use this option on the CHS/MIS Master Menu to access the "View Only" option of the IHS Patient Registration System to find out if the patient is registered in the system. If the local patient registration coordinator has not entered a patient in the patient registration system and has indicated the patient is CHS eligible, a CHS document cannot be issued for the patient.

Select a patient either by name or by chart number. At this time, viewing the information for a particular patient is permitted, but CHS staff cannot make any changes to the data by selecting this option. Refer to the patient registration coordinator to request clarification or correction following local instructions. The initial screen for this option is displayed below.

NOTE: Printing or editing of this information is not permitted.

```
    ***********************************************
    *            INDIAN HEALTH SERVICE            *
    *         PATIENT REGISTRATION SYSTEM         *
    *          VERSION 6.0, NOV 01, 1994          *
    ***********************************************


                 (your facility name)
                Patient Data View System



    Select PATIENT NAME:
```

At the "Select Patient Name" prompt, type the name or chart number of the patient and press <RETURN>. Press <RETURN> to view multiple screens under this option.

Managed Care: For Managed Care activities, patient information is critical and must be accessed, verified, and kept current. It is critical that case managers and providers be provided pertinent patient information and corrections/additions be made immediately.

Various screens are pertinent to the activities within the CHS program. The following list indicates the page numbers for the most significant information:

- Page 1 of the patient registration record provides the patient's address.
- Page 2 of the patient registration record provides the eligibility status.
- Pages 4-7 provide alternate resource information.
- Page 11 provides for any pertinent free text information.
- Page 13 provides information pertaining to Veteran's status.

Quick Keystrokes - Use of these shortcuts allows maneuvering through the patient registration screens without actually scrolling through each page.

"P#" - Type "P" and the page number and press <RETURN>. The selected page is displayed on the screen.

"/.," - Type "/ . ," (slash, period, comma) keys consecutively with no spaces and press <RETURN>. Return to the "Select Patient Name:" prompt.

9 PROVIDER/VENDOR DATA

NOTE: Take special care when adding and/or changing the name of a vendor. Changes to the vendor name can be made only by the CHS Supervisor. Enter all vendor names in accordance with the location/area's format and policy using the standard abbreviations, acronyms, etc. Future data retrieval following a vendor name change requires querying and tabulating data from all names applied to that vendor during the reporting period.

Use this option to request information about specific providers or vendors. Type "VEN" and press <RETURN> in the CHS/MIS Master Menu to display the following screen:

```
                  CONTRACT HEALTH MGMT SYSTEM
                      (your facility name)
                     PROVIDER/VENDOR UPDATE

     ************************************************************
                    Enter Provider/Vendor:
```

Do not type the provider name. Type the EIN of the provider to add to the vendor file and press <RETURN>. By typing the EIN first, the potential for duplicate entries of providers is eliminated (this precautionary measure ensures that the provider is not already entered in the vendor file under a different name). Next, type the EIN number for the provider and press <RETURN>. Repeat the process. Type the provider's EIN number and press <RETURN>, then type information at additional prompts, as requested, including address, etc.

WARNING: To prevent entry of duplicate providers, it is critical that you determine whether the provider being entered is/is not already in the provider file. Do not make assumptions. The provider may be listed in the provider file under other name configurations. Prior entry of EINs may have used the provider's Social Security Number instead of the EIN. Physicians and clinics may be duplicate entries. **IF** duplicate entries are found, the Supervisor determines the appropriate entry to use and other entries are inactivated by the appropriate Site Manager (e.g., if physicians who have previously billed under the name of a clinic choose to bill on an individual physician basis, the name of the physician should be added to the vendor file). The entry of a new provider is a Supervisory function in the MIS. All duplicate providers must be inactivated before using the electronic EOBR. The Area Offices should assume and maintain the function of new provider entries and updates for Area wide standardization to facilitate Service Unit, location-specific, and Area databases. This ensures consistency in data and reports.

9.1 ADDING A NEW VENDOR

When adding a new vendor, have the current EIN and the correct name (including spelling) of the vendor. Type the new vendor's name at the "Enter Vendor/Provider:" prompt and press <RETURN>. Type an individual vendor (physician, dentist, etc.) in Last, First name order. Type organizations in normal order. Do not type commas in an organization's name, because the comma is used to invert the last name and first name of individuals and causes problems when used in Organizational Names.

The following prompts are displayed as the necessary fields to initially create a vendor record:

```
Are you adding "TEST DOCTOR" as a new VENDOR? Y

VENDOR EIN NO.:
VENDOR EIN SUFFIX:
VENDOR MAILING ADDRESS-CITY:
VENDOR Select PREVIOUS EIN NO.:
```

NOTE: This is not a complete list of the fields necessary to create a functional vendor record. After creating the initial record, edit the record to add additional information.

9.1.1   Vendor EIN No.
The response must be 10 numeric characters in length. The Vendor Employer Identification Number (EIN) may be the provider's social security number or it may be a corporate tax identification number. This number must be current as this is the identifier used to report income (payment made to the provider) to the Internal Revenue Service.

9.1.2   Vendor EIN Suffix
The response must be 2 characters in length. If several providers use the same EIN as a part of a corporation, it may be necessary to establish suffixes for the individual providers to distinguish income (payment made to the provider) for that specific provider.

9.1.3   Mailing Address - City
Type the city for the vendor's mailing address and press <RETURN>. This can be 3 to 15 characters in length.

9.1.4   Vendor Select Previous EIN No.
Type a whole number between 1000000000 and 2999999999. This field cross-references any previous EINs under which the provider may have been identified.

After you complete the initial data entry, the screen below is displayed:

```
                CONTRACT HEALTH MGMT SYSTEM
                    (your facility name)
                   PROVIDER/VENDOR UPDATE
**************************************************************
(1). Name: TEST DOCTOR      (2). EIN No.: 1010101010
(3). Status: ACTIVE         (4). Contracts: NONE
(5). UPIN:                  (6). Rate Quotation: NONE ACTIVE
(7). Type of Business:      (8). Agreement: NONE
(9). BPA: NONE

**MAILING/BILLING ADDRESS ** **PROVIDER LOCATION ADDRESS **
(10). Street:            (11). Street:
      City: OKLAHOMA CITY       City:
      State:                    State:
      Zip Code:      PHONE:     Zip Code:
      Atn:
(12).  Vendor Type:        (13).  Fed/Non-Fed: NON-FED
```

```
(14).  Specialty:
  Last Payment Date:             Current FYTD Paid:
*************************************************************
MUST HAVE VENDOR TYPE.
VENDOR TYPE:
```

Type a vendor type at the "Vendor Type" prompt and press <RETURN>. This is a required field. Type "??" and press <RETURN> to see a display of the various vendor type codes. There is no edit in the system to assure accuracy of the vendor type. See the following illustration for selections:

```
ANSWER WITH VENDOR TYPE CODE
 DO YOU WANT THE ENTIRE 19-ENTRY VENDOR TYPE LIST? Y  (YES)

             CHOOSE FROM:
             10   ORTHOPEDIC APPLIANCE COMPANY
             11   OPTICAL COMPANY
             12   PHARMACY
             13   TRANSPORTATION
             14   MORTUARY
             15   X-RAY
             16   ALL OTHER
             17   CHIROPRACTOR
             18   PEDIATRIC (NHSC)
             19   CERTIFIED NURSE MIDWIFE (NHSC)
             01   HOSPITAL GM&S
             02   HOSPITAL TB
             03   HOSPITAL PSYCHIATRIC
             04   NURSING HOME/REHAB CENTER
             05   PHYSICIAN
             06   OPTOMETRIST
             07   DENTIST
             08   NURSE OR HOME HEALTH SERVICE
             09   LABORATORY
```

After selection of the "Vendor Type," an initial record created for that vendor is created. To complete the vendor record, add a complete mailing address, information regarding contracts and agreements, and other items as described in Section 9.3, Editing a Vendor.

9.2   RETRIEVING A VENDOR

Type the Name or the EIN of the vendor. It is recommended that you enter the EIN to assure the correct vendor is selected. However, if you use the name, type it using the same format used in entering the vendor file for the location.

If the vendor name entered is not found, "??" is displayed. Type the vendor name again at the "Select Provider/Vendor" prompt. Also, ensure the correct document number has been entered, or use the "?" and press <RETURN> to list the vendors.

If you type only a few characters or words of the full name, for each match, the screen displays the Name of Vendor, EIN, and City of the respective vendors, as shown below:

```
Select PROVIDER/VENDOR: ADAMS
```

```
     1    ADAMS MD,WARREN   1234567890  WOODWARD
     2    ADAMS MD,WARREN   2222222222  OKLAHOMA CITY
     3    ADAMS,STEPHEN     1730456723A1    DEL CITY

Type (^) to stop, or choose 1-3:
```

Type the corresponding number of the vendor at the "Type (^) to stop, or choose 1-__:" prompt and press <RETURN>.

Managed Care: Use this information to identify and report the volume of care provided by a particular vendor. This information is only as current as the payments that have been posted in the system. Two unnumbered items on the above vendor display screen are "Last Payment Date" and "Current FYTD Paid." These fields reflect the last date a payment was made to this vendor in the current fiscal year and the total of all payments made in the current fiscal year.

NOTE: Although IHS or the FI may have paid a document, it will not be displayed as paid until the payment transaction for that specific document has been either manually posted in the system or paid by download of payment tapes under the electronic payment process. This further supports the requirements for the CHS Program to ensure that all payments are posted in a timely manner, recommended not to exceed two days following receipt of payment documents from Area IHS Finance or the FI (EOBRs).

Presently, information on the Provider Location Address is not used at the Facility level. The Mailing/Billing Address should contain the location to which all authorizations should be mailed.

NOTE: Non-supervisory CHS personnel have View Only access to the Provider/Vendor information. They can look at the data but cannot make any changes and/or add new vendors. All need for changes should be directed to appropriate IHS personnel for necessary action.

9.3 EDITING A VENDOR

NOTE: The editing of a vendor is a Supervisory function in the MIS. Area Offices should assume and maintain the function of vendor updates for Area wide standardization.

The following message is displayed for CHS Supervisors or Site Managers:

```
Want to Edit?  No//
```

Press <RETURN> to accept the default response if no editing of the data is required. To change information on the screen, press "Y" and press <RETURN>. The following is displayed:

```
Change Which Item? (1-14)
```

Select any of the 14 items to add and/or correct. As each item is selected, the default response is displayed (and changes are allowed). After all items for a particular number have been changed, complete information is displayed again.

9.3.1   Name of a Vendor

A name of a vendor is added when the vendor record is created. Use the edit option to change the name of a vendor. After the name change is completed, the vendor record closes and the "Enter Provider/Vendor" prompt is displayed. To make additional changes to a record, type the new vendor name and the record are displayed.

9.3.2   EIN No.

Change the EIN No. if the provider has changed their identification number.

9.3.3   Status

Use this prompt to inactivate a provider that is no longer available for service. Change the status from Active to Inactive and type the date of inactivation.

9.3.4   Contracts

Enter data in this field if the contracting instrument used is actually a Contract. If the contracting instrument for Rate Quotation Methodology, Provider Agreements, or Blanket Purchase Agreements is used, type the data under the appropriate field (see Sections 9.3.6, 9.3.8, and 9.3.9).

Until a contract is entered, this field displays "None." When this item is selected and no contracts currently exist in the vendor file, the following message is displayed:

```
No Contracts On File.

Want to Enter a New Contract?  No//
```

The default response (No) returns the previous screen display. Type "Y" and press <RETURN> to display the following prompts for contract information:

```
CONTRACT NUMBER:
BEGINNING DATE:
ENDING DATE:
DESCRIPTION:
AMOUNT OF CONTRACT:
```

Changes to add or correct/update contract information should be made only in accordance with the face sheets/cover sheets of contracts or contract modification documents immediately upon receipt of this information. Ensure that **correct** contract information is entered.

If this vendor already has contract information on file, the information is displayed for each contract as shown below:

```
Contract Number  Begin Date  Ending Date  Desc. of Service
---------------  ----------  -----------  ------------------
1  286-95-4555  Nov 3, 1994  Mar 1, 1995   Lab Services
2  287-96-5555  Oct 1, 1995  Sep 30, 1996  Med Services
```

Type the one to edit at the "Which one:" prompt and press <RETURN>. Change any particular item for the selected contract.

9.3.5 **UPIN**
Type the Uniform Provider Identification Number. The response must be in the form of 1 alpha and 5 numeric characters.

9.3.6 **Rate Quotation**
Use this field if the contracting instrument used is under the Rate Quotation Methodology. The prompt "Want to Enter a New Vendor Rate Quotation? N//" will be displayed. If "Yes" is entered and <RETURN> is pressed, the following prompt displays:

```
Select AGREEMENT/RATE/BPA NUMBER:
```

Respond with a number between 910000 and 999999 with no decimal digits. The area contracting number and the alpha contract identifier (RQ, A, or PA) is automatically entered.

Type data regarding the rate quotation as follows:

```
INPATIENT RATE DESCRIPTION:
MEDICARE RATE FOR INPATIENT:
OUTPATIENT RATE DESCRIPTION:
MEDICARE RATE FOR OUTPATIENT:
PROF. SERVICES RATE DESC.:
DATE OF AGREEMENT:
EFFECTIVE DATE:
EXPIRATION DATE:
```

After entry for these fields is completed, any data entered (except the agreement number) may be edited and corrected. The following is displayed:

```
#  TYPE  NUMBER  EFF-DATE  EXP-DATE  MCR  DESCRIPTION
-- ----  ------- --------  --------  --- ----------
1  RQ  6-R-0001 10/01/95  09/30/96  YES INP: RG
                                     NO OUT:57%BILL CHGS
                                        PRO:65% BILL CHGS

     Enter # to Edit:  (1-1):
```

9.3.7 **Type of Business**
Enter the type of business code or description. Type "?" at the "Do you want the entire [#]-entry Type of Business List?" prompt. Type the corresponding selection for the type of business.

9.3.8 **Agreement**
Entering an agreement is identical to the process described in Section 9.3.6 Rate Quotation. The only difference is the agreement will be identified with an "A" in the identifier number. This field should be used if the contracting instrument used is a Provider Agreement.

9.3.9   BPA

Entering a BPA or Blanket Purchase Agreement is identical to the process
described in Section 9.3.6 Rate Quotation. The only difference is the BPA is
identified with a "PA" in the identifier number. This field should be used if the
contracting instrument used is a Blanket Purchase Agreement.

9.3.10   Mailing Billing Address

The Mailing Billing Address prints on the purchase delivery order as the provider's
address. Ensure that this address is the correct mailing address, since all labels for
the patient are created using this address.

9.3.10.1   Mailing Billing Address - Street

Type 3-30 characters identifying the street address or mail box address.

9.3.10.2   Mailing Billing Address - City

Type 3-15 characters for the city mailing address.

9.3.10.3   Mailing Billing Address - State

Type with the state or abbreviation of the state where the provider's mail
should be sent.

9.3.10.4   Mailing Billing Address - Zip

Type 5-10 characters with the 5-digit zip code or the 5-digit zip code
plus the 4-digit extension.

9.3.10.5   Mailing Billing Address - Attention

Type 3-20 characters if the mail should be directed to a particular person
or location within the provider's billing office.

9.3.10.6   Mailing Billing Address - Phone

Enter 12 characters in the following format - xxx-xxx-xxxx.

9.3.11   Provider Location Address

This address is entered to provide for a location address should the provider
mailing billing address be different or a mailbox. This provides information to
share with patients regarding where they need to go for their appointment.

9.3.11.1   Provider Location Address - Street

Type 3-30 characters identifying the actual street location for the
provider.

9.3.11.2   Provider Location Address - City

Type 3-15 characters identifying the city in which the provider is
located.

9.3.11.3   Provider Location Address - State

Type the state or abbreviation for the state in which the provider is
located.

9.3.11.4 Provider Location Address - Zip
Type 5-10 characters with the 5-digit zip code or the 5-digit zip code plus the 4-digit extension that corresponds with the provider's location address.

9.3.12 Vendor Type
This is a required field. Type "??" and press <RETURN> to display the various vendor type codes.

9.3.13 Fed/Non-Fed
Select from Federal or Non-Federal. If Federal is selected, it indicates the provider is managed by the Federal government (e.g., a Veteran's Administration hospital).

9.3.14 Physician Specialty
Use this field to identify providers within classifications of specialty. A management report is available that allows generating a report by specialty type.

After editing the vendor record, additional prompts display before returning the "Enter Provider/Vendor:" prompt.

```
Want to see Vendor Contract Information?  No//
```

This prompt reads "Rate Quotation," "Agreement," or "BPA" for each or any type of contracting instrument that has been entered.

A prompt displays as follows:

```
Want to see Prior FY Payments for this Vendor?  No//
```

Type "Y" and press <RETURN> at the above prompt to display Prior FY Payments information similar to the screen below:

```
FISCAL YEAR        AMOUNT          LAST PMT DATE

    1991        $ 1,234.11        JUL 15, 1992
    1992        $57,135.98        DEC  1, 1992
    1993        $ 6,742.51        JUN 15, 1993

Press RETURN...:
```

10 DISPLAY DOCUMENTS

Type "DIS" on the CHS/MIS Master Menu and press <RETURN> to display the Display Documents Menu:

```
              CONTRACT HEALTH MGMT INFORMATION SYSTEM
                      (your facility name)
                        Display Documents


         DID     Display Individual CHS Documents
         VP      View Document Summaries for a Specific Patient
         VV      View Document Summaries by Vendor
         DOCD    Captioned Display of P.O. Document Data


     Select Display Documents Option:
```

Use the Display Documents Menu to select individual documents for display and to see document summaries by Patient and/or Vendor. Each option in the Display Documents Menu is detailed below.

10.1 DISPLAY INDIVIDUAL CHS DOCUMENTS

Type "DID" and press <RETURN> to enter a particular document number in the format described earlier. That document is then displayed. (This is the same display format used in the "Supplement, Cancel and Payment Sections"). Below is a sample display of a document that has been paid, including payment date and amount.

```
Form # 64              REF TYPE   Order No.
Sep 04, 1996           Outpatient Service   1    6-O17-00012
------------------------------------------------------------------
          Patient                |Ordering Facility & Provider
Fac:555220 IHS#:999999 111111111 | OCA IHS RPMS TRAINING
DEMO, PATIENT                    | 3625 N.W. 56TH STREET
TULSA, OK  74124                 | OKLAHOMA CITY OK 73112
11-29-56 F 422 002  947-72-40    | 555220
------------------------------------------------------------------
Est date-of-svc.:SEP 15,1996     | OKLAHOMA CITY CLINIC
EVALUATION                       | 701 NORTHEAST 10TH ST
PVT INS                          | OKLAHOMA CITY, OK  73104
                                 | 1730710161    Open Market
------------------------------------------------------------------
Auth. From SEP 15,1996 to SEP 25,1996
DCR Acct. = PHYS OUTPATIENT    CAN/OBJ: J50AJ74 / 25.4D
 Estimated Charge:        $ 0.00          Hosp Order No:
 Initial Obligation         0.00
 Amount Of Supplements    325.00  ( 09-04-96 )
                          --------
CURRENT OBLIGATION BALANCE    325.00      (IHS) (3rd PARTY)
     FINAL PAYMENT ON SEP 18,1996:      325.00       75.00
                   TOTAL PAYMENTS:      325.00       75.00
Select Document:
```

This Display Individual CHS Documents option displays all the items that were originally entered for a document, plus information regarding supplements, and/or cancel transactions.

Press <RETURN> once to redisplay the Display Documents Menu. Press <RETURN> twice to return to the CHS/MIS Master Menu.

10.2 VIEW DOCUMENT SUMMARIES FOR A SPECIFIC PATIENT

Use this option to view and/or print documents for a specific patient. Type the patient's name or chart number at the "Select Patient:" prompt and press <RETURN>. Once the patient is identified, type the beginning and ending date of the report as shown below:

```
Enter The BEGINNING Date For The DOCUMENTS FOR A PATIENT Report:
Enter The ENDING Date For The DOCUMENTS FOR A PATIENT Report:
```

Type the standard format for a date for each of the above questions. Next, enter the type of service at the "Select Type of service:" prompt, as shown below:

```
TYPE of service: 1    43 (HOSPITAL SERVICE)
                 2    57 (DENTAL SERVICE)
                 3    64 (OUTPATIENT SERVICE)

Select TYPE of service (1 - 3  "A"  = "ALL")  ALL//
```

If 1, 2, or 3 is selected, only that particular type of document will be displayed. Press "A" and press <RETURN>, or press <RETURN>, to display "all" types of documents (43s, 64s, and 57s). Next, type the print device at the "Device:" prompt and press <RETURN>.

```
DEVICE:  HOME//
```

Use this report to help answer questions from providers and patients regarding obligations and payments. Also, use this report to find out if any specific provider has been paid or if you have previously issued an obligation for a specific provider thus eliminating duplicate obligations. It is a valuable reporting and research tool to the location/Service Unit, Area Office, and Headquarters regarding specific patients. A sample report is displayed below:

```
********************************************************************
               CHS DOCUMENTS FOR A SPECIFIC PATIENT

                           USER NAME
                           Page  1
            PATIENT: DEMO,PATIENT    CHART #: 999999
         For the period Oct 01, 1995 through Sep 06, 1996
                        All Documents
********************************************************************
FAC    DOCUMENT  DATED  VENDOR                 TYPE STATUS  AMOUNT
------------------------------------------------------------------
555220 6O1700006 960828 BAPTIST MEDICAL CENTER  43   OPEN  4,055.19
555220 6O1700007 960822 BAPTIST MEDICAL CENTER  43   OPEN 27,000.00
555220 6O1700008 960822 EMERGENCY ROOM BILLING  64   OPEN    875.00
555220 6O1700009 960822 OKLAHOMA CITY CLINIC    64   OPEN 11,275.35
555220 6O1700012 960915 OKLAHOMA CITY CLINIC    64   PAID    325.00
555220 6O1700013 960904 OKLAHOMA LITHOTRIPSY C  64   OPEN      0.50
555220 6O1700014 960828 OKLAHOMA CITY CLINIC    64   OPEN  2,700.00
555220 6O1700018 960904 REECE DDS,C. HERMAN     57   PAID    115.00
                                                            ----------
```

```
Total documents seen: 8                                   $46,346.04
                  LESS CANCELS                                  0.00

                                                          ==========
                                                          $46,346.04

Do you want to view one of the documents listed? NO//
```

NOTE: This report is useful **only** to the extent of the **quality** and **timeliness** of payment information. If payments have been manually posted in error, or if not all payment transactions have been posted following receipt of payment documents from the Area IHS Finance or the FI (EOBRs), the report is not be valid/current.

10.3   VIEW DOCUMENT SUMMARIES BY VENDOR

Use this option to view document information by specific provider. It is very similar to the previous View Patient Document Summaries in that the Provider/Vendor information and the beginning and ending date for the report are entered.

Enter the type of service at the "Select Type of service:" prompt and press <RETURN>, as shown below:

```
Type of Service:      1     43 (HOSPITAL SERVICE)
                      2     57 (DENTAL SERVICE)
                      3     64 (OUTPATIENT SERVICE)

Select TYPE of service (1 - 3  or "A" = "ALL") ALL//
```

Enter the type of report to be printed at the "List All Documents:" prompt and press <RETURN>, as shown below:

```
Type of Report:

1. list only PAID documents
2. list only OPEN documents
3. list only CANCELED documents
4. list ALL documents
5. print TOTALS ONLY (no specific documents)

List ALL documents//
```

After you answer all the questions, a report similar to the following information is displayed and/or printed.

```
******************************************************************
                          USER NAME
                          Page  1
           PROVIDER-SPECIFIC CHS ACTIVITIES SUMMARY
           OKLAHOMA CITY CLINIC    EIN #: 1730710161
        For the period Oct 01, 1995 through Sep 06, 1996

******************************************************************
DOC. #: 6-O17-00009 (Aug 22, 1996) SERVICE:64 (OUTPATIENT SERVICE)
```

```
   DEMO,PATIENT                                  (OPEN: $11,275.35)
-----------------------------------------------------------------
DOC. #: 6-O17-00012 (Sep 15, 1996) SERVICE:64 (OUTPATIENT SERVICE)
   DEMO,PATIENT                                  (PAID: $325.00)
-----------------------------------------------------------------
DOC. #: 6-O17-00014 (Aug 28, 1996) SERVICE:64 (OUTPATIENT SERVICE)
   DEMO,PATIENT                                  (OPEN: $2,700.00)
-----------------------------------------------------------------
Total documents: 3
TOTAL PAID DOCUMENTS:        1    TOTAL DOLLARS PAID:    $325.00
TOTAL OPEN DOCUMENTS:        2    TOTAL DOLLARS OPEN: $13,975.35
Press <RETURN> To Continue...:
```

Managed Care: Use this report to monitor the number, dollar amount, and timeliness of actions on **all** obligations made to a specific provider; to assess the types of service the provider is providing (outpatient, inpatient); and to determine how frequently the provider is being used. It may be furnished to IHS providers, case managers, medical/administrative staff, Project Officers, and Contracting Officers requesting information on use of specific providers and/or specific contracts. It is an excellent reference tool in negotiations of contractual agreements with providers.

NOTE: This report is an excellent tool for **monitoring** open documents and payment status. **However**, this report is only as current as the posting of paid documents. It is also useful in notifying providers of all obligations, dates, patients' names, and payment status for any specified period of time of entry. You can print a report of **open** documents and mail it to providers with periodic requests for open documents claims submission.

10.4   DISPLAY ALL DATA FOR A CHS DOCUMENT

Type "DOCD" in the Display Documents Menu and press <RETURN>. Type the document number in the standard format described above and press <RETURN>. Next, type a print device at the "Device:" prompt and press <RETURN>.

The following type of information is then displayed:

```
ORDER NUMBER: 00012               ORDER DATE: SEP 04, 1996
  BLANKET ORDER: NO
  TYPE OF SERVICE: 64 (OUTPATIENT SERVICE)
  COMMON ACCOUNTING NUMBER: J50AJ74    OBJECT CLASSIFICATION:25.4D
  PROVIDER (VENDOR): OKLAHOMA CITY CLINIC
  TOTAL AMOUNT OBLIGATED: 325           STATUS: PAID
  FISCAL YEAR: 6                        LAST SUPPLEMENT NUMBER: 1
  DOCUMENT DESTINATION: FISCAL AGENT  CHS CLERK: (USER NAME)
  DCR ACCOUNT NUMBER: 4
  PATIENT FACILITY: (YOUR FACILITY NAME)
  CHART NUMBER: 999999                 PATIENT: DEMO,PATIENT
  DESCRIPTION OF SERVICE: EVALUATION
  AUTH BEGINNING DATE: SEP 15, 1996
  AUTH ENDING DATE: SEP 25, 1996
  IHS REFERRAL MEDICAL PRIORITY: II - PREVENTIVE CARE
  ESTIMATED DATE OF SERVICE: SEP 15, 1996
  TOTAL PAYMENT AMOUNT: 325            PAYMENT OBLIG ADJUST: 0
  FINAL PAYMENT DATE: SEP 18, 1996    LAST PAYMENT TYPE: FINAL
  PAYMENT AMOUNT 3RD PARTY: 75.00      FINAL PAYMENT AMOUNT: 325
```

```
   TRANSACTION DATE: SEP 04, 1996      TRANSACTION TYPE: INITIAL
   PATIENT: DEMO,PATIENT               IHS PAYMENT AMOUNT: 0.00
   CHS CLERK: (USER NAME)
   TRANSACTION DATE: SEP 04, 1996
   TRANSACTION TYPE: SUPPLEMENTAL
   PATIENT: DEMO,PATIENT               IHS PAYMENT AMOUNT: 325.00
   SUPPLEMENT NUMBER: 1                CHS CLERK:ROGERS,MARJORIE L
   TRANSACTION DATE: SEP 04, 1996      TRANSACTION TYPE: PAYMENT
   PATIENT: DEMO,PATIENT               IHS PAYMENT AMOUNT: 325
   FULL PAYMENT: PARTIAL PAYMENT       THIRD PARTY PAY AMT: 75.00
   WORKLOAD: 1                         DATE OF SERVICE:SEP 15,1996
   CHS CLERK: (USER NAME)
   THIRD PARTY SOURCE: PACIFICARE OF OKLAHOMA INC
   EOBR DATE: SEP 18, 1996             EOBR CLAIM SEQ NO.: 2
   EOBR PAY TYPE: FINAL                EOBR CONTROL NUMBER: 000
   EOBR CHECK NUMBER: 0                EOBR REMITTANCE NUMBER: 0
   EOBR SERVICES BILLED: PROFESSIONAL
   EOBR OBLIGATION TYPE: P.O. NUMBER

Press <RETURN> To Continue...:
```

The format differs depending on the data contained in the particular document. Fields that do not have data are **not** printed. Press <RETURN> once to return to the Display Documents menu. Press <RETURN> twice to return to the CHS/MIS Master Menu.

11 DOCUMENT CONTROL REGISTER

Use this option to produce a "Document Control Register" (DCR) for the facility. This register is normally printed weekly (Monday through Friday) and contains a document by document listing of all transactions processed since the last DCR period.

Type "DCR" at the prompt in the CHS/MIS Master Menu and press <RETURN> to display the following message:

```
Do You Wish to Re-Print a Prior Register ? NO//
```

The default response is "No" and is used to close the current register and generate the DCR. Closing the current register prevents any more transactions from being entered on this date. For this reason, the following warning is displayed twice:

```
If you print this register, you will CLOSE THIS REGISTER!"
```

A message prompting to print the most current register is displayed (see example below):

```
Print Register Number  4-001  ...OK ? NO//
```

Type "Y" to close the current register and press <RETURN>. The message "The Control Register Has Been Closed For This Date" is displayed if the DCR option is selected again. DCRs for transactions entered for prior years are also generated.

Warning: CHS Supervisors must closely monitor timeliness of DCR closing. The register should be run at the end of the day. Once the DCR has run, payment transactions or obligation transactions to be performed are not allowed for the remainder of the day. Any attempt to generate, cancel, adjust, or pay a document displays the message, "The Register Has Been CLOSED." Each location should designate one person/alternate to run the DCR to prevent someone from accidentally closing the DCR. If the DCR is accidentally closed, do **not** attempt any actions to fix it. Consult the CHS Supervisor or Site Manager for assistance.

The next day, a new Register is opened and the CHS/MIS can then be used. A Closed Register does not prohibit document displays, document printing, or checking on current balances. All that is suspended is the ability to issue, cancel, or pay documents.

The following prompt is displayed:

```
Device:  HOME//
```

Queuing of the DCR as a print option is not allowed in order to provide positive control over the Registers. Select a printer on which to print the DCR. If the default of "Home," is mistakenly selected, the DCR is displayed onscreen. To print the DCR, reprint a prior register with an ending date specified as today's date.

When reprinting a prior register, a default device of the closest printer is displayed. Normally, select the default and the DCR Report begins printing in a few seconds.

The report is divided into three sections. The first section includes two lines of information for every transaction for each document. The two lines contain Patient Name, Document Number, Provider of Service, Provider EIN number, Issue/DOS Serv., Type/Destination (FI or IHS), and the Amount of the Transaction. "Interim" payments are identified on the DCR as "Int-Pmt" and a notation, "Not In Totals." The DCR shows the **amount** of the Interim Payment; however, the Interim Payment is **not** reflected in the obligation data. The Interim Payment(s) is reflected in obligation totals at the time of the final payment.

The second section summarizes the types of documents by printing the Number of Documents and the Obligation Amount for each type of document, a total line for all documents, and the Number of Documents for the Fiscal Agent and for IHS.

The third section prints information for each register, including Beginning Balance, Increased Amount, Decreased Amount, Net Change, and Ending Balance. The printing also includes a total line for all registers and the Obligated Balance for the Period. After processing the printing of the DCR, the Reports Menu is displayed.

12 FACILITY MANAGEMENT

Type "MGT" at the prompt in the CHS/MIS Master Menu and press <RETURN> to display the Facility Management Menu:

```
          CONTRACT HEALTH MGMT INFORMATION SYSTEM
                   (your facility name)
                   Facility Management

        PVD       Provider/Vendor Data
        PR        Reports...
        PAD       Payment Adjustment
        PED       Parameter Edit...
        ALU       Allowance Update
        CDPE      CHS data - prepare for export
        RETD      Re-Export CHS Transmission Data
        EOBR      Facility EOBR menu...
        CHEF      C H E F Management...
        HVP       High Volume Provider Menu...
        TMAN      CHS Tech Manual
        TUPD      Add/Edit CAN, CC, SCC...

     Select Facility Management Option:
```

Each of the options above are detailed in the following sections. These functions are available only by assignment of specific access keys and should be distributed to the CHS Supervisor (and/or designee) and Site Manager.

NOTE: Installation instructions require restricted access to this menu option; however, in lieu of a CHS Supervisor or designated Site Manager, access must be given to an on-site CHS or other staff member for performance of these functions.

12.1 PROVIDER/VENDOR DATA

Type "PVD" and press <RETURN> to obtain access to the Provider/Vendor file. All functions as described in Section 9.0 can be performed via this Facility Management option.

12.2 REPORTS

Type "PR" and press <RETURN> to generate reports at any time. The following menu is displayed:

```
          CONTRACT HEALTH MGMT INFORMATION SYSTEM
                   (your facility name)
                        Reports

        DSR     Document Status Report
        CER     Expenditure Report
        PSR     Document Summary Report
        DSRF    Document Status Report By Fiscal Year
        HOSP    Hospital Log
        MEDI    Medical Data Reports ...
        OPTC    Optional Comments Report
        SCCR    Service Class Reports ...
```

```
        THRD    CHS 3RD Party Payment
        VRPT    Vendor Reports ...


   Select Reports Option:
```

Type one of the above report options and press <RETURN>. At the "Do you want to:" prompt, select a printed copy of the report or Browse the output on screen as follows:

```
Select one of the following:

        P          PRINT Output
        B          BROWSE Output on Screen

Do you want to : PRINT//
```

If "Print" is selected, identify the device on which the report is to be printed. If a default device is displayed, press <RETURN> to select the default device.

If "Browse" is selected, the output is displayed on the screen with the following options at the bottom of the screen. Type "Q" when the browsing has been completed to exit the Browse mode.

```
+    Enter ?? for more actions                                      >>>
+  NEXT SCREEN        -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

12.2.1   Document Status Report
Type "DSR" and press <RETURN> to display the following screen:

```
Enter The BEGINNING ISSUE Date For The DOCUMENT STATUS Report:
Enter The ENDING ISSUE Date For The DOCUMENT STATUS Report:

      Which type of report?
              1   OPEN DOCUMENTS only
              2   CLOSED DOCUMENTS only
              3   COMBINED list

      ENTER OPTION (1-3)  3//
```

This can be a very lengthy report. Because this report includes all transactions during the designated period of time, it includes transactions for prior year activities.

12.2.2   Expenditure Report
Type "CER" and press <RETURN> to display the following screen:

```
Enter The BEGINNING Date For The CHS EXPENDITURE Report:
Enter The ENDING Date For The CHS EXPENDITURE Report:

Print Report by:
1.  By Patient
2.  By Community of Residence
```

```
3.  By Age Grouping
4.  Totals Only
5.  By Tribe

Enter 1 to 5   1//

Which Expenditure Report by [Patient, Community ...,etc.]
for:

1.  Inpatient Services
2.  Dental Services
3.  Outpatient Services
4.  All Services

Enter 1 thru 4   All//
```

A report of expenditures for the period specified in alphabetic order (if specified to sort by patient, community of residence or tribe) is displayed. If specified that the report be based upon age group, it is sorted chronologically.

Managed Care: These reports are excellent tools for reference and analysis in various management and planning activities. These reports can be generated for various periods of time to analyze changes in use of CHS resources (e.g., from one fiscal year to another) and to identify amounts/rate of CHS usage by patients, communities of residence, and age, etc. These reports are especially useful in addressing various inquiries from tribes, IHS management, IHS providers, and other interested parties regarding CHS resources utilization and requirements.

12.2.3 Document Summary Report
Use this option to print a report in the exact format as the Document Control Register. Type "PSR" and press <RETURN> to display the following:

```
Enter The BEGINNING Date For The CHS DOCUMENT SUMMARY Report:
Enter The ENDING Date For The CHS DOCUMENT SUMMARY Report:
```

12.2.4 Document Status Report by Fiscal Year
Type "DSRF" and press <RETURN> to display the following screen:

```
The Following Are Valid Fiscal Years

1994
1995
1996

ENTER FISCAL YEAR: (1994-1996):  1996//

Which type of report?

1.  OPEN DOCUMENTS only
2.  CLOSED DOCUMENTS only
3.  COMBINED list

ENTER OPTION (1-3
```

The report is in the same format as the Document Status Report; however, only documents pertaining to the selected fiscal year are included in the report.

12.2.5 Hospital Log

Type "HOSP" and press <RETURN> to display the CHS Hospital Log screen:

```
          CONTRACT HEALTH MANAGEMENT INFORMATION SYSTEM
                        (your facility name)
                          CHS Hospital Log

This report may take awhile to compile.
It is recommended that you QUEUE your output to a PRINTER.

This report requires 132 column format.

          DEVICE: HOME// PRINTER-132

          Should Output be in CONDENSED PRINT? YES//  YES

Please make sure the printer is loaded with 132 column paper.

             START WITH ORDER DATE: FIRST//T-7
             GO TO ORDER DATE: LAST//T
             DEVICE: HOME       RIGHT MARGIN: 80//
             MARGIN WIDTH IS NORMALLY AT LEAST 132
             ARE YOU SURE? NO//Y
```

Type the beginning and ending order dates for which the report is to run; otherwise, it runs for all document dates that have been entered on the system.

12.2.6 Medical Data Reports

Type "MEDI" and press <RETURN> to display the Medical Data Reports Menu:

```
            CONTRACT HEALTH MGMT INFORMATION SYSTEM
                      (your facility name)
                      Medical Data Reports


     CPRE CPT/REV FileMan Report
     CPT  CPT or Revenue Code
     VCPT CPT Code by VENDOR

     Select Medical Data Reports Option:
```

12.2.6.1 CPT/REV FileMan Report

Type "CPRE" and press <RETURN> to prompt for parameters for this report as shown below.

```
START WITH PROVIDER (VENDOR):  FIRST//
START WITH TYPE OF SERVICE:  FIRST//
START WITH CPT OR REV INFORMATION:  FIRST//
START WITH DOS FROM:  FIRST//
GO TO DOS FROM:  LAST//
```

```
DEVICE:
```

The resulting report has output represented by the following, in addition to having EOBR message number, and Tooth number.

```
TOS CPT/REV                       CHARGES    CHARGES
    CODE      DOS FROM    DOS TO   UNITS     BILLED   ALLOWABLE
-------------------------------------------------------------

   PROVIDER (VENDOR): ACME MATERIALS
43  200    APR 8,1996  APR 10,1996  3      1500.00   1500.00

64 26735   FEB 4,1990  FEB  4,1990  1       650.00    650.00

                                   ---   ---------  --------
SUBTOTAL                             4     2150.00   2150.00
SUBCOUNT                             2        2         2
SUBMEAN                              2     1075.00   1075.00
```

12.2.6.2 CPT or Revenue Code

```
*****CPT Code Summary For (your facility name)*****

       Summary for ALL CPT CODES?  YES//

       Enter the BEGINNING DATE OF SERVICE:
       Enter the ENDING DATE OF SERVICE:

This report may take a while to compile.
It is recommended that you QUEUE to a PRINTER.
```

12.2.6.3 CPT Code by Vendor

```
***** CPT Code Summary for (your facility name) *****

    CPT Code Report for ALL VENDORS?  YES//

    Summary for ALL CPT CODES?  YES//

    Enter the BEGINNING DATE OF SERVICE:
    Enter the ENDING DATE OF SERVICE:

         Select one of the following:
         S  Summary
         D  Detailed

         Report Type:  Summary//
   This report may take awhile to compile. It is
   recommended that you QUEUE to a PRINTER.
```

12.2.7 Optional Comments Report
Type "OPTC" and press <RETURN> to display the following prompts:

```
            CONTRACT HEALTH MGMT INFORMATION SYSTEM
                      (your facility name)
                   Optional Comments Report

         START WITH COMMENTS (OPTIONAL):  FIRST//
         START WITH TYPE OF SERVICE:  FIRST//
               START WITH ORDER DATE:  FIRST//
                  GO TO ORDER DATE:  LAST//
```

Type the appropriate response for each question reflected on the screen and press <RETURN> after each entry. Type of service refers to HRSA 43, 57 and 64. Press <RETURN> at prompt: FIRST// for a report of all documents. Go to order date and type the issue date with which this report is to begin. Type the ending date and press <RETURN>. Indicate the print device and press <RETURN>.

NOTE: This is a free text field of ten character spaces used in accordance with approved practices of the location/Service Unit/Area. Optional comments do not print on the Universal PDO; however, the data is collected and does generate optional comments reports. This free text can be used to identify such items as: Alternate Resources information (Medicare, Medicaid, Private Insurance, Pending T-19); CHEF, HROB (High Risk OB), CHS User's initials, Deferred Services, Referral/Call-In, Initials of Referring IHS Physician, Date of CHS Review Committee's review, etc.

12.2.8 Service Class Reports
Type "SCCR" and press <RETURN> to display the following menu:

```
            CONTRACT HEALTH MGMT INFORMATION SYSTEM
                      (your facility name)
                   Service Class Reports

     RSCC    Service Class Code SUMMARY ONLY
     SCFM    Data by Service Class (FileMan)
     VNDR    Service Class Code BY VENDOR

Select Service Class Reports Option:
```

12.2.8.1 Service Class Code Summary Only

```
 **** Service Class Code Summary for (your facility name)****

Report by
      1) FY, or
      2) Issue dates

Select Report Method:  (1-2):  2//

Enter The BEGINNING DATE For The SERVICE CLASS SUMMARY Report:
Enter The ENDING DATE For The SERVICE CLASS SUMMARY Report:

This report may take awhile to compile.
It is recommended that you QUEUE to a PRINTER.
```

Type option #1, Fiscal Year and press <RETURN>. Next, select a valid fiscal year for which the report is to compile data.

12.2.8.2 Data by Service Class (FileMan)

```
          CONTRACT HEALTH MGMT INFORMATION SYSTEM
                   (your facility name)
                   Data by Service Class

     START WITH NAME:  FIRST//
        START WITH ORDER DATE:  FIRST//
        GO TO ORDER DATE:  LAST//
            START WITH SERVICE CLASSIFICATION:  FIRST//
```

12.2.8.3 Service Class Code by Vendor
Type "VNDR" and press <RETURN> to display the Service Class Code by Vendor screen:

```
          CONTRACT HEALTH MGMT INFORMATION SYSTEM
                   (your facility name)
                 Service Class Code BY VENDOR

*** Service Class Code by VENDOR for (your facility name) ***

       The Following Are Valid Fiscal Years
                 1994
                 1995
                 1996

       ENTER FISCAL YEAR:  (1994-1996):  1996//

  Select One Of The Following:
           SSummary
           DDetailed

  Report Type:  Summary//

This report may take awhile to compile.
It is recommended that you QUEUE to a PRINTER.
```

To print the current fiscal year, press <RETURN>.

To select a prior fiscal year, type one of the available fiscal years shown on the screen and press <RETURN>. Enter the report that is to run.

To print a summary, press <RETURN>; otherwise, type "D" for detailed and press <RETURN>. Select the print device.

The resulting report is sorted by each service classification for which each vendor has provided service, and includes a list of purchase orders, with patient name, chart number, and amounts obligated and paid.

12.2.9 CHS Third Party Payments

Type "THRD" and press <RETURN> to display the CHS 3rd Party Payment screen
(see below):

```
          CONTRACT HEALTH MGMT INFORMATION SYSTEM
                    (your facility name)
                  CHS 3RD Party Payment

 ***** 3rd PARTY PAYMENT REPORT FOR (your facility name)
                        *****

     The Following are Valid Fiscal Years
           1993
           1994
           1995
           1996

     ENTER FISCAL YEAR:  (1993-1996):  1996//

     Select one of the following:
           1    43 (HOSPITAL)
           2    57 (DENTAL)
           3    64 (OUTPATIENT)
           4    ALL

     Service Type:  ALL//

     Include ALL PATIENTS?  YES//

     Select one of the following:
           S    SUMMARY
           D    DETAILED

     Report Type:  Summary//

This report may take a while to compile.
It is recommended that you QUEUE your output to a PRINTER.
```

Type a response to each question reflected on the screen and press <RETURN>.
Type the Fiscal Year and type(s) of documents to be printed. Accept the default to
print a report of all patients. If "NO" is entered at this time, type a specific patient
name, and press <RETURN>. Accept the default of a summary report or type a
"D" for a "detailed" report and then press <RETURN>. Identify the print device
and press <RETURN>.

Managed Care: Both summary and detailed reports for all and specific patients
serve as management tools to assess the use of Alternate Resources. When
generated for a specific patient, the report provides meaningful comparison and
reference in conjunction with the Document Summary for Specific Patient detailed
in Section 9.3.

12.2.10 Vendor Reports

Type "VRPT" and press <RETURN> to display the Vendor Reports Menu:

```
        CONTRACT HEALTH MGMT INFORMATION SYSTEM
                 (your facility name)
                   Vendor Reports


         QVEN    Quarterly Vendor Report
         VFP     Print the VENDOR File
         VPS     Vendor by Physician Specialty/Date
         VUR     Vendor Usage Report

      Select Vendor Reports Option:
```

12.2.10.1 Quarterly Vendor Report

Type "QVEN" and press <RETURN> to display the Quarterly Vendor Report screen. Type a date range of order dates at the prompts, as shown below:

```
        CONTRACT HEALTH MGMT INFORMATION SYSTEM
                 (your facility name)
                Quarterly Vendor Report

      START WITH ORDER DATE:  FIRST//
      GO TO ORDER DATE:  LAST//
```

The Quarterly Vendor Report should be run quarterly. For each vendor providing service in the date range entered, information produced includes the order number, order date, contract, and amounts obligated, paid, and adjusted.

12.2.10.2 Print the Vendor File

Type "VFP" and press <RETURN>. The entire contents of the Vendor file will print or display on the selected device. Device is the only report parameter.

12.2.10.3 Vendor by Physician Specialty/Date

Type "VPS" and press <RETURN to display the Vendor by Physician Specialty/Date screen. Type a range of Physician specialties and purchase order authorization dates at the prompts as shown on the next page:

```
            CONTRACT HEALTH MGMT SYSTEM
                 (your facility name)
         Vendor by Physician Specialty/Date

    START WITH PHYSICIAN SPECIALTY:  FIRST//
          START WITH LAST AUTH DATE:  FIRST//
          GO TO LAST AUTH DATE:  LAST//
```

The report includes the physician specialty, the last date a purchase order was issued for the Vendor, and the name of the Vendor. This report

provides a list of possible service providers for unusual needs, or current information on Vendor use for specialties for CHS personnel.

NOTE: A post-init to Version 2.1 of CHS/MIS updates issuance dates for each Vendor, but you must enter the Specialty code, item 14, through the Vendor edit option, for each Vendor included in the report.

12.2.10.4 Vendor Usage Report

Type "VUR" and press <RETURN>. Enter report parameters at the prompts, as follows:

```
Enter the BEGINNING ISSUE DATE For The Vendor Usage Report:
Enter the ENDING ISSUE DATE For The Vendor Usage Report:

Select One of the Following:
1. ALL documents
2. OPEN documents only

Print which documents:  1//

Print ONE Vendor Per Page?  N//
```

"Open Documents Only" should be selected so that only one vendor prints per page. This provides lists that can be attached to letters to vendors on open documents claims submission. To print open documents for only one or selected vendors, refer to Section 9.3, View Document Summaries by Vendor.

12.2.11   Payment Adjustment

In the event of adjustments in payments for previously paid documents due to errors, additional charges, etc., it is necessary to adjust the payment amount of the PDO. Only PAID documents can be adjusted.

Payment adjustments must be manually entered for an adjustment to previous payments by the Area Finance Office and by all Tribal locations.

All refunds and payment adjustments made by the FI under the electronic EOBR are automatically posted. It is not necessary to manually enter these payment adjustments.

Type "PAD" and press <RETURN> to make adjustments to documents that have been paid on the local system. This usually results from an adjustment by the Fiscal Intermediary (FI). Both positive and negative adjustment amounts are allowed.

The "Select Document:" prompt is displayed. Type the document number to be adjusted and press <RETURN>. If this is not a paid document, the following message is displayed and another selection is prompted:

```
NOT A PAID DOCUMENT -- ONLY PAID DOCUMENTS CAN BE ADJUSTED
```

If a document is canceled and the FI/IHS/Tribe pays before the obligation is canceled in the tribal or Health Accounting System, follow up with appropriate action (e.g., request refund) and consider reconciliation activities, as no canceled document can be adjusted in the IHS system.

When an FI paid document is correctly entered, the document is displayed on the screen, and a prompt for payment information similar to the payment process is also displayed.

```
    Amount of Adjustment:
    Enter Date Document Paid:
    Enter Sequence Number from EOBR:
    EOBR SERVICE BILLED:
    EOBR CONTROL NUMBER:
    EOBR CHECK NUMBER:
    EOBR REMITTANCE NUMBER:
    EOBR OBLIGATION TYPE:
    THIRD PARTY PAY AMT:

Is Everything Correct?  NO//
```

If the document is an IHS document, only the amount, date, and Third Party pay amount are requested. If a pay transaction has already been processed for the date the adjustment transaction is being entered, a prompt for verification to ensure that there are no duplications of pay transactions is displayed.

```
A Transaction Has Been Processed For This Document On This Date.

          (date)

Do You Wish To Continue?  N//
```

It is not necessary to enter a plus (+) when making a positive payment adjustment; however, type a minus (-) when making a negative adjustment. If a negative adjustment in excess of the IHS payment amount is entered, the following message is displayed:

```
NEG ADJ CANNOT BE > PAYMENT AMT
```

When the appropriate amount has been entered, the "Is everything correct? (Y/N) NO//" prompt is displayed. If everything is correct, type "Y" and press <RETURN>.

NOTE: Enter adjustments for any amount less than one dollar as ($0._ _). Entries in this field must be four characters in length including the $.

If the default or "N" is accepted, type an adjustment amount, and press <RETURN>. The message "No Amount Entered" is displayed. Press <RETURN> again to return to the Facility Management Menu.

12.3 PARAMETER EDIT

Type "PED" and press <RETURN> to display Parameter Edit Menu:

```
        CONTRACT HEALTH MGMT INFORMATION SYSTEM
                  (your facility name)
                     Parameter Edit

        LAB      Edit CHS Label spacing
        MAIL     Edit CHS Mailing Address
        NAME     Edit CHS Register Names
        OBLI     Edit CHS Document Obligation Limits
        OVER     Edit CHS Document Overpayment Allowances
        PAR      Edit CHS Site Parameters
        SIG      Edit CHS Document Signatures

        Select Parameter Edit Option:
```

12.3.1 Edit CHS Label Spacing
Type "LAB" and press <RETURN> to display the Edit CHS Label Spacing screen:

```
         CONTRACT HEALTH MGMT INFORMATION SYSTEM
                   (your facility name)
                  Edit CHS Label spacing

    LABEL: VERTICAL SPACING:  1//
    LABEL: NUMBER OF LABELS ACROSS:  1//
    LABEL: HORIZONTAL SPACING:  1//
```

Use these options to edit the CHS label spacing parameters that control vertical and horizontal spacing and number of labels across.

12.3.1.1 Label: Vertical Spacing
Type the number (1-10) of lines to skip between each label and press <RETURN>.

12.3.1.2 Label: Number of Labels Across

Type the number of labels arranged across the page and press <RETURN>.

12.3.1.3 Label: Horizontal Spacing
Type the number (1-60) of character spaces from the left edge of one label across to the left edge of the adjoining label and press <RETURN>.

12.3.2 Edit CHS Mailing Address
Type "MAIL" and press <RETURN> to display the Edit CHS Mailing Address screen:

```
                         Edit CHS Mailing Address

         CHS MAILING ADDRESS - STREET:
         CHS MAILING ADDRESS - CITY:
         CHS MAILING ADDRESS - STATE:
         CHS MAILING ADDRESS - ZIP CODE:
```

Use this option to edit the mailing address of the facility CHS department. This address will be printed on each document generated.

12.3.2.1 CHS Mailing Address - Street
Type the mailing address (street - PO Box) used by CHS and press <RETURN>.

12.3.2.2 CHS Mailing Address - City
Type the mailing address (city) used by CHS and press <RETURN>.

12.3.2.3 CHS Mailing Address - State
Type the mailing address (state) used by CHS and press <RETURN>.

12.3.2.4 CHS Mailing Address - Zip Code
Enter CHS's zip code (5 or 10 characters) and press <RETURN>.

12.3.3 Edit CHS Register Names
Type the Register Name for which various account balances are maintained. These Register names are displayed on the account balance and Document Control Register. There are seven (7) registers.

12.3.4 Edit CHS Document Obligation Limits
Type "OBLI" and press <RETURN> to display the Edit CHS Obligation Limits screen shown on the next page:

```
           CONTRACT HEALTH MGMT INFORMATION SYSTEM
                    (your facility name)
                 Edit CHS Obligation Limits

     Select OBLIGATION TYPE: OUTPATIENT//
           OBLIGATION TYPE: OUTPATIENT//
           NORMAL MAX: 2500//
           ABSOLUTE MAX: 25000//
     Select OBLIGATION TYPE: DENTAL
           OBLIGATION TYPE: DENTAL//
           NORMAL MAX: 2500//
           ABSOLUTE MAX: 20000//
     Select OBLIGATION TYPE: HOSPITAL
           OBLIGATION TYPE: HOSPITAL//
           NORMAL MAX: 10000//
           ABSOLUTE MAX: 100000//
     Select OBLIGATION TYPE:
```

Use this option to set the amount of money that can be obligated for each type of document in the CHS system.

Only the Outpatient type of document (HRSA-64) prompts automatically. Type Dental or Hospital and press <RETURN> to edit obligation limits for HRSA-57 and HRSA-43 documents, respectively. Enter the whole dollar amounts without any commas in the amounts appropriate for the location and press <RETURN>.

12.3.4.1 Normal Max
What is the maximum amount of money to allow to obligate for this type document before a verification message is issued to the entry clerk? This does not prevent obligating over the Normal Max, it merely requests verification.

12.3.4.2 Absolute Max
What is the maximum amount of money allowed to obligate for this type document? The total amount obligated to any PO of this type is not allowed to exceed this amount.

NOTE: The Obligation Limits are maintained in accordance with instructions from the Area CHS Office. Although initial obligations and modifications may generate documents up to the amount of the obligation limit, signature authority remains limited to the level of procurement authority of the authorizing official. For example, a CHS Clerk who has $10,000 procurement authority can generate a $50,000 obligation; however, non-contract documents must be signed by an individual with $50,000 procurement authority). When setting these parameters, accept default amounts or enter limits determined appropriate by the Area. If a need arises to obligate documents in excess of the amounts entered here, the CHS Supervisor is to consult the Site Manager for a one-time exception to override the limit.

12.3.4.3 Edit CHS Document Overpayment Allowances
Type "OVER" and press <RETURN> to display the Edit CHS Document Overpayment Allowances screen:

```
       CONTRACT HEALTH MGMT INFORMATION SYSTEM
                (your facility name)
      Edit CHS Document Overpayment Allowances

  Select DOCUMENT TYPE: OUTPATIENT//
        DOCUMENT TYPE: OUTPATIENT//
        OVERPAYMENT ALLOWED: YES//
        MAXIMUM OVERPAYMENT AMOUNT: 1000//
  Select DOCUMENT TYPE: DENTAL
        DOCUMENT TYPE: DENTAL//
        OVERPAYMENT ALLOWED: YES//
        MAXIMUM OVERPAYMENT AMOUNT: 500//
  Select DOCUMENT TYPE: HOSPITAL
        DOCUMENT TYPE: HOSPITAL//
        OVERPAYMENT ALLOWED: YES//
        MAXIMUM OVERPAYMENT AMOUNT: 5000//
  Select DOCUMENT TYPE:
```

Use this option to set the limit of overpayment for each type of CHS Purchase Order.

Only the Outpatient type of document (HRSA-64) prompts automatically. Type Dental or Hospital to edit obligation limits for HRSA-57 and HRSA-43 documents, respectively.

12.3.4.4 Overpayment Allowed
The prompt "Do you want to allow overpayments on this type document?" is displayed. Type "Y" (Yes) to allow more money to be paid than was obligated for any PO of this type document. Type "N" (No) to disallow overpayment.

12.3.4.5 Maximum Overpayment Amount
If overpayment of this type document is allowed, type the maximum amount of money to allow to be overpaid for any PO of this type document.

NOTE: These Overpayment Amounts are maintained in accordance with instructions from the Area CHS Office.

12.3.5 Edit CHS Site Parameters
Site Parameters are set in accordance with Area Office and/or Service Unit policy regarding the use of the Contract Health Management System. Further information regarding CHS Site Parameters can be found in the Technical Manual.

12.3.6 Edit CHS Document Signatures
Type "SIG" and press <RETURN> to display the following:

```
43 ORDERING SIGNATURE:
```

```
57 ORDERING SIGNATURE:
64 ORDERING SIGNATURE:
```

Use this option to edit the signature blocks that are to be printed on each of the CHS documents as shown below.

12.3.6.1 43 Ordering Signature
Type the name (3-30 chars) of the ordering official for Hospital (HRSA-43) purchase orders. This name is printed in block 10, Signature - Ordering Official, when the forms are printed.

12.3.6.2 57 Ordering Signature
Type the name (3-30 chars) of the Dental (HRSA-57) ordering official. This name is printed in block 3, Signature-Ordering Official, when the forms are printed.

12.3.6.3 64 Ordering Signature

Type the name (3-30 chars) of the Outpatient (HRSA-64) ordering official. This name is printed in block 10, Signature - Ordering Official, when the forms are printed.

NOTE: Follow the Area practices on entering this information. If you are using the Universal Purchase Order, type the same name for the HRSA-43 and HRSA-64 forms. The title is printed in Block 20 and your name is printed in Block 21 - Signature - IHS Ordering Official, when the forms are printed.

12.4 ALLOWANCE UPDATE
The CHS Supervisor periodically requests updating of the CHS Advice of Allowance Amount. The CHS Supervisor is responsible for informing the user of the amount to be entered. Type "ALU" and press <RETURN>. Type the fiscal year and press <RETURN>.

Type the appropriate fiscal year (usually the current one) and press <RETURN>. The current allowance amount and unobligated balances are displayed, as shown below:

```
YTD Allowance for 1996 is:   $   100,000.00
Unobligated Balance is:      $    40,230.00

Enter new YTD Advice of Allowance
```

Type the updated dollar amount on the Advice of Allowance furnished by the CHS Supervisor. Do not enter the amount of the increase shown on the advice of allowance; enter the updated amount of the actual allowance, total year-to-date.

If it is not correct, press <RETURN> and re-type the proper amount. If the amount is correct type "Y" and press <RETURN> and the following is displayed:

```
                ****** ALLOWANCE UPDATED ******

Your Initial Balance values don't = your Advice of Allowance
(That's OK).

Do you want to update the Initial Balance values?  N//

Press RETURN To Continue ...:
```

NOTE: The Site Manager and the CHS Supervisor should both sign and date the Advice of Allowance Document to document posting of the new advice of allowance in the system. The CHS Supervisor retains this for record purposes.

12.5   CHS DATA - PREPARE FOR EXPORT

The CHS function performed most often by the Site Manager is the regular weekly exporting of CHS data to the Area Office. This is to be performed on a regularly scheduled basis (e.g., each Thursday, each Friday, etc.) unless there were no CHS Documents issued and/or processed during the previous week. Regular and timely export of CHS data is necessary to provide the Health Accounting System with timely data. If no DCR is to be generated for a particular week, the CHS Supervisor should notify appropriate Area CHS, Finance and OIRM staff who handle CHS DCR transmissions.

Type "CDPE" and press <RETURN> for the export program then displays the information shown on the next page:

```
Export data will be made for (your facility name)

 Is this Correct (Y/N) ? YES//

 ENTER DATE SENT TO AREA OFFICE :  (8/23/96 - 8/28/96): T//

 ENTER OUTPUT REPORT DEVICE #

****************************************************************
                            ****
                     EXPORT CHS DATA
****************************************************************
                            ****
     Resetting ^ACHSDATA(0)
     Resetting ^ACHSTXPT(0)
     Resetting ^ACHSTXVN(0)
     Resetting ^ACHSTXOB(0)
     Resetting ^ACHSTXPD(0)
     Resetting ^ACHSTXPG(0)

     NUMBER OF RECORDS PROCESSED =
      25     50     75    100    125    150

     BUILDING PATIENT RECORDS FOR AO/FI :
      10     40     50     60     70     90
     100    110    140    150    160    170

     BUILDING VENDOR RECORDS FOR AO/FI :
      10     20     30     40

     BUILDING DOCUMENT RECORDS FOR AO/FI :
      10     20     30     40     50     60
      70     80     90    100    110    120
     130    140    150    160    170    180
     190    200    210    220    230    240
     250    260    270    280    290    300
     310    320

     BUILDING PAYMENT RECORDS FOR AO :

     .....EXPORT CHS DATA
```

This indicates that CHS export records have been generated. The global save utility is called and the export records are copied to a host file. The host file is automatically sent to the Area Office for consolidation into Area CHS data, which then is separated into Area files for submission to higher computing centers. The Site Manager can provide a more detailed explanation of this process, as necessary. Also, you can refer to the ADP Systems Manual on the global save utility, XBGSAVE, for further information.

12.6 RE-EXPORT CHS TRANSMISSION DATA

If an unforeseen loss of data occurs at higher reporting stations, use this option to re-generate (re-export) CHS/MIS. The export global is re-generated using data from the CHS TX Status (transmission status) file. First, verify the facility. If the answer is "Yes," the "Enter Date Sent to Area Office" prompt displays. Answer using any standard date format. A report entitled "Exported Records By Type" prints after re-generation. Type a print device and press <RETURN>.

```
Export data will be made for LAWTON INDIAN HOSPITAL

Is this Correct (Y/N) ? YES//

ENTER DATE SENT TO AREA OFFICE :  (8/28/96 - 9/2/96): T//

ENTER OUTPUT REPORT DEVICE #     RIGHT MARGIN: 80//
```

Select the type of re-export to be performed. With option 2, "Select (up to) 10 transactions," you can selectively export up to 10 transactions. This enables the local facility to clear transactions that are not processing at higher levels. For example, if an FI document is PENDing for no obligation (P259), the SU might selectively re-export the initial obligation transaction of the document. Or, if the HAS is still showing an IHS document as open after a reasonable amount of time has elapsed, the SU might selectively re-export the pay transaction. You usually select Option 1, "Re-Export a Batch," and the following response is displayed: Generate Previous CHS Transmission Data screen. You can also display information about previous exports. If there is a large number of exports, the system displays 10 at a time on a screen, with the most recent information displayed first.

```
Select one of the following:

     1    Re-Export a Batch
     2    Select (up to) 10 transactions

     Which Re-export option: 1//   Re-Export a Batch
********************************************************************
          GENERATE PREVIOUS CHS TRANSMISSION DATA
********************************************************************
          FACILITY NAME: LAWTON INDIAN HOSPITAL

     ENTER NUMBER OF EXPORT ENTRIES TO DISPLAY : 10//
ITM #   EXPORT DATE      BEG DATE         END DATE    # RECORDS
 1     Aug 22, 1996    Aug 19, 1996    Aug 22, 1996     1188
 2     Aug 15, 1996    Aug 12, 1996    Aug 15, 1996      422
 3     Aug 09, 1996    Aug 05, 1996    Aug 09, 1996     1803
 4     Aug 02, 1996    Jul 29, 1996    Aug 02, 1996     1049
 5     Jul 26, 1996    Jul 26, 1996    Jul 26, 1996      100
 6     Jul 25, 1996    Jul 22, 1996    Jul 25, 1996      549
 7     Jul 18, 1996    Jul 12, 1996    Jul 18, 1996      941
 8     Jul 11, 1996    Jul 03, 1996    Jul 11, 1996     1112
 9     Jul 02, 1996    Jun 28, 1996    Jul 02, 1996      140
10     Jun 27, 1996    Jun 21, 1996    Jun 27, 1996      868

       ENTER ITEM # FOR EXPORT DATE:  (1-10): 4
```

After you select the export to regenerate, six work globals are reset and processing continues as described in the normal data export section, "Export Weekly CHS Data to Area Office." When processing is complete, totals are displayed on the screen, including beginning and ending dates, type and number of records are generated, and total records are generated. The same information is printed to the previously selected report device.

```
              *******************NOTICE******************
               The number of records in this re-export
               may differ from the number in the original.
               ******************************************
         Resetting ^ACHSDATA(0)
         Resetting ^ACHSTXPT(0)
         Resetting ^ACHSTXVN(0)
         Resetting ^ACHSTXOB(0)
         Resetting ^ACHSTXPD(0)
         Resetting ^ACHSTXPG(0)

NUMBER OF RECORDS PROCESSED =
  25    50    75   100   125   150   175   200

BUILDING PATIENT RECORDS FOR AO/FI :
  20    60   120   130   200   240

BUILDING VENDOR RECORDS FOR AO/FI :

BUILDING DOCUMENT RECORDS FOR AO/FI :
  10    20    30    40    50    60    70    80    90
 100   110   120   130   140   150   160   170   180
 190   200   210   220   230   240   250   260   270
 280   290   300   310   320   330   340   350   360
 370   380   390   400   410   420   430   440

BUILDING PAYMENT RECORDS FOR AO :

         .....EXPORT CHS DATA

         BEGINNING ADD/UPD DATE  =   Jul 29, 1996
         ENDING ADD/UPD DATE     =   Aug 02, 1996
------------------------------------------------------------------
         T Y P E   O F   R E C O R D                  NUMBER
------------------------------------------------------------------
           DHR RECORDS FOR PCC                          223
           PATIENT RECORDS FOR AO/FI                    245
           VENDOR RECORDS FOR AO/FI                       0
           DOCUMENT RECORDS FOR AO/FI                   446
           PAYMENT RECORDS FOR AO                         2
           IHS STATISTICAL RECORDS                        0
               TOTAL ALL TYPES                          916

         Enter <RETURN> to Continue:
```

Managing data transmission is critical to correctly process the CHS data at higher levels. After the export has successfully regenerated, the global save utility saves the export records to a host file, and the file is automatically sent to the Area Office. When processing is complete, the Facility Management Menu is displayed. The Site Manager can provide further information on the export and telecommunication process, as necessary.

NOTE: The export file is not automatically sent to the Area Office unless the system name of the Area Office's computer is in the RPMS Site File.

12.7   FACILITY EOBR MENU

CHS Facility personnel use this option to process EOBR information received electronically from the Area Office. This process automatically posts the information from an EOBR to the document in the local computer. This includes such items as payment amount, diagnostic and procedure information, and payment status (Final and/or Interim). Also, use this process to print the EOBR.

Two parameters determine the effect of this option. These parameters control the actual printing of EOBRs at posting time and updating of local documents. The Print EOBR parameter is "N." To print all EOBRs after processing, refer to Section 11.7.2 FIRP before processing next EOBR sequence.

Explanation: "Processed Document" is "final" paid documents, including $-0- amounts, and includes Interim payments showing a dollar amount. "Unprocessed Documents" are documents indicated "Interim," with $ -0- dollar amounts.

12.7.1   Process Facility EOBR Data

Type "EOBR" and press <RETURN> to display EOBR processing parameters information. Type a print device for the processing report as follows:

```
Your PRINT EOBR parameter is: N.

Your UPDATE DOCUMENT FROM EOBR parameter is :  Y.

SELECT PRINTER FOR PROCESSING REPORT:HOME//
```

After you select a print device, the system attempts to find EOBR files for the facility. If no files are found, the following information is displayed:

```
No EOBR Files Available for Processing

    Press RETURN To Continue:
```

Press <RETURN> to return to the Facility EOBR Menu. To find an EOBR file, contact the Site Manager. The Site Manager can help determine the status of the EOBR files. If EOBR files for the facility are found, the information on the next page is displayed:

```
Files Available for Processing are Listed Below:
         Last Fac Seq # Processed =     9

Number    File Name      EOBR Proc Date      Fac Seq #
------    -----------    --------------      ----------
  1       EB998877.123    Sep 20, 1998          10

Enter the Number of the Facility EOBR File you want to Process:
(1-1): 1

Process file '/usr/spool/uucppublic/EB707110.231' (Y/N)? N// YES
```

Select the next available EOBR file for processing according to the "Last Fac Seq #
Processed" and press <RETURN>. The facility sequence number ensures that the
files are processed in order of generation at the Area Office. The sequence number
is generated at the Area Office and placed in the EOBR file for each facility. Also,
the EOBR process date is checked to ensure the EOBRs for that date have not been
processed. To select a file to process, type the number on the left side of the screen
that corresponds to the file that is to be processed.

If the checks for sequence number and process dates are valid, confirm that the file
to be processed has been selected. Type "Y" to continue processing the selected
file.

```
BUILDING CHS EOBR MESSAGE FILE...

NO MESSAGE RECORDS TO PROCESS

      Processing EOBR Data for: (Your Facility)
        10    20    30    40    50

      Processing EOBR Data for: (Additional Facility)
                            60

      Total EOBR Records Processed = 61
```

NOTE: For files to process, all CHS users, except the primary operator running the
process, must be logged off the system. To eliminate inconvenience to other users,
the primary operator should process the files during a specified period of low
usage. If any CHS users are still logged on the system, the system will display the
following message:

```
The compiled menu indicates CHS Users are Active EOBRs CANNOT BE POSTED

                       You can Exercise the
                    "Clean old Job Nodes in XUTL"
      option (usually) on the site mgr's menu and try again.

OR, if you're sure no CHS users are active, you can continue? N//
```

The user must then locate operators and ensure they exit from the program.

NOTE: Running account balances before and after processing EOBR File displays the amount of the adjustments made by this transmission and reconciles the amount processed. If the amount differs from summary total, research all entries to identify discrepancies, and correct the discrepancy. Contact the Supervisor/Site Manager, as appropriate.

When this process is complete, the process report and all EOBRs that were not posted to the local computer, prints. A sample report of the EOBR Processing Report is displayed below:

```
Oct 03, 1996@10:26:43   CHS EOBR PROCESSING REPORT       PAGE   1
for Documents Paid on: Sep 9, 1996
for (your Facility name)

COUNT SITE   P.O. NUMBER  P-T CODE   DESCRIPTION or PATIENT IHS COST
----- ----   -----------  --- ----   ----------------------- --------
1346 998877 2-P14-12621   F    64    xxxxxxxxxxxxxxxxxxxxx       0.00
1347 998877 3-P14-03194   I    64    xxxxxxxxxxxxxxxxxxxxx       0.00
1348 998877 4-P14-05504   F    64    xxxxxxxxxxxxxxxxxxxxx      43.00
1349 998877 4-P14-07374   F    64    xxxxxxxxxxxxxxxxxxxxx     620.00
1350 998877 4-P14-10015   F    64    xxxxxxxxxxxxxxxxxxxxx       4.62
1395 998877 4-P14-13508   F    64    xxxxxxxxxxxxxxxxxxxxx     115.00
1396 998877 4-P14-13944   F    64    xxxxxxxxxxxxxxxxxxxxx      89.00
1400 998878 3-P01-04589   F    43    xxxxxxxxxxxxxxxxxxxxx   2,119.78
1418 998879 4-P06-03684   F    57    xxxxxxxxxxxxxxxxxxxxx     330.00
1419 998879 4-P06-03972   F    57    xxxxxxxxxxxxxxxxxxxxx     372.00

    TOTAL AMOUNT THIS RUN:                              $12,521.79

'COUNT' appears at the upper right of the EOBR.
If 'CODE' begins with 'E', the P.O. was not processed.
If 'CODE' begins with 'W', the P.O. was processed but needs
further attention.
```

Documents are listed in numerical order beginning with HRSA-43s and HRSA-64s and ending with the HRSA-57s. Any refunds processed during that period are printed at the end of the report.

NOTE: When this posting process is finished, examine each error to determine what actions the facility and/or the FI needs to take to update the local computer. It is still possible for the facility to post the EOBRs manually, as described in Section 4.1, Pay Documents.

12.7.2   Print EOBR Processing Errors
The EOBR Processing report, along with all EOBRs that were not posted, automatically print following each electronic processing of EOBR files.

WARNING: Print another copy of the EOBR processing summary, EOBR processing errors, and/or all FI EOBRs **before** processing the next electronic EOBR file. Follow local instructions. You cannot go back and print these options once the next consecutive transmission is performed. See Section 12.7.3 for instructions for printing EOBRs by batch, document, and patient.

Type "FIRP" and press <RETURN> to display the following screen:

```
THESE REPORTS WILL ONLY INCLUDE THOSE DOCUMENTS
FROM THE LAST EOBR PROCESSING RUN.

Select one of the following:
1.   Print EOBR Processing Summary Report
2.   Print EOBR Processing Error Documents
3.   Print EOBR Documents

Select:
```

Type the number of the print option to be performed and press <RETURN>. Select the print device and press <RETURN>.

12.7.3   Print EOBR(s)

Type "PEOB" and press <RETURN> to display the Print EOBRs Menu. The alternative options to print EOBRs in a previous file are as follows:

```
             CONTRACT HEALTH MGMT SYSTEM
                  (Your facility name)
                     Print EOBR(s)

        EBAT    Print EOBR(s) by Batch Date
        EDOC    Print EOBR(s) by Document
        EPAT    Print EOBR(s) by Patient
        PFI     Print EOBR(s) from FI File

     Select Print EOBR(s) Option:
```

To make selection, enter appropriate responses at each prompt.

12.7.3.1   Print EOBR(s) by Batch Date

Type "EBAT," and press <RETURN> to display a list of EOBR batches by date. Type the number of the selection and press <RETURN>. Queue to the printer of choice.

12.7.3.2   Print EOBR(s) by Document

Use this option to print an individual document. Type "EDOC" and press <RETURN> to display the screen on the next page:

```
Select Document: ?
    Enter the 'Order Number' for the document
    In the following format:  F-LOC-NUMBER
    Where
        F      Is the one-digit fiscal year code
        LOC    Is the three-character financial location code
        NUMBER Is the 5-digit document number

You May Omit The First Two Items If You Wish
(Current Fiscal Year And Location Code Will Be Assumed)
Also, leading zeros on the document are OPTIONAL.
 Do you wish to see a list of documents?  NO//
Select Document:  ?
```

Type the document number and select the print device for the EOBR. The EOBR can also be displayed on the screen. The display pauses after several lines so you can view the EOBR information.

12.7.3.3 Print EOBR(s) by Patient
Use this option to print an EOBR for a document for a selected patient. Type "EPAT" and press <RETURN> to select a patient. A list of purchase orders for that patient are displayed. The EOBR to print or display can be selected from this list. Then select the desired EOBR and device for printing or displaying.

```
Select PATIENT NAME: DOE,JOHN M 04-13-30 408126936  PHOENIX 4534

ENTRY #   DOCUMENT #     PATIENT NAME    CHART #     TRANS DATE
-------   ----------    ------------    -------     -----------
1.      4-001-03631    DOE,JOHN        4534        OCT 28,1993
2.      4-001-03842    DOE,JOHN        4534        SEP 9,1993
3.      4-001-04527    DOE,JOHN        4534        OCT 28,1993
```

12.8 CHEF MANAGEMENT
Options on this menu provide for functions that search, record, and print CHEF cases. The default threshold value can be edited through the CHS Site Parameters Menu in the field CHEF Threshold. Type "CHEF" and press <RETURN> on the Facility Management Menu to display the CHEF Management Menu:

```
            CONTRACT HEALTH MGMT INFORMATION SYSTEM
                   (your facility name)
                   C H E F  Management

        AED   Add/Edit/Delete CHEF Cases
        REQ   Print a CHEF Request
        SRCH  Search for CHEF Cases
        VP    View Document Summaries for a Specific Patient


    Select C H E F  Management Option:
```

12.8.1 Add/Edit/Delete CHEF Cases

Use this option to add and edit CHEF cases. Purchase orders added to each CHEF case are those purchase orders used in printing the CHEF case application. Type "AED" and press <RETURN> to display the following information:

```
    Select CHEF NUMBER:
    CHEF NUMBER:
    PATIENT:
    TOTAL FUNDS RECEIVED:
    Select PURCHASE ORDERS:
```

CHEF NUMBER can identify a desired CHEF case. This number is printed on the form produced by the "Print a CHEF Request" option. Enter as many CHEF cases as needed. Select the Patient associated with this CHEF case. If funds have been received for this case, type the total cumulative amount in Total Funds Received. This amount is printed on the CHEF request form. Associate as many Purchase Orders with a CHEF case as needed. Ensure that purchase orders selected are valid for the CHEF case in question.

NOTE: This option is a simple register. None of the values are required to interact with any of the other calculations in CHS/MIS. Deleting CHEF cases from this register has no effect on other parts of the application.

12.8.2 Print a CHEF Request

Type "REQ" and press <RETURN> to print a previously entered CHEF case on a CHEF Reimbursement Request form. Next, type the number of a CHEF case entered into the CHEF registry using the "Add/Edit/Delete CHEF Cases" option, previously described. Select a print device and press <RETURN>. Information on the selected CHEF case is printed on a CHEF Reimbursement Request form, which should be checked for accuracy and completeness prior to submitting to higher levels. This information can also be displayed on the screen.

12.8.3 Search for CHEF Cases

Type "SRCH" and press <RETURN> to display the Search for CHEF Cases screen. Next, enter the total obligation/disbursement amount on which to report. The default amount is obtained from a parameter that can be changed by the CHS manager, but you can enter a lower or higher amount appropriate for your use. Enter a beginning and ending date of the documents issued and the type of service to be reported (inpatient, dental, outpatient, or all services). Finally, specify the print device.

```
                CONTRACT HEALTH MGMT INFORMATION SYSTEM
                        (your facility name)
                        Search for CHEF Cases

Enter TOTAL OBLIGATION/DISBURSEMENT AMOUNT on which to report:

Enter The BEGINNING Date For The CHEF by Date of Service Report:
Enter The ENDING Date For The CHEF by Date of Service Report:

TYPE of service:  1    43 (HOSPITAL SERVICE)
                  2    57 (DENTAL SERVICE)
                  3    64 (OUTPATIENT SERVICE)

Select TYPE of Service (1-3  'A'  = 'ALL')  ALL//

DEVICE:
```

The resulting report can be printed or displayed on the screen and includes all documents issued for a specific patient. It is critical to assess all documents to determine those charges related to a specific episode of care to determine whether total related charges meet the CHEF threshold. Then use the report to enter information into the CHEF registry using the "Add/Edit/Delete CHEF Cases" option previously described.

Managed Care: This report serves as a tool for inclusion in the Managed Care activities as it allows identification of high cost patients and assesses comparative costs for frequent users of CHS, including non-CHEF cases. It is similar to the patient specific document summary; however, it provides for total costs that can be provided to the High Cost Case Manager (HCCM) and to the CHS Review Committee/Managed Care Committee.

12.8.4   View Document Summaries for a Specific Patient
This option is described in Section 6.0, Display Documents.

12.9   HIGH VOLUME PROVIDER MENU
Use this menu when a relationship has been established with a local Provider that provides all or most of the services for patients at a facility. A facility can save work and resources if it condenses the procedures involved to authorize work.

This is a summary of the High-Volume Provider Procedures. A High-Volume Provider creates a list of patients from a facility that has received or requested care. This list, called a Notification Report, contains information on the patient and the care requested or provided. The notification report is transmitted from the High-Volume Provider to the facility. The facility determines eligibility or non-eligibility and generates purchase orders and the Master Delivery Order List (MDOL) for those patients found eligible, or the Master Delivery Denial List (MDDL) for non-eligibles. The facility then transmits the report(s) back to the High-Volume Provider.

Type "HVP" and press <RETURN> to display the High-Volume Provider menu as follows:

```
            CONTRACT HEALTH MGMT INFORMATION SYSTEM
                      (your facility name)
                   High Volume Provider Menu


            EDIT    Enter/Edit HV Providers
            MDOL    Print MDOL
            PDEN    Denial Listing
            PNR     Notification Report
            PTL     Telecommunications Log
            RNR     Receive Notification Reports
            XMIT    Transmit MDOL to Vendor

        Select High Volume Provider Menu Option:
```

12.9.1 Enter/Edit HV Providers

Use this option to select providers that have sufficient volume with the facility to justify using the high-volume procedures. Type the provider into this option for all the high-volume functions with that provider to work. Next, select one of the vendors currently entered into the local computer. If the provider is not on the list, enter them using the "PVD" or "VEN" options previously described to enter or edit vendors.

Type "EDIT" and press <RETURN> to display the following:

```
Select HIGH VOLUME PROVIDERS:
    HIGH VOLUME PROVIDERS:
    EXPORT ABREVIATION CHARACTER:
```

The "Export Abbreviation Character" is used to differentiate between names of files that can be exchanged with each High-Volume Provider. It is an upper-case single character. The software prevents you from using the same character for more than one provider.

12.9.2 Print MDOL

Use this option is to print a Master Delivery Order Listing (MDOL) for a selected provider on a selected date. You can electronically transmit to the provider, if you and the provider have established the ability to transmit and receive files.

Type "MDOL" and press <RETURN> to display the information shown on the next page:

```
Select HIGH VOLUME PROVIDERS:

Recent MDOL dates:
        Jun 07, 1996
        May 26, 1996
        May 18, 1996
        May 13, 1996
        May 08, 1996
        Apr 26, 1996
        Apr 19, 1996
        Apr 08, 1996
Enter Report Date:  APR 19

Do you want generate a TX FILE for this REPORT ? Y// NO

Enter Printer Output Device:
    (This report requires 132 Width Printer format)

Should Output be in CONDENSED PRINT? Y//

     Your Request is now being Processed
```

Mail, carry, or transmit the MDOL to the High-Volume Provider after it prints. The MDOL provides space for signatory authority from the facility to the High-Volume Provider to provide the services summarized on the MDOL.

12.9.3   Denial Listing

Use this option to print a report of Denials by a specific High-Volume Provider issued for a specific date of service. Generate a transmission file if electronic communications have been established with the High-Volume Provider. The transmission file is an image of the printed report.

Type "PDEN" and press <RETURN> to display the following information:

```
Select HIGH VOLUME PROVIDERS:

Enter Report Date :  ??

Recent MDOL dates:
       Sep 23, 1996
       May 06, 1996
       Jul 18, 1994
       Jul 07, 1994
   Enter Report Date :  SEP 23
Do you want generate a TX FILE for this REPORT ? Y// NO

Enter Printer Output Device: PRINTER-132//
     (This report requires 132 Width Printer format)
Should Output be in CONDENSED PRINT? Y// NO
     Your Request is now being Processed
```

Mail, carry, or telecommunicate the MDOL to the High-Volume Provider after it is printed.

12.9.4   Notification Report

Use this option to print Notification Reports from High-Volume Providers. If electronic communications have been established with the provider, a list of files from which to select are displayed. The files are associated with a provider using the single character identifier entered for the provider in the Enter/Edit HV Providers Menu previously discussed. After a file and a device are selected, the notification report prints.

12.9.5   Telecommunications Log

Use this option only if electronic telecommunications with the High-Volume Provider has been established. It allows listing of files recently received or transmitted.

12.9.6   Receive Notification Reports

Use this option only if electronic telecommunications with the High-Volume Provider has been established. It allows notification reports from the High-Volume Provider to be electronically received. This further streamlines the exchange of data with the High-Volume Provider.

NOTE: The built-in method of receiving notification reports is through the 3780 terminal emulation utility. See a Site Manager or Area ISC to establish and use other methods of receiving notification reports if the High-Volume Providers are unable to use 3780.

12.9.7   Transmit MDOL to Vendor

Use this option only if electronic telecommunications with the High-Volume Providers has been established. It allows Master Delivery Order Listings (MDOL) reports to the High-Volume Provider to be electronically transmitted. This further streamlines the exchange of data with the High-Volume Provider.

NOTE: The built-in method of transmitting MDOL reports is through the 3780 terminal emulation utility. See the Site Manager or Area ISC to establish and use other methods of transmitting reports if the High-Volume Providers are unable to use 3780.

12.10   ADD/EDIT CAN, CC, SCC

Use the options on this menu to add, edit, and report Common Accounting Numbers (CAN), Cost Centers (CC), Service Classifications (SCC), and to edit and report the relationship among them.

Type "TUPD" and press <RETURN> to display the Add/Edit CAN, CC, SCC Menu:

```
          CONTRACT HEALTH MGMT INFORMATION SYSTEM
                  (your facility name)
                  Add/Edit CAN, CC, SCC


          CAN   Add/Edit CAN Number
          CC    Add/Edit Cost Center
          SCC   Add/Edit Service Classification
          PCCC  Print CANs/Cost Centers
```

```
              PSCC   Print SCC, CC, and Register

        Select Add/Edit CAN, CC, SCC Option:
```

12.10.1 Add/Edit CAN Number
Type "CAN" and press <RETURN> to display the following screen:

```
Select CHS COMMON ACCOUNTING NUMBER (CAN NUMBER):
COST CENTER:
FACILITY:
CAN EXPIRATION DATE:
Select FISCAL YEAR:
```

Type a Cost Center and Facility for the CAN to be used by the software. Expiration Date and Fiscal Year are optional. The Cost Center is used to relate the CAN to a Service Classification.

12.10.2 Add/Edit Cost Center
Type "CC" and press <RETURN> to display the following screen:

NOTE: Cost centers rarely change.

```
Select CHS COST CENTER CODE:
                   DESCRIPTION:
```

12.10.3 Add/Edit Service Classification
Type "SCC" and press <RETURN> to display the screen below. Type a Service Classification Code (SCC) as follows:

```
Select CODE:
DESCRIPTION:
PAYMENT DESTINATION:
Select COST CENTER:
DCR ACCOUNT #1:
DCR ACCOUNT #2:
DCR ACCOUNT #3:
```

Payment Destination provides the default value, either IHS or the Fiscal Intermediary, for the destination of the document information when a purchase order is being created. This is a default value only; you can change the destination.

Enter three DCR account numbers into each Cost Center associated with the SCC. These values determine which of the seven Document Commitment Registers is to be used when a purchase order with a Cost Center is being processed. If more than one DCR is entered, type which DCR to use when a new purchase order is entered at the prompt.

12.10.4 Print CANs/Cost Centers
Use this option to produce a report on CANs and their associated Cost Center.

12.10.5 Print SCC, CC, and Register

Use this option to produce a report on each Service Class Code (SCC), and each associated Cost Center and DCR.

13 DEN - CHS DENIAL/DEFERRED SERVICES

The CHS Denial/Deferred Services option is designed to store and print information about the CHS requests that have been denied or deferred for various reasons.

Type "DEN" in the CHS/MIS Master Menu and press <RETURN> to display the CHS Denial/Deferred System Menu below:

```
        ****************************************
        *          Indian Health Service       *
        *      CONTRACT HEALTH MGMT SYSTEM      *
        *               Version 3.1            *
        *                                      *
        ****************************************

                        RPMS/CMB

        ADD     Enter New Document(s) ...
        CAN     Cancel Document ...
        PAR     Parameters ...
        PRT     Print Patient and/or Vendor Letters ...
        REP     Reports ...
        SUPP    Enter Supplemental Information ...

     Select CHS Denial/Deferred Services Option:
```

Each option in the CHS Denial/Deferred System Menu is described in detail in the following sections.

13.1 ADD - ENTER NEW DOCUMENT(S)

Selection of this option from the CHS Denial/Deferred Services menu displays the following menu:

```
                  Enter New Document(s)

   DEFA    Enter New Deferred Service
   DENA    Enter New Denial

Select Enter New Document(s) Option:
```

13.1.1 DEFA - Enter New Deferred Service

When you select this menu option, you are asked the following questions:

Is Patient Registered?
Answer this prompt with either a Yes or No.
Yes: If the patient is registered, press <RETURN>, since the default answer is Yes.
When you are prompted for the Registered Patient's name, you can enter the name, or the patient's chart number, or "**??**" to view the list of registered patients. The patient you indicated is then displayed as follows:

```
REGISTERED PATIENT: MCDONALD,BOB   M 12-01-12   567888777   59702
```

If no further information displays, there is no address on file in the Registration System. Contact the Medical Records Department or appropriate staff so that the patient's registration record can be updated. An address is necessary to generate the denial letter.

No: If the patient is not registered or you cannot find the patient in the look-up list, enter "No" and press <RETURN>, then enter the following information about the patient as each prompt is displayed. Here is an example of entries to these prompts:

```
PATIENT NAME: JANEL HARGEN
MAILING ADDRESS-STREET: 7930 SOLAND DRIVE
MAILING ADDRESS-CITY: ALBUQUERQUE
MAILING ADDRESS-STATE: NM  NEW MEXICO
MAILING ADDRESS-ZIP: 87109
CHART# (OTHER FACILITY): 345097
PATIENT TELEPHONE: 505-297-9000
```

NOTE: At the PATIENT NAME prompt, you can type the patient's full name, last name first, or the chart number. At the CHART# prompt, you can type the patient's chart number at any other facility, if known, by typing first the chart number, then the facility at which it resides.

Date Request Received: Type the date the IHS department received this request for CHS services and press <RETURN>. If the patient was referred by an IHS provider, type the date the patient was seen and the referral was issued. If the service was reported by "call-in" or other notification, type the date the notification was received.

Enter Deferred Services Category: Answer with one of the following options by which the patient's requested service can be categorized. These options may vary because they are defined using the "CAT - Deferred Services Categories/Sub-Categories" option on the Denial/Deferrred Services Parameters menu.

A-Preventive Services: Requested service was preventative in nature.

B-Acute/Chronic Pri/Sec Care: Requested service was from a primary or secondary healthcare provider or site.

C-Acute/Chronic Tertiary Care: Requested service was from a tertiary health care site.

D-Experimental Care: Requested service is considered experimental and has not been formally approved by the American Medical Association.

Enter Deferred Service Subcategory: After your selection of a Service Category, you are asked to select a Subcategory. Enter "??" to view the list of subcategories appropriate to the Category you selected previously and make your selection.

Deferred Service Type: At this prompt, you are asked to indicate whether the patient received the indicated service as an Outpatient (O) or as an Inpatient (I).

Number Of Units: This prompt is asking for the number of the indicated service the patient received (for example, the number of visits, or the number of hospital days, or the number of treatments, etc).

Estimated Cost: At this prompt, enter a dollar amount that contains no more than 2 decimal digits.

Select Deferred Service Proc (CPT): This prompt is asking for a CPT Code for the procedure performed on the patient. You can enter any one of the following responses:

- The CPT code if you know it.

- A short name of the procedure (you will be asked to select from a list of matches to your entry).

- A CPT Category.

- "??" to view the full list of CPT codes (this list is extensive).

Your entry is displayed for confirmation before any further prompting occurs.

Deferred SVC Proc (CPT) Narr: At this prompt, type in a brief description of the procedure that was performed for this patient. This entry can be no more than 30 characters in length.

Deferred Service Comment: At this prompt, you can enter any pertinent comments you want to about this deferred service or just press <RETURN> through the blank field. The field automatically wraps any text you enter and numbers your comment lines. If you make an entry, the following formatting rules apply to any text is you then output from this field:

- Lines containing only punctuation characters or lines containing tabs stand by themselves; that is, there is no wrap-around.

- Any line beginning with one or more spaces starts on a new line.

- Expressions between '|' characters are evaluated as 'computed-field' expressions. For example, entry of the expression '|NAME|' causes the current name to be inserted in the text.

If you enter one or more comments to this field, the following **Edit Option** prompt is displayed when you press <RETURN> after your last comment:

Edit Option: At this prompt, you have four choices: 1) Select, by entering its first letter, one of the following Word Processing Commands, 2) type "??" to display a list of editing options, 3) type the number of the line you want to change, or 4) just press <RETURN> through a blank field to bypass this prompt. (This displays the line and prompts for its replacement.)

Add Lines to End of Text: The system displays adds a new blank line after the last numbered line of your comment.

Break a Line into Two: The system asks you after which character you want to break the line, then does it.

Change Every String to Another in a Range of Lines: The system prompts for what you want to change (Change every:) and what you want to change it to (to:), then asks if you want to confirm the change on each line it finds.

Delete Line(s): The system asks what lines you want to delete (from line: _ thru: _).

Edit a Line: The system prompts you for the line you want to change (Replace __) and the line with which you want to replace it (With __).

Insert Line(s) after an Existing Line: The system asks after which line you want to make an insertion, then displays that line and provides a new blank line for your insertion.

Join Line to the One Following: The system asks for the line to be joined.

List a Range of Lines: The system asks for the first and last lines in the range of lines to be displayed.

Move Lines to New Location within Text: The system asks for the line(s) you want to move, then asks after which you want to move the indicated line(s). You are asked to confirm the move before it is made.

Print Lines as Formatted Output: The system asks for the first and last lines in the range of lines to be printed, then asks if you want to print the line numbers, if you want the print in a rough draft, and to what device and margin size.

Repeat Lines at a New Location: You are asked to indicate what lines you want repeated and after which line they are to be repeated, then you confirm your selections.

Search for a String: When asked, enter the words you want to find. The system finds and displays them.

Transfer Lines From Another Document: When asked, enter the line after which you want to insert text, then enter the file or syntax that indicates the text to be appended. Type "?" for a description of the syntax.

Utility Sub-Menu: This sub-menu offers options to change the text editor, to transfer a file from a different computer, and to indicate a text terminator.

Enter Document Control Information Now: Answer "Yes" if the patient or their representative is picking up the document in person. Answer "No" if the document is being mailed.

- **Receipt Type:** Indicate whether the person is going to receive the Deferred services letter in person (I) or by certified mail (C).

- **Date Letter Received:** Enter the date on which the letter was received in person or by certified mail.

- **Person Receiving Letter:** Enter the name of the person who received the letter either in person or by certified mail.

The system now displays the choices you have made over the last seven prompts and displays the following prompt allowing you to edit any of your entries:

Enter Number Of Field To Edit or <RETURN> To Accept: (1-7): At this prompt, type in the number(s) of the prompt whose entry you want to change. Use a comma to separate the numbers of the prompts (ex: 1,2,3) or use a dash to indicate a range (ex. 1-3). Press <RETURN> through the blank field to leave your previous entries as they are.

The system now tells you the new deferral has been posted and gives you its document number, as shown below:

```
This DEFERRED SERVICE has been posted. The DOCUMENT NUMBER
is: D12-QCMB-14
```

Press <RETURN> to exit this process and return to the Add New Document menu.

13.1.2   DENA - Enter New Denial
When you select this menu option, you are asked the following questions:

Is Patient Registered? Answer this prompt with either a Yes or No.
Yes: If the patient is registered, press <RETURN>, since the default answer is Yes. When you are prompted for the Registered Patient's name, you can enter the name, or the patient's chart number, or "??" to view the list of registered patients. The patient you indicated is then displayed as follows:

```
REGISTERED PATIENT: MCDONALD,BOB   M 12-01-12   567888777    59702
```

If no information displays, there is no address on file in the Registration System. Contact the Medical Records Department or appropriate staff to update the patient's registration record. An address is necessary to generate the denial letter.

No: If the patient is not registered or you cannot find the patient in the look-up list, enter "No" and press <RETURN>, then enter the following information about the patient as each prompt is displayed. Here is an example of entries to these prompts:

```
PATIENT NAME: JANEL HARGEN
MAILING ADDRESS-STREET: 7930 SOLAND DRIVE
MAILING ADDRESS-CITY: ALBUQUERQUE
MAILING ADDRESS-STATE: NM  NEW MEXICO
MAILING ADDRESS-ZIP: 87109
CHART# (OTHER FACILITY): 345097
PATIENT TELEPHONE: 505-297-9000
```

NOTE: At the PATIENT NAME prompt, you can type the patient's full name, last name first, or the chart number. At the CHART# prompt, you can type the patient's chart number at any other facility, if known, by typing first the chart number, then the facility at which it resides.

Date Of Medical Service: Type the date on which the medical service was provided to this patient.

Date Request Received: Type the date the IHS department received this request for CHS services and press <RETURN>. If the patient was referred by an IHS provider, type the date the patient was seen and the referral was issued. If the service was reported by "call-in" or other notification, type the date the notification was received.

Send Letter To Patient?: At this prompt, type "Yes" to indicate that the denial letter should go to the patient or "No" to indicate it should go to someone else (for example, the patient's guardian).

> If you enter **No**, you are then prompted for the **Alternate Recipient**. At this prompt, type the name and address of the person who should receive the denial letter, making sure to type the name and each line of the address on a different line, as follows:

> > Tim Goggles
> > 3 Maple Ave.
> > Cosgrove, PA 12398

Is the Primary Provider In The Vendor file: The primary provider has primary responsibility for the service and will receive the letter. If the vendor is on file, press <RETURN> to accept the default answer of **Yes**, then identify the provider in the vendor file in the usual manner.

If the provider is not on file or cannot be found in the file, type "No" and press <RETURN>. Then, when prompted, enter the name of the primary provider and the street address, city, state, and zip code.

> **Est. Charge (Prim. Prov.) and Actual Charges (Prim. Prov.):** Type estimated charges (if known) or actual charges (if known) and press <RETURN>. Always enter money amounts with no dollar sign and no commas (for example: 2489.60 not $2,489.60 and 50 not 50.00). (*NOTE*: The information you enter is kept in the CHS file system, **not** in the vendor file.)

> **Are there any other providers (vendors):** If other providers are involved in this denial and should receive the denial letter, type "Y" and press <RETURN>. Type the providers just as the primary provider. Add as many other providers as necessary. The Type of Service question is not asked for these other providers. If no other providers are involved, type "N" (or press <RETURN>) to the question above.

(*NOTE*: The information you enter is kept in the CHS file system, **not** in the vendor file.)

Select Provider Account Number: This field is used to store the number that the provider uses to refer to this service. Type the provider's account number consisting of between 1 and 15 characters.

Type Of Service: The five types are Inpatient, Outpatient, Ambulance, Patient Escort, and Dental. Type "?" and press <RETURN> to see this list. Enter the first letter of the desired option and press <RETURN>.

Enter Denial Reason: The denial reasons have been defined by the CHS workgroup, and cannot be changed. Type in the reason payment is denied or type "?" to see the following list:

- Alternate Resource Available
- Care Not Within Medical Priority
- Eligibility Not Established
- Emergency Service
- IHS Facility Was Available
- Lives Outside Local CHS Service
- Non-Emergency Service

Type the first few letters of the denial reason (about 5) and press <RETURN>. (*NOTE*: This field is case sensitive; type the entry, in upper and lowercase, exactly as it is shown in the list.) The computer completes the response or gives a smaller list from which to choose.

Enter Denial Reason Option: Some denial reasons have options that further explain why the coverage was denied. For example, the reason **Alternate Resource Available** has two options:

- Other Coverage Available

- Would Have Been Eligible for Other coverage

Type ?? to see the options, if there are any.

Primary Denial Reason Comment: At this prompt, you can enter any pertinent comments you want to about this denied service or just press <RETURN> through the blank field. Refer to the **Deferred Service Comment** field under the "DEFA -- Enter New Deferred Service" option for instructions for working with this field.

You can enter more than one reason for a denial. When you are asked for another denial reason (**Enter Other Denial Reason:**), you can either enter one and repeat this process above or press <RETURN> through a blank field to continue.

Medical Priority Category: Type "?" and press <RETURN> to see the list of medical priorities from which to choose. Enter the appropriate category and press <RETURN>.

Select Procedure (CPT): Answer this prompt with a CPT code, a short name for the procedure, a CPT category, or the corresponding ICD code(s).

Procedure (CPT) Narrative: At this prompt, type in a narrative description of the procedure that was performed for this patient. This entry can be no more than 30 characters in length.

Procedure (CPT) Comment: Type in any comment(s) you may wish to make

about the selected procedure.

The prompts for another procedure, its narrative description, and a comment continue until you have entered all that are necessary and you press <RETURN> through a blank field at the **Select Procedure (CPT)** prompt.

Select Other Resources: If the patient has another resource that can help pay for the service, type the name of that resource here (for example: Blue Cross). Next, enter how much money this resource paid. Enter the dollars with no $ and no commas. The Other Resources question displays again so you can enter as many resources as you need. Press <RETURN> when you are finished.

Enter Document Control Information Now: Answer "Yes" if the patient or their representative is picking up the document in person. Answer "No" if the document is being mailed.

- **Receipt Type:** Indicate whether the person is going to receive the Deferred services letter in person (I) or by certified mail (C).

- **Date Denial Received:** Enter the date on which the letter was received in person or by certified mail.

- **Person Receiving Denial:** Enter the name of the person who received the letter either in person or by certified mail.

CHS Office Comments: To this field, enter any comments you wish to attach to this denial record. These comments are only seen on the office copy of the letter.

Enter Number Of Field To Edit or <RETURN> To Accept: (1-7): The system now displays the choices you have made over the last seven prompts and displays this prompt allowing you to edit any of your entries. Type in the number(s) of the prompt whose entry you want to change. Use a comma to separate the numbers of the prompts (ex: 1,2,3) or use a dash to indicate a range (ex. 1-3). Press <RETURN> through the blank field to leave your previous entries as they are.

The system now tells you the new denial has been posted and gives you its document number, as shown below:

```
This denial has been posted. The DENIAL NUMBER is: 012-QCMB-22
```

This document number consists of three parts:

- The fiscal year and quarter (based on the date of service or the issue date for unmet need (012).

- The IHS Area and facility (QCHB).

- The sequence number of the denial for that fiscal year (22).

Press <RETURN> back out to the CHS Denial/Deferred Services menu.

13.2 CAN - CANCEL DOCUMENT

Selection of this option from the CHS Denial/Deferred Services menu displays the following menu:

```
                    Cancel Document(s)

   DEFC   Cancel Deferred Services Document
   DENC   Cancel Denial Document

Select Cancel Document(s) Option:
```

13.2.1 DEFC - Cancel Deferred Services Document

Use this option to cancel a Deferred Services document. The document information is not actually deleted from the system, but it is marked as being cancelled and will not appear in any reports. To cancel a deferral document, enter "DEFC" and <RETURN> on the CHS Cancel Document(s) menu.

Enter the Deferred Service Number or Patient Name: The fastest way to find the desired deferral document is to type the entire document number (for example: 872-OCLR-421) and press <RETURN>. If the document number is unknown, enter the patient's last name, comma, first initial, and press <RETURN>. (For example: DILHAM,L). A list of this patient's deferrals appears, showing each deferral number and date of issue. As a last resort, enter "??" and press <RETURN> to get a list of all deferrals.

```
Are you sure you want to cancel this Deferral?
Once cancelled it can never be retrieved again.
Are you sure you want to cancel this Deferral? NO//
```

To complete this cancellation, enter "Yes" and <RETURN>. A message tells you the selected deferral has been cancelled.

To stop this cancellation, enter "No" and press <RETURN>. The message "Nothing Cancelled" displays and the system again prompts for the Deferred Service Number or Patient Name. Press <RETURN> to return to the CHS Denial/Deferred Services menu.

13.2.2 DENC - Cancel Denial Document

Use this option cancel a Denial Document entered in error. The information on the denial is retained on the local machine for historical reference and can be printed using the "DUMP" option. To cancel a denial, enter "DENC" and <RETURN> on the CHS Cancel Document menu. The system prompts to enter the denial number or patient name and <RETURN>.

The fastest way to find the denial document desired is to type its entire document number (for example: 872-OCLR-421) and press <RETURN>. If the document number is unknown, enter the patient''s last name, comma, first initial, and press <RETURN>. (For example: DILHAM,L). A list of this patient's denials appears, showing each denial number and date of issue. As a last resort, enter "??" and press <RETURN> to get a list of all denials.

After you choose a document, the following screen displays:

```
Are you sure you want to cancel this Denial?
Once cancelled it can never be retrieved again
Are you sure you want to cancel this Denial? NO//
```

To complete this cancellation, enter "Yes" and <RETURN>. A message tells you the selected denial has been cancelled.

To stop this cancellation, enter "No" and press <RETURN>. The message "Nothing Cancelled" displays and the system again prompts for the Denial Number or Patient Name. Press <RETURN> to return to the CHS Denial System menu.

13.3 PARAMETERS

Selection of this option from the CHS Denial/Deferred Services menu displays the following menu:

```
                        ACHS
                      RPMS/CMB
                      Parameters


    AD    Area Director
    AMT   Amount on Denial Letters
    CAT   Deferred Services Categories/Sub-Categories
    CLS   Closing Text
    FAC   Facility Abbreviation
    HEAD  Letter-Head
    MPRI  Medical Priorities
    NUM   Number of Letters/Fact Sheets
    SIG   Letter-Signature Block
    SU    Service Unit Director

 Select Parameters Option:
```

13.3.1 AD - Area Director

Use this option to indicate the name of your Area Director as you want it to appear on denial and deferral letters. At the Area Director prompt, enter the name as you want it to appear.

When prompted for each, enter the Area Director's street address, city, state, zip code, and Area office telephone number, pressing <RETURN> after each entry. If the existing entry is correct, just press <RETURN> at the prompt to accept it.

13.3.2 AMT - Amount on Denial Letters

Answer "Y" (YES) if the amount of the denial is to be printed on the denial letters sent to the patient and the provider(s). Answer "N" (NO) to prevent printing of the amount on the letters.

13.3.3   CAT - Deferred Services Categories/Subcategories

Use this option to set up the categories and subcategories of deferred services. To enter a new category, type its name, consisting of 3 - 100 characters, at the **Select CHS Deferred Services Category** prompt. Enter "Yes" to indicate you are adding this entry as a new CHS Deferred Services Category. Select or enter its subcategory(ies) at the **Select Subcategory** prompt. Remember, at both prompts, you can enter "??" to view the list of existing categories and their sub-categories.

13.3.4   CLS - Closing Text

Use this option to compose the text with which the denial letter is closed. You can either enter the phrase you want (for example: "Thank you for your continuing support") or you can enter ?? to list the word processing commands available to you. These commands are described under **Deferred Service Comment** in Section **13.1.1**, **DEFA - Enter New Deferred Service.**

13.3.5   FAC - Facility Abbreviation

This 3-character field is used to build denial numbers for your facility. For historical consistency, you should not change this field after denials have been entered for your facility.

13.3.6   HEAD - Letter Head

Use this option to edit the text that is to be the "header" for denial letters. Indicate whether or not letterhead is to be used, then enter the facility's mailing address as the header.

13.3.7   MPRI - Medical Priorities

Use this option to define new or revise the existing medical priorities that display as a selection list in other options.

13.3.8   Number of Letters/Fact Sheets

Use this option to change the default number of copies of the denial letter that are printed for the patient, the vendor, and the fact sheet. To each prompt, enter the number of copies (0-10) that are to be printed.

13.3.9   Letter-Signature Block

Use this option to edit the signature block printed at the end of denial letters.

13.3.10   Service Unit Director

Use this option to identify or revise the name, address, and phone number of the Service Unit Director. Enter the name, title of the Service Unit Director for IHS direct locations and the designated executive official authorized to deny CHS requests for Tribal 638 location.

13.4   PRT - PRINT PATIENT AND/OR VENDOR LETTERS ...

Selection of this option from the CHS Denial/Deferred Services menu displays the following menu:

```
                              ACHS
                            RPMS/CMB
                Print Patient and/or Vendor Letters
```

```
         DEFL    Print Deferred Services Letter(s) ...
         DENL    Print Denial Letter(s) ...

   Select Print Patient and/or Vendor Letters Option:
```

13.4.1   DEFL - Print Deferred Services Letter(s)

Selection of this option from the Print Patient and/or Vendor Letters menu displays or prints the most recently issued deferred services letter to the selected patient or deferred services number.

13.4.2   DENL - Print Denial Letter(s)

Selection of this option from the Print Patient and/or Vendor Letters menu displays the following menu:

```
                         ACHS
                       RPMS/CMB
                   Print Denial Letter(s)

      ALTA    Print Appeal to Alternate Resource
      ALTR    Print Alternate Resource Letter
      DEN     Print Denial Letters and Fact Sheets

   Select Print Denial Letter(s) Option:
```

13.4.2.1   ALTA - Print Appeal to Alternate Resource

Use this option to print appeal documentation to submit to an alternate resource for an identified patient or denial document.

Enter the denial number or patient name and confirm it.

If the patient has no alternate resource on file, you are given the option to enter one or view the list of known resources from which to make a selection.

Enter the date on which the denial was received from this alternate resource and the amount previously paid.

If there are appeal options identified for the alternate resource, they are listed. Then you are prompted to enter any comments that are relevant to this appeal.

When prompted, indicate the device to which the documentation is to be sent.

13.4.2.2   ALTR - Print Alternate Resource Letter

Use this option to print a letter to an alternate resource. First identify the patient or denial number and confirm your entry.

Indicate the amount paid by this resource, enter any comments you believe necessary, and indicate the device to which the letter should be sent.

13.4.2.3 DEN - Print Denial Letters and Fact Sheets
Selection of this option gives you a choice between the following two printing methods:

Print Individual Ltrs & Fact Sheet: This option prints a denial letter and fact sheet for an individual patient (or an individual denial number).

Print range by Issue Date: This option prints all denial letters and fact sheets who issue dates fall within the beginning and ending dates you indicate.

In each case, you are asked to indicate the number of copies of the letter(s) to be made for the patient and each vendor and how many copies of the fact sheet are necessary.

```
How many LETTERS for the patient? 1//
How many LETTERS for each vendor? 1 each//
How many copies (0-10) of the FACT SHEET 1//
```

Answer each question by pressing <RETURN> (if the default answer is desired), or enter another number and press <RETURN>. For example, to print 2 letters for each vendor, enter "2" when asked the second question. Two letters would then be printed for each of the listed vendors.

13.5 REP - REPORTS
Selection of this option from the CHS Denial/Deferred Services menu displays the following menu:

```
                         ACHS
                       RPMS/CMB
                        Reports

        DEFR    Deferred Services Reports ...
        DENR    Denial Reports ...

    Select Reports Option:
```

13.5.1 DEFR - Deferred Services Reports…
Selection of this option from the Reports menu displays the following menu:

```
                         ACHS
                       RPMS/CMB
                  Deferred Services Reports

    ACC    Accrued Deferred Services Report
```

```
    CAPD  Captioned Display of A Deferred Services Document
    DEFX  Deferred Services Expenditure Report
    LID   List of Deferred Services Docs by Issue Date

Select Deferred Services Reports Option:
```

13.5.1.1 ACC - Accrued Deferred Services Report

This report displays all the accrued deferred services, including the units and estimated cost for each, within an indicated date range by category and subcategory. Enter the beginning and ending dates of the range to be reflected in the report and select the device.

13.5.1.2 CAPD - Captioned Display of a Deferred Services Document

This report displays information about a selected deferred service document including its issue date; request received date; the category, subcategory, type, and coding of the deferred service; number of units and estimated cost of the deferred service; and the method and date of its receipt. When prompted, enter the patient name or deferred service document number and select the device.

13.5.1.3 DEFX - Deferred Services Expenditure Report

This report displays, for each deferred service documents falling within a specified date range, dates of the service and its deferral, service category and subcategory, diagnostic/procedural coding, and the cost. When prompted, enter the beginning and ending of the desired date range and select the device.

13.5.1.4 LID List of Deferred Services Docs by Issue Date

This report displays a list of either all deferred services by issue date or those falling within a specified date range and includes patient name and cost for each. When asked if you want all deferred services, enter "Yes" to display them all or enter "No" to specify the beginning and ending date of a range.

13.5.2 DENR - Denial Reports…

Selection of this option from the Reports menu displays the following menu:

```
                       ACHS
                     RPMS/CMB
                   Denial Reports

    LID    List of Denial Documents by Issue Date
    LAD    Print List of All Denial Reasons
    FDS    Facility Denial Statistics
    DUMP   Captioned Display of A Denial Document
    HQ1    HQ Table 1
    LIDA   List of Denial Documents in Alpha Order
    PVDN   Denials By Provider (Not On-File)
    PVDO   Denials By Provider (On-File)

Select Denial Reports Option:
```

13.5.2.1 LID - List of Denial Documents by Issue Date

This option prints a list of all denials between any two issue dates of choosing. The default answer allows printing of all denials on file. The report, in issue-date order, prints the issue date, denial number, patient's name, and the net dollar amount of the document. **NOTE**: Net dollar amounts are the total of the provider's bills less the amount paid by "other resources," if any. The total denials and total dollars for the report are also given. When asked if you want all denials, enter "Yes" to display them all or enter "No" to specify the beginning and ending date of a range.

13.5.2.2 LAD - Print list of All Denial Reasons

This option displays the "short form" and "letter text" for each of the denial reasons that are on the master list. Some of these reasons may not appear as choices when entering a denial document, since they are assigned to each facility individually. When prompted, just indicate the device that is to print or display the report.

13.5.2.3 FDS - Facility Denial Statistics

This report displays, for each denial reason, the number of patients denied service by type and medical priority, including dollar amounts for those services. This report was conceived as the document that will be sent to the area office for reporting purposes each month. At the prompts, indicate the beginning and ending dates for the time period to be covered in the report.

13.5.2.4 DUMP - Captioned Display of a Denial Document

This report displays information associated with a selected denial, including, for instance, denial reasons, provider, medical priority category, procedure code, whether or not the letter was sent to the patient, and dates of service and the denial. Select the denial number or patient name and indicate the device.

13.5.2.5 HQ1 - HQ Table 1

This report supplies information requested by IHS Headquarters for the annual budget tables and lists the reasons for denial and for each, the number of denials issued during the indicated period of time. Indicate the beginning and ending dates for the time period to be covered in the report, then select the device.

13.5.2.6 LIDA - List of Denial Documents in Alpha Order

This report lists all issued denials or those falling within the period of time indicated. Denials are listed alphabetically by patient name with the issue date, document number, and amount in dollars. Either select all denials or indicate the beginning and ending dates for the time period, then select the device.

13.5.2.7 PVDN - Denials by Provider (Not On-File)
This report lists denials issued to providers that were not included in the provider/vendor listing on the automated system. It includes for each denial its issue date, document number, type of service, and estimated and actual amounts in dollars. Indicate the beginning and ending dates for the time period, then select the device.

13.5.2.8 PVDO - Denials by Provider (On-File)
This report lists denials issued to providers that were included in the provider/vendor listing on the automated system. It includes for each denial its issue date, document number, type of service, and estimated and actual amounts in dollars. Indicate the beginning and ending dates for the time period, then select the device.

13.6 SUPP - ENTER SUPPLEMENTAL INFORMATION

Selection of this option from the CHS Denial/Deferred Services menu displays the following Supplemental Information menu:

```
              Enter Supplemental Information

    DEFS    Deferred Services Supplemental Information ...
    DENS    Denial Supplemental Information ...

Select Enter Supplemental Information Option:
```

13.6.1 DEFS - Deferred Services Supplemental Information
Selection of this option from the Supplemental Information menu displays the following menu:

```
                         ACHS
                       RPMS/CMB
            Deferred Services Supplemental Information

              DFDC   Enter Document Control Information
              DFDN   Enter Denial Information
              DFPO   Enter Purchase Order Information

       Select Deferred Services Supplemental Information Option:
```

13.6.1.1 DFDC - Enter Document Control Information
Use this option to record information about the delivery of deferred services letters. Identify the Deferred Service Number, then indicate how the person received the letter, the date the letter was received, and the name of the person who received it.

13.6.1.2 DFDN - Enter Denial Information
Use this option to change a deferred service to a denial. Select the deferred service number, then enter the new denial number that is 10-15 characters in length.

13.6.1.3 DFPO - Enter Purchase Order Information
Use this option to enter the number of the purchase order that was used to provide the deferred services recorded in a specified Deferred Service Number. The Purchase Order must be entered for this facility in the CHS system on this machine. The PO number must be in the format *nn-ann-nnnnn*

13.6.2   DENS   Denial Supplemental Information
Selection of this option from the Supplemental Information menu displays the following menu:

```
                         ACHS
                       RPMS/CMB
              Denial Supplemental Information

      DNAP   Enter Appeal to Other Resource Information
      DNDC   Enter Denial Document Control Information
      PROV   Add Provider to Existing Denial

 Select Denial Supplemental Information Option:
```

13.6.2.1 DNAP - Enter Appeal to Other Resource Information
This option allows entry of information needed for appeals to Alternate Resources. Use this option to track what other resources have been applied for, or applied to, this Denial.

13.6.2.2 DNDC - Enter Denial Document Control Information
This option allows entry of Document Control Information (date received, person receiving, and method of receipt) into the Denial Document that has already been issued.

13.6.2.3 PROV - Add Provider to Existing Denial
This option allows entry to a denial document of additional providers from whom late bills were received but should be denied for the same episode of care.

14 USE OF THE RATE QUOTE METHODOLOGY - RQM

Because of the requisite approvals, Site Managers must not enter RQM parameter edits without specific written approval of the Area CHS Office. To initiate the use of the RQM at your location, you must obtain all the appropriate approvals/clearance described in the RQM Operating Instructions. You also **must** coordinate any initializing of the RQM with the Area Office and the Fiscal Intermediary.

If your location is to use the Rate Quote Methodology, RQM, it is necessary for the Site Manager to edit the CHS Site Parameter, "Use Universal PO for 43 and 64: NO//," under Facility Management, by entering "Y" for YES. After this edit has been entered, the CHS MIS configures all entries for 43s and 64s to the format of the universal CHS Purchase Order, IHS-843.

This form encompasses all pertinent information from the 43 and 64 plus information pertaining to use of the Rate Quote Methodology. It replaces both the HRSA 43 and the HRSA 64.

NOTE: RQM does NOT yet include the Dental Services purchase order, HRSA Form 57. Form 57 has not yet been tested and authorized for use with the Universal form. Therefore, you need to generate 57s for any dental documents.

Entries for CHS transactions under Rate Quote Methodology are identical to the entries required for locations not using the RQM, except for the selection of agreement if RQM is in effect for the vendor selected. Note that under the RQM, the screens on the CHS/MIS do not display "IHS-843" in the listing of document types under the Document Generation menu. The screen displays HRSA 43, 57, and 64. This allows selecting of a "43" indicating inpatient services and "64" indicating other than inpatient services. The system prompts for all information required for use of the Universal Purchase Order. Only respond to the items prompted.

Refer to the RQM Operating Instructions for direction and guidance in regard to use of ranking lists and selection of vendors.

14.1 RATE QUOTATIONS

If the vendor has an active Rate Quotation in the vendor file, the system prompts with the first active rate quotation. Use a question mark to display all rate quotations for the vendor. If you do not select one, the default is "open market." The @ sign may also be used to default to open market. If the vendor contract information was previously selected, the rate information is not displayed.

Because the vendor has the ability to bill at different rates using the same rate quotation number, the question, "Will charges be paid at Medicare rate?" appears if Medicare was answered "Yes" to when the rate information was set up for the vendor.

This is just like the rate information. If a rate quotation or contract was not previously selected and there is an active Provider Agreement number for the vendor, the first active Provider Agreement serves as the default number.

Refer to Section 8.2.2 for instructions on adding vendor under RQM. The system prompts for pertinent information when entering RQM information as for a contract or Agreement.

14.2   INITIAL DOCUMENT RATE QUOTE AND AGREEMENT

If the Vendor selected during the initial entry of a purchase order has Rate Quote (RQ), Blanket Purchase Agreement (BPA), or Agreement (A) information entered for them, the system displays the effective entries and asks you to select one:

```
Select PROVIDER/VENDOR: VISTA MONTE HOSPITAL//

#  Type  Number    Eff-Date Exp-Date  MCR Description
-- ----  --------- -------- --------  --- -----------------
1  BPA  96-A-0002 05-08-96 09-20-97  YES INP: I/P rate desc.
                                     YES OUT: O/P rate desc
                                         PRO: prof svrc sate.

2  PA   96-PA-003 05-08-96 09-20-97  YES INP: I/P rate desc.
                                     YES OUT: o/p rate desc.
                                         PRO: prof svrcs rate

3  RQ   96-R-0001 05-08-96 09-20-97  YES INP: I/P rate desc.
                                     YES OUT: O/P rate desc.
                                         PRO: prof Svrcs rate

Enter Corresponding CONTRACT, AGREEMENT OR RATE QUOTE #. 3

Enter Corresponding CONTRACT, AGREEMENT OR RATE QUOTE #. 96-R-0001//
           |----------------------------|
DESCRIPTION OF SERVICE:
```

Enter the number at the left that corresponds with the selection to be used for this purchase order. If you make no selection , "open market" is used. Delete the selection with an "@" during any editing of the purchase order information before confirmation and generation of the purchase order number.

14.3   ADDING A VENDOR UPIN

You can add a Uniform Provider ID Number (UPIN) to a vendor through CHS/MIS using the "Provider/Vendor Data" option located on the main menu or the Facility Management menu. With UPIN, item 5 on that screen, you can enter, edit, or delete a UPIN as follows:

```
Want to Edit?  NO// Y

Change Which Item:  (1-14): 5

UNIFORM PROVIDER ID NUMBER: ?
Enter the Uniform provider Identification number, answer must be
in the form of 1 alpha and 5 numeric
UNIFORM PROVIDER ID NUMBER: I12345
```

The UPIN is given by the provider. It is not mandatory because all providers may not have one assigned to them.

14.4   ADDING RQ, BPA, AND AGREEMENT INFO

The following are examples of adding rate and agreement quotations to the vendor file. The information is provided to the CHS personnel by the Area Contracting Office.

The first 2 digits are the fiscal year. The rate number is coordinated with the area contracting number so, if you enter 920001, on the form it prints as 248-92-0001.

14.4.1   Example of Adding Rate Quotation

```
Want to Edit?  NO// Y

Change Which Item:  (1-14): 6

Want to enter a new Vendor RATE QUOTATION? N// YES
Select AGREEMENT/RATE/BPA NUMBER: ?
  Answer with AGREEMENT/RATE/BPA NUMBER
  You may enter a new AGREEMENT/RATE/BPA NUMBER, if you wish
  Type a Number between 910000 and 999999, 0 Decimal Digits,
       beginning with the last 2 digits of the current year.
  Select AGREEMENT/RATE/BPA NUMBER: ??
```

This number identifies the Rate or BPA agreement with this Vendor. The number is actually 4 digits, prefixed by the current year (e.g., 960008 would refer to the eighth agreement with this vendor in the year 1996).

The system displays what has been entered and allows you to edit the information:

```
Select AGREEMENT/RATE/BPA NUMBER: 970001
Are you adding '970001' as a new AGREEMENT/RATE/BPA NUMBER
(the 1ST for this VENDOR)? Y  (Yes)

     INPATIENT RATE DESCRIPTION:
     MEDICARE RATE FOR INPATIENT:
     OUTPATIENT RATE DESCRIPTION:
     MEDICARE RATE FOR OUTPATIENT:
     PROF. SERVICES RATE DESC.:
     DATE OF AGREEMENT: T  (OCT 04, 1996)
     EFFECTIVE DATE: T  (OCT 04, 1996)
     EXPIRATION DATE: T+200  (APR 22, 1997)
```

If today's date falls within the dates entered, the number of active agreements are displayed on item 6 of the Vendor edit information screen. That portion of the screen is displayed here:

```
(1). Name: OUTLAND MEDICAL CENTER   (2). EIN No.: 1856003005-A1
(3). Status: ACTIVE                 (4). Contracts: NONE
(5). UPIN:                          (6). Rate Quotation: ACTIVE=1
(7). Type of Business:              (8). Agreement: NONE
(9). BPA: NONE
```

You add, edit, and display the Agreement and BPA information in the same way.

```
#  Type  Number    Eff-Date  Exp-Date  MCR  Description
-- ----  --------  --------  --------- ---  -------------
1  RQ    97-R-0001 10/04/96  04/22/97

     Enter # to Edit:  (1-1): 1
```

14.4.2   Example of Adding Business Classification

The Business Classification information is kept and displayed on the "Provider/Vendor Data" screen as item 7. The values in the Type of Business table are determined by higher levels and are not subject to change. If an entry is determined to be invalid, contact the Site Manager or Area ISC. Type of Business (Business Classification) can be used in several types of reporting activities for different reasons. It can be important to enter and maintain accurate classification information on each vendor used. The display below begins at the bottom of the "Provider/Vendor Data" entry screen, illustrates entering or editing the business classification, and lists the existing possible choices:

```
Want to Edit?  NO// Y

Change Which Item:  (1-14): 7

TYPE OF BUSINESS: ?
 Answer with TYPE OF BUSINESS CODE, or DESCRIPTION, or GROUP
 Do you want the entire 16-Entry TYPE OF BUSINESS List? Y  (Yes)
Choose from:
   A1   DISADVANTAGED BUSINESS - 8(a)  SMALL BUSINESS
   A2   SB OWNED BY MINORITY GROUP     SMALL BUSINESS
   A3   OTHER SMALL BUSINESS           SMALL BUSINESS
   B1   MINORITY OWNED BUSINESS        LARGE BUSINESS
   B2   OTHER LARGE BUSINESS           LARGE BUSINESS
   C1   EDUCATIONAL                    NONPROFIT ORGANIZATION
   C2   HOSPITAL                       NONPROFIT ORGANIZATION
   C3   RESEARCH INST/FOUNDAT/LABS     NONPROFIT ORGANIZATION
   C4   OTHER NONPROFIT ORG/INSTITU    NONPROFIT ORGANIZATION
   C5   SHELTERED WORKSHOP             NONPROFIT ORGANIZATION
   D1   EDUCATIONAL                    STATE/LOCAL GOVERNMENT
   D2   HOSPITAL                       STATE/LOCAL GOVERNMENT
   D3   RESEARCH ORGANIZATIONS         STATE/LOCAL GOVERNMENT
   D4   OTHER STATE/LOCAL              STATE/LOCAL GOVERNMENT
   E1   ACQUIRED/USED OUTSIDE US       STATE/LOCAL GOVERNMENT
   E2   ACQUIRED OUTSIDE/USED INSIDE   STATE/LOCAL GOVERNMENT

TYPE OF BUSINESS: C3// HOSP
    1   HOSPITAL  C2        HOSPITAL    NONPROFIT ORGANIZATION
    2   HOSPITAL  D2        HOSPITAL     STATE/LOCAL GOVERNMENT
CHOOSE 1-2: 1  C2
```

This causes the type of business code to be displayed as item 7 on the vendor edit screen:

```
(1). Name: OUTLAND MEDICAL CENTER   (2). EIN No.: 1856003005-A1
(3). Status: ACTIVE                 (4). Contracts: NONE
(5). UPIN:                          (6). Rate Quotation: ACTIVE=1
(7). Type of Business: C2           (8). Agreement: NONE
```

14.5   DISPLAY RQM INFO AT VENDOR EXIT

Use the "Provider/Vendor Data" option to display the RQ, BPA, Agreement, and other

information at any of the appropriate prompts. Just answer "Yes" to the respective question and see the information as previously described:

```
Want to Edit?  NO//

Want to see Vendor Contract Information?  NO//

Want to see Vendor Rate Quotation Information?  NO// Y

# Type   Number    Eff-Date  Exp-Date   MCR  Description
------ --------- -------- --------   --- --------------------
1  RQ  96-R-0001  05/08/96  09/20/97   YES  INP: I/P rate desc.
                                       YES  OUT: O/P rate desc.
                                            PRO: prof Svcs rate
```

If you take the default of "NO," you step through the questions until you exit the "Provider/Vendor Data" option, shown below:

```
     Want to Edit?  NO//

     Want to see Vendor Contract Information?  NO//

     Want to see Vendor Rate Quotation Information?  NO//

     Want to see Vendor Agreement Information?  NO//

     Want to see Vendor BPA Information?  NO//

     Want to see Prior FY Payments for this Vendor?  NO//
```

If you do not enter any RQ, BPA, or Agreement information for the selected vendor, the system prompts you to display the information.

15 AREA OFFICE OPERATIONS

This section describes the necessary procedures for operating the CHS/MIS from the IHS Area Office perspective including a detailed description of the necessary processing steps.

The operation of the CHS/MIS at the Area Office provide for the consolidation and processing (split-out) of facility data, printing of DHR export data, transmitting of data to/from PCC and FI, and processing of EOBR information. The Area Office CHS/MIS Menu is displayed below.

```
              CONTRACT HEALTH MGMT INFORMATION SYSTEM
                       (your facility name)
                  Area Office CHS Data Processing


     ACON         Area CHS Consolidate Data From Facilities
     SPLT         Area CHS Splitout / Export to Parklawn/FI
     DHRL         Area CHS Print CHS DHR Data
     EOBP         Area CHS Process EOBR DATA
     PAR          Edit Area Office CHS Parameters
     SVRP         PRINT AO Special Vendor Report


Select Area Office CHS Data Processing Option:
```

15.1   AREA CHS CONSOLIDATION DATA FROM FACILITIES

The "Area CHS Consolidate Data From Facilities" option enables the Area Office to combine data from several facilities in order to aggregate the individual facility export files and send them to the Information Technology Support Center (ITSC) and/or the Fiscal Intermediary (FI).

The process expects the utility files to be in a specified directory. The UNIX directory is called */usr/spool/uucppublic*. When this program is run, the operator is prompted to "Enter Printer Device for Consolidation Report" and, following the entry of an appropriate printer, the screen displays a list of the CHS Facility files available for processing similar to the screen on the following page:

```
PROCESS FI DATA parameter = 'Y'
PROCESS AREA OFFICE DATA parameter = 'Y'

Previously Consolidated CHS Facility Data has been Deleted

Enter Printer Device for Consolidation Report: HOME// 93  ADP OPERATIONS

Files available for CHS Consolidation are listed Below:
Seq # File Name        Facility Name          #R DateExported/Process(ed)

 1    ACHS505301.235  CLINTON INDIAN HOSPI  650      Aug 22, 1996
 2    ACHS505501.235  LAWTON INDIAN HOSPIT 1165      Aug 22, 1996
 3    ACHS505611.235  WHITE EAGLE HEALTH C  292      Aug 22, 1996
 4    ACHS505612.235  PAWNEE INDIAN HEALTH  704      Aug 22, 1996
 5    ACHS505901.235  W. W. HASTINGS INDIA  410      Aug 22, 1996
 6    ACHS506411.235  WEWOKA INDIAN HEALTH  285      Aug 22, 1996

Enter Seq # of File to Process  (1-6 for All):  (1-6):
```

Enter the appropriate number or numbers as indicated above. When any numbers are entered, the computer redisplays the screen above and inserts a "Y" in the Process(ed) Column for each file to be consolidated. Then, you can see the message "Files Selected Above will Now be Processed - Is This Correct? (Y/N)? N//." If the information displayed is correct, enter a "Y."

For each facility processed, the following information displays:

```
^ACHSDATA( Data  -- As Listed Below

FACILITY NAME         :     CLINTON INDIAN HOSPITAL
DATE EXPORT RUN    :        Aug 22, 1996
DATE OF FIRST RECORD:       Aug 21, 1996
DATE OF LAST RECORD :       Aug 22, 1996
NUMBER OF RECORDS   :       650


Transferring 650 CHS Data Records...
10    20    30    40    50    60    70    80    90   100
110  120  130  140  150  160  170  180  190   200
210  220  230  240  250  260  270  280  290   300
310  320  330  340  350  360  370  380  390   400
410  420  430  440  450  460  470  480  490   500
510  520  530  540  550  560  570  580  590   600
610  620  630  640  650  660

          T Y P E   O F   D A T A       # TRANSFERRED
      2  DHR RECORDS FOR PCC                 135
      3  PATIENT RECORDS FOR AO/FI           220
      4  VENDOR RECORDS FOR AO/FI             36
      5  DOCUMENT RECORDS FOR AO/FI          270
      6  PAYMENT RECORDS FOR AO                0
      7  IHS STATISTICAL RECORDS              0

        TOTAL ALL TYPES                     661
```

After processing all the facility data, the system displays a report on the local terminal and sends it to the selected printer device. A sample report is displayed below.

```
              AREA OFFICE CHS CONSOLIDATION REPORT
                 FOR OKLAHOMA CITY AREA OFFICE
                       Aug 23, 1996
-------------------------------------------------------------------------------
FACILITY FAC-CD|-----R E C O R D   T Y P E S---|TRCD| EXP-DATE| F-R DATE| L-R
DATE
-------------------------------------------------------------------------------
                  2     3     4     5   6     7
-------------------------------------------------------------------------------
CLINTON  505301   135   220    36   270        61   08-22-96 08-21-96 8-22-96
LAWTON I 505501   250   422    14   500   2   188   08-22-96 08-19-96 8-22-96
WHITE EA 505611    54   125    20   108       307   08-22-96 08-13-96 8-22-96
PAWNEE I 505612   145   302     1   290       753   08-22-96 08-16-96 8-22-96
W. W. HA 505901    85   125    46   170       426   08-22-96 08-21-96 8-22-96
WEWOKA I 506411   156   131     8   112       307   08-22-96 08-16-96 8-22-96
    TOTALS        725  1325   140  1450   2 3642
    moving your facility files to '/usr3/chsdata/'...
    Press <RETURN> to END:
```

15.2   AREA CHS SPLITOUT/EXPORT TO PARKLAWN/FI

Use this option to create files that are to be exported to Information Technology Support Center (DHR Records), the IHS FI (Patient, Vendor, & Document) and the IHS 1166 Area Office Payment Program (IHS Pay Records).

When you select this option, the splitout banner displays along with the name of the Area Office and the Area Office Accounting Point Prefix. Next, a message displays indicating where the resulting data (e.g., DHR information) should be transmitted (e.g. ITS and/or FI (BCBS). Now you are prompted to enter an "Effective Transaction Date." The default is today's date. This date is important because it is the effective transaction date inserted in every DHR record. This is especially important at the end of each month and end of the fiscal year. Check with the Area Office Financial Management Branch if you have any questions regarding end of month and/or end of fiscal year cut-off processing dates.

Next you are prompted to "Enter Device # For Summary Report." In most cases this should be a local printer. The computer now generates a series of messages indicating the various stages in the processing of the Area Office CHS Data Files.

First of all, the number of DHR records generated for ITS is displayed (e.g. "Total DHR Records Generated = 91"). After the DHR records are generated the computer displays the message "Number Of Previously Exported Files = (Some Number). Do you want to List Previously Exported Files? Y//."

The above dialogue is repeated for each type of data to be exported (e.g., BCBS, Vendor Records, AO Payment Records, IHS Statistical Records). After this step is completed, the DHR data can be printed using the Menu Option discussed below.

15.3   AREA CHS PRINT AO CHS DHR DATA

Use this option to print a copy of the DHR Data file that is transmitted to PCC. When you select this program, you are prompted for an output device. One of the AO high-speed printers should be selected. This option can be used as many times as required.

15.4   IHS 3780 TELECOMMUNICATIONS - MASTER MENU

NOTE: 3780 is no longer supported by CHS software and has been replaced with an automated FTP system.

15.5   AREA CHS PROCESS EOBR DATA

Use this menu option to process EOBR data at the Area Office. Each of the items on the following menu are discussed below.

```
            CONTRACT HEALTH MGMT INFORMATION SYSTEM
                  OKLAHOMA CITY AREA OFFICE
                   Area CHS Process EOBR DATA
```

```
EOBI    Area CHS Process EOBR FILE From FI
EOBO    Area CHS Generate Facility EOBR Files
LFAC    Area CHS List Facilities Receiving EOBR Data

   Select Area CHS Process EOBR DATA Option:
```

15.5.1   Area CHS Process EOBR File from FI
This option is used to process electronic EOBR data received from the FI. This
information is received once a week after each FI payment processing run. The file
is usually available Monday morning.

When you select this option, an appropriate header is displayed and the following
information is display:

```
The '^ACHSEOBR(' work global is about to be killed.

Are you sure previously processed EOBRs were sent to your
facilities via the EOBR OUT Area option?
Enter Yes or No: N// Y   ES

      Select one of the following:

       N    NO REPORT
       S    SUMMARY REPORT - Total # of EOBR's by Facility
       D    DETAILED REPORT - Listing of each EOBR plus
            Summary Report

Enter Type Of Report To Print: SUMMARY// S
      SUMMARY REPORT - Total # of EOBR's by Facility

Enter Printer For Report:HOME// BAND  BAND PRINTER - 1
PART ADP OPERATIONS
```

Usually you will take the default response (Summary) and a report by facility is
generated. (A sample report is shown later in the section.) After you select the
report type, you are prompted to select the device for the printing of the report.
Next, the computer displays a list of the current EOBR files available for
processing as shown on the next page:

```
*************************************************************
        ***    SELECT EOBR FILE FOR PROCESSING    ***
           LAST AREA OFFICE SEQUENCE NUMBER = 336
     FI/EOBR Files Archive Directory = '/usr3/chsdata/'.
*************************************************************

Delete ALL FI EOBR FILES With Process Date BEFORE Jun 08,
1996? Y// YES
              bcbseob.007  has been DELETED
              bcbseob.006  has been DELETED

NUMB    FILE NAME    FI PROCESS DATE    # RCDS    SEQ #
----    ---------    ---------------    -------   ------
 1      bcbseob.011  Aug 21, 1996        9,826     338
 2      bcbseob.008  Aug 15, 1996        9,254     337
```

```
3        bcbseob.003   Aug 10, 1996        8,447      336
4        bcbseob.005   Jul 06, 1996        5,238      331
5        bcbseob.004   Jun 29, 1996        9,842      330
6        bcbseob.002   Jun 15, 1996       11,345      328

Enter NUMB of EOBR FILE to Process From Above List: (1-6):2
```

You are asked to select a particular sequence # for processing. The sequence
number selected must correspond to the next report number (REPT #) in the last
column of the table above.

```
                BUILDING CHS EOBR MESSAGE FILE...

M001  M002  M003  M004  M005  M006  M007  M008
M009  M010  M011  M012  M016  M091  M100  M101
M102  M103  M104  M105  M106  M107  M109  M110
M112  M113  M119  M120  M129  M130  M131  M132
M139  M140  M184  M199  M203  M204  M205  M206
||
R222  R223  R224  R225  R226  R227  R258  R259
R260  R261  R262  R300  R301  R313  R749  R754
R755  R756  R761  R762  R763  R764  R765  R776
R900  1001  1002  1003  1004  I005  1006  1007

144 EOBR MESSAGES ADDED/UPDATED

   Processing EOBR Data for: MIAMI INDIAN HEALTH CENTER
10
   Processing EOBR Data for: HOLTON INDIAN HEALTH CENTER
20
   Processing EOBR Data for: LAWTON INDIAN HOSPITAL
30      40      50
|| etc....
   Processing EOBR Data for: WEWOKA INDIAN HEALTH CENTER
850     860     870
    Processing EOBR Data for: HASKELL INDIAN HEALTH CENTER
880

Total EOBR Records Processed = 880
Archive of '/usr/spool/uucppublic/bcbseob.008' to
'/usr3/chsdata/bcbseob.008'

Press RETURN To Continue...:
```

Once you have selected the appropriate report for processing, the computer
displays information for every facility that is processed, similar to the screen shown
below:

```
            CHS EOBR PROCESSING REPORT         PAGE 1
       for Documents Processed on: Aug 24, 1996
            for OKLAHOMA CITY AREA OFFICE

    Facility                          # EOBR's
    -----------------------------------------------

    CLAREMORE INDIAN HOSPITAL          138
```

```
       CLINTON INDIAN HOSPITAL                43

       SHAWNEE INDIAN HEALTH CENTER           63

       W. W. HASTINGS INDIAN HOSPITAL        116

       PAWNEE BENEFIT PACKAGE                311

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

       Total For All Facilities =           671
```

After this step is processed at the Area Office, you now generate Unix Files to be sent to Facilities for processing on their local computers.

15.5.2   Area CHS Generate Facility EOBR Files
This option generates individual EOBR files that are automatically transmitted to the local facility via the Area Office Computer.

When you select this option, the computer first checks the EOBR Destination information to make sure it exists in the AO Destination Tables. A message is generated for each facility that does not have Destination Data. You then are prompted to continue with incomplete Destination information. The usual response is a "Yes."

You now see several messages on the screen similar to the one on the next page:

```
Area CHS Generate Facility EOBR Files

Checking EOBR destinations...

...SORRY, JUST A MOMENT PLEASE...
Destination not on file for CLAREMORE INDIAN HOSPITAL
Destination not on file for MIAMI INDIAN HEALTH CENTER
Destination not on file for CLINTON INDIAN HOSPITAL

You can use the 'Area Office Parameters' option to add a
destination to
                FACILITIES RECEIVING EOBR DATA.

Want to Continue with Incomplete EOBR Destination Information?
N//YES

Copying EOBR data for SHAWNEE INDIAN HEALTH CENTER to host file.

Host File Being Created
Please Standby-Copying Data to Host File
/usr/spool/uucppublic/EB505810.337

...HMMM, HOLD ON...

          EOBR Messages Copied to Output Media

50    100   150   200   250   300   350   400   450   500
550   600   650   700   750   800   850   900   950   1000
1050  1100  1150  1200  1250  1300  1350

Export file EB505810.337 queued up to be sent to okcshw...

Press RETURN To Continue...:
```

15.5.3   Area CHS List Facilities Receiving EOBR Data
This option displays a report similar to the following example indicating which facilities in an Area Office are receiving EOBR data.

```
    RECEIVING CHS EOBR DATA                AUG 23,1996  08:51  PAGE 1


                                    LAST
                                    FAC
                                    EOBR  LAST FAC
          FAC'S RECV   LAST FAC     SEQ   EOBR PROC
LOCATION  EOBR DATA    EOBR MSG UPD NUMB  DATE      SUB-FACILITY
-------------------------------------------------------------------------
OKLAHOMA CITY
          CLAREMORE IN             64    CLAREMORE INDIA
          CLINTON INDI             72    CLINTON INDIAN
          HASKELL INDI             69    HASKELL INDIAN
          HOLTON INDIA             73    HOLTON INDIAN H
          LAWTON INDIA             69    LAWTON INDIAN H
          W. W. HASTIN             68    W. W. HASTINGS
          WEWOKA INDIA             83    WEWOKA INDIAN H
Press RETURN To Continue...:
```

There should be entries in this table for the necessary EOBR data to be sent to the local facilities. The definition of this table should be done by the Area CHS Office.

15.6   PRINT AO SPECIAL VENDOR REPORT

This option generates a special CHS report that lists all the purchase orders and related information for a particular vendor for all facilities in an area. This report is generated automatically during CHS Area Consolidation if a particular vendor is designated a "special provider." This report can be generated manually by following the procedure below:

```
Select SPECIAL REPORT VENDORS:
   ANSWER WITH SPECIAL REPORT VENDORS
CHOOSE FROM:

     OKLAHOMA MEDICAL CENTER
     BAPTIST MED CENTER HOSP-OKC
     ST. JOSEPH REG. MEDICAL CENTER

Select SPECIAL REPORT VENDORS:  BAPTIST MED CENTER HOSP-OKC

Do you want a FAX Cover Sheet Generated for This Vendor (Y/N)?
Y//
DEVICE:
DO YOU WANT YOUR OUTPUT QUEUED?  NO//
```

As shown above, an option is available for printing a FAX cover sheet for each vendor selected. One of the main purposes of this report is to notify the "special vendor" of all POs generated the previous week by all facilities in an area. Send this report to the "special vendors" by the Area CHS Office. A sample report is shown below:

```
          CHS AUTHORIZATIONS FROM OKLAHOMA ADMINISTRATION FACILITIES
                      FOR BAPTIST MED CENTER HOSP-OKC
            FOR AUTHORIZATIONS ISSUED BETWEEN 01/21/93 AND 04/09/93


JUL 30, 1993@09:39:03                                      PAGE 1
---------------------------------------------------------------------------
LOCATION     PATIENT NAME   DOCUMENT #      TYPE   IHS #    AUTHDTE       $ AMT

IGNACIO HC   DEMO, PATIENT  3-Q11-00061     43-S   050937   01/21/93     40.00
(202611)     TRIBE-CD-151   COMM-CD-0293408

TOWAOC HC    DEMO, BABY     3-Q14-00055     43-C   050428   01/21/93   -443.00
(202614)     TRIBE-CD-084   COMM-CD-0223408

ZUNI HOSP    DOE, JOHN      3-Q01-00112     64-I   053013   04/09/93    939.00
(202501)     TRIBE-CD-166   COMM-CD-0293408
```

A sample of the FAX cover sheet is shown below:

```
                        INDIAN HEALTH SERVICE
                       OKLAHOMA ADMINISTRATION
                          3625 NW 56TH ST.
                       OKLAHOMA CITY, OK  73112


        DATE:        JUL 30, 1996
```

```
          DELIVER TO: BAPTIST MED CENTER HOSP-OKC
                      300 N W EXPRESSWAY
                      OKLAHOMA CITY OK   73112

          FAX #:      (405) 555-1111

          FROM:       Contract Health Services
                       OKLAHOMA ADMINISTRATION

          SUBJECT:    CHS PURCHASE ORDERS
```

15.7   EDIT AREA OFFICE CHS PARAMETERS

You can edit the CHS parameters for the Area Office by entering "PAR" and <RETURN>. The system prompts for the information listed below. Refer to the Area Office Parameters chapter of the CHS Technical Manual or use online help for additional information.

```
                   CONTRACT HEALTH MGMT SYSTEM
                         (area office name)
                  Edit Area Office CHS Parameters

       Select CHS AREA OFFICE PARAMETERS NAME:
       PROCESS FI DATA:
       PROCESS AREA OFFICE DATA:
       PRINT EOBR'S:
       EXPORT DHR DATA TO FI:
       POST FAC PAYMENTS TO AO ODF:
       EOBR IMPORT DIRECTORY:
       EOBR ARCHIVE DIRECTORY:
       Select FACILITIES RECEIVING EOBR DATA:
         FACILITIES RECEIVING EOBR DATA:
          Select SUB-FACILITY:
       Select FACILITIES EXPORTING FI DATA:
       Select SPECIAL REPORT VENDORS:
```

16 HELP PROCEDURES AND TECHNIQUES

It has been requested that each user contact the qualified technician in their area before calling the help desk or developer. This qualified person is usually the site manager who can provide support in the user's specific area.

If a site manager or supervisor needs help or does not understand any part of CHS or this manual, they may feel free to call the Support Center. The Support Center is staffed by two computer specialists tasked with assisting the field in resolving questions associated with RPMS software. They assess and attempt to resolve the call immediately. If the call is not resolved, they contact a member of the CHS team to resolve the question. They monitor the progress of resolution and follow up on the call. This three-step responsibility ensures that the questions the customers have are resolved as quickly and efficiently as possible. It has been requested that the end user contact their supervisor and/or site manager for help first, so that help may be rendered most efficiently.

Calls may be initiated by phone or e-mail: (505) 248-4371
E-mail: HQW Help Desk

Manuals for all software packages may be found under Package Releases:
ftp://cmbsyb.hqw.ihs.gov/pub/DIST/
At this site they are part of the distributed package and are distributed in PDF format. For assistance in opening or retrieving these manuals, please call the Support Center.

You can also find the manuals in PDF format on the RPMS home page:
http://www.ihs.gov/cio/rpms/index.asp

Patches for all software packages may be found under Patch Distributions:
ftp://cmbsyb.hqw.ihs.gov/pub/PATCHES/
For assistance in opening, retrieving, or utilizing a patch to the software, please contact your site manager, supervisor, or Support Center

17 GLOSSARY

Access Code – A unique code that is used by the computer to identify the user so that you may gain access to the program.

CPU (**C**entral **P**rocessing **U**nit) – The main section of the computer that will process the data. For RPMS applications, the CPU is a central unit for a facility.

CHS/MIS (**C**ontract **H**ealth **M**anagement **I**nformation **S**ystem) - A facility-based automated document and fiscal management system for the Indian Health Service (IHS) Contract Health Service (CHS) Program.

Common Menu – Menu that displays the selections: User's Toolbox, View Alerts, Continue, Halt, Mailman Menu, Restart Session, Time and Where am I. To see the Common Menu type double question marks (??) at the Primary Menu prompt.

Computed Field – Creates a value by performing an operation on values in other fields (e.g., payment adjustment).

Cursor – Rectangle or blinking line indicating when a response is needed and the position in which it is to be typed.

Database - All of the information contained in all of the files within the computer system.

Date – This field is set to only accept a variety of formats for entering the date (e.g., Formats: 2/11/74, 021174, T (= Today's date), T+7 (= Today's date + 7 days), T-4 (= Today's date – 4 days)).

Double Arrow Key – Press the 6 key two times while holding down the shift key to display a Double Up Arrow (also known as a double up hat or double caret that looks like (^^)). This takes you to the primary menu or main application menu.

Fields – Various prompts in the database represent a field. A collection of fields makes up a record.

FileMan - A database management system used by Indian Health Service.

Files – A collection of records with like information stored together.

Free Text – A field that accepts numbers, letters, and most of the symbols on the keyboard.

Halt – Type **"HALT"** and press <RETURN> to sign off of the system.

Hardware – The various machines and physical components connected to the computer (such as the Central Processing Unit (CPU), keyboard, monitor (terminal), printer, etc....

Interactive Dialogue – Communication between you and your computer through typed words shown on the monitor.

Mainframe - A large computer that runs the Headquarters supply program (STORES).

Menu – The list of different options from which you may select.

MUMPS (**M**assachusetts general hospital **U**tility **M**ulti **P**rogramming **S**ystem) - The computer language used to create FileMan and SAMS. It also is known as the "M" language.

Numeric – This field only accepts numbers.

Pointer to a File – A Field that directs the computer to another file for information (e.g., vendor file).

Primary Menu – Menu that includes all RPMS and system applications to which you have been granted access keys. This menu is also known as the CORE menu.

Prompt – Instruction the computer displays on the screen that informs you that the computer is waiting for you to type a command. In the MUMPS system, the prompt is the > character. In FileMan, the prompt can be any word followed by a : character.

Queue – Entering a "Q" at the "Device:" prompt assigns the printing job to a specific device at a specific location at a specified time. This allows you to queue a print job while the printer is performing another task.

Records – A record is a group of fields that has a name.

Resource and Patient Management System (RPMS) - The RPMS is a decentralized automated information system that operates on computers at approximately 300 IHS and tribal hospitals and clinics throughout the continental U.S. and Alaska.

Return Key – Pressing the <RETURN> key without entering a given choice allow you to return to the previous menu (see section 2.3.2 for details).

Set of Codes – This field only accepts one or two characters (e.g., Type of Document (43, 57, or 64), and Y or N (Yes or No responses)).

Software – Set of instructions that allows interaction with the computer which controls what is seen on the screen, how information is entered, and what the computer does with the information or instructions entered.

Sub-Menu – Any application menu or subsequent menu within an application that perform specific tasks.

Up Arrow Jump – Allows JUMPing through menus without passing through the menu hierarchy (see section 2.3.2 for details).

Up Arrow (Up Hat) – Press the 6 key while holding down the shift key to display an up-arrow (also known as an up-hat or caret). This function allows you to return to the previous menu.

Verify Code - A unique code that is used by the computer to verify your access after you have typed in your access code.