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Any comments or suggestions regarding this publication are welcomed and should be forwarded to the attention of

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Preface

This volume of the *STAR Patient Care Reference Guide* provides a detailed explanation of the Utilization Management Module.

Included is information on Utilization Management maintenance, options, and reports.

Documentation Conventions

Documentation for McKesson's STAR 2000™ line of products follows these conventions:

Revisions
Text revisions are indicated by a change bar in the left margin. Paragraphs that contain grammatical changes that do not affect content are not marked.

Canadian Documentation
This volume may include documentation for Canadian users of this product. Complete sections of Canadian text are identified by "CN" and "CN Only."

Key Names
Named keys, such as ENTER, SHIFT, CTRL, and ALT, appear in this document in uppercase (capital) letters. Symbol keys display according to the key name, followed by the symbol on the key in parentheses, such as hyphen (-) and asterisk (*).

Key Chords
Key chords are key entries that require you to hold down one or more keys (typically, CTRL, ALT, or SHIFT) before pressing another key. In this document, key chords display as the names of each key in the chord with a hyphen (-) between each (for example, CTRL-ALT-DEL). You should press the keys in the order indicated.

ENTER
ENTER is a key on a computer keyboard used to complete an entry on the STAR system. (This key may also be referred to as NEW LINE or NL in the STAR system.)

Data Entries
Letters or words you enter in response to the system display in **boldface** letters in this document. For example: Enter **Y** for Yes or **N** for No.

Selecting an Entry
This document often instructs you to "select an entry." The method you use to select an entry depends on whether you are using STAR from a terminal or IBM-compatible personal computer. Entry methods include:

- Entering the option number
- Using your arrow keys to highlight the option and pressing ENTER
- Clicking on the option using a mouse or other pointing device (PC only)

For more information about these options, see the *General Information Volume*.

Prompts
System prompts display at the bottom of many STAR screens when the system requests an entry or displays a message. Prompts display in this document italicized and indented from the rest of the text. For example:

Enter patient name--

Field Characteristics

STAR product documentation provides field explanation codes, in addition to a narrative description for each field on a screen. These codes display the maximum length of your entry in the field, the type of entry you make in the field, and whether the field is required. This information displays in the following format:

- DISPLAY ONLY for a field you cannot edit.
- For X-YY-Z field types, where:
  - X is the maximum number of characters permitted in the field:
    - P for a field length determined by a Parameter
    - T for a field length determined by a Table
    - U for a field having an Undefined length
  - YY is the type of entry technique permitted in the field:
    - A for Letters only
    - N for Numerals only
    - C for Characters (including punctuation)
    - AC for Letters and Punctuation only (no numbers)
    - NC for Numerals and Punctuation only (no letters)
    - AN for Letters and Numerals only (no punctuation)
  - Z is the requirement indicator of the field:
    - R if an entry is required to complete the function

      NOTE: Facilities can designate that certain fields be required. STAR product documentation does not display R for fields designated as required by a facility.

    - O if an entry is optional to complete the function
    - C if an entry is conditionally required or optional
  - For YY-Z field types, where YY is:
    - TABLE LOOKUP for a field that enables you to select from a displayed table. See the *General Information Volume* for more information regarding this entry technique.
    - SPECIAL FORMAT for a field having data entry requirements not conforming to standard format. The field definition contains the specific data entry requirements for the field.
    - DATE for a field subject to the date entry conventions described in the *General Information Volume*.
    - TIME for a field subject to the time entry conventions described in the *General Information Volume*.

    NOTE: For use of the Z position in this format, refer to the explanations for Z under X-YY-Z.

Table of Contents

Appendix A - INFORMATION WINDOWS

Table of Illustrations

Introduction

A utilization management system is an integral part of data gathering in hospitals and can assist an organization in meeting the objectives of their utilization management program. These objectives are designed to improve patient management, improve cash flow, reduce resource utilization, and improve physician and patient relations. The Utilization Management Coordinator performs the review process, which assists the facility in meeting these objectives.

The Utilization Management Module provides facilities with a tool to document review activity on a patient while the patient is in the hospital and to report on utilization activity such as avoidable and non-covered days, contacts to physicians, contacts to advisors, discharge planning, and special studies. The following are highlighted features of this module:

- Accommodates up to 999 reviews per patient visit
- Hospital-defined criteria to determine patient inclusion/exclusion for review
- Hospital-defined sort parameters for batch reports
- Hospital-defined criteria to define patient readmission status
- Ability to screen preadmission patients by utilizing inclusion/exclusion criteria
- Hospital-defined data table that enables each facility to meet data and reporting needs
- Collection and verification of UB data that networks to STAR Financials
- Online updating of data utilized by admitting, nursing, and financials
- Set of demand reports, each with processing parameters and multiple sort options
- Ability to view, fax, or print review data
- Ability to add free-form comments on most data collection screens
- Ability to associate reviews to any of the patient's insurance plans
- Ability to transfer a patient's reviews from one insurer to another
- Ability to create special studies with user-defined questions and responses
- Ability to view MPI, medical records, and insurance information via PC-based information windows

- Streamlined screens and menus for easy entry of and access to patient data
- Ability to create SQL reports since all UM data elements are mapped
- Ability to separately control purging of UM data and special studies information

This reference guide contains the following chapters:

Chapter 1: UM Maintenance

This chapter provides information on UM Maintenance functions. Elements, components, exceptions, readmission criteria, parameter maintenance, and report parameters are discussed in this chapter.

Chapter 2: UM Options

This chapter provides information on the following UM options: UM Review, Special Studies, Medical Records information, and Clinical Data inquiry.

Chapter 3: UM Batch Reports

This chapter provides information on and samples of the UM Admissions/Revisions Report, the UM Readmission Report, and the UM Worksheet.

Chapter 4: UM Online Demand Reports

This chapter provides information on the UM demand reports that can be created via online processing.

Appendix A: Information Windows

This chapter provides information on using Information Windows, which display patients' medical information, physicians of record, insurance information, and pharmacy information.

Chapter 1 - UM MAINTENANCE

Illustrations

INTRODUCTION

Many of the processes performed in the Utilization Management Department are dictated by needs of the internal organization as well as by industries outside of the healthcare facility. Third-party payors, Medicare, Medicaid, Worker's Compensation Program, Rate Review Boards, etc., all have information needs that are often the responsibility of the UM Coordinator. These include, but are not limited to, the following:

- Contract managed care organizations requiring third-party payor review
- Concurrent screening for other areas of the facility (for example, QA, Risk Management, Medical Records, Admissions, Business Office)
- Preadmission screening
- Outpatient requirements
- Management of resource consumption during the patient stay
- Complying with Uniform Clinical Data Systems (UCDS)
- Use of ancillary departments in defining patient management
- Monitoring of medically indigent patients
- Determination of patient's social/psych needs and legal implications thereof
- Determination of when care can be given at a lower level outside of the acute setting
- Discharge planning that begins at the time of admission or preadmission
- Determination of who requires review

OVERVIEW OF SCREENING CRITERIA AND PARAMETERS

The process of screening admissions to the facility requires comparison of the patient's information with a set of criteria of similar information. The goals of the screening are to prevent financial loss by the facility and improve the process of patient care.

To determine which patients require review, the UM Coordinator must pass each patient through a set of screening criteria. It is unrealistic and unproductive for the coordinator to manually perform this screening every day on every patient admitted to the facility, thus automation of this process is essential.

In automating the screening criteria and related functionality, the following items are included in the UM Module to increase flexibility and ease of use:

- The ability for each facility to select inclusion/exclusion components. The system includes a screen of elements comprised of a sublist of existing STAR tables and data elements. You can indicate for each of these elements which components include or exclude a patient from the Utilization Management Census.

- The ability to enter multiple selections on any of the elements with a table lookup. Many of the elements access existing STAR tables.

- The ability to enter exceptions for each of the elements. Exceptions are instances where a patient's record contains a combination of information that prevents them from being included in or excluded from the UM Census.

- Nightly system checks of in-house patients' log records against the criteria. Changes made to a patient's data or status could result in the system changing the patient's status from inclusion to exclusion and vice versa.

- A manual override function to manually include a patient in the UM Census. After a patient is manually added to the census, they must be manually changed again if necessary. After a patient's status is manually manipulated, the patient does not pass through the criteria again during Midnight Processing as outlined previously. An indicator displays on the UM Admission/Revision Report to indicate manual inclusion. A patient can be removed from the UM Census at any time by marking the UM Abstract complete.

- Module parameters that include purging of data, trigger for next review date, and sorts for batch reports.

- The ability to set up readmission criteria. The Readmission Selection Criteria option enables the customer to define the current patient type, the previous patient type, and the number of days between the two visits that causes the patient to be considered a readmission.

- A report to display the patients who meet any of the readmission criteria. This report is discussed in the UM Batch Reports chapter of this document.

DEFINITION OF ELEMENTS, COMPONENTS, EXCEPTIONS

Element - an element is a piece of data that currently exists in the STAR system. An element is either an existing table or a data item commonly found in the patient's record. Elements that are tables are defined STAR tables, such as financial class, employer, insurance plan, medical service, nursing station, etc. Elements can also be data items in the patient's record, such as age, DRG, or ICD code. In the Inclusion/ Exclusion Selection Criteria of UM Maintenance, there are 13 predefined elements.

Component - a component is a piece of data that relates to an element. The component is either an existing table entry or data item found in the patient's record. Components that are table entries have been defined by the customer in a STAR table. For example, for the element financial class, the only possible components are those financial classes in the facility's STAR Financial Class table. Components that are data items in the patient's record must match the defined components of the elements mentioned above. For example, if the data item is the patient's age, then the component of the element Age should be an age range (i.e., 55-70) or a specified age.

Exception - an exception encompasses both elements and components. An exception must be a data item that is defined as an element, and the component of the exception must match the element as illustrated in the examples above.

Readmission - a readmission is defined by patient type and is determined by comparing the current patient type to the previous patient types within a defined time period.

NOTE: The following illustrations use scrolling screens. For detailed information on using scrolling screens, please refer to Chapter 4, Information Entry Techniques, in the *STAR Patient Care Reference Guide, General Information Volume*.

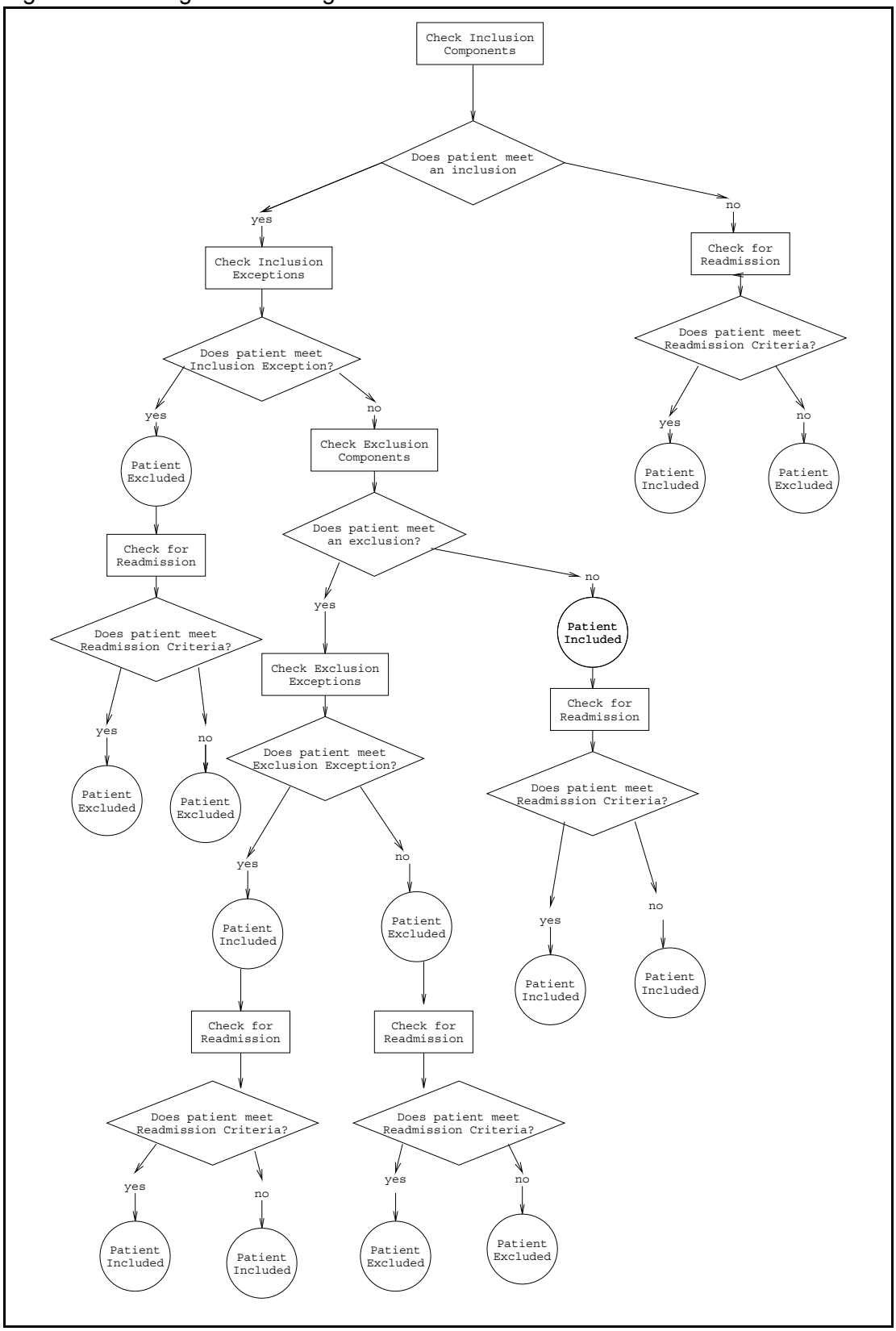
LOGIC OF ELEMENTS, COMPONENTS, EXCEPTIONS

The following is an example of how elements, components, exceptions, and readmissions work together:

```
Element         Inclusion Components          Exclusion Components
Age             >64                           13
DRG
DRG Payor
Diagnosis
Employer        180,500,400
Fin Class       Medicare, Medicaid, Champus   Blue Cross, Comm
Ins Carrier
Ins Plan
Nursing St
Pt Type         I/P, OBS, OPO, MIA
Physician       155
Procedure
Service

Inclusion Exceptions
Element         Component & Element    Component
Physician       155       & Procedure  60

Exclusion Exceptions
Element         Component & Element    Component
Age             13        & Service    OBS

Readmission Criteria
Current Patient Type    Previous Patient Type    Days Between
 I/P                     I/P                      30
 I/P,ER,OPO,SDS          SDS,OPO,OP,ER            3
```

In this example, there are defined inclusion and exclusion components, inclusion exceptions, exclusion exceptions, and readmission criteria. The flow chart in Figure 1.1 illustrates what takes place during Midnight Processing.

Figure 1.1 Midnight Processing Flow Chart for UM



Explanation of Midnight Processing Flow Chart for UM:

1. The system checks a patient's data against the inclusion components for the first element (Age). If the first element does not have associated components, it checks the next element. The system continues checking the patient's data against the inclusion elements until it matches a component. The patient can be included if only one component matches the patient's data.

2. If the patient does not meet any inclusion components, the system **does not** check the patient's record against the exclusion components, regardless of whether the patient's record contains any data to cause exclusion. However, the system does check the patient against the readmission criteria. If the patient meets the readmission criteria but also meets exclusion criteria, the patient is not added to the UM Census; however, the patient prints on the Readmission Report.

3. If the patient's data does match an inclusion component, the system immediately checks for inclusion exceptions for that element.

4. If there are no inclusion exceptions for the element, the system returns to checking for inclusion components. If inclusion exceptions exist for the element, the system checks the patient's record to determine if it qualifies as an inclusion exception. If the patient is an inclusion exception, the patient is excluded from the UM Census, and the system does not continue to check this patient against the remaining elements and components. However, the system does check the patient against the readmission criteria. In this case, even if the patient meets the readmission criteria, they are still excluded from the UM Census, but are included on the UM Readmission Report. If the patient is not an inclusion exception, the system repeats steps 1-4 until it has checked the patient's record against all inclusion components and possible exceptions.

5. If the patient matches any inclusion components, but no inclusion exceptions, the system checks the patient's record against the exclusion components.

6. If the patient's record matches an exclusion component, the system immediately checks for exclusion exceptions for the same element.

7. If there are noexclusion exceptions for the element, the system continues checking for exclusion components. When the system matches another exclusion, the system immediately checks for exclusion exceptions for the element and whether the patient's record qualifies as an exclusion exception. If the patient matches an exclusion exception, the patient is included in the UM Census, and the system does not continue to check this patient against the remaining exclusion elements and exceptions. However, the system does check the patient against the readmission criteria.

8. If the patient matches an exclusion component but no exclusion exceptions, the patient is excluded from the UM Census. The system then checks the patient's record against the readmission criteria. If the patient qualifies as a readmission,

the patient is excluded from the UM Census, but still displays on the UM Readmission Report because the patient met the readmission criteria. If the patient does not qualify as a readmission, the patient is not included in the UM Census and is not on the UM Readmission Report.

Summary:

- A patient is not checked against the exclusion components if the patient does not meet an inclusion component.
- Every patient is checked against the readmission criteria.
- Once a patient meets an inclusion exception, the patient is not in the UM Census regardless of what other inclusions are met.
- Once a patient meets an exclusion exception, the patient is in the UM Census regardless of what other exclusions are met.
- If a patient who qualifies as a readmission does not meet any inclusion components, then no exclusion components can be met.
- Discharged patients are not checked against the Inclusion/Exclusion criteria.

After you select the UM Maintenance option, the following submenu displays:

```
                General Hospital UM Maintenance Processor
                                                Tue Sep 16, 2003 02:24 pm
UM Maintenance Input Options

            Option No.  Option
            ---------------------------------------
                1       Element/Component Selection
                2       Inclusion Exception Selection
                3       Exclusion Exception Selection
                4       Readmission Criteria Selection
                5       Parameter Maintenance
                6       Report Parameters









Enter option number--
```

The functions on this submenu are discussed in this chapter.

ELEMENT/COMPONENT SELECTION

This function is used to define the components that cause the patient to be included in or excluded from review. When you select this option, the first Element/Component Selection screen is displayed:

```
             General Hospital Element/Component Selection Processor
                                                  Tue Apr 06, 1999 10:32 am
Element          Criteria Defined                                          *
Age In           >64
    Out          <14
DRG In           107-109,014
    Out
DRG Payor In     M
          Out
Diagnosis In     25000-25099,650,486,600,496
          Out
Employer In      123456,0009,998765
         Out     ASDF98,1
Fin Class In     B,C,H,K,M,O,W
          Out    S
Ins Carrier In
            Out
Ins Plan In      100100,100200,100300,123012,123001,123002,123003,123123,12,more
         Out
Nurse Sta In
          Out
Patient Type In  OPO,OPS,I/P
                     Enter a "*" to delete the entire entry.
               F1Prev Page F2Next Page F6 Reset  F7  Exit   ?
```

Pressing F2 displays the second screen (you can also scroll to see these fields):

```
General Hospital Element/Component Selection Processor
                                                  Tue Apr 06, 1999 10:38 am
Element          Criteria Defined                                          *
            Out DIA,ER,LTC,MH,OB,OP
Physician In
          Out
Procedure In
          Out
Service In
        Out      ERS,NUR,OBS,PED









                     Enter a "*" to delete the entire entry.
               F1Prev Page F2Next Page F6 Reset  F7  Exit   ?
```

These screens list the elements that are used to indicate inclusion and exclusion screening criteria. The In components are included, and the Out components are excluded. Each component is modified by using the cursor to move to that field.

NOTE: The asterisk (*) in the top right corner of the screen indicates the maximum amount of data that can be entered or displayed on any line. This maximum applies only to fields where a table lookup is not available or the table codes are entered directly into the field instead of selected from the table lookup.

The following fields have an associated table lookup: DRG Payor, Employer, Financial Class, Insurance Carrier, Insurance Plan, Nurse Station, Patient Type, Physician, and Service.

The number of entries that can be accepted into the Age, DRG, Diagnosis, and Procedure fields is based on the number of entries that can display. For the remainder of the fields, the number of entries that can be selected from the table controls the number of entries in the field. The amount of entries that can be selected vary by component, depending on the length of the code in the associated user-defined code tables. For example, financial class codes are one to two characters in length, whereas physician codes can be up to six characters.

You can enter an asterisk (*) while the cursor is in any field to delete the entire entry in that field.

All codes must be entered on this screen exactly as they exist in the user-defined tables. If you enter an invalid code, the system displays the following message:

Error: Use '-' for table--

Enter a hyphen (-) to access the appropriate table of valid codes.

Please refer to the Information Entry Techniques chapter of the *STAR Patient Care Reference Guide, General Information Volume* for additional information on using scrolling screens.

Field Explanations

AGE
This data element indicates an age or age range of patients to be included in or excluded from the UM Census. The system checks this against the age of the patient at the time of admission.

DRG
This data element indicates DRGs that determine if a patient is included in or excluded from the UM Census. The system checks these against the Provisional DRG. Separate the entry of more than one DRG by a comma (for example, 127,096,211).

DRG PAYOR
This data element indicates the DRG Payors that determine if a patient is included in or excluded from the UM Census. The system checks these against the DRG Payor associated with the primary financial class. The system prevents you from selecting the same payor for both the In and Out field. Enter the DRG Payor code(s) if you know it (separated by commas if you enter more than one code), or press hyphen (-) followed by ENTER to display the DRG Payor table for selection.

DIAGNOSIS
This data element indicates the ICD Diagnosis Codes that determine if a patient is included in or excluded from the UM Census. The system checks these against the UM Working Diagnosis found in the UM Abstract. Enter diagnosis code(s), and/or range of codes, separated by commas. You need only enter the first three digits of the diagnosis code (i.e., the numbers to the left of the decimal) since the system checks only the first three digits of the UM Working Diagnosis. For example, if you are using diabetes as an exclusion, enter 250.

EMPLOYER
This data element indicates the employer code(s) that determines if a patient is included in or excluded from the UM Census. The system checks this against the patient and guarantor employer codes in the patient's record. The system prevents you from selecting the same code for both the In and Out fields. Enter the employer code(s) if you know it (separated by commas if you enter more than one code), or press hyphen (-) and ENTER to display the Employer table for selection.

FINANCIAL CLASS
This data element indicates the financial class code(s) that determines if a patient is included in or excluded from the UM Census. The system checks this against the primary financial class in the patient's record. The system prevents you from selecting the same code for both the In and Out fields. Enter the financial class code(s) if you know it (separated by commas if you enter more than one code), or press hyphen (-) followed by ENTER to display the Financial Class table for selection.

INSURANCE CARRIER
This data element indicates the insurance carrier code(s) that determines if a patient is included in or excluded from the UM Census. The system checks this against the first four insurance carriers in the patient's record. The system prevents you from selecting the same code for both the In and Out fields. Enter the insurance carrier code(s) if you know it (separated by commas if you enter more than one code), or press hyphen (-) followed by ENTER to display the Insurance Carrier table for selection.

INSURANCE PLAN
This data element indicates the insurance plan code(s) that determines if a patient is included in or excluded from the UM Census. The system checks this against the first four insurance plans in the patient's record. The system prevents you from selecting the same code for both the In and Out fields. Enter the insurance plan code(s) if you know it (separated by commas if you enter more than one code), or press hyphen (-) followed by ENTER to display the Insurance Plan table for selection.

NURSING STATION
This data element indicates the nursing station that determines if a patient is included in or excluded from the UM Census. The system checks this against the current location of the patient. The system prevents you from selecting the same code for both the In and Out fields. Enter the nursing station code(s) if you know it (separated by commas if you enter more than one code), or press hyphen (-) followed by ENTER to display the Nursing Station Code table for selection.

PATIENT TYPE
This data element indicates the patient type that determines if a patient is included in or excluded from the UM Census. The system checks this against the current patient type of the patient. The system prevents you from selecting the same code for the In and Out fields. Enter the patient type code(s) if you know it (separated by commas if you enter more than one code), or press hyphen (-) followed by ENTER to display the Patient Type table for selection.

PHYSICIAN
This data element indicates the physician(s) that determines if a patient is included in or excluded from the UM Census. The system checks this against the attending physician of record. The system prevents you from selecting the same code for the In and Out fields. Enter the physician's code if you know it (separated by commas if you enter more than one code), or press hyphen (-) followed by ENTER to display the Physician table for selection.

PROCEDURE
This data element indicates the ICD Procedure Code that determines if a patient is included in or excluded from the UM Census. The system checks this against the procedure code found in the Surgery Scheduled field of the MPI & UM Abstract (in the Miscellaneous screen). You need only enter the first two digits of the procedure code (i.e., the numbers to the left of the decimal). For example, if you are using prostatic procedures, you need only enter 60. If you are entering more than one code, separate the codes by commas.

SERVICE
This data element indicates the hospital service that determines if a patient is included in or excluded from the UM Census. The system checks this against the service of record. The system prevents you from selecting the same code for the In and Out fields. Enter the service code(s) if you know it (separated by commas if you enter more than one code), or press hyphen (-) followed by ENTER to display the Hospital Service table for selection.

After you complete all fields on this screen, press the **F7** key to accept the information. After you accept the screen, the UM Maintenance menu redisplays.

INCLUSION EXCEPTION SELECTION

This function is used to indicate to the system the elements and components that set up an exception to a patient being included in the UM Census. It is not required that exceptions be set up; however, when they are, you must associate two elements and components together to form an "if and" statement. On the following sample screen, the system reads the first set of elements as: "If this patient's record contains an age of >64 **and** a diagnosis code of 650, this patient is an exception to being included and thus is excluded."

You cannot set up a single element and component as an exception since that only duplicates the criteria set up on the Element/Component Selection screen.

After you select the Inclusion Exception option, the following screen is displayed:

```
          General Hospital Inclusion Exception Selection Processor
                                              Wed May 07, 1997 01:22 pm


Element              Component       &  Element              Component
01-Age               >64                04-Diagnosis        650
```

F1Prev Page F2Next Page F4 Delete F6 Reset F7 Exit ?

NOTE: When you enter this screen for the first time, **no** elements or components are displayed. You enter this information.

The information on this screen indicates the elements and associated components that are used in nightly processing to determine if a patient's record contains data that may set up an exception to the already established inclusion components.

The system checks for an inclusion exception on each element for which the patient may be included. If the patient matches an inclusion exception component, the patient is excluded.

Field Explanations

ELEMENT
This field is used for entry of any of the 13 elements from the UM Element table. Enter the element code if you know it, or press hyphen (-) and ENTER to display the UM

Element table for selection. This is a hard-coded table and cannot be manipulated by the facility.

COMPONENT
This field is used for entry of the component(s) associated with the element in the previous field. Refer to the Element/Component Selection Process screen Field Explanations for information on how to complete this field for the selected element.

You can set up as many as five exception statements (using two elements for each "and/if" statement). For each element in the statement, you can enter/select up to three components. Press **F4** to delete an entire statement.

NOTE: When setting up inclusion exception statements, the first component defined must also be defined in the inclusion column of the Element/Component Selection screen or the system does not recognize it as an exception.

After you finish making entries, press **F7** to exit this screen. The system displays the message *Filed!* and the UM Maintenance menu is redisplayed.

EXCLUSION EXCEPTION SELECTION

This function is used to indicate to the system those elements and components that set up an exception to a patient being excluded from the UM Census. It is not required that exceptions be set up; however, when they are, you must associate two elements and components together to form an "if and" statement. On the following sample screen, the system reads the first set of elements as: "If this patient's financial class is Blue Cross **and** the record contains DRG 128, this patient is an exception to being excluded, and thus included."

You cannot set up a single element and component as an exception since that only duplicates the criteria set up in the Element/Component Selection screen.

After you select the Exclusion Exception Selection option, the following screen displays:

```
          General Hospital Exclusion Exception Selection Processor
                                                Wed May 07, 1997 03:48 pm


Element             Component     &     Element              Component
06-Financial Class  B                   02-DRG               128









         F1Prev Page F2Next Page F4 Delete  F6 Reset  F7  Exit   ?
```

NOTE: When you enter this screen for the first time, **no** elements or components are displayed. You enter this information.

The information on this screen indicates the elements and associated components that are used in determining if a patient's record contains data that may set up an exception to the already established exclusion components.

The system checks for an exclusion exception on each element for which the patient may be excluded. If the patient matches an exclusion exception component, the patient is included.

Field Explanations

ELEMENT (TABLE LOOKUP)
This field is used for entry of any of the 13 elements from the UM Element table. Enter the element code if you know it, or press hyphen (-) and ENTER to display the UM Element table for selection. This is a hard-coded table and cannot be manipulated by the facility.

COMPONENT (TABLE LOOKUP)
This field is used for entry of the component(s) associated with the element in the previous field. Refer to the Element/Component Selection Process screen Field Explanations for information on how to complete this field for the selected element.

You can set up as many as five exception statements (using two elements for each "and/if" statement). For each element in the statement, you can enter/select up to three components. Press **F4** to delete an entire statement.

NOTE: When setting up exclusion exception statements, the first component defined must also be defined in the inclusion column of the Element/Component Selection screen or the system does not recognize it as an exception.

After you finish making entries, press **F7** to exit this screen. The system displays the message *Filed!* and the UM Maintenance menu redisplays.

READMISSION CRITERIA SELECTION

This function is used to indicate to the system under what conditions a patient is considered to be a readmission. It is not required that you establish readmission criteria. Even if a patient meets the readmission criteria, they are not automatically included in the UM Census because the patient still must pass the other selection and exception criteria. However, if a patient is not included or excluded based on the criteria, but does match a readmission, they are included in the UM Census. Patients who match the readmission criteria display on the UM Readmission Report regardless of whether or not they are included in the UM Census (which prints during Midnight Processing). Patients manually added are not compared to the readmission criteria.

After you select Readmission Criteria Selection, the following screen displays:

```
              General Hospital Readmission Criteria Selection Processor
                                                 Fri Aug 31, 2001 02:17 pm



Current Patient Type                Previous Patient Type      Days Between
 I/P                                PSY                        5
 I/P                                ER                         3

















         F1Prev Page F2Next Page F4 Delete  F6 Reset  F7  Exit   ?
```

When you first enter this screen, no patient types or days between display.

This screen enables you to define under what conditions a patient is considered a UM readmission. This sample screen provides the following example of the readmission logic:

- If a patient's current patient type is I/P, and
- The patient had a previous ER patient type visit, and
- The visits occurred within three days of each other, then

  the patient is considered a UM readmission.

Field Explanations

CURRENT PATIENT TYPE (TABLE LOOKUP)
This field indicates the patient type of the current episode of care that causes evaluation for readmission. Enter the patient type code if you know it, or press hyphen (-) and ENTER to display the Patient Type table for selection. You can select up to five patient types for this field. To change your selections, access the field and update your table selections.

PREVIOUS PATIENT TYPE (TABLE LOOKUP)
This field indicates the patient type of a previous episode of care that when compared to the current patient type causes evaluation for readmission (if it occurs in the defined time frame). Enter the patient type code if you know it, or press hyphen (-) followed by ENTER to display the Patient Type table for selection. You can select up to five patient types as necessary to complete this field. To change your selections, access the field and update your table selections.

DAYS BETWEEN (2-N-R)
This field indicates the number of days between the current episode of care and the previous episode of care within the timeframe that causes evaluation for readmission.

You can enter up to four sets of readmission criteria. If you select a current patient type, you must complete all fields.

After you complete and accept this screen, the UM Maintenance menu is redisplayed.

PARAMETER MAINTENANCE

The Parameter Maintenance option is used to define other processing information. When you select this option, the following screen displays:

```
              General Hospital Parameter Maintenance Processor
                                                 Fri Apr 07, 2000 03:49 pm

( 1)UM Abstract Retention    : 100
( 2)Special Study Retention  : 3
( 3)Fax Audit Retention      : 100
( 4)Automatic Worksheet      : Yes
( 5)Next Review Date         : No
( 6)Complete on Discharge    : Yes









Enter field number or '/' starting field number--
```

Field Explanations

1. UM ABSTRACT RETENTION (4-N-R)
This field indicates the number of days all information in the UM Abstract is to be retained on the system. The purge counter begins when the UM abstract is marked complete. When you access this field, the following prompt displays:

Enter number of days for UM Abstract retention--

The more days you retain this information in the system, the greater the effect on disk space and time required for Midnight Processing.

NOTE: The number of days entered in this field cannot be less than that in the Fax Audit Retention field.

2. UM SPECIAL STUDY RETENTION (4-N-R)
This field indicates the number of days the UM Special Study information is to be retained on the system. The purge counter begins on the date the UM Special Study data is entered for the patient. Once the information is purged off the system, it is no longer available for viewing or reporting. When you access this field, the following prompt displays:

Enter number of days for UM Special Study retention--

The more days you retain this information in the system, the greater the effect on disk space and time required for Midnight Processing.

3. FAX AUDIT RETENTION (4-N-O)
This field indicates the number of days (from the date the fax was generated) fax audit data should be retained. This data is used on the UM Faxing Audit Report.

NOTE: The number of days entered in this field cannot be greater than that in the UM Abstract Retention field.

4. AUTOMATIC WORKSHEET (1-A-R)
This field indicates if a UM Worksheet continues to print for a patient until the initial review is performed. This applies only to patients who have met the appropriate criteria to print on the worksheet. When you access this field the following prompt displays:

Print patient on list until initial review has been done? (Y/N)--

If you enter **Y** for Yes, a UM Worksheet continues to print (daily) for a patient until the initial review is performed. From that point on, the patient prints on the worksheet based on the date of the next review. If you enter **N** for No, patients only print on the worksheet the first day after admission. It is helpful to continue to print patients on the worksheet until the initial review when there is not seven day coverage in the UM Department.

5. NEXT REVIEW DATE (1-A-R)
This field contains a Y/N flag and indicates to the system how a patient's next review date is calculated. When you enter this field, the following prompt displays:

Does Certified Days indicate next review date? (Y/N)--

If you enter **Y** for Yes, you are indicating to the system that the Certified Days field (in the Add/Edit Review screen) added to the review date create the next review date. If you enter **N** for No, you are indicating to the system that the Day Till Next Review field (in the Add/Edit Review screen) added to the review date create the next review date.

If you enter Yes and no certified days are entered (in the Add/Edit Review screen), the system automatically places one day in the Days Certified field and calculates the next review date.

6. COMPLETE ON DISCHARGE (1-A-R)
This field indicates whether a patient's discharge automatically marks the UM abstract complete. When you access this field, the following prompt displays:

Does a discharge date automatically mark the abstract complete? (Y/N)--

If you enter **N** for No, the UM abstract must be manually completed by entering C for complete at the appropriate prompt within the Review function. If you enter **Y** for Yes,

the UM abstract is automatically marked complete during the first Midnight Processing after the patient is discharged. When the system marks the UM abstract complete, the complete date is filled in on the header information, however, the initials of the person completing the abstract are substituted with three asterisks (***).

If you enter **Y** for Yes, manually added abstracts are automatically marked complete during the first Midnight Processing after the patient is discharged. Once the system has marked the UM Abstract complete, a UM Worksheet does not print based on the Next Review Date in the Add/Edit Review function.

If the patient is discharged after a one-day visit, the system prints a UM Worksheet the day after discharge if the patient's visit was not included on previous Midnight Processing worksheets and the patient meets the inclusion criteria.

REPORT PARAMETERS

The Report Parameters function is used to define sorts and paging for the UM reports that are processed and printed during Midnight Processing. The online UM reports have sort options that are selected at the time the report is created.

When you select this option, the following screen displays:

```
                General Hospital Report Parameters Processor
                                                Wed Jul 01, 1992 03:49 pm

( 1)UM Worksheet Sort Option         : Insurance
( 2)One patient per page             : No
( 3)Readm. Report Sort Option        : Patient Name
( 4)Page Breaks                      : No









Enter field number or '/' starting field number--
```

Field Explanations

UM WORKSHEET SORT OPTION (1-A-R)
This field applies to the nightly printing of the UM Worksheet. When you access this field, the following prompt displays:

Sort by 'N'urse Station, 'P'atient Type, 'I'nsurance--

Select one of the following options:

- Enter **N** to indicate the worksheets should be sorted by nursing station. If a patient has been discharged, the patient's worksheet prints at the beginning of the report in account number order since no nursing station exists. If the patient is not in a nursing station, the patient's worksheet prints at the beginning of the report as well. Patients in a bed sort in the order of station, then room.

- Enter **P** to indicate the worksheets should be sorted based on the patient type and account number.

- Enter **I** to indicate the worksheets should be sorted by insurance carrier. Patients without a carrier and plan print at the beginning of the report in account number order.

The sort option for the UM Worksheet can be changed by the UM Department.

ONE PATIENT PER PAGE (1-A-R)
This field indicates whether or not the UM Worksheet should print one patient per page. When you access this field, the following prompt displays:

Print one patient per page? (Y/N)--

Select one of the following options:

- Enter **Y** to indicate the UM Worksheet should only contain one patient per page as opposed to continuously printing patients. If a worksheet for one patient requires more than one page, the system page breaks prior to printing the worksheet for the next patient.

- Enter **N** to indicate the UM Worksheet should print as many patients as possible on one page. If a worksheet for one patient requires more than one page, the system prints the worksheet for the next patient immediately following without a page break in between.

READM. REPORT SORT OPTION (1-A-R)
The UM Readmission Report is created during Midnight Processing, and based on the information you enter here, the system determines the sort of the report.

When you access this field, the following prompt displays:

Sort by 'N'urse Station, 'P'atient Name, 'A'ttending Physician, or 'F'in Class--

Select one of the following options:

- Enter **N** to indicate the report should be sorted by nursing station. If a patient has been discharged or is not in a nursing station, the patient displays at the beginning of the report.

- Enter **P** to indicate the report should be sorted in alphabetical order by the patient's last name .

- Enter **A** to indicate the report should be sorted in alphabetical order by the last name of the attending physician.

- Enter **F** to indicate the report should be sorted by the primary financial class code.

The sort option for the UM Readmission Report can be changed by the UM Department.

PAGE BREAKS
This field is used to indicate whether or not the Readmission Report should contain a page break between each change in the element of the sort option (in other words, a page break between each nursing station, attending physician, or financial class). If the sort option you select is P for patient name, it maybe unnecessary to place a page break between each patient. When you access this field, the following prompt displays:

Page break between sort elements? (Y/N)--

Select one of the following entry options:

- Enter **Y** to indicate the UM Readmission Report should contain a page break when the element on which it is sorting changes.
- Enter **N** to indicate the UM Readmission Report should not contain a page break when there is a change in the element on which it is sorting.

Chapter 2 - UM OPTIONS

Illustrations

HEADER INFORMATION

The following information displays on most of the UM screens' headers:

- Account number
- Patient name
- Unit number
- Birthdate with age display
- Sex
- Admission date
- Attending physician
- Patient type
- Diagnosis
- Length of stay
- Financial class
- Number of insurance plans
- Days certified
- Nursing station/room/bed
- Complete date with initials
- Total number of reviews

The following is an example of how information in the full header displays:

```
Account No     Name                                Unit Number   Birthdate
0219100002     TANNER,CHARLES                      000-00-2308   12/17/87 14Y
Sex  Adm Date  Attending Dr           Pt Type  Diagnosis                    LOS
M    07/10/02  ADAIR,FRANK C         I/P      540.9-ACUTE APPENDICITIS NO  40
F/C #Plans Cert Days Nurse Sta/Rm/Bd    Comp Date/Init # Revs
M    2     1         *HOME OR SELF CARE                 1
```

Field Explanations

ACCOUNT NO (DISPLAY ONLY)
This is the account number associated with this patient's current episode of care.

NAME (DISPLAY ONLY)
This is the name of the patient. The header displays up to 25 characters of the name in the order of last,first,middle.

UNIT NUMBER (DISPLAY ONLY)
This is the unit number of the patient for this facility.

BIRTHDATE (DISPLAY ONLY)
This is the birthdate of the patient followed by the patient's age.

SEX (DISPLAY ONLY)
This is the patient's gender and displays as M or F.

ADM DATE (DISPLAY ONLY)
This is the admission date of the current episode of care for this patient.

ATTENDING DR (DISPLAY ONLY)
This is the attending physician for the patient as entered during the admission process. Up to 25 characters of the physician's name displays in the order of last,first,middle.

PT TYPE (DISPLAY ONLY)
This is the current patient type for this episode of care. If the patient type changes, this field is updated accordingly.

DIAGNOSIS (DISPLAY ONLY)
This is the ICD code description that corresponds to the working diagnosis of the patient. When the UM Coordinator updates the UM working diagnosis, this data item is updated as well.

LOS (DISPLAY ONLY)
This is the current length of stay for this episode of care.

F/C (DISPLAY ONLY)
This is the primary financial class for this episode of care. If there is a change in the primary payor, this field is updated accordingly. Once the patient is discharged, further changes to the financial class do not update this field. This is to indicate the financial class under which this patient's reviews were determined.

#PLANS (DISPLAY ONLY)
This indicates the number of insurance plans for this patient's episode.

CERT DAYS (DISPLAY ONLY)
This indicates the combined total number of certified days entered for all insurance plans. As reviews are entered and certified days are added, this number increases accordingly.

NURSE STA/RM/BD (DISPLAY ONLY)
This is the current location of the patient including the nursing station, room and bed. Once a patient is discharged, this field contains the patient's discharge disposition.

COMP DATE/INIT (DISPLAY ONLY)
This field displays the date the UM Abstract is marked complete and the initials of the person completing the abstract. If the patient is still in-house and the abstract is not complete, this field is blank. If the abstract is marked complete by the system (on discharge), the initials are three asterisks (***).

 # REVS (DISPLAY ONLY)
This indicates the total number of reviews done on this patient to date. As the number of reviews changes, this field updates accordingly.

When you select the Utilization Management Functions from the Abstracting, DRG & UM Functions menu, the following displays:

```
         General Hospital Utilization Management Functions Processor
                                                 Wed Aug 21, 2002 04:10 pm
Utilization Management Functions Input Options

            Option No.  Option
            ---------------------------------------
                1       Utilization Management Functions
                2       Reports
                3       UM Maintenance









Enter option number--
```

Select Utilization Management Functions, and the following submenu is displayed:

```
             General Hospital Utilization Management Functions Processor
                                                Wed May 08, 2002 01:01 pm

Utilization Management Functions Input Options

            Option No.  Option
            ----------------------------------------
                1       Review
                2       View Review
                3       Print Review
                4       Transfer Review
                5       Copy Review
                6       Fax Review
                7       Special Studies
                8       Medical Records
                9       Clinical Data
               10       Print Form




Enter option number--
```

REVIEW

If you select the Review option from the previous submenu, the standard MPI patient lookup prompt displays for selection of a patient. If you select a patient that is not in the UM Census, the following prompt displays:

Add this patient to UM Census? (Y/N) [N]--

Select one of the following entry options:

- Press ENTER to accept the default **N** for No, and the MPI patient lookup prompt redisplays for selection of another patient.
- Enter **Y** for Yes and press ENTER to indicate that this patient is being manually added to the UM Census. The reason for manual inclusion in the UM Census can be entered in the Add/Edit Review Processor screen. Your UM Criteria Met table should include codes and descriptions that define manual inclusion criteria.

  NOTE: Once a patient is manually added to the census, the patient remains active in the census until the UM Abstract is marked complete. Once manually added, the system only processes the patient against the UM Readmission Criteria during Midnight Processing, regardless of the changes made to the patient's record.

If you are utilizing the PC-based Information Windows and you select a patient account, the system downloads the information and the following message displays:

Downloading Information Windows....Please wait!

For more information on Information Windows, refer to Appendix A - INFORMATION WINDOWS in this manual.

After you select a patient or manually add a patient to the UM Census, the following submenu is displayed:

```
        General Hospital Utilization Management Functions Processor
                                                Wed May 08, 2002 09:24 am
Utilization Management Functions Input Options

            Option No.  Option
            ----------------------------------------
                1       Add/Edit Review
                2       Miscellaneous Review Information
                3       Avoidable/Non-Covered Days
                4       UM Contact to Physician
                5       UM contact to Advisor
                6       Discharge Planning
                7       UB Non-Covered Days Summary
                8       UB Condition Codes
                9       UB Occurrence Codes
               10       Alternate Level of Care Information
               11       View/Print Elec Rpts




Enter option number--
```

All screens accessed on this submenu comprise the UM Abstract for the selected patient. The View/Print Elec Rpts option allows you to view and/or print the electronic reports that have been transcribed for the selected patient if the transcription interface is active at your facility. See page 2-63 for information on this function.

Add/Edit Review

If you select the menu option Add/Edit Review, a screen similar to the following is displayed:

```
              General Hospital Add/Edit Review Processor
                                                Thu Aug 22, 2002 01:26 pm
Account No     Name                             Unit Number   Birthdate
0219100002     TANNER,CHARLES                   7             12/17/87 14Y
Sex  Adm Date  Attending Dr           Pt Type  Diagnosis                    LOS
M    07/10/02  ADAIR,FRANK C          I/P      540.9-ACUTE APPENDICITIS NO  40
F/C #Plans Cert Days Nurse Sta/Rm/Bd    Comp Date/Init # Revs
M    2     1         *HOME OR SELF CARE                  1
Page 01PLAN                  PHONE #        APPROVAL #       REF #      V  C
     APPR LOS REVIEW AGENCY                 PHONE #        CONTACT NAME
( 1) MEDICARE PART A         (404)698-5512  APPROVALNUMBERX              Y
     5        MEDICAL REVIEWERS OF GA X     (404)987-6543  CONTACT NAME GOES HX
( 2) MEDICARE PROFESSIONAL CO(404)698-5512POAPPROVALNUMBERXENT           Y  Y
     5        MEDICAL REVIEWERS OF GA X     (404)987-6543  CONTACT NAME GOES HX
( 3) CHAMPUS                 (404)888-8888  APPROVALNUMBERX
     5        CHAMPUS REVIEWERS OF GA X     (404)837-4837  CONTACT NAME GOES HX
( 4) BLUE CROSS GEORGIA POWER(404)123-4567                               Y  Y
              BLUE CROSS REVIEWERS OF X     (404)234-5123  JANICE SMITH-OMALLEY


Select Insurance Plan to add or edit review--
```

This screen displays the insurance plans associated with this patient. The screen displays the plans in the order of claim responsibility as determined at the time of admission or as updated by the business office. The information on this screen is display only and cannot be edited.

Field Explanations

PLAN
This field displays the insurance plan(s) associated with this patient. The plan(s) that displays is that which was entered during the admission process or updated by the business office.

PHONE #
This field displays the contact phone number associated with this insurer and plan.

APPROVAL #
This field displays the approval number given by the insurer for this episode.

REF #
This field displays the reference number given by the outside review agency when making inquiries on this case.

V
This field indicates whether this plan requires verification of a patient's visit to the facility. The Y or N that displays indicates whether the verification has been done.

C
This field indicates whether this plan requires certification of a patient's visit to the facility and the current status of that certification. NR is displayed if the plan does not require certification. Pre is displayed if the plan requires certification and a Notified Date has been entered, but an Approval Date has not been entered on the Plan Demographics page of the Insurance Process. Y is displayed if the plan requires certification, and both a Notified Date and an Approval Date have been entered on the Plan Demographics page. N is displayed if the plan requires certification and neither a Notified Date nor an Approval Date have been entered.

APPR LOS
This field displays the approved length of stay (LOS) for the primary insurance entered in the insurance information screen during the admission process. This is the approved LOS determined by the insurer for the specified plan. If this field is not completed during the admission process, it is blank here. This information can be updated for the primary insurance plan via the Miscellaneous Review Information screen in the UM Abstract.

REVIEW AGENCY
This field displays the review agency for this insurance plan. This information can be associated with each insurance plan via the Insurance Plan table or can be entered in the Insurance Processor screen at the time of admission. When the plan is associated

with a patient and the review agency has been entered in the plan, it displays on this screen. The information in this field can be updated by the UM Coordinator via the Revise Admission function. However, if the information is incorrect for the insurance plan, the Insurance Plan table should be updated as well.

PHONE #
This field displays the phone number of the review agency displayed in the Review Agency field. Like the review agency, this information can be associated with each insurance plan via the Insurance Plan table or can be entered in the Insurance Processor screen at the time of admission. When the plan is associated with a patient and this information is available, it displays on this screen. The phone number can be updated by the UM Coordinator via the Revise Admission function; however, if the information is incorrect for the insurance plan, the Insurance Plan table should be updated as well.

CONTACT NAME
This field displays the contact name of the person at the review agency listed above. Like the phone number, this information can be associated with each insurance plan via the Insurance Plan table or entered in the Insurance Processor screen at the time of admission. When the plan is associated with a patient, and this information is available, it displays on this screen. The contact name in this field can be updated by the UM Coordinator via the Revise Admission function; however, if the information is incorrect for the insurance plan, the Insurance Plan table should be updated as well.

You are prompted to select the insurance plan for which to add or edit reviews. Enter the number to the left of the insurance plan and press ENTER. If there are currently no reviews for the selected insurance plan, the system bypasses the summary screen and automatically displays the detail screen for entry of review data.

If there are reviews already associated with the selected insurance plan, a screen displays first listing a summary of reviews previously entered. You can edit or fax any of the reviews that are displayed on the summary screen, or you can add additional reviews.

The following is an example of the review summary screen:

```
                General Hospital Add/Edit Review Processor
                                                Thu Aug 22, 2002 03:41 pm
Account No     Name                              Unit Number   Birthdate
0219100002     TANNER,CHARLES                    000-00-2308   12/17/87 14Y
Sex  Adm Date  Attending Dr           Pt Type  Diagnosis                    LOS
M    07/10/02  ADAIR,FRANK C          I/P      540.9-ACUTE APPENDICITIS NO  40
F/C #Plans Cert Days Nurse Sta/Rm/Bd    Comp Date/Init # Revs
M    2     1         *HOME OR SELF CARE                 1


Page:01   REV    INIT    REV       # CRIT  DAYS    NEXT    TRANS/COPY
     #    DATE           TYPE        MET   CERT    REV     FROM
( 1) 1   08/22/02 A W  J-RETRO REVI   1    1     09/01/02




Select OPTION# to edit, 'A'dd, `F`ax a review--
```

If there are no reviews associated with the selected insurance, this screen does not display, and the next screen displays for entry of review data.

When reviews exist for the selected insurance, this screen displays a summary of those reviews. The reviews display in reverse chronological order with the most recent review for the selected insurance listed first. Reviews are numbered sequentially, regardless of the insurance plan with which they are associated.

The information on this screen is view only. The field explanations provided for the next screen in this section apply to the review summary columns that display on this screen. One additional field, Trans/Copy From, displays in the review summary but is not included on the next screen. The Trans/Copy From field displays the name of the insurance plan from which a review was transferred or copied. A review transfer can result from deleting an insurance plan that had a review associated with it or from manually transferring or copying the review using the UM Transfer Review or Copy Review function. The system automatically makes an entry in this field, when applicable, regardless of how the transfer/copy occurred.

From the summary screen, select one of the following entry options:

- Enter the review number to edit.
- Enter **F** to fax a review. For information on faxing reviews, see "FAX REVIEW" on page 2-79.
- Enter **A** to add a review. If 999 reviews already exist for this account, the system displays the following error message:

  Error: 999 exists, cannot add more reviews!

The message displays briefly; then the previous prompt is redisplayed.

- Press period (.) followed by ENTER to redisplay the screen listing the insurance plans for this patient.

When you enter a review number to edit or enter **A** to add a review, or if the system bypasses the summary screen because the patient currently has no reviews, the following screen displays:

```
                General Hospital Add/Edit Review Processor
                                                Thu Aug 22, 2002 03:41 pm
Account No     Name                             Unit Number   Birthdate
0219100002     TANNER,CHARLES                   000-00-2308   12/17/87 14Y
Sex  Adm Date  Attending Dr           Pt Type  Diagnosis                    LOS
M    07/10/02  ADAIR,FRANK C          I/P      540.9-ACUTE APPENDICITIS NO  40
F/C #Plans Cert Days Nurse Sta/Rm/Bd    Comp Date/Init # Revs
M    2     1         *HOME OR SELF CARE                 1
( 1)Rev#           : 2
( 2)Rev Date       : 08/22/02
( 3)Init           : A W
( 4)Rev Type       :
( 5)Review Reason  :
( 6)Crit Met       :



( 7)Severity Level :
( 8)Day/Next Rev   :
( 9)Days Cert      :
(10)Next Rev Date  : 08/23/02
(11)Review Notes   :
Enter table code or '-' for table--
```

This screen is used to enter review-specific information. If you are editing the selected review, all fields on this screen display the previously entered information. You can edit all fields except the REV # field. When you are adding a review, the system automatically make entries in the first three fields.

Field Explanations

1. REV# (DISPLAY ONLY)
This field indicates the current review number and is automatically completed by the system with the next consecutive number since the last review regardless of the insurance plan selected. When this number increments, the total number of reviews in the header increments as well.

2. REV DATE (DATE)
This field indicates the date this review is performed and is automatically completed by the system with the current date. If the review date is not the current date you can enter a slash (/) and the field number to access the field and edit the date. The review date can be before or after the admission and discharge dates. This is to accommodate preadmission and retrospective reviews.

3. INIT (3-A-R)
This field indicates, by initials, the reviewer performing this review. The field is automatically completed by the system using the initials of the person who signed onto the system. If the initials are incorrect, you can enter a slash (/) and the field number to access the field and edit the initials. This field accepts up to three characters for the initials.

4. REV TYPE (TABLE LOOKUP-R)
This field indicates the type of review being performed. Examples of review types are admission, continued stay, discharge, etc. Due to the fact that this is the first field on this screen not automatically completed by the system [when adding a review], this is where the cursor and prompt are located. To complete this field, enter the UM Review Type code if you know it, or press hyphen (-) followed by ENTER to display the UM Review Type table for selection. This field displays the UM Review Type code and description.

5. REVIEW REASON (TABLE LOOKUP-R)
This field indicates the reason for this review. Enter the UM Rev Reason code if you know it, or press hyphen (-) followed by ENTER to display the UM Review Reason table for selection. The UM Review Reason code and description display. Examples of Review Reasons are: admission screening met, manual add, required insurance review, retrospective review, etc.

6. CRIT MET (TABLE LOOKUP-O)
This field indicates the criteria that determined whether to certify or not certify the patient's stay in the facility and/or the reason why this patient has been manually added to the UM Census. Enter the UM Criteria Met code if you know it, or press hyphen (-) followed by ENTER to display the UM Criteria Met table for selection. You can enter up to three codes for Criteria Met in this field. The UM Criteria Met code and description display; however, on the review summary screen, only the number of criteria met displays. This field is best utilized if the associated code table contains specific entries such as those provided by CMS or local insurance companies.

7. SEVERITY LEVEL (TABLE LOOKUP-O)
This field is used to indicate the patient's severity at the time of this review. Enter the severity level code if you know, or press hyphen (-) followed by ENTER to display the Severity Level table for selection. The code and description display. This field is separate and different from the Severity Code field in the MR Abstract. This field is not integrated or interfaced with a severity system, however this field is mapped in the SQL database for use in reporting.

8. DAY/NEXT REV (3-N-O)
This field indicates the number of days until the next review. This field is directly tied to the Next Review Date field in the Parameter Maintenance option in UM Maintenance. If you have entered **Y** in the Next Review Date field, the system ignores the number in this field, since you are indicating that the Days Cert field determines the date of the next review. If you have entered **N** in the Next Review Date parameter, the system uses this field to determine the next review date. This field does accept a zero. Therefore, if this is the final review and you do not want to indicate a next review date,

you can enter zero. If this is the final review, you should also mark the abstract complete or the system prints a worksheet the next day (even if azero is entered here). The default for this field is 1 day.

9. DAYS CERT (3-N-O)
This field indicates the number of certified days for continued stay of the patient. This field is directly tied to the Next Review Date parameter field in the Parameter Maintenance option in UM Maintenance. If you entered **Y** in the Next Review Date parameter field, the system uses the number in the Days Cert field to determine the next review date. If you entered **N** in the Next Review Date parameter field, the system uses the number in the previous field, Days/Next Rev, to determine the next review date. This field does accept a zero. Therefore, if the patient is being reviewed but has no certified days you can enter zero. If this is the final review, you should also mark the abstract complete or the system prints a worksheet the next day (even if a zero is entered here). If you enter certified days, the system increments the total number of certified days for the insurance for which this review has been associated.

Please see the field explanation for Next Review Date in the Parameter Maintenance option of UM Maintenance for additional information on the use of this field in conjunction with the previous field.

10. NEXT REV DATE (DISPLAY OR DATE FORMAT)
This field indicates the next date the patient is expected to be reviewed. The system automatically completes this field based on the number of days entered in the Day/ Next Rev field or on the number of days entered in the Days Cert field. If both of these fields are blank, the system automatically completes this field with the review date from the Rev Date field. The system uses this field to determine when the next UM Worksheet prints for this patient. This field can be edited by changing the information in either the Day/Next Rev Date or the Days Cert field or by entering a new date in this field. You cannot enter a date that is earlier than the date in the Rev Date field.

11. REVIEW NOTES (SPECIAL FORMAT-O)
This field is used to enter free-form notes regarding this review. The UM Coordinator should enter the most pertinent data in the first three lines of the text, as this is the portion that displays most frequently on the UM Worksheet.

When you access the Review Notes field, the following screen is displayed. The Review Notes screen utilizes STAR's Softkey Editor functionality.

```
                    General Hospital Add/Edit Review ProcessPage: 1
                                                 Sun May 12, 2002 12:32 pm
Account No     Name                              Unit Number   Birthdate
0120600005     PROFFITT,UMA                      000-00-2439   01/03/64 38Y
Sex  Adm Date  Attending Dr           Pt Type  Diagnosis                    LOS
F    07/24/01  JERDEN,ROY             MH       300.00-ANXIETY STATE NOS     209
F/C #Plans Cert Days Nurse Sta/Rm/Bd    Comp Date/Init # Revs Rev Type
K    2     1         HOME HEALTH CARE O                  3    J-RETRO REVIEW

01|                                                                          |
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 1Ins 2Ln  3    4Scn 5Scn   6Ins 7Ins 8Ctr 9Del 1Del   1Mrk 1Mrk 1Fmt 1Prt 1End
  ert  Fct       Fwd  Bck    Txt  Ln    Ln   Ln  0Wrd   1Ln  2Pge 3Scn 4Doc 5Edt
```

Since the display screen is limited in width, function key identification is normally shortened into meaningful abbreviations. Following is an explanation of the keys and their functions. Refer to the SOFTKEY EDITOR chapter in the *STAR Patient Care Reference Guide, General Information Volume* for more details.

KEY	FUNCTION	ON-SCREEN ABBREVIATION
F1	Insert or Overwrite	Insert / Ovr-Wrt
F2	Line Functions **NOTE:** This brings up a new set of function keys. Refer to page 2-19 for explanations.	Ln Fct
F3	None	Blank
F4	Screen Forward	Scn Fwd
F5	Screen Back	Scn Bck
F6	Insert Text or End Text	Ins Txt/End Txt
F7	Insert Line	Ins Ln
F8	Center Line	Ctr Ln
F9	Delete Line	Del Ln
F10	Delete Word	Del Wrd
F11 or ALT-F1	Mark Line	Mrk Ln

KEY	FUNCTION	ON-SCREEN ABBREVIATION
F12 or ALT-F2	Mark Page	Mrk Pge
F13 or ALT-F3	Format Screen	Fmt Scn
F14 or ALT-F4	Print Document	Prt Doc
F15 or ALT-F5	End Edit	End Edt

Function Key Descriptions

F1 INSERT/OVERWRITE

This key is a toggle switch at which you can shift back and forth between Overwrite and Insert modes. Insert mode is the default mode you are in when entering Softkey Editor. Through this key, you can enter (Insert) additional text at the cursor location by moving existing text to the right. When the line lacks free space, the system automatically takes you into Insert Text mode unless you are at the end of the document (See the F6 key). In Overwrite mode, you can type over existing text in the line. When you reach the end of the line, the system automatically takes you into Insert Text mode unless you are typing at the end of the document. Note that the TAB key functionality varies according to the mode. In Insert mode, by pressing the TAB key, you can insert five blank spaces at the cursor position pushing all text to the right of the cursor further to the right. If the line does not have enough room for the inserted five blanks plus the remaining text, the system automatically takes you into Insert Text mode. Upon your exit from Insert Text mode, the system reformats the text. In Overwrite mode, when you press the TAB key, the system overwrites five characters with blank spaces beginning at the cursor position.

F2 LINE FUNCTIONS

You can access the second level function keys by pressing this key. See the section on "LINE FUNCTIONS (AVAILABLE WITH F2 KEY)" on page 2-19 for more information.

F4 SCREEN FORWARD

You can advance the display of your document by a number of lines; the number of lines varies by the function from which you access the Softkey Editor utility. The last line of the screen text displays in dim reverse above the first line of the new text for easy position location when appropriate. When you edit a multi-screen document and are not on its last page, the system displays the number of remaining pages in dim reverse at the bottom right-hand corner of the document. Also in a multi-screen document, if you are on a screen other than the first, the system displays the number of preceding screens in the document in dim reverse video at the top right-hand corner. When you are on the last screen of your document, the system displays a message stating that no next screen exists.

F5 SCREEN BACKWARD

You can move back one screen of text at a time. The last line of the screen text displays in dim reverse above the first line of the new screen text for easy position

location. When you are on the first screen of your document and attempt to "screen back", the system displays a message stating that no next screen exists.

F6 INSERT TEXT/END INSERT
You can open the document at the cursor's location and insert several lines of text. The End Text function enables you to format the screen into an organized display. While in this mode, the system “removes” all the text following the cursor enabling you to type lines into an empty window. The system displays the “removed” text in dim video on the line below the last line of text within the window for easy position location.

The following keys are inactive while in the Insert Text mode: F2, F3, F14, and F15. If you press one of these four keys, the system displays a message stating that you must first exit the Insert Text mode. While in the Insert Text mode, you can type past the end of the screen. The system advances the screen while displaying a blank window on which you can continue inserting text. While inserting text, you cannot place the cursor on lines not part of the inserted material, preventing problems associated with modifying non-inserted text. When you finish inserting the text, press the F6 or F13 key to exit the Insert Text mode.

You can backup on the same line before your previous location and insert more text. If the line has no extra space, the system displays an error message stating you must first finish the insert; Note you cannot enter "double" Insert Text Mode or the text to follow. When the appropriate error message displays, exit the Insert Text mode to complete your second insert then re-position the cursor and resume entering data. Keep in mind the Insert Text mode and Insert mode have differing functionality.

F7 INSERT LINE
You can open the text to insert text one line at a time; the system inserts a blank line at the cursor in your document. The text that occupied the line (and all following lines) is moved down one line.

F8 CENTER LINE
The line of text with the cursor, if shorter than the line length, is centered within the margins.

F9 DELETE LINE
You can delete the entire line on which the cursor is located. If you attempt to delete the only line of text in a document, the system displays a message stating this line is the last one. The Softkey Editor utility cannot process a blank document; at least one line must exist.

F10 DELETE WORD
If you position the cursor on a non-blank space within the document, the system deletes the word at that position along with the blank space following it. All text following the deleted text is moved to the left. The system does not automatically reformat the screen; If you want to reconstruct the paragraph, press the F13 key. If the cursor is not positioned on a word, the system displays a message stating it cannot find a word to delete.

F11 or ALT-F1 MARK LINE

When you press this function key, the cursor line is "line marked." Only the cursor line is prevented from being concatenated to the line above it in a reformat operation (See the F13--Reformat Screen). To ensure that this line is kept exactly as-is, the line following the cursor line may also require marking. A letter L in dim reverse displays in the margin to the right of the line indicating the line is marked. Press this key again to remove the mark.

F12 or ALT-F2 MARK PAGE

When you press this function key, you can establish a new page to the document before you reach line 60 (the last line of a page). When F12 is pressed, a new page is established at the location of the cursor and this page is marked with an uppercase **P** in the left margin. The lines on this new page are reformatted so the new page starts with line number one at the location of the page mark indicator on the left margin.

NOTE: The system automatically creates a new page after line 60. This makes the first line after line 60 a new page. The system-generated new page is indicated by a lowercase **p** page mark on the left margin of the screen.

F13 or ALT-F3 FORMAT SCREEN

You can format the screen into an organized display for a later printing. When you press this function key (also when you exit Insert Text mode), the system reformats the document in the region of the current screen display. The system scans backwards the lines in the document past the top of the current screenuntil the start of a paragraph (or the start of the document), and forward past the end of the current screen until the end of a paragraph (or the end of the document). The system processes the range of lines and forms paragraphs using the following rules:

- A paragraph begins with a line that:
  - Has line or page marks
  - Contains one or more blanks in the first position(s)
  - Follows a blank line
  - Is the first line of the document
- A paragraph ends with a line that:
  - Is followed by a blank line
  - Is the last line of the document
  - Is followed by a line- or page-marked line
- Text is placed on the 72-character line without trailing blank spaces. When lines are joined, if they lack a single space between them, the system inserts one.

- Blank lines are preserved. During the reformat process, lines can be joined to reduce the total number of lines. The system maintains the relative cursor line position, when possible, if displaying the screen. If the only line of the current screen display is moved upwards and lost, the system automatically moves to the previous screen and places the cursor on the last line. As described previously, the process of exiting the Insert Text mode involves using the Reformat Screen function to ensure the inserted text is properly reformed into paragraphs. Just prior to initiating the reformat, the system joins the text following the point of insertion at the cursor position, possibly at the start of a blank line. To ensure a blank line, the line above the cursor line must be blank.

F14 or ALT-F4 PRINT DOCUMENT

When this key is pressed, the message *printing!* displays in the lower left corner of the screen and the document prints on the designated printer. The *printing!* message is removed from the screen when another key is pressed.

NOTE: Before attempting to print edited text using the F14 key, it is necessary to move the cursor from the last edited line by using the arrow keys or pressing ENTER.

F15 or ALT-F5 END EDIT

You can leave Softkey Editor and retain all documentation changes through this last key on both Softkey Editor screens. In the Insert Text mode, this key is temporarily disabled.

LINE FUNCTIONS (AVAILABLE WITH F2 KEY)

All line functions operate on complete lines of text regardless of paragraph positions and line or page-marks. The system clears the marks placed on text lines. Function keys F4, F5 and F15 (Screen Forward, Screen Backward and Exit Softkey Editor) function as previously described.

You cannot type text into the document in the Line Functions mode. If you attempt to enter text, the system displays an error message saying to exit the line functions mode. If you press an undefined function key while in Line Functions mode, the system displays the Invalid Key error message.

Press the F2 key, and these Line Functions become operational:

KEY	FUNCTION	ON-SCREEN ABBREVIATION
F1	None	Blank
F2	None	Blank
F3	Patient Block	Pat Blk
F4	Screen Forward	Scn Fwd
F5	Screen Back	Scn Bck
F6	Set Start Mark	Str Mrk

KEY	FUNCTION	ON-SCREEN ABBREVIATION
F7	Set End Mark	End Mrk
F8	Copy Text	Cpy Txt
F9	Move Text	Mv Txt
F10	Delete Text	Del Txt
F11 or ALT-F1	Clear Mark	Clr Mrk
F12 or ALT-F2	Horizontal Lines	Hor Ln
F13 or ALT-F3	Vertical Lines	Ver Ln
F14 or ALT-F4	Main Menu	Mn Mnu
F15 or ALT-F5	End Edit	End Edt

Function Key Descriptions

F3 PATIENT BLOCK

This key enables you to specify the location of the patient's demographic block on a page. When the key is pressed, the system displays *Left (L), Right(R) or NL to exit*. By entering either L or R, lines display on the screen outlining the space reserved for printing the patient demographic block. If you enter L, the block is on the left side of the page beginning at the location of the cursor. If you enter R, the block displays on the right side of the page beginning at the location of the cursor. If the cursor is too close to the bottom of the page to accommodate the full size of the patient block (cursor at line 55), the system displays *Too close to page bottom*.

F4 SCREEN FORWARD

You can advance the display of your document by a FORWARD number of lines; the number of lines varies according to the function from which you access the Softkey Editor utility. The last line of the screen text displays in dim reverse above the first line of the new screen text for easy position location when appropriate. When you edit a multi-screen document while on a page other than its last, the system displays the number of remaining pages in dim reverse at the bottom right-hand corner of the document. Also if you are on a screen other than the first in a multi-screen document, the system displays the number of preceding screens in the

document in dim reverse video number at the top right-hand corner. When you are on the last screen of your document, the system displays a message stating that no next screen exists.

F5 SCREEN BACKWARD

You can move back one screen of text at a time. The last line of the text displays in dim reverse above the first line of the new text for easy position location. When you are on the first screen of your document and attempt to "screen back", the system displays a message stating that no next screen exists.

F6 SET START MARK
Identify a point in which a future copy, move, or deletion should be made by using both this key and the End Mark key. If a start mark was set on another line, the system moves the start mark to the cursor line. Note the marked line displays in reverse video along with a dim reverse letter S in the left margin. If you attempt to set a start mark on a line that comes after the one containing the end mark, the system displays the Start Mark After End Mark message indicating you need to re-position the cursor. If you attempt to copy, move or delete without setting a start mark, the system displays the Missing Start Mark message indicating you must place a start mark before continuing. If you attempt to copy, move or delete text without setting marks, the system displays the Must Define Block First message indicating you need to mark the text line(s) before continuing.

F7 SET END MARK
You can identify the ending line of text being copied, moved or deleted when using this key. Note the mark is not required for copying, moving or deleting a single line of text. To remove an end mark, press the Clear Mark key. If an end mark was previously set on another line, the system places the end mark at the cursor line. Note the cursor line and all lines between the start and end marks display in reverse video unless just an end mark is set; Also, a dim reverse letter E displays just to the right of the right margin. If you attempt to set an end mark on a line that displays before the one containing the start mark, the system displays the End Mark Before Start Mark message. At this point, re-position the cursor.

F8 COPY TEXT
You can copy typed text to other locations through this function. The system copies the lines indicated by the start and end marks to the ones following the current cursor line. Place the cursor in front of the text to be copied then press the Start Mark (F6). Move the cursor to the end of this information and press the End Mark (F7). Now, move to the text's destination point using the Screen Forward (F4) and Screen Backward (F5) functions, then press Copy Text (F8). The system displays the text at both the source and destination locations, while moving the cursor to the line above the copied text lines. Note the total number of lines in the document is increased by the number of lines copied.

After performing a copy, the system clears the marks. If you attempt to copy text to an area within the marked text lines, the system displays the Within Marked Text message indicating a copy function into the middle of text to be copied cannot be performed. At this point, move the cursor to a line outside of the marked area to try again.

F9 MOVE TEXT
Use this key with Start and End marks. Once you identify starting and ending points, move the cursor to the desired location, then press the Move Text key. The system moves the lines between the start and end marks to the lines following the current cursor line. It then deletes the original marked line(s) from the document leaving the total number of lines unaffected. Next, the system places the cursor on the same line prior to the move unless you perform a move from a point in the document before the cursor line; in the latter case, the system moves the cursor down (forward) by the

number of moved lines in the document thus displaying it on the last moved line. After the move, the system automatically clears the start and end marks. If the cursor is on a line within the marked text lines, the system displays the Within Marked Text message indicating a move function into the middle of text to be copied cannot be performed. At this point, move the cursor to a line outside of the marked area to make another attempt.

F10 DELETE TEXT

This key is equivalent to the F9--Delete key on the main menu; the lines indicated by the start and end marks are deleted from the document. You can delete large portions of text by placing the cursor at the beginning of the text which is to be deleted. Press Start Mark (F6). Then move the cursor to the end of the text which is to be deleted and press End Mark (F7). The system deletes the text within the marked lines, then clears the marks. Note the start and end marks must be on the current screen; you cannot delete lines not currently displayed. If you attempt to delete lines not on the current screen display, the system displays the Start Or End Mark Off Screen message. At this point, you must construct a marked area entirely on the current screen before a deletion can be performed.

F11 or ALT-F1 CLEAR MARK

After completing a Copy or Move Text operation, you can remove beginning or ending marks from the screen to ensure future copy and move operations within the text.

F12 or ALT-F2 HORIZONTAL LINES

This key enables you to add horizontal lines to the current page of the document. When you press this key, the system displays *Horizontal Lines (Separated By Commas) at Rows--*. Horizontal lines may be entered for page lines 1 through 60. If lines greater than 60 are entered (for example, 10, 30, 50, 65), the following error message displays in the lower left corner of the screen:

Enter row #'s from 1 to 60 separated by commas (eg: 5, 10, 15)

Requesting horizontal lines on a page establishes the line or row numbers for the page if the line/row numbers have not already been established. When the row numbers are entered and ENTER pressed, Start at Column [1]-- displays. This enables you to determine the length of the horizontal lines entered in the previous prompt. The system then displays End at column [75]. If 0 (zero) or a number greater than 75 is entered, the system displays the following error message: Enter a column # from 1 to 75. When the horizontal row numbers are identified as well as the start/stop columns, the horizontal lines automatically display on the screen.

F13 or ALT-F3 VERTICAL LINES

This key enables you to add vertical lines. When you press this key, *Vertical Lines (Separated By Commas) at columns--* displays. Vertical lines may be entered on columns 1 through 75. If you enter a number greater than 75, the system displays *Enter column #s From 1 to 75 separated by commas (eg 5,10,15)*. When the column numbers are entered and ENTER pressed, *Start at Row [1]--* displays. This prompt enables you to determine the length of the vertical line(s) from Row 1 to 60. The

system then displays *End at Row [60]*--. If 0 (zero) or a number greater than 60 is entered, the system displays the following error message:

Enter a row # from 1 to 60--

When the vertical lines are identified by entering the column numbers and the stop/start rows defined for the length of the vertical lines, the vertical lines automatically display on the screen.

F14 or ALT-F4 MAIN MENU
Exit the second level of keys by pressing this key. The system clears any start or end marks placed but not acted upon.

F15 or ALT-F5 END EDIT
Exit the Softkey Editor utility by pressing this key. Press this key on both screens when editing is complete.

When you complete the Add/Edit Review screen for a new review, the following prompt displays:

Accept this screen? (Y/N) [Y]--

Select one of the following entry options:

- Enter **N** for No to not accept the screen and the following prompt displays:

  Enter field number or '/' starting field number--

  Enter the number of the field you want to update, or press ENTER to redisplay the prompt for acceptance of the screen.

- Enter **Y** for Yes to accept the screen.

When you update a previously entered review, the following prompt displays:

Accept this screen? (Y/N/'D'elete) [Y]--

Select one of the following entry options:

- Enter **N** for No to not accept the screen and the following prompt displays:

  Enter field number or '/' starting field number--

  Enter the number of the field you want to update, or press ENTER to redisplay the prompt for acceptance of the screen.

- Enter **Y** for Yes and the screen is accepted and the information is filed.

  NOTE: Information from the review screen does not update the Certified Days field in the UM header unless you accept the review screen.

- Enter **D** to delete this review. Once a review is deleted, the information is no longer available. The # Rev in the header is adjusted accordingly and the review are resequenced accordingly. The Cert Days in header is adjusted as well.

- Press period (.) followed by ENTER to return to the summary screen. The updated entry is not filed.

After you respond to the previous prompts, the following is displayed:

Print Review?(Y/N) [N]--

Enter **Y** to print the review, or enter **N** (or press ENTER) not to print the review.

Another prompt is then displayed:

Access Avoidable Non-Covered Day Screen?(Y/N) [N]--

Enter **Y** to access the Avoidable/Non-Covered Days screen for this patient (refer to Avoidable/Non-Covered Days on page 2-31 for information on this function). Enter **N** or press ENTER, and the review summary screen redisplays and now contains summary information from the newly added review (if applicable). At this point, you can edit or add a review, or exit this screen. If you want to exit this screen, press ENTER to return to the screen listing the Insurance Plans. Press ENTER again and this prompt displays:

C'omplete this abstract or Continue with review [NL]--

Select one of the following entry options:

- Enter **C** to complete this UM Abstract. The date of completion and the initials of the person signed on display in the header information. Completing the UM Abstract begins the countdown for the purging of UM data. Purging is based on the number of days set up in the UM Maintenance Parameters option.

- Press ENTER and the UM Review submenu redisplays.

Miscellaneous Review Information

When you select the Miscellaneous Review Information option, this screen displays:

```
           General Hospital Miscellaneous Review Information Processor
                                                Wed Jul 15, 2009 09:52 pm
Account No     Name                             Unit Number   Birthdate
0917300001     TONEY,EX                         000-00-6094   01/01/63 46Y
Sex  Adm Date  Attending Dr           Pt Type  Diagnosis - ICD 10           LOS
M    06/22/09  COLEMAN,MICHAEL       LTC                                  1
F/C #Plans Cert Days Nurse Sta/Rm/Bd    Comp Date/Init # Revs
B    1              *HOME OR SELF CARE 06/23/09/***
 1 Admitting Diagnosis                    2 ICD 10 Admitting Diagnosis
                                            A00.0-Cholera due to Vibrio cholera
 3 UM Working Diagnosis                   4 ICD 10 UM Working Diagnosis
->                                          A00.0-Cholera due to Vibrio cholera
 5 Surgery Scheduled                                          6 Date

 7 US ICD 10 Surgery Scheduled                              8 Readmit Ind

 9 Admission Type           10 Admission Source      11 Referring Facility
   3 ELECTIVE                  7 ER
12 Reason Referred          13 Appr LOS  14 Mcare Assgnmt Letter 15 ROI Consent
                                                                    No
16 URO #1 Primary      17 URO Ref #1      18 URO Status #1      19 URO Auth #1
   GEORGIA PRO            1234567
Enter ICD-9-CM diagnosis code--                                    |
                     `U-`ser Dx, `-` for list, -free form
```

This screen contains miscellaneous data regarding this patient's visit that is relevant and necessary to the UM Coordinator. The information on this screen, with the exception of URO information and Readmit Ind., is brought forward from other areas such as admitting and nursing.

Field Explanations

1. ADMITTING DIAGNOSIS (DISPLAY ONLY)
This field contains the admitting diagnosis entered on the Medical Page during the admission process. Regardless of whether the admitting staff enters an ICD-9-CM code or a free-form description, the information displays in this field. This field is to be used in conjunction with, and as a comparison to the next field, UM Working Diagnosis.

If you enter an inactive ICD-9-CM code for the admitting diagnosis, the system displays the following error message:

This code is INACTIVE! Do you want to continue? (Y/N) [N]—

Enter **Y** for Yes or **N** for No to indicate whether or not to keep the inactive code.

If you enter an admitting diagnosis code that has been defined for a sex that does not match the patient's sex, the system displays the following error message and does not allow entry of that code:

This code valid for [sex] only--

where [sex] is male or female.

Likewise, if you enter a code defined for an age range that does not include the patient's age, the system displays the following message and does not allow entry of that code:

This code valid for patients ages # to # only --

where **#** is the lower or upper age number.

2. ICD 10 ADMITTING DIAGNOSIS
This field contains the admitting diagnosis entered on the Medical Page during the admission process. Regardless of whether the admitting staff enters an ICD-10 code or a free-form description, the information displays in this field. This field is to be used in conjunction with, and as a comparison to the next field, UM Working Diagnosis.

If you enter an inactive ICD-10 code for the admitting diagnosis, the system displays the following error message:

This code is INACTIVE! Do you want to continue? (Y/N) [N]—

Enter **Y** for Yes or **N** for No to indicate whether or not to keep the inactive code.

If you enter an admitting diagnosis code that has been defined for a sex that does not match the patient's sex, the system displays the following error message and does not allow entry of that code:

This code valid for [sex] only--

where [sex] is male or female.

Likewise, if you enter a code defined for an age range that does not include the patient's age, the system displays the following message and does not allow entry of that code:

This code valid for patients ages # to # only --

where **#** is the lower or upper age number.

3. UM WORKING DIAGNOSIS (TABLE LOOKUP-R)
This field is used to enter the UM working diagnosis or the diagnosis the UM Coordinator is currently using as the basis for review and stay certification. It may or may not be the same as the Admitting Diagnosis in the previous field. It should be the diagnosis most closely related to what will ultimately be the patient's principal diagnosis. This field can be updated throughout the patient's stay as diagnostic information becomes available. The initial diagnosis in this field is the same as that in the Admitting Diagnosis field until it is updated by the UM Coordinator. Changes made to the information in this field do not update the Working Diagnosis in admitting medical records, nursing or any of the clinical areas, and vice versa. This field is for the UM Coordinator to document the diagnosis being used for determination of continued stay.

It is this diagnosis that displays in the header information of the UM screens and on reports. When you enter this field, the following prompt displays:

Enter ICD-9-CM diagnosis code, 'U-'ser diagnosis code, '-' for list, or -freeform--

Select one of the following entry options:

- Enter the ICD-9-CM code if you know it.
- Enter **U** and a hyphen (-) to display the user-defined pointers set up with user-defined terminology that display the corresponding ICD-9-CM code. If you enter U and a letter (or letters) followed by a hyphen (-), all user-defined pointers that start with that letter(s) display. You can select an entry from this listing.
- Press hyphen (-) followed byENTER to display a list ofall the ICD-9-CM diagnoses codes in numeric order. If you know that the code you are searching for is in a specific group of codes, you can narrow the search by entering the number followed by a hyphen (-). For example, you can enter 780-, and all codes beginning with 780 display in numeric order. You can select an entry from this listing.
- Enter a free-form description by entering a hyphen (-) followed by a description up to 34 characters in length (including the preceding hyphen).

4. ICD 10 WORKING DIAGNOSIS

This field is used to enter the UM working diagnosis or the diagnosis the UM Coordinator is currently using as the basis for review and stay certification. It may or may not be the same as the Admitting Diagnosis in the previous field. It should be the diagnosis most closely related to what will ultimately be the patient's principal diagnosis. This field can be updated throughout the patient's stay as diagnostic information becomes available. The initial diagnosis in this field is the same as that in the Admitting Diagnosis field until it is updated by the UM Coordinator. Changes made to the information in this field do not update the Working Diagnosis in admitting medical records, nursing or any of the clinical areas, and vice versa. This field is for the UM Coordinator to document the diagnosis being used for determination of continued stay. It is this diagnosis that displays in the header information of the UM screens and on reports. When you enter this field, the following prompt displays:

Enter ICD-10-CM diagnosis code-- |
`U-`ser Dx, `-` for list, -free form

Select one of the following entry options:

- Enter the ICD-10-CM code if you know it.
- Enter **U** and a hyphen (-) to display the user-defined pointers set up with user-defined terminology that display the corresponding ICD-10-CM code. If you enter U and a letter (or letters) followed by a hyphen (-), all user-defined pointers that start with that letter(s) display. You can select an entry from this listing.

- Press hyphen (-) followed by ENTER to display a list of all the ICD-10-CM diagnoses codes in numeric order. If you know that the code you are searchingfor is in a specific group of codes, you can narrow the search by entering the number followed by a hyphen (-). For example, you can enter 780-, and all codes beginning with 780 display in numeric order. You can select an entry from this listing.

- Enter a free-form description by entering a hyphen (-) followed by a description up to 34 characters in length (including the preceding hyphen).

5. SURGERY SCHEDULED (TABLE LOOKUP-O)
This field is used to indicate a surgical procedure scheduled for or performed on this patient. Surgery information entered at the time of admission displays in this field. Changes made to this field also the update the Surgery Scheduled field located in the Medical Page of theRevise Patient function within the Nursing Module, and vice versa. Surgical information can be entered in this field using the same entry options described previously for the UM Working Diagnosis field. If an ICD-9-CM code is entered, the code and description display.

6. DATE (DATE-O)
This field is used to indicate the date of the surgical procedure entered in the Surgery Scheduled field. Changes made to this field update the Date field located in the Medical Page of theRevise Patient function within the Nursing Module, and vice versa.

7. US ICD 10 SURGERY SCHEDULED (TABLE LOOKUP-O)
This field is used to indicate a surgical procedure scheduled for or performed on this patient. Surgery information entered at the time of admission displays in this field. Changes made to this field also the update the Surgery Scheduled field located in the Medical Page of theRevise Patient function within the Nursing Module, and vice versa. Surgical information can be entered in this field using the same entry options described previously for the UM Working Diagnosis field. If an ICD-10-PCS code is entered, the code and description display.

8. READMIT IND (DISPLAY ONLY)
This field indicates if this patient is a readmission that has met the Readmission Criteria as defined in the UM Maintenance option, Readmission Criteria Selection. This field displays Yes if the patient meets the readmission criteria, whether or not the patient is included in the UM Census. The field is blank if the patient does not meet the readmission criteria.

9. ADMISSION TYPE (TABLE LOOKUP-R)
This field indicates the admission type for this patient. The code and description that display in this field were entered in the Medical Page of the admission process. Changes made to this field update the data in the Medical Page in the MPI and the Episode Detail-2 screen in the Medical Record Abstract. The code in this field is passed to STAR Financials for entry on the UB claim form.

To update this field, select one of the following entry options:

- Enter the admission type code if you know it.

- Press hyphen (-) followed by ENTER to display the Admission Type table for selection.

10. ADMISSION SOURCE (TABLE LOOKUP-R)
This field indicates the admission source for this patient. The code and description that display in this field were entered in the Medical Page in the admission process. Changes made to this field update the data in the Medical Page of the MPI and the Episode Detail-2 screen in the Medical Record Abstract. The code in this field is passed to STAR Financials for entry on the UB claim form.

To update this field, select one of the following entry options:

- Enter the admission source code if you know it.

- Press hyphen (-) followed by ENTER to display the Admission Source table for selection.

11. REFERRING FACILITY (TABLE LOOKUP-O)
This field is used to indicate the location that referred (or transferred) the patient to your facility. The table code and description display. If this information was entered in the admission process, it displays on this screen. However, the data can be updated here. Updating the information here updates the MPI and displays in the UM Discharge Planning screen as well.

To update this field, select one of the following entry options:

- Enter the referring institution/facility code if you know it.

- Press hyphen (-) followed by ENTER to display the Referring Institution/Facility table for selection.

12. REASON REFERRED (TABLE LOOKUP-O)
This field is used in conjunction with the Referring Facility field to indicate the reason this patient was referred to your facility. The code and description display.

To update this field, select one of the following entry options:

- Enter the reason referred code if you know it.

- Press hyphen (-) followed by ENTER to display the Reason Referred table for selection.

13. APPR LOS (3-N-O)
This field displays the approved Length of Stay (LOS) associated with the primary insurance. The approved LOS can be entered in the insurance information screen during the admission process. This is the approved LOS determined by the insurer for the specified plan. If this field is not completed during the admission process, it is blank here. The following prompt displays:

Enter the approved length of stay for this insurance--

The information you enter in this field updates the insurance information screen in the MPI, and the insurance screen that displays for Add/Edit Review.

14. MCARE ASSGNMT LETTER (1-A-O)
This field contains a Yes/No flag indicating whether or not the facility has on file a signed form authorizing Medicare to pay directly to the facility (i.e., provider). This letter is commonly referred to as the Medicare Assignment of Benefits Certification. This field is also located in the Patient Information section of the Medicare Secondary Payor (MSP) screen of the Insurance Processor, and should be completed during the admission process. If the field contains Y, it indicates that a signed letter is on file. If the field contains N, it indicates that a signed letter is not available or this field was not completed. This field can be updated by the UM Coordinator, and it also updates the MSP screen of the MPI. The following prompt displays:

Has the patient signed the Medicare Assignment of Benefits Letter? (Y/N)--

15. ROI CONSENT (1-A-O)
This field contains a Yes/No flag indicating whether or not the facility has on file a signed statement permitting the third party payor to release data to other organizations to adjudicate the claim or otherwise fulfill state reporting requirements. This field is also located in the Admission Number Assignment screen, and should be completed during the admission process. If this field contains Y, it indicates that a signed statement is on file. If this field contains N, it indicates that a signed statement is not available or this field was not completed. This field can be updated by the UM Coordinator. The following prompt displays:

Has the patient signed the Release of Information Certification? (Y/N)--

16. URO #1 PRIMARY (21-C-O or TABLE LOOKUP-O)
This field displays the name of the utilization review organization (or agency) associated with the primary insurance. If this information is associated with the patient's insurance plan or was entered during the admission process, it displays in this field. This field can be updated, and if you do so, the MPI and the insurance screen preceding the Add/Edit Review function are also updated. To complete or update this field, enter the UM Review Agency code ifyou know it, or press hyphen (-) followed by ENTER to display the UM Review Agency table for selection. The code and description display. This field also enables a free-form response of 21 characters (including the preceding hyphen). The agency you enter in this field displays on the Add/Edit screen. For more information, refer to Add/Edit Review.

17. URO REF #1 (15-AN-O)
This field displays the reference number for this patient's visit. This number is provided by URO #1. If this information is associated with the insurance during the admission process, it displays in this field. If the reference number was not available or was not entered at the time of the admission, it can be entered here. The MPI screen and the insurance screen preceding the Add/Edit Review function are also updated.

18. URO STATUS #1 (TABLE LOOKUP-O)
This field indicates the type of review activity the utilization review organization expects for this patient. This URO Status applies to the URO displayed or entered in the URO #1 field. Enter the URO Status code if you know it, or press hyphen (-) followed by ENTER to display the URO Status table for selection. The code and description display.

19. URO AUTH NUM #1 (12-C-O)
This field is used for entry of any preauthorization, authorization, or approval codes provided by URO #1. This number may be different than the reference number entered. This field accepts a free-form entry.

After you complete the fields on this screen, the following prompt displays:

Accept this screen? (Y/N) [Y]--

Select one of the following entry options:

- Enter **N** for No to not accept the screen and the following prompt displays:

  Enter field number or '/' starting field number--

  Enter the number of the field you want to update, or press ENTER to redisplay the prompt for acceptance of the screen.

- Enter **Y** for Yes and the screen is accepted.

After you accept the screen, the following prompt displays:

'C'omplete this abstract or Continue with review[NL]--

Select one of the following entry options:

- Enter **C** to complete this UM Abstract. The date of completion and the initials of the person signed on display in the header information. This begins the countdown for the purging of data based on the number of days set up in the UM Maintenance Parameters option.

- Press ENTER to continue this review for this patient. The UM Review submenu redisplays.

Avoidable/Non-Covered Days

This function is used to track the days of a patient's stay that the UM Coordinator has determined to be non-covered or avoidable. The difference between non-covered and avoidable are as follows: A non-covered day code is associated with a UB type and may be placed on the UB claim form. An avoidable day may not necessarily be reported on the UB, but the UM Coordinator wants to track the information for internal

purposes. The avoidable/non-covered day information is visit-specific versus review-specific. This information is mapped to TRENDSTAR®. If you select the Avoidable/ Non-Covered Days option, and avoidable/non-covered day information currently exists for this patient, the following screen displays:

```
              General Hospital Avoidable/Non-Covered Days Processor
                                                  Thu Aug 22, 2002 04:09 pm
Account No     Name                               Unit Number   Birthdate
0219100002     TANNER,CHARLES                     000-00-2308   12/17/87 14Y
Sex  Adm Date  Attending Dr           Pt Type  Diagnosis                    LOS
M    07/10/02  ADAIR,FRANK C          I/P      540.9-ACUTE APPENDICITIS NO  40
F/C #Plans Cert Days Nurse Sta/Rm/Bd    Comp Date/Init # Revs
M    12    1         *HOME OR SELF CARE                  2


Page:01  Date Init  Begin Date  End Date  Days  Day Type           Notes
( 1) 08/22/02 A W   07/11/02    07/13/02   2    PAT-PATIENT'S DELAY   N









Enter number to edit/view or 'A'dd avoidable/noncovered days info--
```

This screen displays summary information regarding avoidable/non-covered day information. If there are no avoidable/non-covered days associated with this patient, the summary screen does not display, and the system automatically displays the detail screen for entry of avoidable/non-covered day information. Select one of the following entry options on the summary screen:

- Select a current entry to edit or review by entering the number to the left of the data.
- Enter **A** to add avoidable/non-covered days information.

Selecting either of these entry options causes the following screen to display:

```
            General Hospital Avoidable/Non-Covered Days Processor
                                                Thu Apr 23, 1992 03:07 pm
Account No     Name                             Unit Number   Birthdate
92114-00001    ROBERTSON,ROBBIE H               0000-9000-75  05/05/05 86Y

( 1)Date               : 04/23/92
( 2)Init               : LTR
( 3)Begin Date         :
( 4)End Date           :
( 5)Number of Days     :
( 6)Responsible Party  :
( 7)Responsible Type   :
( 8)Non-Covered Day Type:
( 9)Avoidable Day Type :
(10)Notes              :









Enter begin date--
```

When you are editing or reviewing a selected entry from the previous screen, all fields on this screen display the entered data. You can edit any field on this screen except the Number of Days field. When adding a new entry, the first two fields are automatically completed by the system.

Field Explanations

1. DATE (DATE-O)
This field displays the date the avoidable day information was entered. The system automatically enters the current date. You can edit the date if necessary. This field accepts dates before or after the admission and discharge dates.

2. INIT (3-A-O)
This field displays the initials of the person entering the avoidable day information. The system automatically enters the initials of the person signed onto the system. You can edit the initials if necessary.

3. BEGIN DATE (DATE-R)
This field indicates the date the avoidable/non-covered day(s) begins. The date must be between the admission and discharge date.

4. END DATE (DATE-O)
This field indicates the date the avoidable/non-covered day(s) ends. The date must be between the admission and discharge date and must be the same date or later than the date entered in the Begin Date field.

5. NUMBER OF DAYS (DISPLAY ONLY)
This field indicates the number of avoidable days for this entry. This number is automatically calculated by the system based on the begin date and end date entered previously. For example, if the begin date is 02/14/02 and the end date is 12/16/02, the number in this field is 2. You cannot edit this field. In order to change this field, you must change either the date in the Begin Date or End Date field.

6. RESPONSIBLE PARTY (TABLE LOOKUP-R)
This field indicates the party responsible for the avoidable/non-covered day(s). When you access this field, the system displays a prompt giving you the choice to access the Physician table, the Departments table, entering an equals (=) sign to bring the attending physician forward, or a hyphen (-) followed by free-form text.

The Departments table that you access by entering **D** is the Departments table built *within* the Physicians table. To add or revise the Departments table within the Physician Table Maintenance function, contact the designated person in your facility who maintains STAR Patient Care tables.

When you access the ResponsibleParty field and you enter **D** to choose a department, you can then enter a hyphen (-) to select from the displayed list of previously built departments within the Physician Table Maintenance function.

When you access the Responsible Party field, you can enter **P** to access the physicians built in the Physicians option within the Physician Table Maintenance function. To add or revise a physician within the Physician Table Maintenance function, contact the designated person in your facility who maintains STAR Patient Care tables. After you enter P to select a physician, the system prompts you to enter the physician's code, perform a partial name lookup, or enter a hyphen (-) to choose from the displayed list of previously built physicians within the Physician Table Maintenance function.

You can enter an equals sign (=) when you access the Responsible Party field to pull in the attending physician, or you can enter a hyphen (-) followed by a free-form entry.

7. RESPONSIBLE TYPE (TABLE LOOKUP-R)
This field indicates the type of responsible party. This field accesses the Physician Type table. To complete this field, enter the Physician Type code if you know it, or press hyphen (-) followed by ENTER to display the Physician Type table for selection. The code and description display.

8. NON-COVERED DAY TYPE (TABLE LOOKUP-O)
This field indicates the reason why this stay has non-covered days. To complete this field, enter the UM Non-Covered Day Type Code if you know it or press hyphen (-) followed by ENTER to display the UM Non-Covered Day Type table for selection. The code and description display. Within the Non-Covered Day table, each code is associated with one of the UB codes. This information is summarized in the UB Non-Covered Days Summary screen. If you enter a non-covered day type code in this field, you cannot enter an avoidable day type code in the next field. Each entry of days in

this screen can only have one or the other day type associated with it, however, you can enter non-covered codes or avoidable codes that cover the same dates as long as they are separate entries.

9. AVOIDABLE DAY TYPE (TABLE LOOKUP-O)
This field indicates the reason for the avoidable days. Enter the UM Avoidable Day Type Code if you know it or press hyphen (-) followed by ENTER to display the UM Avoidable Day table for selection. The code and description display. This information is summarized in the UB Non-Covered Days Summary screen, however avoidable day codes are NOT associated with UB day types, and are not available for entry on the UB for the patient. If you entered a non-covered day type in the Non-Covered Day Type field, you cannot enter an avoidable day type code on this screen. Each ertry of days in this screen can only have one or the other day type associated with it, however, you can enter avoidable codes and non-covered codes that pertain to the same dates as long as they are separate entries.

10. NOTES (SPECIAL FORMAT-O)
This field is used to enter any additional comments that may be pertinent to the avoidable/non-covered days. When you enter this field, the system displays a 12 line free text entry area for completion. When you enter comments, Y displays on the summary screen indicating there is additional information for this entry. If you do not enter comments, N displays on the summary screen.

When you are completing this screen for a new entry, the following prompt displays:

Accept this screen? (Y/N) [Y]--

Select one of the following entry options:

- Enter **N** for No to not accept the screen and the following prompt displays:

  Enter field number or '/' starting field number--

  Enter the number of the field you want to update, or press ENTER to redisplay the prompt for acceptance of the screen.

- Enter **Y** for Yes and the screen is accepted.

When you are updating previously entered information, the following prompt displays:

Accept this screen? (Y/N/'D'elete) [Y]--

Select one of the following entry options:

- Enter **N** for No to not accept the screen and the following prompt displays:

  Enter field number or '/' starting field number--

Enter the number of the field you want to update, or press ENTER to redisplay the prompt for acceptance of the screen.

- Enter **Y** for Yes and the screen is accepted and the information is filed.
- Enter **D** to delete this entry. Once an entry is deleted, the information is no longer available.

After you accept or delete the information, the initial Avoidable/Non-Covered Days summary screen redisplays. This screen is now updated with summary information from the newly added entry (if applicable). You can edit or add another entry. If you want to exit this screen, press ENTER and the following prompt displays:

'C'omplete this abstract or Continue with review [NL]--

Select one of the following entry options:

- Enter **C** to complete this UM Abstract. The date of completion and the initials of the person signed on display in the header information. This also begins the countdown for the purging of data based on the number of days set up in the UM Maintenance Parameters option.
- Press ENTER to continue this review for this patient. The UM Review submenu redisplays.

UM Contact to Physician

One of the responsibilities of a UM Coordinator is to contact a patient's physician (not necessarily the attending physician) regarding issues of utilization, length of stay, questionable care, record documentation, or quality. This function provides summary and detail information of all contact made with a physician(s) during this patient's episode of care.

When you select the UM Contact to Physician option, the following screen may be displayed:

```
            General Hospital UM Contact to Physician Processor
                                                 Wed Jul 15, 2009 10:43 pm
Account No     Name                              Unit Number   Birthdate
0917300001     TONEY,EX                          000-00-6094   01/01/63 46Y
Sex  Adm Date  Attending Dr           Pt Type  Diagnosis - ICD 10           LOS
M    06/22/09  COLEMAN,MICHAEL        LTC      A00.0-Cholera due to Vibrio  1
F/C #Plans Cert Days Nurse Sta/Rm/Bd    Comp Date/Init # Revs
B    1               *HOME OR SELF CARE


Page:01 Date  Init  Physician            Type                Contact   Respond
( 1) 07/15/09 JJW   COLEMAN,MICHAEL K    ATTENDING           07/01/09  07/10/09









Enter number to edit/view or 'A'dd an entry--
```

This screen displays a summary of all contacts done for this patient. If there are no contact to physician entries associated with this patient, this summary screen does not display and the system automatically displays the next screen for entry of contact to physician information. On the summary screen, you can select one of the following options:

- Select a current entry to edit by entering the number to the left of the data.
- Enter **A** to add physician contact information.

Regardless of whether you are editing or adding an entry, a screen similar to the following is displayed:

```
               General Hospital UM Contact to Physician Processor
                                                  Sun Jun 28, 1992 11:14 am
Account No     Name                               Unit Number   Birthdate
92132-00001    ROBERTSON,FRED HOWARD              0000-9000-85  06/09/61 31Y
( 1)Date               : 06/28/92
( 2)Init               : KGC
( 3)Physician          : 32 ADAIR,FRANKLIN B
( 4)Physician Type     :
( 5)Contact Date       :
( 6)Respond Date       :
( 7)Contact Reason     :

( 8)Action/Determination:

( 9)Notes              :









Enter table code--
```

When you are editing or reviewing an entry from the previous screen, all fields on this screen display the entered data. You can edit any field on this screen. When you are adding contact information, the first three fields are automatically completed by the system.

Field Explanations

1. DATE (DATE-O)
This field indicates the date the UM Coordinator enters the contact information into this screen. The system automatically completes this field with the current date, or you can edit the date.

2. INIT (3-A-O)
This field displays the initials of the person entering the contact information. The system automatically enters the initials of the person signed onto the system, however, you can edit the initials if necessary.

3. PHYSICIAN (TABLE LOOKUP-R)
This field indicates the physician the UM Coordinator contacted. The system automatically completes this field with the number and name of the attending physician. However, you can edit this field. When you access the field, the following prompt displays:

Enter table code, '-', ('-) for staff, (\-)NSCG name to override, --
or '=' for physician

Enter the physician's name if you know it, enter a hyphen (-) to select from the physician table listing, enter (-') to select from a staff listing, enter (\-) to select from a non-staff care giver (NSCG) listing, or enter a hyphen (-) followed by a free-form entry. If you previously changed the physician, you can enter an equal sign (=) to re-enter the attending physician for this patient. The number and name of the selected physician displays if you select a table code.

4. PHYSICIAN TYPE (TABLE LOOKUP-R)
This field indicates the type of physician contacted. Enter the Physician Type code if you know it, or press hyphen (-)followed by ENTER to display the Physician Type table for selection. The code and description display.

5. CONTACT DATE (DATE-R)
This field is used to enter the date the UM Coordinator contacted the physician indicated in the Physician Name field.

6. RESPOND DATE (DATE-O)
This field is used to enter the date the physician responds to the UM Department.

7. CONTACT REASON (TABLE LOOKUP-R)
This field is used to indicate the reason the physician is contacted. Enter the UM Contact Reason code(s) if you know it, or press hyphen (-) followed by ENTER to display the UM Contact Reason table for selection. You can select up to four codes for this field. The code(s) and description(s) display.

8. ACTION/DETERMINATION (TABLE LOOKUP-O)
This field is used to indicate the action or follow-up that has taken place or is to take place on this contact. Enter the UM Action/Determination code(s) if you know it, or press hyphen (-) followed by ENTER to display the UM Action/Determination table for selection. You can select up to four codes for this field. The code(s) and description(s) display.

9. NOTES (SPECIAL FORMAT-O)
This field is used to enter additional free-form comments regarding the contact to the physician. You can enter up to two lines of text, 75 characters each.

When you are completing this screen with a new entry, the following prompt displays:

Accept this screen? (Y/N) [Y]--

Select one of the following options:

- Enter **N** for No to not accept the screen and the following prompt displays:

  Enter field number or '/' starting field number--

  Enter the number of the field you want to update, or press ENTER to redisplay the prompt for acceptance of the screen.

- Enter **Y** for Yes and the screen is accepted.
- Press period (.) followed by ENTER to return to the previous screen. The entry is not filed.

When you are updating previously entered information, the following prompt displays:

Accept this screen? (Y/N/'D'elete) [Y]--

Select one of the following options:

- Enter **N** for No to not accept the screen and the following prompt displays:

  Enter field number or '/' starting field number--

  Enter the number of the field you want to update, or press ENTER to redisplay the prompt for acceptance of the screen.

- Enter **Y** for Yes and the screen is accepted and the information is filed.
- Enter **D** to delete this entry. Once an entry is deleted, the information is no longer available.

After you accept or delete the information, you are returned to the UM Contact to Physician summary screen, which is now updated with summary information from the newly added entry (if applicable). You can edit or add another entry. If you want to exit this screen, press ENTER, and the following prompt displays:

C'omplete this abstract or Continue with review [NL]--

Select one of the following options:

- Enter **C** to complete this UM Abstract. The date of completion and the initials of the person signed on display in the header information. This begins the countdown for the purging of data based on the number of days set up in the UM Maintenance Parameters option.
- Press ENTER to continue this review for this patient. The UM Review submenu redisplays.

UM Contact to Advisor

One of the responsibilities of a UM Coordinator is to contact a physician advisor (one not associated with the care of the patient) regarding an issue of utilization, length of stay, quality, documentation, or possible termination of benefits. This option enables you to document that contact.

When you select the UM Contact to Advisor option, the following screen may be displayed:

```
              General Hospital UM Contact to Advisor Processor
                                                  Wed Jul 15, 2009 10:46 pm
Account No     Name                               Unit Number   Birthdate
0917300001     TONEY,EX                           000-00-6094   01/01/63 46Y
Sex  Adm Date  Attending Dr           Pt Type  Diagnosis - ICD 10           LOS
M    06/22/09  COLEMAN,MICHAEL        LTC      A00.0-Cholera due to Vibrio  1
F/C #Plans Cert Days Nurse Sta/Rm/Bd    Comp Date/Init # Revs
B    1               *HOME OR SELF CARE


Page:01 Date  Init  Physician                          Contacted  Responded
( 1) 07/15/09 JJW   MODEL PHYSICIAN                   07/01/09   07/10/09









Enter number to edit/view or 'A'dd an entry--
```

This screen displays a summary of all contacts done for this patient. If there are no contact to advisor entries associated with this patient, this summary screen does not display and the system automatically displays the next screen for entry of contact to advisor information. On the summary screen, you can select one of the following options:

- Select a current entry to edit by entering the number to the left of the data.
- Enter **A** to add physician contact information.

Regardless of whether you are editing or adding an entry, a screen similar to the following is displayed:

```
               General Hospital UM Contact to Advisor Processor
                                                  Sun Jun 28, 1992 12:14 pm
Account No     Name                               Unit Number   Birthdate
92132-00001    ROBERTSON,ROBBIE H                 0000-9000-85  06/09/61 31Y
( 1)Date               : 06/28/92
( 2)Init               : KGC
( 3)Contact Date       :
( 4)Physician Advisor  :
( 5)Time Spent         :
( 6)Referral Reason    :

( 7)Action/Determination:

( 8)Respond Date       :
( 9)Notice Date        :
(10)Denial Date        :
(11)Reinst Date        :
(12)Notes              :




Enter contact date--
```

When you are editing or reviewing a selected entry from the previous screen, all fields on this screen display the entered data. You can edit any field on this screen. When you are adding advisor information, the first two fields are automatically completed by the system.

Field Explanations

1. DATE (DATE-O)
This field indicates the date the UM Coordinator enters the advisor information into this screen. The system automatically completes this field with the current date, or you can edit this date.

2. INIT (3-A-O)
This field displays the initials of the person entering the physician advisor information. The system automatically enters the initials of the person signed onto the system, however, you can edit the initials if necessary.

3. CONTACT DATE (DATE-R)
This field is used to enter the date the UM Coordinator actually contacts the physician advisor.

4. PHYSICIAN ADVISOR (TABLE LOOKUP-R)
This field is used to enter the physician advisor the UM Coordinator contacted. Enter the physician advisor code if you know it, or press hyphen (-) followed by ENTER to display the UM Physician Advisor table for selection. The code and name of the physician advisor display.

5. TIME SPENT (TIME-O)
This field is used to enter the amount of time the physician advisor spent on this case. The total time can be entered in quarter hours. For example, if the advisor spent two and three quarter hours, you would enter the time as 2.75.

6. CONTACT REASON (TABLE LOOKUP-R)
This field is used to indicate the reason this case is being referred to an advisor. Enter the Contact Reason code(s) if you know it, or press hyphen (-) followed by ENTER to display the UM Contact Reason table for selection. You can select up to four codes for this field. The code(s) and description(s) display.

7. ACTION/DETERMINATION (TABLE LOOKUP-O)
This field is used to indicate the action to be taken or the follow-up that is to be performed for this contact. Enter the Action/Determination code(s) if you know it, or press hyphen (-) followed by ENTER to display the UM Action/Determination table for selection. You can select up to four codes for this field. The code(s) and description(s) display.

8. RESPOND DATE (DATE-O)
This field is used to enter the date the physician advisor responded to the UM Department.

9. NOTICE DATE (DATE-O)
This field is used to enter the date on which the UM Department notified the patient regarding termination of benefits. The date entered here also displays on the UB Non-Covered Days Summary screen.

10. DENIAL DATE (DATE-O)
This field is used to enter the date on which the patient's benefits are terminated.

11. REINST DATE (DATE-O)
This field is used to enter the date on which the patient's benefits are reinstated. The date entered here also displays on the UB Non-Covered Days Summary screen.

12. NOTES (SPECIAL FORMAT-O)
This field is used to enter additional free-form comments regarding the advisor contact. You can enter up to two lines of text, 75 characters each.

When you are completing this screen with a new entry, the following prompt displays:

Accept this screen? (Y/N) [Y]--

Select one of the following options:

- Enter **N** for No to not accept the screen and this prompt displays:

  Enter field number or '/' starting field number--

Enter the number of the field you want to update, or press ENTER to redisplay the prompt for acceptance of the screen.

- Enter **Y** for Yes and the screen is accepted.

When you are updating previously entered information, the following prompt displays:

Accept this screen? (Y/N/'D'elete) [Y]--

Select one of the following options:

- Enter **N** for No to not accept the screen and the following prompt displays:

  Enter field number or '/' starting field number--

  Enter the number of the field you want to update, or press ENTER to redisplay the prompt for acceptance of the screen.

- Enter **Y** for Yes and the screen is accepted and the information is filed.

- Enter **D** to delete this entry. Once an entry is deleted the information is no longer available.

After you accept or delete the information, the summary screen of UM Contact to Advisor redisplays and the screen is now updated with summary information from the newly added entry (if applicable). You can edit an entry or add another entry. If you want to exit this screen, press ENTER and the following prompt displays:

C'omplete this abstract or Continue with review[NL]--

Select one of the following options:

- Enter **C** to complete this UM Abstract. The date of completion and the initials of the person signed on display in the header information. This begins the countdown for the purging of data based on the number of days set up in the UM Maintenance Parameters option.

- Press ENTER to continue this review for this patient. The UM Review submenu redisplays.

Discharge Planning

One of the responsibilities and activities of a UM Coordinator is to perform and/or document any discharge planning to ensure prompt discharge from the facility and to best promote the continued health of the patient. This function documents the discharge planning process.

When you select the Discharge Planning option, the following screen may be displayed:

```
            General Hospital Discharge Planning Processor
                                                 Wed Jul 15, 2009 10:36 pm
Account No     Name                              Unit Number   Birthdate
0917300001     TONEY,EX                          000-00-6094   01/01/63 46Y
Sex  Adm Date  Attending Dr           Pt Type  Diagnosis - ICD 10           LOS
M    06/22/09  COLEMAN,MICHAEL        LTC                                  1
F/C #Plans Cert Days Nurse Sta/Rm/Bd    Comp Date/Init # Revs
B    12              *HOME OR SELF CARE


     Date     Init  D/C Planning     Referred From  Referred To    Notes Page:01
( 1) 07/15/09 JJW   FAMILY CARE      REGIONAL HOSPITBAPTIST HOSPITA   Y









Enter number to edit/view or 'A'dd an entry--
```

The screen displays a summary of all discharge planning done for this patient. If there are no discharge planning entries associated with this patient, this summary screen does not display and the system automatically displays the next screen for entry of discharge planning information. On the summary screen, you can select one of the following options:

- Select a current entry to edit by entering the number to the left of the data.
- Enter **A** to add discharge planning information.

If you select either of these options, the following screen is displayed:

```
               General Hospital UM Contact to Physician Processor
                                                  Sun Jun 28, 1992 11:14 am
Account No     Name                               Unit Number   Birthdate
92132-00001    ROBERTSON,ROBBIE H                 0000-9000-85  06/09/61 31Y
( 1)Date               : 06/28/92
( 2)Init               : KGC
( 3)Planning Code      :
( 4)Referred From      :
( 5)Referred To        :
( 6)Notes              :









Enter the UM Discharge Planning Code or '-' to list--
```

When you are editing or reviewing an entry from the previous screen, all fields on this screen display the entered data. You can edit any field on this screen except the Referred From field. When you are adding discharge planning information, the first two fields are automatically completed by the system.

Field Explanations

1. DATE (DATE-O)
This field indicates the date the UM Coordinator enters the discharge planning information into this screen. The system automatically completes this field with the current date, or you can edit the date.

2. INIT (3-A-O)
This field displays the initials of the person entering the information. The system automatically enters the initials of the person signed onto the system, however, you can edit the initials if necessary.

3. PLANNING CODE (TABLE LOOKUP-R)
This field is used to enter the discharge planning code. Enter the code if you know it, or press hyphen (-) followed by ENTER to display the UM Discharge Planning table for selection. The code and description display. This information is separate and different from the information entered via the STAR Nursing product.

NOTE: This information does not update the MR Abstract.

4. REFERRED FROM (DISPLAY ONLY)
This field is used to indicate the referring facility/institution from which this patient was referred. This information passes from the admission process and the MR Abstract, and can be updated on the UM Miscellaneous screen.

NOTE: This information updates the Referring Facility field on the Episode Detail-2 screen of the MR Abstract.

5. REFERRED TO (TABLE LOOKUP-O)
This field is used to indicate the referring institution/facility to which this patient is being referred. For example, if the patient's discharge planning code indicates transfer to a skilled nursing facility, this field can be used to indicate the facility name. Enter the code if you know it, or press hyphen (-) followed by ENTER to display the Referring Institution/Facility table for selection. The code and description display.

NOTE: This information does not update the MR Abstract.

6. NOTES (SPECIAL FORMAT-O)
This field is used for entry of additional information regarding the discharge planning of this patient. You can enter up to 12 lines of text. If text is entered, Y for Yes displays on the summary screen indicating that there is additional information. If no notes are entered here, the summary screen displays N for No.

When you are completing this screen with a new entry, the following prompt displays:

Accept this screen? (Y/N) [Y]--

Select one of the following options:

- Enter **N** for No to not accept the screen and the following prompt displays:

  Enter field number or '/' starting field number--

  Enter the number of the field you want to update, or press ENTER to redisplay the prompt for acceptance of the screen.

- Enter **Y** for Yes and the screen is accepted.

When you are updating previously entered information, the following prompt displays:

Accept this screen? (Y/N/'D'elete) [Y]--

Select one of the following options:

- Enter **N** for No to not accept the screen and the following prompt displays:

  Enter field number or '/' starting field number--

Enter the number of the field you want to update, or press ENTER to redisplay the prompt for acceptance of the screen.

- Enter **Y** for Yes and the screen is accepted and the information is filed.
- Enter **D** to delete this entry. Once an entry is deleted, the information is no longer available.

After you accept or delete the information, you are returned to the summary screen of UM Discharge Planning; however, the screen is now updated with summary information from the newly added data (if applicable). You can edit an entry or add another entry. If you want to exit this screen, press ENTER and the following prompt displays:

C'omplete this abstract or Continue with review [NL]--

Select one of the following options:

- Enter **C** to complete this UM Abstract. The date of completion and the initials of the person signed on display in the header information. This begins the countdown for the purging of data based on the number of days set up in the UM Maintenance Parameters option.
- Press ENTER to continue this review for this patient. The UM Review submenu redisplays.

UB Non-Covered Days Summary

This function summarizes the acute and non-covered day information for the patient's stay. There are two types of summarized days. One type, Non-Covered Days, is tied to the UB buckets (i.e.,LOA, Grace, SNF, etc) in the UM Non-Covered Days table. The other type, Avoidable Days, is not assigned to the UB bucket days and is not linked to the UB. Avoidable Days are determined by the UM Coordinator to be avoidable, unnecessary, and/or non-covered, but differ from the definition of UM UB Non-Covered Days.

When you select the UM UB Non-Covered Days Summary option, the following screen is displayed:

```
            General Hospital UM UB Non-Covered Days Summary Processor
                                                 Wed Jul 15, 2009 10:48 pm
Account No     Name                              Unit Number   Birthdate
0917300001     TONEY,ED                          000-00-6094   01/01/63 46Y
Sex  Adm Date  Attending Dr           Pt Type  Diagnosis - ICD 10           LOS
M    06/22/09  COLEMAN,MICHAEL        LTC                                  1
F/C #Plans Cert Days Nurse Sta/Rm/Bd    Comp Date/Init # Revs
B    1               *HOME OR SELF CARE
 1 Approval Ind                    2 App From   3 App To     4 Tot Non-Cov Days
->                                                           0
 5 ICF Days    6 SNF Days    7 Denied Days    8 Grace Days    9 LOA Days

10 Tot Avoid Days   11 Tot Acute Days        12 ALOC Days   13 RES Days
                       1
14 Notice Date   15 Reinst. Date  16 Steri/Hyster Ind  17 Co-Pay Exception Code
   07/12/09




Enter table code--
```

Field Explanations

1. APPROVAL IND (TABLE LOOKUP-O)
This field is used to indicate the type of approval given to this patient's stay. Enter the Approval Indicator Code if you know it, or press hyphen (-) followed by ENTER to display the UM Approval Indicator table for selection. The code and description display.

2. APP FROM (DATE)
This field is used to indicate thebeginning date of approval. The system automatically completes this field with the admission date of the patient, or you can edit the date.

3. APP TO (DATE)
This field is used to indicate the ending date of approval. The system automatically completes this field with the discharge date of the patient, or you can edit the date. If the patient has not been discharged, this field is blank.

4. TOT NON-COV (DISPLAY ONLY)
This field indicates the total number of non-covered days for this patient's stay. The number in this field reflects the number of days associated with a Non-Covered Days Code that is tied to the UB buckets. The system automatically calculates this number based on the information entered in the Avoidable/Non-Covered Days screen of the Add/Edit Review function. This field can only be edited by updating the information in the Avoidable/Non-Covered Days screen.

5. ICF DAYS (DISPLAY ONLY)
This field contains the number of Intermediate Care Facility Days as defined by CMS and/or the facility's fiscal intermediary. This field is automatically completed by the system based on the number of days in the Non-Covered Day Type field of the Avoidable/Non-Covered Days screen with a link to this UB bucket type. This field can only be edited by updating the information in the Avoidable/Non-Covered Days screen.

6. SNF DAYS (DISPLAY ONLY)
This field contains the number of Skilled Nursing Facility Days as defined by CMS and/or the facility's fiscal intermediary. This field is automatically completed by the system based on the number of days in the Non-Covered Day Type field in the Avoidable/Non-Covered Days screen with a link to this UB bucket type. This field can only be edited by updating the information in the Avoidable/Non-Covered Days screen.

7. DENIED DAYS (DISPLAY ONLY)
This field contains the number of Denied Days as defined by CMS and/or the facility's fiscal intermediary. This field is automatically completed by the system based on the number of days in the Non-Covered Day Type field of the Avoidable/Non-Covered Days screen with a link to this UB bucket type. This field can only be edited by updating the information in the Avoidable/Non-Covered Days screen.

8. GRACE DAYS (DISPLAY ONLY)
This field contains the number of Grace Days as defined by CMS and/or the facility's fiscal intermediary. This field is automatically completed by the system based on the number of days in the Non-Covered Day Type field of the Avoidable/Non-Covered Days screen with a link to this UB bucket type. This field can only be edited by updating the non-covered days information in the UM Avoidable/Non-Covered Days screen.

9. LOA DAYS (DISPLAY ONLY)
This field contains the number of Leave of Absence Days as defined by CMS and/or the facility's fiscal intermediary. This field is automatically completed by the system based on the number of days in the Non-Covered Day Type field of the Avoidable/Non-Covered Days screen with a link to this UB bucket type. This field can only be edited by updating the non-covered days information in the UM Avoidable/Non-Covered Days screen.

10. TOT AVOID DAYS (DISPLAY ONLY)
This field contains the total number of avoidable days. This field is automatically completed by the system based on the number of days associated with an Avoidable Days Code in the Avoidable/Non-Covered Days screen of the Add/Edit Review function. This field can only be edited by updating the Avoidable Day Type field in this screen.

11. TOT ACUTE DAYS (DISPLAY ONLY)
This field contains the total number of acute care days administered to an inpatient during this stay. This field is automatically completed by the system based on the total length of stay minus the total non-covered days. This field can only be edited by updating the Non-Covered Day Type field in the UM Avoidable/Non-Covered Days screen.

NOTE: Acute Days do not display for patients that have not been assigned to a room. For example, series patients do not get an acute day total because they are not assigned to a bed and do not receive acute care.

12. ALOC DAYS
Enter the total number of Alternate Level of Care days for the patient. ALOC Days information is required by the 3M Encoding product if using the New York or New Jersey Multiple Grouper interface.

If you use the UM Alternate Level of Care screen to enter ALOC information, the number of days from that screen updates this field. If you then edit this field, the new information overrides the old information but does not update the Alternate Level of Care screen.

13. RES DAYS
Enter the number of Residential Level of Care Days for this patient. RES days maybe added to the UB Non-Covered Summary screen. Users manually enter the Avoidable Days total in this field.

14. NOTICE DATE (DISPLAY ONLY)
This field contains the date on which the patient received notice regarding termination of benefits. This field is automatically completed by the system based on the information in the UM Contact to Advisor detail screen of the Add/Edit Review function. This field can only be edited by updating the information in the UM Contact to Advisor screen.

15. REINST DATE (DISPLAY ONLY)
This field contains the date on which the patient's benefits were reinstated. This field is automatically completed by the system based on the information in the UM Contact to Advisor screen of the Add/Edit Review function. This field can only be edited by updating the information in the UM Contact to Advisor screen.

16. STERI/HYSTER IND (1-A-O)
This field indicates if the Sterilization/Hysterectomy consent form has been signed. Enter Y for Yes, N for No, or leave the field blank. This is not a required field.

17. CO-PAY EXCEPTION CODE (2-N-O)
This field contains the two-digit numeric code that indicates the reason for which the patient is exempt from co-payment. This is not a required field.

Valid entries are as follows:

- 01 = Pregnancy
- 02 = Resident of an OMH/OMRDD Certified Community Residence

When you update this screen, the following prompt displays:

Accept this screen? (Y/N) [Y]--

Select one of the following options:

- Enter **N** for No to not accept the screen and the following prompt displays:

  Enter field number or '/' starting field number--

  Enter the number of the field you want to update, or press ENTER to redisplay the prompt for acceptance of the screen.

- Enter **Y** for Yes and the screen is accepted.

After you accept the screen, the following prompt displays:

C'omplete this abstract or Continue with review [NL]--

Select one of the following options:

- Enter **C** to complete this UM Abstract. The date of completion and the initials of the person signed on display in the header information. This begins the countdown for the purging of data based on the number of days set up in the UM Maintenance Parameters option.
- Press ENTER to continue this review for this patient. The UM Review submenu redisplays.

UB Condition Codes

When you select the UM UB Condition Codes option, the following screen is displayed:

```
          General Hospital UM UB Condition Codes Processor
                                              Mon Jul 13, 2009 09:41 am
Account No     Name                           Unit Number   Birthdate
0917300001     TONEY,EDWARD                   000-00-6094   01/01/63 46Y
 1 Condition Code 1          2 Condition Indicator 1    3 Condition Code 2
->
 4 Condition Indicator 2    5 Condition Code 3          6 Condition Indicator 3

 7 Condition Code 4          8 Condition Indicator 4    9 Condition Code 5

10 Condition Indicator 5   11 Condition Code 6         12 Condition Indicator 6

13 Condition Code 7         14 Condition Indicator 7   15 Condition Code 8

16 Condition Indicator 8   17 Condition Code 9         18 Condition Indicator 9

19 Condition Code 10        20 Condition Indicator 10  21 Condition Code 11

22 Condition Indicator 11

23 Treatment Authorization 24 Special Program

Enter UB Condition Code or `-` to list--
```

Field Explanations

1. CONDITION CODE 1 (TABLE LOOKUP)
Enter the code that specifies the first UB condition code related to this visit, for example, 02 - Condition Employment Related. Both the code and description display.

2. CONDITION INDICATOR 1 (TABLE LOOKUP-C)
Enter the UB Condition Indicator for Condition Code 1.

NOTE: This field is required if code entered in the Condition Code 1 field has the Indicator Required field set to Yes in the UB Condition Codes table. Otherwise, it cannot be accessed.

3. CONDITION CODE 2 (TABLE LOOKUP)
Enter the code that specifies the second UB condition code related to this visit. Both the code and description display.

4. CONDITION INDICATOR 2 (TABLE LOOKUP-C)
Enter the UB Condition Indicator for Condition Code 2.

NOTE: This field is required if code entered in the Condition Code 2 field has the Indicator Required field set to Yes in the UB Condition Codes table. Otherwise, it cannot be accessed.

5. CONDITION CODE 3 (TABLE LOOKUP)
Enter the code that specifies the third UB condition code related to this visit. Both the code and description display.

6. CONDITION INDICATOR 3 (TABLE LOOKUP-C)
Enter the UB Condition Indicator for Condition Code 3.

NOTE: This field is required if code entered in the Condition Code 3 field has the Indicator Required field set to Yes in the UB Condition Codes table. Otherwise, it cannot be accessed.

7. CONDITION CODE 4 (TABLE LOOKUP)
Enter the code that specifies the fourth UB condition code related to this visit. Both the code and description display.

8. CONDITION INDICATOR 4 (TABLE LOOKUP-C)
Enter the UB Condition Indicator for Condition Code 4.

NOTE: This field is required if code entered in the Condition Code 4 field has the Indicator Required field set to Yes in the UB Condition Codes table. Otherwise, it cannot be accessed.

9. CONDITION CODE 5 (TABLE LOOKUP)
Enter the code that specifies the fifth UB condition code related to this visit. Both the code and description display.

10. CONDITION INDICATOR 5 (TABLE LOOKUP-C)
Enter the UB Condition Indicator for Condition Code 5.

NOTE: This field is required if code entered in the Condition Code 5 field has the Indicator Required field set to Yes in the UB Condition Codes table. Otherwise, it cannot be accessed.

11. CONDITION CODE 6 (TABLE LOOKUP)
Enter the code that specifies the sixth UB condition code related to this visit. Both the code and description display.

12. CONDITION INDICATOR 6 (TABLE LOOKUP-C)
Enter the UB Condition Indicator for Condition Code 6.

NOTE: This field is required if code entered in the Condition Code 6 field has the Indicator Required field set to Yes in the UB Condition Codes table. Otherwise, it cannot be accessed.

13. CONDITION CODE 7 (TABLE LOOKUP)
Enter the code that specifies the seventh UB condition code related to this visit. Both the code and description display.

14. CONDITION INDICATOR 7 (TABLE LOOKUP-C)
Enter the UB Condition Indicator for Condition Code 7.

NOTE: This field is required if code entered in the Condition Code 7 field has the Indicator Required field set to Yes in the UB Condition Codes table. Otherwise, it cannot be accessed.

15. CONDITION CODE 8 (TABLE LOOKUP)
Enter the code that specifies the eighth UB condition code related to this visit. Both the code and description display.

16. CONDITION INDICATOR 8 (TABLE LOOKUP-C)
Enter the UB Condition Indicator for Condition Code 8.

NOTE: This field is required if code entered in the Condition Code 8 field has the Indicator Required field set to Yes in the UB Condition Codes table. Otherwise, it cannot be accessed.

17. CONDITION CODE 9 (TABLE LOOKUP)
Enter the code that specifies the ninth UB condition code related to this visit. Both the code and description display.

18. CONDITION INDICATOR 9 (TABLE LOOKUP-C)
Enter the UB Condition Indicator for Condition Code 9.

NOTE: This field is required if code entered in the Condition Code 9 field has the Indicator Required field set to Yes in the UB Condition Codes table. Otherwise, it cannot be accessed.

19. CONDITION CODE 10 (TABLE LOOKUP)
Enter the code that specifies the tenth UB condition code related to this visit. Both the code and description display.

20. CONDITION INDICATOR 10 (TABLE LOOKUP-C)
Enter the UB Condition Indicator for Condition Code 10.

NOTE: This field is required if code entered in the Condition Code 10 field has the Indicator Required field set to Yes in the UB Condition Codes table. Otherwise, it cannot be accessed.

21. CONDITION CODE 11 (TABLE LOOKUP)
Enter the code that specifies the eleventh UB condition code related to this visit. Both the code and description display.

22. CONDITION INDICATOR 11 (TABLE LOOKUP-C)
Enter the UB Condition Indicator for Condition Code 11.

NOTE: This field is required if code entered in the Condition Code 7 field has the Indicator Required field set to Yes in the UB Condition Codes table. Otherwise, it cannot be accessed.

If ENTER is pressed on any of the condition code fields, the cursor advances to the Treatment Authorization field.

23. TREATMENT AUTHORIZATION (18-AN-O)
Enter the treatment authorization number assigned as a result of the insurance verification process.

24. SPECIAL PROGRAM (TABLE LOOKUP)
Enter the code that specifies the UB special program code that is applicable to this patient's visit, for example, 03 - Special Federal Funding. This field is only used for the UB claim forms. With the UB, special program codes should be entered as alphanumeric condition codes, for example, A3 - Special Federal Funding. Both the code and description display.

UB Occurrence Codes

When you select the UM UB Occurrence Codes option, the following screen is displayed:

```
            General Hospital UB Occurrence Codes Processor
                                                 Mon Jul 13, 2009 09:44 am
Account No     Name                              Unit Number   Birthdate
0917300001     TONEY,EDWARD                      000-00-6094   01/01/63 46Y
 1 Occurrence Code 1       2 Date        3 Occurrence Code 2       4 Date

 5 Occurrence Code 3       6 Date        7 Occurrence Code 4       8 Date

 9 Occurrence Code 5      10 Date       11 Occurrence Code 6      12 Date

13 Occurrence Code 7      14 Date       15 Occurrence Code 8      16 Date

17 Occurrence Span Codes









Enter field number or '/' starting field number--
```

Field Explanations

1. OCCURRENCE CODE 1 (TABLE LOOKUP)
Enter the code that specifies the first UB occurrence related to this visit, for example - 01 Auto Accident. Both the code and description display.

2. DATE (25-C-O)
Enter the date related to the first occurrence code. There are several formats you can use to enter the date. Refer to the Information Entry Techniques chapter in the *General Information Volume* of the *STAR Patient Care Reference Guide* for details.

3. OCCURRENCE CODE 2 (TABLE LOOKUP)
Enter the code that specifies the second UB occurrence related to this visit. Both the code and description display.

4. DATE (25-C-O)
Enter the date related to the second occurrence code. There are several formats you can use to enter the date. Refer to the Information Entry Techniques chapter in the *General Information Volume* of the *STAR Patient Care Reference Guide* for details.

5. OCCURRENCE CODE 3 (TABLE LOOKUP)
Enter the code that specifies the third UB occurrence related to this visit. Both the code and description display.

6. DATE (25-C-O)
Enter the date related to the third occurrence code. There are several formats you can use to enter the date. Refer to the Information Entry Techniques chapter in the *STAR Patient Care Reference Guide, General Information Volume* for details.

7. OCCURRENCE CODE 4 (TABLE LOOKUP)
Enter the code that specifies the fourth UB occurrence related to this visit. Both the code and description display.

8. DATE (25-C-O)
Enter the date related to the fourth occurrence code. There are several formats you can use to enter the date. Refer to the Information Entry Techniques chapter in the *STAR Patient Care Reference Guide, General Information Volume* for details.

9. OCCURRENCE CODE 5 (TABLE LOOKUP)
Enter the code that specifies the fifth UB occurrence related to this visit. Both the code and description display.

10. DATE (25-C-O)
Enter the date related to the fifth occurrence code. There are several formats you can use to enter the date. Refer to the Information Entry Techniques chapter in the *STAR Patient Care Reference Guide, General Information Volume* for details.

11. OCCURRENCE CODE 6 (TABLE LOOKUP)
Enter the code that specifies the sixth UB occurrence related to this visit. Both the code and description display.

12. DATE (25-C-O)
Enter the date related to the sixth occurrence code. There are several formats you can use to enter the date. Refer to the Information Entry Techniques chapter in the *STAR Patient Care Reference Guide, General Information Volume* for details.

13. OCCURRENCE CODE 7 (TABLE LOOKUP)
Enter the code that specifies the seventh UB occurrence related to this visit. Both the code and description display.

14. DATE (25-C-O)
Enter the date related to the seventh occurrence code. There are several formats you can use to enter the date. Refer to the Information Entry Techniques chapter in the *STAR Patient Care Reference Guide, General Information Volume* for details.

15. OCCURRENCE CODE 8 (TABLE LOOKUP)
Enter the code that specifies the eighth UB occurrence related to this visit. Both the code and description display.

16. DATE (25-C-O)
Enter the date related to the eighth occurrence code. There are several formats you can use to enter the date. Refer to the Information Entry Techniques chapter in the *STAR Patient Care Reference Guide, General Information Volume* for details.

17. OCCURRENCE SPAN CODES (TABLE LOOKUP)
When you access this field, the following prompt is displayed:

Edit Span Codes Information? (Y/N) [N]--

Enter Y to edit span codes information, and the following screen is displayed:

```
               General Hospital UM Review Processor
                                                  Mon Jul 13, 2009 09:44 am
Account No     Name                               Unit Number   Birthdate
0917300001     TONEY,EDWARD                       000-00-6094   01/01/63 46Y
 1 Occurrence Span A       2 From Date A    3 Thru Date A
->
 4 Occurrence Span B       5 From Date B    6 Thru Date B

 7 Occurrence Span C       8 From Date C    9 Thru Date C

10 Occurrence Span D      11 From Date D   12 Thru Date D









Enter UB Occu Span Code or `-` to list--
```

1. OCCURRENCE SPAN A (TABLE LOOKUP)
Enter the code that specifies the first UB occurrence span code related to this visit (for example, 71 Prior Stay Dates). Both the code and description are displayed.

2. FROM DATE A (10-C-C)
Enter the date that the first occurrence span began. There are several formats you can use to enter the date. Refer to the Information Entry Techniques chapter in the *STAR Patient Care Reference Guide, General Information Volume* for details. This field is required if the Occurrence Span field is entered.

3. THROUGH DATE A (10-C-C)
Enter the date that the first occurrence span ended. There are several formats you can use to enter the date. Refer to the Information Entry Techniques chapter in the *STAR Patient Care Reference Guide, General Information Volume* for details. This field is required if the Occurrence Span field is entered.

4. OCCURRENCE SPAN B (TABLE LOOKUP)
Enter the code that specifies the second UB occurrence span code related to this visit. Both the code and description are displayed.

5. FROM DATE B (10-C-C)
Enter the date that the second occurrence span began. There are several formats you can use to enter the date. Refer to the Information Entry Techniques chapter in the *STAR Patient Care Reference Guide, General Information Volume* for details. This field is required if the Occurrence Span field is entered.

6. THROUGH DATE B (10-C-C)
Enter the date that the second occurrence span ended. There are several formats you can use to enter the date. Refer to the Information Entry Techniques chapter in the *STAR Patient Care Reference Guide, General Information Volume* for details. This field is required if the Occurrence Span field is entered.

7. OCCURRENCE SPAN C (TABLE LOOKUP)
Enter the code that specifies the first UB occurrence span code related to this visit (for example, 71 Prior Stay Dates). Both the code and description are displayed.

8. FROM DATE C (10-C-C)
Enter the date that the first occurrence span began. There are several formats you can use to enter the date. Refer to the Information Entry Techniques chapter in the *STAR Patient Care Reference Guide, General Information Volume* for details. This field is required if the Occurrence Span field is entered.

9. THROUGH DATE C (10-C-C)
Enter the date that the first occurrence span ended. There are several formats you can use to enter the date. Refer to the Information Entry Techniques chapter in the *STAR Patient Care Reference Guide, General Information Volume* for details. This field is required if the Occurrence Span field is entered.

10. OCCURRENCE SPAN D (TABLE LOOKUP)
Enter the code that specifies the second UB occurrence span code related to this visit. Both the code and description are displayed.

11. FROM DATE D (10-C-C)
Enter the date that the second occurrence span began. There are several formats you can use to enter the date. Refer to the Information Entry Techniques chapter in the *STAR Patient Care Reference Guide, General Information Volume* for details. This field is required if the Occurrence Span field is entered.

12. THROUGH DATE D (10-C-C)
Enter the date that the second occurrence span ended. There are several formats you can use to enter the date. Refer to the Information Entry Techniques chapter in the *STAR Patient Care Reference Guide, General Information Volume* for details. This field is required if the Occurrence Span field is entered.

Alternate Level of Care Information

The Alternate Level of Care (ALC) Information screen was originally created for facilities in New York and New Jersey, but it can also be used by other facilities to capture ALC information. This data can be used for SQL Reporting.

When you select the Alternate Level of Care Information option, the following screen is displayed:

```
        General Hospital Alternate Level of Care Information Processor
                                                  Wed Jul 15, 2009 10:50 pm
Account No     Name                               Unit Number   Birthdate
0917300001     TONEY,ED                           000-00-6094   01/01/63 46Y
Sex  Adm Date  Attending Dr           Pt Type  Diagnosis - ICD 10           LOS
M    06/22/09  COLEMAN,MICHAEL        LTC                                  1
F/C #Plans Cert Days Nurse Sta/Rm/Bd    Comp Date/Init # Revs
B    1              *HOME OR SELF CARE
Seq# ALC  ALC  ALC  Description  Date ALC ALC Note From     Thru     ALC    LOS
     Code Type Rate              Required Date     Date     Date   Grc Days Days
1    100  4    8765 PRE-OP DDT/L 05/08/03 05/08/03 05/08/03 05/21/03  0     14
2    200  1    2962 PSYCH SNF&HR 05/21/03 05/20/03 05/22/03 5/26/03   2      5









    F1Prev Page F2Next Page F3 Insert  F4 Delete  F6 Reset  F7  Exit   ?
```

This screen uses *scrolling screen* functionality. The function keys displayed at the bottom of the screen are used to maneuver around the screen. For complete instructions on scrolling screen logistics please refer to the Entry Techniques chapter of the *STAR Patient Care Reference Guide, General Information Volume*.

Field Explanations

The screen header is the header currently used in the other Utilization Management options.

SEQ #
A sequence number of one or two digits is automatically assigned for each ALC entry.

ALC CODE
Enter the three-digit numeric code for the appropriate ALC Type. Press hyphen (-) to select an ALC Type from the UM ALC Code table.

ALC TYPE
The system automatically displays the ALC Type associated with the ALC code entered in the ALC Code field. This link is defined in the UM ALC Code table. The ALC Type is a one-digit code. This field is display only.

Valid codes are as follows:

1 = Residential Health Care Facility (SNF)
2 = Health Related Facility

3 = Domiciliary Care
4 = Other Institution
5 = Home Health Service

ALC RATE
The system automatically displays the four-digit ALC Rate code associated with the ALC code entered in the ALC Code field. This link is defined in the UM ALC Code table. This field is display only.

DESCRIPTION
This field displays a 25-character alphanumeric description of the ALC code. This description is system generated, derived from the ALC Code table, and cannot be edited.

DATE ALC REQ
Enter the date a new ALC is required for this patient. The date can be entered without (/) slashes. The date must be within the patient's admission and discharge dates. The date must not have already been entered in a previous ALC entry on this screen.

ALC NOTE DATE
Enter the date that the patient was notified that acute care was no longer required. This date is considered to be an acute care day. The date entered must be on or after the admission date and on or before the From Date for the ALC code.

FROM DATE
Enter the service from date for this type of ALC. The date must be within the patient's admission and discharge dates. The date must not have already been entered in a previous ALC entry on this screen. This is a required field.

THRU DATE
Enter the service thru date for this type of ALC. The date must be within the patient's admission and discharge dates. The date must not have already been entered in a previous ALC entry on this screen. This is a required field.

ALC GRACE DAYS
The system automatically displays the difference between the Notify Date and the From Date for the ALC Code. If the Notify Date and the From Date are the same, then the ALC Grace Days is 0 for that code. This field is display only.

LOS DAYS
The system automatically displays the total number of days between the From and Thru dates for this ALC Type. This field displays up to three digits. This field is display only.

The number of days in this field automatically fills in the ALOC Days field on the UM UB Non-Covered Days Summary screen. Changes made on that screen do not update this field.

Press F7 to save information. After saving the following prompt displays:

Accept? (Y/N)

Enter **Y** for Yes to accept the screen and **N** for No to edit information already entered.

If you enter **Y**, the second screen is displayed as follows:

```
         General Hospital Alternate Level of Care Information Processor
                                                  Tue May 27, 2003 02:56 pm
Account No     Name                               Unit Number   Birthdate
03121-00002    SMITH,JOHN                         100004090     01/19/33 69Y


Stay Days Summary

ALC LOS:                      19
Acute ALC Days:               14
Non Acute ALC Grace Days:      2
Non Acute ALC Days:            5









Press NL--
```

Field Explanations

ALC LOS (DISPLAY ONLY)
This field displays the total length of stay (LOS) for all ALC codes, both Acute Care (identified by a blank ALC Type) and Non Acute Care. This amount may differ from other LOS calculations that exclude either the admission date for non-discharged accounts or the discharge date for discharged accounts. This field checks only the Alternate Level of Care information and does not exclude any days on that screen. Days that do not have an ALC code entered are not reflected in the ALC LOS calculation.

ACUTE ALC DAYS (DISPLAY ONLY)
This field displays the total number of days that have an ALC code with a blank ALC Type. Since the Acute Care days are not necessarily the beginning portion of a patient's stay (for example, when a patient goes from Rehab to Acute Care and back to Rehab), the ALC code for Acute Care should be entered for the Acute Care days, and this ALC code should have a blank ALC Type. The days are then determined by the From and Thru Dates for each of the ALC codes with a blank ALC Type on the account.

NON ACUTE ALC GRACE DAYS (DISPLAY ONLY)
This field displays the total number of Grace Days for the ALC codes that have an ALC Type entered. Since the Acute Care Days should have an ALC code with a blank ALC

Type, this field excludes any Grace Days on an Acute Care ALC code. The Grace Days are the days from the Notify Date to the From Date for each of the ALC codes on the account.

NON ACUTE ALC DAYS (DISPLAY ONLY)
This field displays the total number of days that have an ALC code with an ALC Type entered (the ALC Type is not blank). The days are then determined by the From and Thru Dates for each of the ALC Codes with an ALC Type entered on the account.

When you finish viewing this screen, press ENTER and the following prompt is displayed:

'C'omplete this abstract or Continue with review[NL]--

Enter **C** if the ALC Information is complete. By pressing **C** you complete the UM Abstract. Press ENTER to return to the menu if more data is to be entered in the UM Abstract.

View/Print Electronic Reports

The View/Print Electronic Reports option enables you to view and/or print electronic reports generated by the Medical Record Transcription interface.

When the View/Print Electronic Reports option is selected, STAR displays a list of all known report headers in STAR for the patient. The following is an example of this screen:

```
              General Hospital  View/Print Elec Rpts Processor
                                  <New Msgs>      Mon Apr 16, 2000 02:07 pm
  No          Name              Sex    BD     Room    Physician      SVC   Status
9903300001    ANDERSON,MARY      F  08/21/63  100-01  DOCTOR,ADMITT  MED   I/P 63

Choice#  Report Type      Date      Time     Adm Date   Dis Date  Elec Signed
          Document Authenticator(s)
1          Hist & Phys    09/28/99 08:31     09/28/99
2          Consult        09/29/99 09:45     09/28/99
3          Consult        09/29/99 12:35     09/28/99
4          Consult        09/30/99 15:00     09/28/99
5          Operative      10/03/99 07:30     09/28/99
6          Operative      10/12/99 08:00     09/28/99
7          Operative      10/27/99 14:30     09/28/99
8          Operative      11/08/99 09:00     09/28/99
9          Operative      11/12/99 09:00     09/28/99
10         Operative      11/19/99 20:45     09/28/99
11         Discharge Sum  12/06/99 08:00     09/28/99
12         Pathology Rpt  12/06/99 08:30     09/28/99

Enter choices separated by commas, `-` to remove, More(M)--
                             next page (/)
```

The screen displays a list of the transcribed medical record reports for the patient for which a report header was transmitted to STAR from the transcription system. The

report header is transmitted, not the full report. A query must be made to the transcription system if the full report is to be viewed.

Field Explanations

REPORT TYPE
The information under this header indicates the type of medical record report. The system displays the report description associated with the transcription report type code, as defined in the Transcription Report Types table. If the report type has not been defined in the Transcription Report Types table, this field displays the code originally transmitted from the transcription system.

DATE
The information under this header indicates the date the report became available for viewing.

TIME
The information under this header indicates the time the report became available for viewing.

ADM DATE
The information under this header indicates the admission/registration date of the patient that is applicable to this report.

DIS DATE
The information under this header indicates the discharge/disposition date of the patient that is applicable to this report. If the patient has not been discharged/ dispositioned, this field is blank.

ELEC SIGNED
This field indicates whether an electronic signature has been entered for this report via STAR. The field displays Yes or No. The report does not have to be electronically signed by the physician viewing the report in order for the indicator to display. If the report had been sent electronically, but signed manually, this field still displays an N for No, since STAR has no way of knowing when a report is manually signed.

DOCUMENT AUTHENTICATOR(S)
This field indicates the physician/clinician(s) responsible for authenticating (signing) the transcribed report. This information is transmitted from the transcription vendor. If the document authenticator is not included in the transmitted report header, this field is blank. Up to three document authenticators display in this field.

You have the following entry options on this screen:

- Enter a period (.) and press ENTER to exit this process and return to the submenu.

- Enter the number to the left to indicate the type for selection. Once the report(s) has been selected, STAR begins retrieving the report(s) from the transcription system as described below.

- Enter a hyphen (**-**) followed by the number to the left to deselect a selected report.

- Enter **M** to see more than the reports listed on this screen. The listing on the screen includes only those reports for which a report header was transmitted to STAR. There may be reports in the transcription system that you want to view, but a report header is not listed. If you enter **M**, an additional selection screen is displayed, which enables you to enter criteria for report selection.

If there were no known report headers in STAR for the selected patient, the screen displays without any entries. The associated prompt still displays, enabling you to enter an **M** in order to query the transcription system for more reports for the patient.

NOTE: Any reports selected from the previous screen are no longer queried on when **M** for more is selected.

The following is an example of the query search selection screen:

```
              General Hospital View/Print Elec Rpts Processor
                                                  Sat Aug 25, 2001 06:30 pm
  No          Name              Sex    BD     Room    Physician     SVC   Status
01093-00008   TECK,TWELVEMONTHG F  04/03/00 2112-02 ANATOMIC,PATH MED   IPB 145

Query Search Selection Criteria
 1 Start Date         2 End Date      3 Report Type
   08/18/01             08/25/01        All









Enter field number or '/' starting field number--
```

Field Explanations

1. START DATE (DATE ENTRY)
This field is used to narrow the search to a specific time period. STAR automatically defaults the value of the current date minus the number of days indicated in the Default Date Range field of the Report Query Parameter; however, you can enter a different date.

When you access this field, the following prompt is displayed:

Enter start date--

Enter the date that indicates the beginning date to use in the search of the patient's report, along with the End Date. This date is transmitted to the transcription system for the query and is compared against the report dates that fall within the specified time period.

If you enter only 2 digits for the year, the system defaults the century of 20 for years of 00 - 10 and 19 for years of 11 - 99. The start time sent is 0000.

If you leave the Start Date field blank, the system displays the following error message:

Incomplete date range - request aborted

NOTE: The greater the time span being searched upon, the longer the search time required.

2. END DATE (DATE ENTRY)
This field is used to narrow the search to a specific time period. STAR automatically defaults the value to the current date; however, you can enter a different date.

When this field is entered, the following prompt is displayed:

Enter end date--

Enter a date that indicates the ending date to use in the search of the patient's report (this date cannot precede the start date entered in the previous field). When this date entry, along with that entered in the Start Date field is transmitted, to the transcription system for the query, it is compared against the report dates that fall within the specified time period.

If you enter only 2 digits for the year, the system defaults the century of 20 for years of 00 - 10 and defaults 19 for years of 11 - 99. The end time sent is 2359.

If you leave the End Date field blank, the system displays the following error message:

Incomplete date range - request aborted

NOTE: The greater the time span being searched upon, the longer the search time required.

3. REPORT TYPE (TABLE LOOKUP)
This field is used to narrow the search to a specific report type. STAR automatically defaults the value to All. When this field is entered, STAR automatically displays the Message Types associated with transcription for selection.

When the selection criteria screen is complete, the following occurs:

- A query is transmitted to the transcription system requesting a list of all the transcribed reports for the patient that meet the criteria entered on the selection screen.

- The requested list is transmitted to STAR and is displayed on the screen. If there are no additional entries to transmit from the transcription system, the screen displays a message indicating such.

- You can select an entry from the updated listing. The processing steps are described below.

NOTE: For reports of only a selected type to display, your facility must use the QRF-04 segment instead of the QRF-01 segment in the HL7 query message. Your transcription vendor may need to make adjustments on their side to process the QRF-04 segment.

If the QRF-01 segment is used, all reports are returned from the transcription vendor instead of only the indicated report type.

There can be reports in the transcription system for the patient that are not available because they have not been released by the supervisor, or they have been secured to prevent access. These security checks are controlled by the transcription system, not by STAR. If there is a report you are not able to access, check with the Transcription Department at the facility.

When the report has been selected, STAR begins retrieving the report from the transcription system and this messages displays:

Retrieving report(s).....one moment please

The message is displayed until the report query has completed and the first report displays. If more than one report was selected, they are displayed consecutively.

The following prompt is displayed at the bottom of the screen when the reports have been retrieved:

Enter next page(/), previous page(/P), stop (S), print(P), previous report(/R), next report (R) [R]--

This prompt allows you to page through the selected report, stop viewing, print the report, or view the previous or next report. If there is no previous report, the /R option does not display.

The report is transmitted in ASCII format, without any fonting or special highlighting. The report header includes patient identification information on all pages of the report.

After you have viewed and/or printed the selected report(s), the screen displays the list of reports for the patient. This enables you to continue the process.

NOTE: When you print reports from the transcription interface, the system automatically prints the following in the header:

SYSTEM COPY - NOT FROM CHARTED ORIGINAL
THIS IS NOT AN OFFICIAL AND LEGAL DOCUMENT.

VIEW REVIEW

When you select View Review, the MPI patient lookup prompt displays for selection of a patient. If you select a patient who has not been included in the UM Census, the following message displays:

Patient not in UM Census

The message displays briefly, then the MPI patient lookup prompt redisplays for selection of another patient.

After you select a valid patient, the following submenu displays:

```
                    General Hospital UM Review Processor
                                              Wed Jul 3, 1996 02:13 pm
  Account No     Name                              Unit No        Corp No
  92098-00002    ROBERTSON,ROBBIE H                0000-9000-46   00000258

          Option No.  Option
          ---------------------------------------
              1       Review
              2       Miscellaneous Review Information
              3       Avoidable/Non-Covered Days
              4       UM Contact to Physician
              5       UM Contact to Advisor
              6       Discharge Planning
              7       UB Information
              8       UB Condition Codes
              9       UB Occurrence Codes
             10       Alternate Level of Care Information




Enter option number--
```

You can view the same screens that are available via the Add/Edit Review option. The data on the screens is the same, however, View Review only enables you to view the information. You cannot edit, delete, or add information. For detailed screens and field explanations for each of these menu options, refer to the Review section discussed previously.

After you view the information and press ENTER, the initial UM Options menu redisplays.

PRINT REVIEW

When you select Print Review, the MPI patient lookup prompt displays for selection of a patient. If you select a patient who has not been included in the UM Census, the following message displays:

Error: Patient not in UM Census, cannot print!

The message displays briefly, then the MPI patient lookup prompt redisplays for selection of another patient.

After you select a valid patient, the following submenu displays:

```
                    General Hospital UM Review Processor
                                                Wed Jul 15, 2009 10:57 pm
  Account No     Name                          ICD    Unit No        Corp No
  0917300001     TONEY,ED                      10     000-00-6094    00006788
          Option No.  Option
          ---------------------------------------
              1       Print All Reviews
              2       Print Reviews for Selected Insurance Plans
              3       Print Last 3 Reviews
              4       Print Last Review









Enter option number--
```

This screen displays the available print options. The options are as follows:

- Print All Reviews prints the review information associated with all reviews regardless of the insurance plan to which they are attached.
- Print Reviews for Selected Insurance Plans displays the insurance screen for this patient. Select the insurance plans on which to print the reviews. The system prints all reviews for the selected insurance plan.
- Print Last 3 Reviews prints the last three reviews for this patient, regardless of the insurance plan to which they were associated.
- Print Last Review prints the last review for this patient, regardless of the insurance plan with which it was associated.

After you make your selection, the review(s) automatically begins printing and the following message is displayed:

Generating Report XXX

where *XXX* is the spooler name of the default printer defined for that CRT.

The following is an example of a printed UM Review:

Figure 2.1 Sample Printed UM Review

```
                General Hospital View Reports Processor
                                                Thu Dec 03, 1992 10:09 am

Thu Dec 03, 1992 10:08 am     GENERAL HOSPITAL A                      Page 1
                               Print All Reviews

Account No     Name                                Unit Number   Birthdate
92197-00005    ROSS,TINA                           0000-9003-39  07/08/14 78Y
Sex  Adm Date  Attending Dr                         Pt Type  Diagnosis LOS
F    07/15/92  CHERECK,BOB                         ECU      428.0     5
F/C #Plans    Cert Days Nurse Sta/Rm/Bd           Comp Date/Init    # Revs
C    3        30              ECU/1100/01         DIS                  2

INS PLAN: GENERAL PLAN

Rev#: 1             Rev Date: 07/16/92  Init: LTR
Rev Type: 1-ADMISSION REVIEW
Review Reason: 2-ADM-INTENSITY OF SERVICE MET
Crit Met:
Severity Level: BB-SEVERITY LEVEL BB
Days/Next Rev:   2  Days Cert:  30      Next Rev Date: 07/18/92

NOTES:
PATIENT ADMITTED WITH CHRONIC PULMONARY DISEASE.  PATIENT ADMITTED TO ECU
AND APPROVED FOR 30 DAYS.  PATIENT NOT ABLE TO CARE FOR SELF, AND HAD SOME
ACUTE MEDICAL PROBLEMS.

Rev#: 2             Rev Date: 07/18/92  Init: LTR
Rev Type: 2-PRO REVIEW
Review Reason: 3-ADM-SEVERITY OF ILLNESS MET
Crit Met:
Severity Level: -
Days/Next Rev:      Days Cert:          Next Rev Date: 07/18/92

End of Report
```

TRANSFER REVIEW

The Transfer Review function is used when the UM Coordinator determines that a patient's review(s) needs to be transferred from one insurance plan to another. This may occur as a result of a change in the primary insurance, or a review may have been mistakenly associated with the wrong insurance.

When you select Transfer Review, the MPI patient lookup prompt displays for selection of a patient. If you select a patient who has not been included in the UM Census, the following message displays:

Error: Patient not in UM Census, cannot transfer review!

The message displays briefly, then the MPI patient lookup prompt redisplays for selection of another patient. After you select a valid patient, the screen listing the insurance plans associated with the selected visit displays. The following is a sample of this screen:

```
                General Hospital Transfer Review Processor
                                                Fri Aug 23, 2002 11:30 am
Account No     Name                             Unit Number   Birthdate
0219100002     TANNER,CHARLES                   000-00-2308   12/17/87 14Y
Sex  Adm Date  Attending Dr           Pt Type  Diagnosis                    LOS
M    07/10/02  ADAIR,FRANK C         I/P      540.9-ACUTE APPENDICITIS NO  40
F/C #Plans Cert Days Nurse Sta/Rm/Bd    Comp Date/Init # Revs
M    2     1         *HOME OR SELF CARE                 2
Page 01PLAN              PHONE #       APPROVAL #      REF #           V  C
     APPR LOS REVIEW AGENCY             PHONE #         CONTACT NAME
( 1) MEDICARE A            (404)555-1212                REF1234         N  N
              REVIEW                    (708)999-1111   REVIEW CONTACT
( 2) MEDICARE PROFESSIONAL (404)555-1212                                  N




Select Insurance to Transfer from--
```

This screen contains a list of all insurance plans currently associated with the selected patient. You are prompted to select the insurance **from** which reviews are to be transferred. Enter the number to the left of the insurance description. If you select an insurance for which no reviews are associated, the system returns to the UM Functions submenu.

If you select an insurance with reviews, the following sample screen displays:

```
                    General Hospital Transfer Review Processor
                                                 Fri Aug 23, 2002 12:07 pm
Account No     Name                              Unit Number   Birthdate
0219100002     TANNER,CHARLES                    000-00-2308   12/17/87 14Y
Sex  Adm Date  Attending Dr           Pt Type  Diagnosis                    LOS
M    07/10/02  ADAIR,FRANK C          I/P      540.9-ACUTE APPENDICITIS NO  40
F/C #Plans Cert Days Nurse Sta/Rm/Bd    Comp Date/Init # Revs
M    2     1         *HOME OR SELF CARE                 2


Page:01   REV    INIT    REV       # CRIT  DAYS    NEXT       ##=Current Choices
     #    DATE           TYPE        MET   CERT    REV     TRANS/COPY FROM
( 1) 2   08/22/02 A W  C-DELEGATED              08/23/02
( 2) 1   08/22/02 A W  J-RETRO REVI   1    1     09/01/02









Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
                                 end select(NL)
```

This screen contains a list of all reviews associated with the selected insurance. Select the review(s) to be transferred by entering the review number(s) or **A** for all.

After you select the reviews, the following screen redisplays:

```
                    General Hospital Transfer Review Processor
                                                 Fri Aug 23, 2002 12:07 pm
Account No     Name                              Unit Number   Birthdate
0219100002     TANNER,CHARLES                    000-00-2308   12/17/87 14Y
Sex  Adm Date  Attending Dr           Pt Type  Diagnosis                    LOS
M    07/10/02  ADAIR,FRANK C          I/P      540.9-ACUTE APPENDICITIS NO  40
F/C #Plans Cert Days Nurse Sta/Rm/Bd    Comp Date/Init # Revs
M    2     1         *HOME OR SELF CARE                 2
Page 01PLAN                  PHONE #        APPROVAL #       REF #      V  C
     APPR LOS REVIEW AGENCY                 PHONE #        CONTACT NAME
( 1) MEDICARE A            (404)555-1212                  REF1234          N  N
              REVIEW                      (708)999-1111   REVIEW CONTACT
( 2) MEDICARE PROFESSIONAL (404)555-1212                                    N









Select Insurance to Transfer to--
```

The screen of insurance plans redisplays for selection of the insurance **to** which the reviews are to be transferred. Enter the number to the left of the insurance description. The system does not allow you to transfer reviews to the same insurance. After you make your selection, the following prompt displays:

Transfer selected reviews? (Y/N) [Y]--

Select one of the following options:

- Enter **Y** for Yes or press ENTER to accept the default indicating that the reviews should be transferred to the selected insurance. The following message displays:

  Review transfer completed!

  The message displays briefly, and then you are returned to the listing of insurance plans for this patient.

- If you do not want to select another insurance or continue the transfer process, press ENTER to return to the menu.

COPY REVIEW

The Copy Review function is used when the UM Coordinator determines that a patient's review(s) needs to be copied from one insurance plan to another. This may occur as a result of a change in the primary insurance.

When you select Copy Review, the MPI patient lookup prompt displays for selection of a patient. If you select a patient who is not included in the UM Census, the following message is displayed briefly:

Error: Patient not in UM Census, cannot copy review!

The MPI patient lookup prompt redisplays for selection of another patient. After you select a valid patient and visit, the screen listing the insurance plans associated with the selected visit is displayed. The following is a sample of this screen:

```
                  General Hospital Copy Review Processor
                                                Fri Aug 23, 2002 11:30 am
Account No     Name                           Unit Number   Birthdate
0219100002     TANNER,CHARLES                 000-00-2308   12/17/87 14Y
Sex  Adm Date  Attending Dr           Pt Type  Diagnosis                  LOS
M    07/10/02  ADAIR,FRANK C         I/P      540.9-ACUTE APPENDICITIS NO  40
F/C #Plans Cert Days Nurse Sta/Rm/Bd    Comp Date/Init # Revs
M    2     1         *HOME OR SELF CARE                 2
Page 01PLAN               PHONE #       APPROVAL #      REF #           V  C
     APPR LOS REVIEW AGENCY             PHONE #         CONTACT NAME
( 1) MEDICARE A            (404)555-1212                 REF1234         N  N
              REVIEW                    (708)999-1111   REVIEW CONTACT
( 2) MEDICARE PROFESSIONAL (404)555-1212                                   N




Select Insurance to Copy from--
```

This screen contains a list of all insurance plans currently associated with the selected patient. You are prompted to select the insurance **from** which reviews are to be copied. Enter the number to the left of the insurance description. If you select an insurance for which no reviews are associated, the system returns to the UM Functions submenu.

If you select an insurance with reviews, a screen similar to the following is displayed:

```
                    General Hospital Copy Review Processor
                                                Fri Aug 23, 2002 12:07 pm
Account No     Name                             Unit Number   Birthdate
0219100002     TANNER,CHARLES                   000-00-2308   12/17/87 14Y
Sex  Adm Date  Attending Dr           Pt Type  Diagnosis                    LOS
M    07/10/02  ADAIR,FRANK C          I/P      540.9-ACUTE APPENDICITIS NO  40
F/C #Plans Cert Days Nurse Sta/Rm/Bd    Comp Date/Init # Revs
M    2     1         *HOME OR SELF CARE                 2


Page:01   REV    INIT    REV       # CRIT  DAYS    NEXT       ##=Current Choices
     #    DATE           TYPE        MET   CERT    REV     TRANS/COPY FROM
( 1) 2   08/22/02 A W  C-DELEGATED              08/23/02
( 2) 1   08/22/02 A W  J-RETRO REVI   1    1     09/01/02









Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
                                 end select(NL)
```

This screen contains a list of all reviews associated with the selected insurance. Select the review(s) to be copied by entering the number(s) to the left of the review number(s).

After you select the reviews, the following screen is redisplayed:

```
                    General Hospital Copy Review Processor
                                                Fri Aug 23, 2002 12:07 pm
Account No     Name                             Unit Number   Birthdate
0219100002     TANNER,CHARLES                   000-00-2308   12/17/87 14Y
Sex  Adm Date  Attending Dr           Pt Type  Diagnosis                    LOS
M    07/10/02  ADAIR,FRANK C          I/P      540.9-ACUTE APPENDICITIS NO  40
F/C #Plans Cert Days Nurse Sta/Rm/Bd    Comp Date/Init # Revs
M    2     1         *HOME OR SELF CARE                 2
Page 01PLAN                  PHONE #        APPROVAL #       REF #      V  C
     APPR LOS REVIEW AGENCY                 PHONE #        CONTACT NAME
( 1) MEDICARE A            (404)555-1212                  REF1234          N  N
              REVIEW                      (708)999-1111   REVIEW CONTACT
( 2) MEDICARE PROFESSIONAL (404)555-1212                                    N









Select Insurance to Copy to--
```

The screen of insurance plans redisplays for selection of the insurance **to** which the reviews are to be copied. Enter the number to the left of the insurance description. After you make your selection, the following prompt is displayed:

Copy selected review(s)? (Y/N) [Y]--

Select one of the following options:

- Enter **Y** for Yes or press ENTER to accept the default indicating that the reviews should be copied to the selected insurance. A messages similar to the following is displayed:

  Total Certified days has changed from 6 to 12 [Press Enter]--

  This message indicates that the number of certified days associated with the copied reviews have been added to total number of certified days. If the certified days associated with the copied reviews should not be included in the total number of certified days, use the Review function to update the number of certified days.

  The next message to display is similar to the following:

  Next review date has changed from 04/07/99 to 04/09/99 [Press Enter]--

  This message indicates that the next UM Worksheet for this patient prints based on this next review date. If the new next review date associated with the copied review(s) should not be used in determining when the next worksheet prints, use the Review function to update this information.

  The last message to display is the following:

  Copy completed!

  You are then returned to the listing of insurance plans for the patient. If you do not want to select another insurance or continue the copy process, press ENTER to return to the UM menu.

- Enter **N** for No and the copy is not performed.

Impact

When a review is copied from one insurance plan to another (or to the same insurance plan), the copied review is assigned the next sequential review number. For example, if three reviews currently exist for a patient and one of those is copied from one insurance plan to another, the copied review is assigned review number four. The copied review retains the original information entered at the time the review was initially completed, except the review date, initials of the person entering the review, and the next review date. This information is changed as follows:

- Review date is set to the current date.
- Reviewer initials are set to the person performing the copy.

- Next review date is calculated based on the current date plus the setting of the UM parameter that controls whether certified days or days until next review is used to calculate the next review date.

STAR determines when the next UM Worksheet prints based on the next review date of the last review entered for that patient (regardless of the insurance plan). When reviews are copied from one plan to another and given a review number, the next review date associated with a copied review is used to determine when the next UM Worksheet prints. If more than one review was copied, the review with the highest review number is used to determine when the worksheet prints. Therefore, when reviews are copied, the next review date associated with the copy of the review should be checked to determine if that date should be altered.

FAX REVIEW

NOTE: This function requires that the FaxBox is installed in the STAR environment.

The Fax Review function is used to fax review information to a requester (such as an insurance company or physician office) without leaving the STAR system.

When you select Fax Review, the MPI patient lookup prompt displays for selection of a patient. If you select a patient who is not included in the UM Census, the following message is displayed briefly:

Error: Patient not in UM Census, cannot fax review!

The MPI patient lookup prompt redisplays for selection of another patient. After you select a valid patient and visit, the screen listing the insurance plans associated with the selected visit is displayed. The following is a sample of this screen:

```
                    General Hospital Fax Review Processor
                                              Fri Aug 23, 2002 12:36 pm
Account No     Name                           Unit Number   Birthdate
0219100002     TANNER,CHARLES                 000-00-2308   12/17/87 14Y
Sex  Adm Date  Attending Dr          Pt Type  Diagnosis                   LOS
M    07/10/02  ADAIR,FRANK C        I/P      540.9-ACUTE APPENDICITIS NO  40
F/C #Plans Cert Days Nurse Sta/Rm/Bd    Comp Date/Init # Revs
M    2     1         *HOME OR SELF CARE                 2
Page 01PLAN               PHONE #       APPROVAL #      REF #           V  C
     APPR LOS REVIEW AGENCY             PHONE #         CONTACT NAME
( 1) MEDICARE A           (404)555-1212                  REF1234         N  N
              REVIEW                    (708)999-1111   REVIEW CONTACT
( 2) MEDICARE PROFESSIONAL (404)555-1212                                  N




Select Insurance to Fax reviews--
```

This screen contains a list of all insurance plans currently associated with the selected patient. You are prompted to select the insurance that contains the review you want to fax. Enter the number to the left of the insurance description. If you select an insurance for which no reviews are associated, the system returns to the UM Functions submenu.

If you select an insurance with reviews, a screen similar to the following is displayed:

```
                General Hospital Fax Review Processor
                                                Fri Aug 23, 2002 12:36 pm
Account No     Name                             Unit Number   Birthdate
0219100002     TANNER,CHARLES                   000-00-2308   12/17/87 14Y
Sex  Adm Date  Attending Dr           Pt Type  Diagnosis                    LOS
M    07/10/02  ADAIR,FRANK C          I/P      540.9-ACUTE APPENDICITIS NO  40
F/C #Plans Cert Days Nurse Sta/Rm/Bd    Comp Date/Init # Revs
M    2     1         *HOME OR SELF CARE                 2


Page:01   REV    INIT    REV       # CRIT  DAYS    NEXT       ##=Current Choices
     #    DATE           TYPE        MET   CERT    REV     TRANS/COPY FROM
( 1) 2   08/22/02 A W  C-DELEGATED              08/23/02
( 2) 1   08/22/02 A W  J-RETRO REVI   1    1     09/01/02









Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
                                 end select(NL)
```

This screen contains a list of all reviews associated with the selected insurance. Select the review(s) to be faxed by entering the number(s) to the left of the review number(s).

When you select the review(s) you want to fax, the following screen is displayed:

```
                     General Hospital Fax Review Processor
                                                Fri Aug 23, 2002 12:38 pm
    Account No     Name                              Unit No        Corp No
    0219100002     TANNER,CHARLES                    000-00-2308    00002663

Faxing Information
( 1)Fax to (Company)    :
( 2)Fax to (Name)       :
( 3)Fax Number          :
( 4)Initials            : A R
( 5)Message             :









Enter the receiving company,department or location--                        |
```

Field Explanations

1. FAX TO (COMPANY) (25-C-O)
Enter the name of the company, department, or location to which the fax is being sent.

2. FAX TO (NAME) (25-C-O)
Enter the name of the person who is to receive the fax. If the fax is not directed to a specific person, leave this field blank and complete the previous field.

NOTE: You must enter either a Fax To Company or Name. You cannot leave both fields blank.

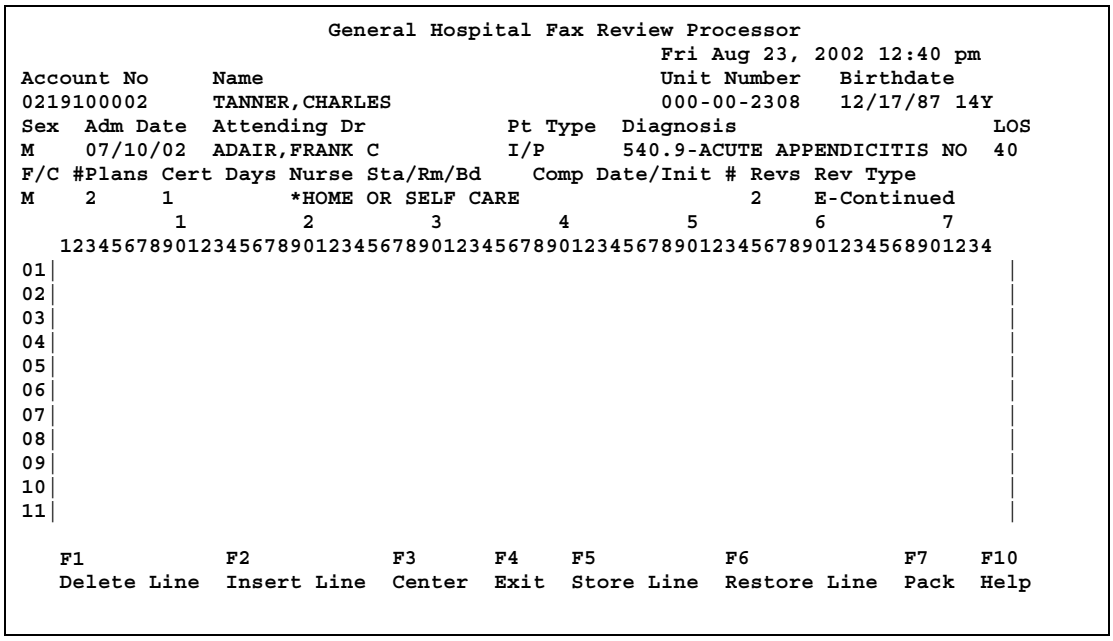
3. FAX NUMBER (12-N-R)
Enter the number of the fax machine that is to receive the fax.

4. INITIALS (DISPLAY ONLY)
This field displays the initials of the person signed on to the system when the fax is generated. It cannot be edited.

5. MESSAGE (814-C-O)
This field allows you to add a message that prints on the fax cover sheet. When you access this field, the following prompt is displayed at the bottom of the screen:

Enter Message (Y/N)?--

To add a message, enter **Y**, and the following screen is displayed:



You can enter 11 lines of up to 74 characters each, using the functions keys at the bottom of the screen to complete the task. When you have finished entering your message, press **F4** to Exit.

When you have completed the Faxing Information fields, the following prompt is displayed:

Accept this screen? (Y/N) [Y]--

Enter **Y** for Yes to accept the screen and send the fax. If you need to edit any field, enter **N** for No.

UM SPECIAL STUDIES FUNCTION

The UM Special Studies function uses the UM Special Study table to associate special study information with a patient. You can add a special study to any patient in the MPI. The patient does not have to be in the UM Census.

Retention of special study information is controlled by the UM Special Study Retention parameter in the Parameter Maintenance screen. For more information, refer to the PARAMETER MAINTENANCE discussion in Chapter 1: UM MAINTENANCE.

NOTE: Special studies entered in this function and those entered in the Medical Record Abstracting function are separate and distinct, and they use different tables. Refer to the *STAR Patient Care Reference Guide, Tables Volume* for additional information on setting up a special study using the UM Special Study table.

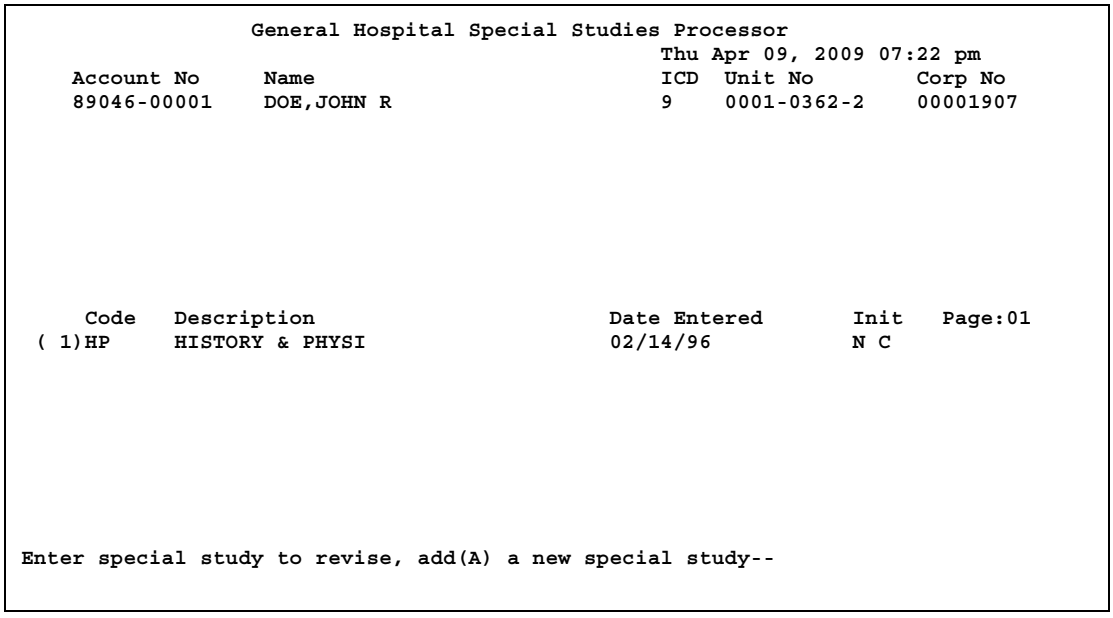
Special Studies Screen

Follow these steps to add Special Study information on a patient's visit.

1. Select the Special Studies option from the Utilization Management Functions menu.

2. If you are in a multifacility environment, select the appropriate facility.

3. Select the appropriate patient and visit from the MPI lookup. If the patient and visit you select currently has associated special study information, the system displays a screen similar to the one below, and prompts you to select a special study to revise or add.



If the patient you select does not have associated special study information, the system displays this prompt instead:

Enter the UM Special Study Code or '-' to list--

If you see this prompt, go to Step 5. Otherwise, go to the next step.

4. You have two choices:

   - Select the special study you want to view, revise, or delete.
   - Enter **A** to add a new special study.

   If you choose to view, revise, or delete a special study, the system displays the special studies page. For the steps on editing or deleting special studies, refer to the next section.

   If you choose to add a new study, the system displays this prompt:

   Enter the UM Special Study Code or '-' for list--

   Go to Step 5.

5. Do one of the following:

   - Enter the UM Special Study code if you know it.
   - Press hyphen (-) followed by ENTER to list the UM Special Study table for selection.

   Continue to the next section.

NOTE: If you select a special study that has an expired effective date, the system displays this message:

Error: Special Study Code no longer valid!

You see this message whether you are trying to revise a study already associated with a patient's visit or trying to add a new one. The system displays the message briefly, then redisplays the prompt for you to select or add a special study.

Special Studies Page

When you select a special study to revise or add, the system displays a screen similar to the one below. (If you are accessing an existing study, the questions already have responses.)

NOTE: The study's questions are based on what is created in the UM Special Study table.

```
                General Hospital Special Studies Processor
                                                 Thu Apr 09, 2009 07:22 pm
   Account No     Name                          ICD  Unit No        Corp No
   89046-00001    DOE,JOHN R                    9    0001-0362-2    00001907
IS THIS PATIENT ON ANY PRESCRIPTION DRUG?

INDICATE ANY PRESCRIPTION DRUGS TAKEN REGULARLY BY THE PATIENT

INDICATE ANY NON-PRESCRIPTION DRUGS THE PT TAKES ON A REGULAR BASIS

TIME OF LAST MEDICATION?

BLOOD PRESSURE ON ARRIVAL

TEMPERATURE ON ARRIVAL

WAS DRUG SCREEN ORDERED FOR PATIENT?
```

This screen displays the questions associated with the special study code you selected. When you first access this screen, the cursor is on theresponse field for the first question. If you respond to the questions for the first time, you are adding a new special study to the patient's record. If you revise the existing responses, you are revising the existing special study.

REVISING OR ADDING A SPECIAL STUDY

When you access a question, the prompt at the bottom left indicates the format of the information you are to enter in that field. Response formats are selected for questions at the time the special study is created in the UM Special Study table.

The table below lists the available formats along with their associated prompts:

Format	Prompt
Value	*Enter numeric value--*
Freeform	*Enter text up to 30 characters--*
Table Lookup	*Enter code or '-' to list--*
Date	*Enter date--*
Time	*Enter time--*
Date/Time	*Enter date and time--*

In response to the freeform prompt, enter a hyphen(-) followed by the freeform entry. The system converts any colon (:) in your freeform response to a slash (/), as STAR uses colons in internal processing.

In response to the table lookup prompt, perform one of these steps:

- Enter the code of the answer if you know it.
- Enter a hyphen (**-**). The system displays the table listing the codes and their corresponding descriptions from which you make your selection.

When you enter the code, the system automatically fills the response field with the code's corresponding description. The code and description are defined in the UM Special Study table.

In response to the Date, Time, and Date/Time prompts, you can enter one of these letters to have the system automatically enter the current values:

- **T** for the current date
- **N** for the current time
- **T N** (with a space between the letters) for the current date and time

The special study screen scrolls, so you can use the arrow keys to move from one question to the next.

Some questions may require a response. If you try to skip past one without entering any information, the system displays an error message indicating that a response is required.

There are four function keys listed at the bottom of the screen. These are available while you are editing the special study. The function of each key is described in the table below.

Key	Function
F1PrevPage	Moves the cursor to the previous page.
F2NextPage	Moves the cursor to the subsequent page.
F6Reset	Deletes the response in a field before you exit that field, allowing you to enter a different response.
F7Exit	Saves the answers when you are finished responding to the questions.

When you respond to the final question, the screen no longer scrolls forward. If you are finished with the special study, press the F7 key. The system displays the following prompt:

Accept screen? (Y/N/D) [Y]--

You have three choices:

- Press **Y** or ENTER for Yes to accept the screen as it is. The system saves the responses and redisplays the screen listing the special studies entered for this visit. If you have just added a special study, then its code, description, and date, as well as your initials, are now in the list.

  NOTE: If you change your mind about adding a special study, exit by pressing **Y** without responding to the questions. However, if you exit a study that has the first response defined as *not* being required, the special study code and description appear in the listing as if you had added it. To remove it from the list, follow the steps in the next section to delete a special study.

- Press **N** for No to delete all responses from the response fields. The system places your cursor back in the first response field.

  NOTE: If you want to change one (or more) of the responses but do not want to reenter ALL responses, press Y to accept the screen and exit. You can then select that study to revise, and change only those answers that you need to.

- Press **D** for Delete. Follow the steps in the next section to delete a special study associated with a patient's visit.

Once you exit the special study, the system redisplays the screen listing any associated special studies entered for this visit. You can continue adding, revising, or deleting special studies.

DELETING A SPECIAL STUDY

When you access the Special Studies screen, the system displays this prompt:

Enter special study to revise, add(A) a new special study--

When you see this prompt, you can delete a special study from the patient's visit record. Follow these steps:

1. Enter the option number to the left of the special study to be deleted.

   The system displays the special study page.

2. Press the F7 key. The system displays this prompt:

   Accept screen? (Y/N/D) [Y]--

3. Press **D** for Delete. The system prompts you to confirm the deletion:

   Delete Special Study? (Y/N) [Y]--

4. Do one of the following:

   - Press **Y** or ENTER for Yes to delete this special study.
   - Press **N** for No to *not* delete the special study.

If you enter **Y,** this message displays:

Special Study Deleted

The system displays this message briefly and then redisplays the screen listing any associated special studies entered for this visit. You can continue deleting, adding, or revising special studies.

Impact

After you accept this screen, Special Study information entered is available for reporting through the Reports function on the Utilization Management Functions Input Options menu. The system report name is UMSSX.

NOTE: The main purpose of the UM Special Study Report is to list those patients with a specified special study. Because each facility can define specific questions and responses for each special study code, it is not possible to create and maintain any other type of base reports. Therefore, you should use the STAR SQL report writer for detailed reporting on special study response information.

MEDICAL RECORDS

When you select the Medical Records option, the following submenu displays:

```
               General Hospital Medical Records Processor
                                                    Mon Nov 30, 1992 03:01 pm
Medical Records Input Options

             Option No.   Option
             ----------------------------------
                  1       Revise Admission
                  2       Revise MPI
                  3       DRG Assignment
                  4       Census









Enter option number--
```

Revise Admission

The Revise Admission option is used to revise specific information regarding the current admission of the patient. When you select this option, the inpatient MPI lookup displays for selection of a patient. For detailed information on the Revise Admission function, refer to the *STAR Patient Care Reference Guide, Patient Processing Module*.

Revise MPI

The Revise MPI option is used to revise specific information regarding any patient visit. If the patient is currently active, you need to utilize the Revise Admission option to update information regarding the active visit. When you select this option, the MPI lookup displays for selection of a patient. For detailed information on the Revise MPI function, refer to the *STAR Patient Care Reference Guide, Patient Processing Module*.

DRG Assignment

The DRG Assignment option is used to enter diagnosis and procedure information on a patient in order to receive and view DRG and related reimbursement information. When you select this option, the MPI lookup displays for selection of a patient. For detailed information on the DRG Assignment function, refer to the *STAR Patient Care Reference Guide, DRG Assignment Module*.

Census

The Census option is used to obtain online patient census information. When you select this option, the following submenu displays:

```
                        General Hospital Census Processor
                                                Wed May 08, 2002 04:57 pm
Census Input Options

            Option No.  Option
            ---------------------------------------
   Display      1       Station Census
                2       LOS Census by Patient Type
                3       Physician Patient List
                4       Religious Census
                5       Isolation Census
                6       Precaution Census
                7       IV Therapy Census
                8       Oxygen Therapy Census
                9       Exception Census
               10       Discharge Census
               11       Alphabetic Census
               12       Patient Groups Census
               13       Service Census
               14       Census Summary
               15       Daily Patient Process Review
   Print       16       Print Census
Enter option number--
```

For additional information on each of the census options, refer to the *STAR Patient Care Reference Guide, Patient Processing Module*.

CLINICAL DATA

When you select the Clinical Data option from the Utilization Management Options menu, the following submenu displays:

```
                General Hospital Clinical Data Processor
                                                 Tue Aug 06, 2002 03:26 pm
Clinical Data Input Options

            Option No.   Option
            ----------------------------------------
                1        Laboratory Results Inquiry
                2        Radiology Results Inquiry
                3        Order Inquiry
                4        Charge Inquiry
                5        Last 48 Hour Vital Signs
                6        Last 48 Hour Fluid Balances









Enter option number--
```

These functions are for active patients only.

Laboratory Results Inquiry

The Laboratory Results Inquiry option is used to view results of STAR Laboratory tests that have been ordered for a patient. When you select this option, the system displays the active patient lookup prompt for identification of a patient. The screens that follow prompt you to indicate the orders that are to be viewed. The following is a sample of this screen:

```
          General Hospital Laboratory Results Inquiry Processor
                                                 Mon Nov 30, 1992 03:44 pm
Unit #     Name             Sex Birthdate   Room    Physician     Srv  Status
A0000900314ROBERTSON,FRED H M  06/09/1961  1N1-3   ADAIR,FRANKLI CCU    I/P 145

                                              Date:  11/17/92
Acct#: A9219100003
Opt#   Order#         Acc #  Test Name                 Time       Status
  1    0045          NC3221  ACID FAST CULTURE         1353       Ordered  *STAT
                         Spec Type:Blood









                          All work listed for: 11/17/92


Enter option(s) (sep by `,`s),All(A) or `P` for previous day or date--
                                 other options(*)
```

Follow the screen prompts to select orders for a previous day, all orders, or to select an order displayed on the current screen. The status of the test indicates if it is completed, ordered, cancelled, or in progress.

Radiology Results Inquiry

The Radiology Results Inquiry option is used to view results of STAR Radiology tests that have been ordered for a patient. When you select this option, the system displays the inpatient MPI lookup prompt for selection of a patient. The screens that follow prompt you to indicate the orders that are to be viewed. The following is an example of this screen:

```
              General Hospital Radiology Exam Summary Processor
                                                    Wed Mar 18, 2009 02:58 pm
Unit #      Name              Sx Birthdate  Room    Physician   Srv  ICD Status
A0002900332 MCTYRE,MAMMREVISI F 02/14/1950  2102-1  SMITH,JIM B MED  10  I/P 140
                                                     Contrast Reactions Exhibited

Opt# Order   Chk-In #   Exam Name               Ordered         Status
  1  0014        1415   CHEST                   10/13/92 1249   COMPLETED
  2  0013         275   CT AORTA GRAFT SCAN     08/20/92 1241   IN PROGRESS
  3  0011         215   CERVICAL SPINE LATERAL  08/01/92 1113   COMPLETED*STAT*
  4  0011         215   SCOLIOSIS SERIES        08/01/92 1113   COMPLETED*STAT*
     0012         216   CHEST FOR RIBS          08/01/92 1055   ORDERED
                        CHEST PA & LATERAL
  5  0010         198   NM ACTH                 07/30/92 1418   REPT PENDIN
  6  0009         196   NM T4 PBL               07/30/92 1205   REPT PENDIN
  7  0008         193   NM ACTH                 07/29/92 1256   REPT PENDIN
  8  0008         193   NM HCG BETA SUB UNIT    07/29/92 1256   IN PROGRESS
  9  0008         193   NM ANTI-HBCAG           07/29/92 1256   IN PROGRESS
 10  0007         176   NM IGE RAST ALLERGEN    07/24/92 1620   IN PROGRESS
 11  0007         176   NM CALCITONIN           07/24/92 1620   IN PROGRESS
 12  0007         176   US LEFT UPPER QUADRANT  07/24/92 1620   COMPLETED

Enter option(s) (sep by `,`s) or all(A) [/] --
                                 `/` for next screen
```

Follow the screen prompts to select a test on which to view results. The status of the test indicates if it is completed, ordered, in progress, or pending.

Order Inquiry

This function is no longer supported. Please use the Order Review functionality.

Charge Inquiry

The Charge Inquiry option can be used to view daily charges or a summary of all charges for an active patient. When you select this option, the system displays the inpatient MPI lookup prompt for selection of a patient.

Last 48 Hour Vital Signs

The Last 48 Hour Vital Signs option can be used to view and/or graph the vital signs that have been charted for a patient via the STAR Patient Care Nursing Module. If the

vital signs have not been entered into the system, this information is unavailable for viewing. The following is an example of this screen:

```
              General Hospital Last 48 Hour Vital Signs Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician   SVC ICD  Status
92231-00003   ROSS,TINA          F  03/03/45 1110-1  COLEMAN,M   MED 10   I/P 105

                                  Last 48 Hours
DATE                                                                  CHT  ENT
  TIME    VITAL SIGN      VALUE  UNIT  SITE      EQUIPMENT  MODIFIER  BY   BY
11/30/92
  3:58pm  Temp - ADULT     98.4   F    O         G                    ltr  LTR
11/30/92
  3:58pm  Pulse             66          R                             ltr  LTR
11/30/92
  3:58pm  Blood Pressure 115/70   MMG            C          L         ltr  LTR
11/30/92
  3:58pm  Weight           132     LBS            STD        UND       ltr  LTR

                                  End of Report



Press NL to continue or print(P)--
```

Last 48 Hour Fluid Balances

The Last 48 Hour Fluid Balances option can be used to view the fluid balances that have been charted for a patient via the STAR Patient Care Nursing Module. If the fluid balances have not been entered into the system, this information is unavailable for viewing. The following is an example of this screen:

```
          General Hospital Last 48 Hour Fluid Balances Processor
Station 1 NORTH                                   Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician   SVC ICD  Status
92231-00003   ROSS,TINA          F  03/03/45 1110-1  COLEMAN,M   MED 10   I/P 105

                        Last 48 Hour Fluid Balances
                    Day          Evening          Night          Totals
               7:00am-2:59pm   3:00pm-10:59pm  11:00pm-6:59am

11/30/92

INTAKE
    Oral              -             323.0            -             323.0 cc
    IV                -             500.0            -             500.0 cc
                   -------         -------        -------         -------
    * TOTAL IN          .0            823.0             .0           823.0 cc

OUTPUT
    Urine - vol       -              12.0            -              12.0 cc
                   -------         -------        -------         -------

Press NL to continue or print(P)--
```

PRINT FORM

Print Form allows printing or reprinting of admission forms, admission cards, preadmission forms, emergency room forms, outpatient admission forms, embosser cards, and demand bills. The forms associated with the patient type are defined for each CRT in the CRT Names table. Inpatient form types are displayed if an inpatient is selected, and associated outpatient forms are displayed if an outpatient is selected.

Use the MPI Search process to locate the patient you want to print form(s) for. After locating the appropriate patient, all currently active visits display. Select the visit, and the system displays the following:

```
                        General Hospital Print Form Processor
                                                 Tue Feb 24, 2009 02:25 pm
  No.         Name              Sex    BD    Room    Physician      SVC ICD Status
0000001222    TURNER,JOY MELISS F  01/25/76         ADAIR,FRANK C  MED 10  LSP

Page:01                             FORMTYPES                ##=Current Choices
( 1) ADMISSION FORM A
( 2) ADMISSION CARD
( 3) PRE-ADM FORM A
( 4) EMBOSSER
( 5) DEMAND BILL FORM
( 6) MSP FORM









Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
                               end selection(NL)
```

Output

Once you make your selection, the selected form or forms are printed on the associated printer as assigned in the CRT Names table.

NOTE: Forms can be printed for inactive visits as well as preadmission records. All available information prints on the selected forms. (Use the MPI Account Number Search option if you want to print form(s) for inactive accounts.)

Chapter 3 - UM BATCH REPORTS

Illustrations

INTRODUCTION

The Utilization Management Module contains three reports that are created as a result of Midnight Processing. These reports include UM Admissions/Revisions, UM Readmission, and the UM Worksheet. The UM Worksheet is the one most frequently taken to the various nursing stations. Each of these reports is discussed in detail in this chapter.

UM ADMISSIONS/REVISIONS REPORT (UADMX)

The UM Admissions/Revisions Report is generated from Midnight Processing. The report prints on a wide-carriage (132-character) printer. It lists patients who have been added to the UM Census, those who are now included after being previously excluded, and those who are now excluded after being previously included. The report is sorted by Nursing Station. Each report contains a page break between each Nursing Station and a page break between each section of the report.

The report is divided into three sections:

- Section One - UM Admissions

  This first section of the UM Admissions/Revisions Report lists those patients who, via an admission, were added to the UM Census because they met the criteria established in UM Maintenance. You can determine which elements were met for each patient by the "X" that displays under each element heading for that patient.

- Section Two - UM Inclusions

  The second section of the report lists those patients who, via a revision to data in their record, have been added to the UM Census because they now meet the inclusion criteria. Patients listed in this section are in-house patients who were previously admitted but were originally excluded from the census or who were patients that meet an exclusion exception. You can determine which element(s) caused the patient to become included in the census by the "X" that displays under each element header for that patient.

- Section Three - UM Exclusions

  The third section of the report lists those patients who, via a revision to data in their record, have been removed from the UM Census because they now meet an exclusion criteria established in UM Maintenance. Patients listed in this section are in-house patients who were previously admitted and who were originally included in the census.

The following is an example of the first section of this report UM Admissions:

Figure 3.1 Example of First Section of UM Admissions Report (UMADMX)

```
Thu Jun 18,1992 12:35 am              GENERAL HOSPITAL A                              Page 1
                                  UM Admission/Revision Report

UM ADMISSIONS
Nursing Station: 1 North

Rm/Bed     Acct Number  Patient Name              Age  Unit Number  Adm Date  F/C  P/T  Attending Physician  Ser
Criteria Met -  AGE  DRG DP  DX    EMP  FC  IC   IP   NS   PT  DR  PR   SER     Manual Add
-------------------------------------------------------------------------------------------------------------
1110-1   92169-00001  BREN,ULA                  72Y  0000-9003-39 06/18/92   M   I/P  ADAIR,FRANKLIN       MED
               X                        X          X                 X
1134-2   92169-00032  BOOTHEN,TERESA            66Y  0000-9008-76 06/18/92   C   I/P  CHERECK,BOB          SUR
                                                                             Smith, Charles Q
1121-2   92169-00098  ZOHNER,ROBERTA            36Y  0000-9001-54 06/18/92   T   OBS  ADAMS,RICARDO        MED
                                        X          X        X
```

Field Explanations

RM/BD
This is the room and bed occupied by this patient. If the patient is not in a bed, this field is blank.

PATIENT NAME
This is the name of the patient and is displayed as LAST,FIRST MIDDLE. This field accommodates up to 25 characters and truncates any portion of the middle or first name that does not fall into the first 25 characters.

ACCT NUMBER
This is the account number of the patient's current episode of care. This field accommodates up to 12 digits.

AGE
This is the age of the patient when the report prints.

UNIT NUMBER
This is the unit number of the patient for this facility. This field accommodates up to 12 digits.

ADM DATE
This is the admission date for this episode of care.

F/C
This field contains the patient's primary financial class for this episode of care. The field displays the financial class code, but not the description.

NOTE: For discharged patients, this field displays the financial class at the time of discharge. Financial class changes made after the patient is discharged are not reflected on this report.

P/T
This field contains the patient type for this patient's episode of care. The field displays the three-character patient type code, but not the description.

ATTENDING PHYSICIAN
This field contains the name of the attending physician and is displayed as LAST,FIRST MIDDLE. This field accommodates up to 20 characters and truncates any portion of the middle or first name that does not fall into the first 20 characters.

SER
This field displays the hospital service to which the patient was admitted. The field displays the three-character service code, but not the description.

CRITERIA MET
This line of the header displays the 13 elements used in the UM Maintenance function for establishing inclusion/exclusion criteria. An X under the element indicates that the patient met a criteria component for this element.

The following table lists the element abbreviations and their full descriptions:

Element Abbreviation	Description
AGE	Age
DRG	DRG
DP	DRG Payor
DX	Diagnosis
MP	Employer
FC	Financial Class
IC	Insurance Carrier
IP	Insurance Plan
NS	Nursing Station
PT	Patient Type
DR	Doctor/Physician
PR	Procedure
SER	Service

MANUAL ADD
This is the name of the employee, as it appears in the Employee Master table, who was signed on to the CPU when a manual add occurs.

The other two sections of the report, UM Inclusions and UM Exclusions, have the same report display and field explanations. These sections are different in that they list the reasons why the patients display on the report.

UM READMISSION REPORT (UREAX)

The UM Readmission Report is a listing of those patients who are considered readmissions to the facility based on the Readmission Criteria set up in UM Maintenance. These patients are included in the UM Census unless they match an exclusion. This report helps the UM Coordinator in identifying patients who may be reviewed by third party agencies for improper readmission. The report may also be valuable to the Quality Assurance Department in identifying patients who may have been discharged prematurely or inappropriately. This report contains all UM readmissions, not just those in the UM Census.

The UM Readmission Report is created at Midnight Processing and prints on standard 8 1/2 x 11 paper (80 character). The report can be sorted by nursing station, patient name, attending physician, or financial class. Each facility defines the sort option in UM Reports Maintenance. The report contains those patients admitted since the previous Midnight Processing and who display only on the report for that one run. Therefore, it is suggested that each facility set the number of retertion days (in Reports Maintenance) to at least 3-5.

An example of the UM Readmission Report follows.

Figure 3.2 Example of UM Readmission Report (UREAX)

```
Thu Jun 18,1992 12:35 am              GENERAL HOSPITAL A                              Page 1
                                    UM Readmission Report
Sort: Patient Name

Patient Name                  Sta/Rm/Bed   Acct Number    Unit Number    Interim Days
Current - Adm Date         P/T   FC           Admitting Diagnosis       Admitting Phy
Prev    - Dis Date         P/T   FC           Principal Diagnosis       Attending Phy
-------------------------------------------------------------------------------------
THOMPSON,VICTOR                             92170-00002    00009001234         7
          06/17/92         I/P   COMMERCIAL   FEVER & VOMITING          ADAMS,HAROLD
          06/10/92         SDS   COMMERCIAL   INGUINAL HERNIA           CHERECK,BOB




End of Report
```

Field Explanations

PATIENT NAME
This is the name of the patient and is displayed as LAST,FIRST MIDDLE. This field accommodates up to 25 characters and truncates any portion of the middle or first name that does not fall into the first 25 characters.

STA/RM/BD
This is the nursing station, room, and bed for this patient. If the patient is not in a bed, this field is blank.

ACCT NUMBER
This is the account number of the patient's current episode of care. This field accommodates up to 12 digits.

UNIT NUMBER
This is the unit number of the patient for this facility. This field accommodates up to 12 digits.

ADMITTING PHYS
This field contains the name of the admitting physician and displays as LAST,FIRST,MIDDLE. This field accommodates up to 20 characters and truncates any portion of the middle or first name that does not fall into the first 20 characters.

ATTENDING PHYS
This field contains the name of the attending physician and is displayed as LAST,FIRST MIDDLE. This field accommodates up to 20 characters and truncates any portion of the middle or first name that does not fall into the first 20 characters.

CURRENT

This line contains data items from this current episode of care.

ADM DATE
This field contains the current admission date for this episode of care.

P/T
This field contains the patient type for this patient's episode of care. The field displays the three-character patient type code, but does not display the description.

FC
This field contains the patient's primary financial class for this episode of care. The field displays up to 10 characters of the financial class description, but not the code.

NOTE: For discharged patients, this field displays the financial class at the time of discharge. Financial class changes made after the patient is discharged are not reflected on this report.

ADMITTING DIAGNOSIS
This field contains the admitting diagnosis for this patient. The field displays up to 20 characters of the freeform entry or the standard ICD description but does not display the ICD code.

INTERIM DAYS
This field indicates the number of days since the discharge of the last visit to the admission of the current visit. Interim days are calculated by subtracting the admission date from the previous discharge date. The number of interim days is 1 if the previous discharge date is the same as the admission date.

PREV

This line contains data items from the previous episode of care.

DIS DATE
This field contains the date of discharge of the previous admission.

P/T
This field contains the patient type for this patient's previous episode of care. The field displays the three-character patient type code, but does not display the description.

FC
This field contains the patient's primary financial class for the previous episode of care. The field displays up to 10 characters of the financial class description, but not the code.

NOTE: For discharged patients, this field displays the financial class at the time of discharge. Financial class changes made after the patient is discharged are not reflected on this report.

PRINCIPAL DIAGNOSIS
This field contains the final or principal diagnosis for this patient's previous episode of care. The field displays up to 20 characters of the standard ICD description but does not display the ICD code.

UM WORKSHEET (UWLSX)

The UM Worksheet is designed to facilitate the collection of review data. It contains detailed information that provides the UM Coordinator with a comprehensive view of the UM history of the patient. The worksheet also provides a place to record the results of the current review should a terminal not be available at the time the review is being performed. The worksheet can be printed on standard letter-size (8 1/2 x 11) paper.

The UM Worksheet is created as a result of Midnight Processing; however, it can also be requested on an as-needed-basis from the UM Reports Menu.

NOTE: You can use the STAR Audit Service to audit user requests for UM Worksheets. The Audit Service collects and stores information such as worksheet request date and time, the name of the user requesting the worksheet, and the criteria selected for the worksheet. For more information, see the *STAR Audit Service Reference Guide*.

During Midnight Processing, a worksheet is created for each patient who meets the following conditions:

1. A worksheet prints for each patient admitted on the previous day (i.e., prior to Midnight Processing) who has been included in the UM Census (based on the UM Criteria that has been established).

   NOTE: A worksheet does not print for a patient admitted on the previous day if the patient's UM Abstract contains a review date past the day after admission.

   For example, if a patient is admitted on June 18 and on June 18 a UM review is entered with a next review date of June 20, a worksheet automatically prints on June 20. In this example, a worksheet does not automatically print the day after admission (June 19), because a next review date has been entered.

2. If the patient's UM Abstract contains a date for the next review, a worksheet prints for that patient on the day the review is due. For example, if the current date is 6/15 and the patient's next review date is 6/18, a worksheet is not automatically printed for this patient until 6/18.

3. A worksheet continues to print for any patient whose review was not performed. For example, if a patient's next review date was set for 6/18, but for whatever reason the review is not done, the system continues to print a worksheet for that patient until a review is done or the UM Abstract is marked complete.

4. A worksheet prints the day after discharge when the following conditions are met:

   - The Complete on Discharge parameter is set to Yes.

- The patient's visit has not previously been included on the worksheets generated by Midnight Processing (e.g., a one-day stay patient).

- The patient meets the inclusion criteria.

The version of the UM Worksheet created at Midnight Processing can be sorted by nursing station, patient type, or insurance. The sort option is entered via the UM Maintenance option, Report Parameters. You also have the option to indicate whether the report prints one patient per page or multiple patients per page.

To demand an individual worksheet for a patient, select the option, UM Worksheet, from the Reports menu. Once this option is selected, the system displays the MPI lookup for selection of a patient. If the patient is currently not in the UM Census, this message displays:

Error: Patient not in census!

The message displays briefly, and then you are returned to the MPI lookup for selection of another patient. Once a valid patient is selected, this prompt displays:

Print Individual Worksheet? (Y/N) [Y]--

You have the following entry options:

- Enter **Y** to indicate the worksheet should print. Once a **Y** is entered, this message displays:

  Worksheet processing and printing!

  The message displays briefly. Then you are returned to the reports menu.

- Enter **N** to indicate the worksheet should not print. Once **N** is entered, you are returned to the reports menu.

The report contains three sections for each patient. The first section is the header, which contains demographic, financial, and UM data. The second section is for the UM Coordinator to write notes regarding this review (when immediate access to a terminal is not possible). The third section is a summary of previous review information.

The following is a sample of the header section of the worksheet:

Figure 3.3 Sample Header Section of UM Worksheet (UWLSX)

```
Sta/RM/Bed  Acct Number  Patient Name              Unit Number   Birthdate/Age
            0106400002   KING,TIMOTHY              000-00-1804   01/01/20 82Y
S MS  Adm Date   Attending Physician       Ptype Adm Type  UM Working diagnosis
M  U  03/05/01   BABB,GARY H               ER    EMERGENC  411.1-INTERMED CORON
FC Pri Ins Carrier  Insurance Plan       Policy#/Claim#
M  MEDICARE         MEDICARE A           /
App Days  URO Auth #       App/Auth #    Review Agency
                                         REVIEW

Other Insurance Plans      Days      Auth#             Next Review Date
MEDICARE A                                             05/03/02
MEDICARE PROFESSIONAL COMPONENT
Surgery Scheduled/Date         Discharge Plan/Date        Dis Date   Readm Ind
/                                                         03/15/01
Prov/Final DRG          SLOS Nxt Rev Dt Rev Reason  #Cert  LOS Denial   Reinst
470                          05/03/02   ADM/SEVERI     0   10
```

Field Explanations

STA/RM/BED
This is the room number and bed the patient currently occupies. If the patient is transferred to another station, room, or bed before the next worksheet is printed, this information is updated accordingly. This field is blank if the patient is not in a bed.

ACCT NUMBER
This is the account number of the patient's current episode of care. This field accommodates up to 12 digits.

PATIENT NAME
This is the name of the patient and is displayed as LAST,FIRST MIDDLE. This field accommodates up to 25 characters and truncates any portion of the first or middle name that does fall into the first 25 characters.

UNIT NUMBER
This is the unit number of the patient for this facility. This field accommodates up to 12 digits.

BIRTHDATE/AGE
This fields displays the patient's birthdate followed by the age of the patient.

S (SEX)
This field displays the patient's sex. This field contains either M for male or F for female.

MS
This field displays the patient's marital status. This field contains the single character user-defined marital status code for this patient, but does not display the description.

ADM DATE
This field displays the patient's admission date for this episode of care.

ATTENDING PHYSICIAN
This field contains the name of the attending physician and is displayed as LAST,FIRST MIDDLE. The field accommodates up to 20 characters and truncates any portion of the first or middle name that does fall into the first 20 characters.

PTYPE
This field contains the patient type for this patient's episode of care. The field displays the 3-character patient type code associated with this patient, but does not display the description.

ADM TYPE
This field contains the admission type for this patient's episode of care. The field displays up to 8 characters of the admission type description, but does not display the code.

UM WORKING DIAGNOSIS
This field contains the UM working diagnosis that is entered on the Miscellaneous screen of the UM Abstract for this patient. The field displays the ICD code and up to 14 characters of the description.

FC
This field contains the patient's primary financial class for this episode of care. The field displays the two-character financial class code, but not the description. This field displays the financial class assigned at the time of discharge, since edits to financial class after discharge do not update UM.

NOTE: For discharged patients, this field displays the financial class at the time of discharge. Financial class changes made after the patient is discharged are not reflected on this report.

PRI INS CARRIER
This field contains the primary insurance carrier for this patient. The field displays up to 15 characters of the insurance carrier description, but does not display the code.

INSURANCE PLAN
This field contains the primary insurance plan associated with the primary insurance carrier that displays in the previous field. The field displays up to 15 characters of the insurance plan description, but does not display the code.

POLICY #/CLAIM #
This field contains the policy and claim numbers associated with the primary insurance plan. The field displays up to 20 characters of the policy number entered on the second Insurance page in the Admission process and up to 15 digits of the claim number entered on the first Insurance page in the Admission process. If this information is not available, this field is blank.

NOTE: Depending on the type of insurance, this field is labeled differently in the admission insurance screens. For example, the policy number for Blue Cross displays in the field labeled "Subscriber ID Number" on the insurance

screens, while Medicaid has the policy number displaying in the field "Recipient Number." It is important to understand this distinction when referring to the Policy Number on the UM Worksheet.

APP DAYS
This field contains the number of approved days associated with the primary insurance plan that displays in the previous field. The field displays a number up to 999. If this information is not associated with the primary insurance plan, this field is blank.

URO AUTH #
This field contains the URO #1 authorization number. The field displays up to 12 digits. This information is extracted from the field of the same name in the UM Miscellaneous screen. If this information is not available, this field is blank.

APP/AUTH #
This field contains any approval or authorization number associated with the primary insurance plan. This information is extracted from the approval # field located on the second page of insurance information. The field displays up to 10 digits of the approval or authorization number. If this information is not available this field is blank.

REVIEW AGENCY
This field contains the agency for the primary insurance plan displayed in the Insurance processor and Miscellaneous screens in UM. The field displays up to 14 digits.

OTHER INSURANCE PLANS
This field contains up to four secondary insurance plans for the patient. The field displays up to 15 characters of the insurance plan description, but does not display the code. If this information is not available or does not exist for this patient, this field is blank.

DAYS
This field contains the number of approved days associated with the secondary insurance plan that is displayed in the previous field. The field displays a number up to 999. If this information is not associated with the secondary insurance plan, this field is blank.

AUTH#
This field contains any authorization number associated with the secondary insurance plan. This information is extracted from the approval # field located on the second page of insurance information. The field displays up to 10 digits of the approval or authorization number. If this information is not available this field is blank.

NEXT REVIEW DATE
This field contains the next review date for this patient. This information is extracted from the most recent UM review for this patient. If this is a new admission and no reviews have been entered, then this date is the day after admission. However, if a review was not done as scheduled, this date may differ since it reflects the date the review was initially scheduled and may differ from the current report date.

SURGERY SCHEDULED/DATE
This field contains the description of any scheduled surgery and date of the surgery. The field displays upto 25 characters for the surgery description concatenated with the date.

DISCHARGE PLAN/DATE
This field contains the date the discharge plan was entered for this patient. This date corresponds to the discharge plan description located in the previous field. If multiple discharge planning dates exist for this patient, this field displays the most current date entered. If the patient's UM Abstract does not contain a discharge plan date, this field is blank.

DIS DATE
This field contains the discharge date for this patient's episode of care. If the patient has not been discharged, this field is blank.

READM IND
This field contains the last discharge date of this patient's previous episode of care at this facility. This field contains a discharge date only if the patient's current admission and previous admission have met the readmission criteria set up in UM Maintenance. If the patient does not meet the criteria ordoes not have any previous admissions, this field is blank.

PROV/FINAL DRG
This field contains either the provisional (predischarge) or final (post discharge) DRG. The field displays up to 25 characters, which includes the 3 digit DRG number concatenated with the DRG description. This information is extracted from the DRG Assignment function. This field is blank if a DRG does not exist for this patient.

SLOS
This field contains the standard length of stay associated with the DRG in the previous field. This information is extracted from the current Rate Master associated with the DRG payor of the patient's primary financial class. This field is blank if a DRG does not exist for this patient.

NXT REV DT
This field contains the next review date for this patient. This information is extracted from the most recent UM review for this patient. If this is a new admission and no reviews have been entered, then this date is the day after admission. However, if a review was not done as scheduled, this date may differ since it reflects the date the review was initially scheduled and may differ from the current report date.

REV REASON
This field contains the review reason. The field displays up to 10 characters of the review reason description, but not the code. This information is extracted from the most recent review entered for the patient.

#CERT
This field contains the total number of certified days that have been entered in the UM Abstract for this patient. This field accommodates up to 4 digits.

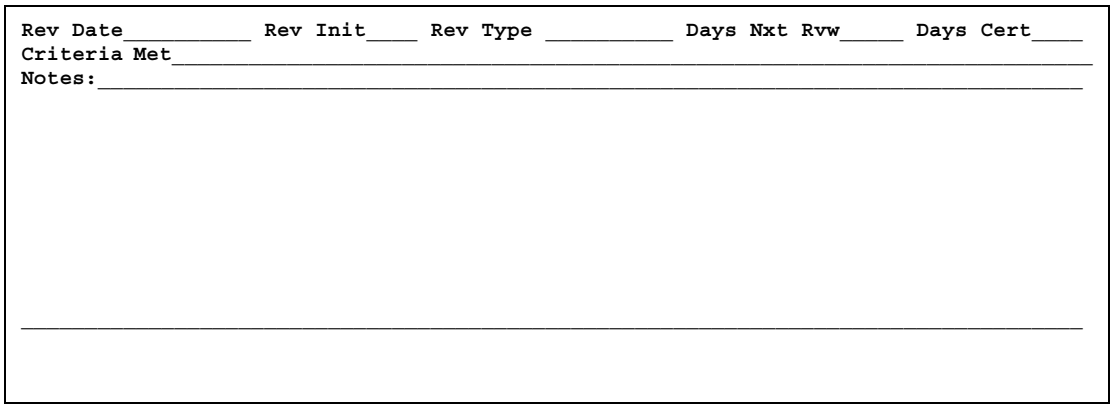
LOS
This field contains the patient's length of stay.

DENIAL
This field contains the denial date that has been associated with this patient's episode of care. This information is extracted from data entered in the UM Contact to Advisor screen. If the patient's UM Abstract does not contain a denial date, this field is blank.

REINST
This field contains the reinstatement date that has been associated with this patient's episode of care. This information is extracted from data entered in the UM Contact to Advisor screen. If the patient's UM Abstract does not contain a reinstatement date, this field is blank.

The second section of the report contains an area for the UM Coordinator to write information specific to the review being performed. If the UM Coordinator has immediate access to a terminal, it is more efficient to enter the information directly into the UM Abstract. However, if access to a terminal is not possible, this section can be used to enter review information that can later be entered in the UM Abstract. The following is an example of this section:

Figure 3.4 Sample Note Section of UM Worksheet (UWLSX)



Field Explanations

REV DATE
This field is used to enter the date of this review.

REV INIT
This field is used to enter the initials of the person performing this review.

REV TYPE
This field is used to enter the review type for this review. The reviewer must utilize the codes that have been established in the UM Review Type table.

DAYS NXT RVW
This field is used to enter the number of days until the next review.

DAYS CERT
This field is used to enter the number of certified days for this patient's continued stay.

CRIT MET
This field is used to enter the criteria met on this review. The reviewer must utilize the codes that have been established in the UM Criteria Met table.

NOTES
This field is used for entry of free-form notes about this review. The reviewer can enter an unlimited amount of notes in the system. The first three lines should contain summary information regarding the review. These first three lines are those that will appear on future worksheets.

The third section of the worksheet contains previous review information. This section contains the most recent five reviews plus information from the first three reviews. The worksheet displays the first 12 lines of the review notes from the most recent review and the first three lines of review notes from the others. These previous reviews are displayed in reverse chronological order so that the most recent notes display first. The following is an example of the information that displays for previous review notes:

Figure 3.5 Sample Review Section of UM Worksheet (UWLSX)

```
Rev#:  09   Date:  06/07/92   Revwr:  LTR   Type: C-Continued Cert Days:   3
NOTESSSSSXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```

Field Explanations

REVIEW NO
This field contains the review number for this previously entered review. This review number corresponds to the review number that displays on the review summary screen in the Add/Edit Review function of the UM Abstract.

DATE
This field displays the date this review was initially performed. This information is extracted from the Add/Edit Review processor of the UM Abstract for this patient.

REVIEWER
This field displays the initials of the person performing the review. This information is extracted from the Add/Edit Review processor of the UM Abstract for this patient.

TYPE
This field contains the review type for this review. The field displays the review type code and description. This information is extracted from the Add/Edit Review processor of the UM Abstract for this patient.

CERT DAYS
This field displays the number of certified days entered when this review was initially performed. This is not a cumulative number of certified days from all reviews. This information is extracted from the Add/Edit Review processor ofthe UM Abstract for this patient.

NOTES
This field contains the notes from the indicated review number. If this is the most recent review performed, up to 12 lines of review notes display. If this contains notes for any other previously entered reviews, only the first 3 lines of review notes display.

A sample UM Worksheet follows.

Figure 3.6 Example of UM Worksheet (UWLSX)

```
Mon May 13, 2002 12:35 am          GENERAL HOSPITAL A                          Page 1
                              UM Worksheet for 05/14/02
                                Sort: Nursing Station

Sta/RM/Bed  Acct Number  Patient Name             Unit Number   Birthdate/Age
            0106400002   KING,TIMOTHY             000-00-1804   01/01/20 82Y
S MS  Adm Date   Attending Physician      Ptype Adm Type  UM Working diagnosis
M  U  03/05/02   BABB,GARY H              ER    EMERGENC  411.1-INTERMED CORON
FC Pri Ins Carrier  Insurance Plan      Policy#/Claim#
M  MEDICARE         MEDICARE A          /
App Days  URO Auth #       App/Auth #    Review Agency
                                        REVIEW

Other Insurance Plans      Days      Auth#            Next Review Date
MEDICARE A                                            05/03/02
MEDICARE PROFESSIONAL COMPONENT
Surgery Scheduled/Date         Discharge Plan/Date        Dis Date   Readm Ind
/                                                         03/15/02
Prov/Final DRG          SLOS Nxt Rev Dt Rev Reason  #Cert  LOS Denial   Reinst
470                          05/03/02   ADM/SEVERI     0   10

Rev Date__________ Rev Init____ Rev Type __________ Days Nxt Rvw_____ Days Cert____
Criteria Met________________________________________________________________________
Notes:________________________________________________________________________________
______________________________________________________________________________________

Review No:  08   Date:  05/10/02   Reviewer:  LTR   Type: C-Continued Cert Days:   3
NOTESSSSSXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXX

Review No:  07   Date:  05/07/02   Reviewer:  LTR   Type: C-Continued Cert Days:   3
NOTESSSSSXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Review No:  06   Date:  05/04/02   Reviewer:  LTR   Type: C-Continued Cert Days:   3
NOTESSSSSXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Review No:  05   Date:  05/01/02   Reviewer:  LTR   Type: C-Continued Cert Days:   3
NOTESSSSSXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Review No:  04   Date:  04/28/02   Reviewer:  LTR   Type: C-Continued Cert Days:   3
NOTESSSSSXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Review No:  03   Date:  04/19/02   Reviewer:  LTR   Type: C-Continued Cert Days:   3
NOTESSSSSXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Review No:  02   Date:  04/16/02   Reviewer:  LTR   Type: C-Continued Cert Days:   3
NOTESSSSSXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Review No:  01   Date:  04/13/02   Reviewer:  LTR   Type: A-Admission Cert Days:   3
NOTESSSSSXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```
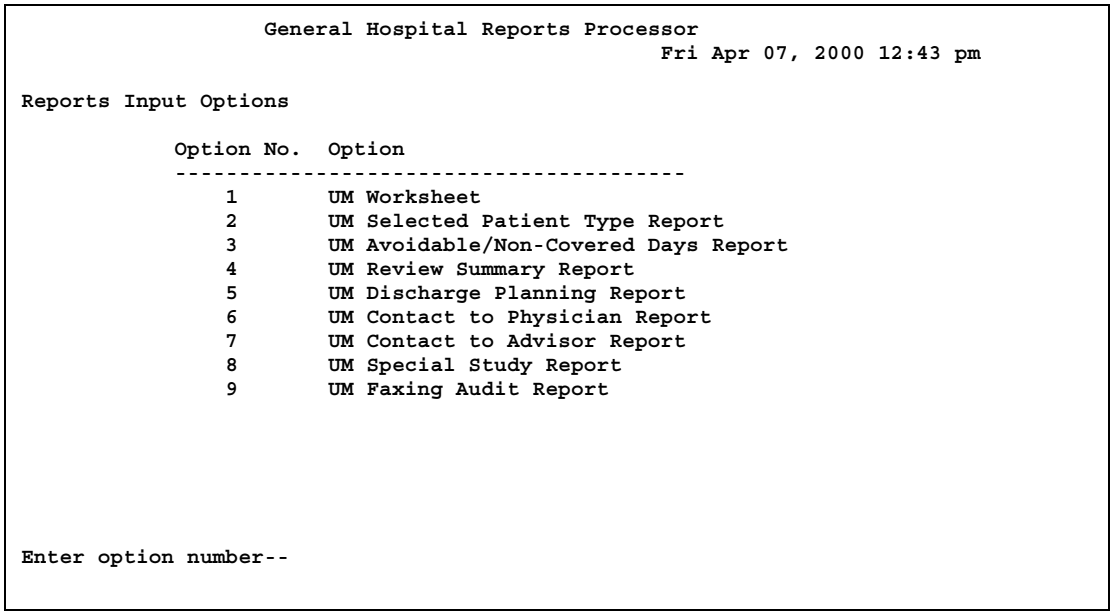

Chapter 4 - UM ONLINE DEMAND REPORTS

Illustrations

INTRODUCTION

The Utilization Management Module contains nine demand reports that can be created via online processing. This chapter of the reference guide contains information on the content of the reports as well as instructions for processing and printing each of the UM demand reports. The Reports option is located on the Utilization Management Functions menu. When this option is selected, the following submenu is displayed:



UM WORKSHEET

This report prints to the default printer for the CRT (as defined in the CRT Names table). For information on UM Worksheets, refer to UM WORKSHEET (UWLSX) in Chapter 3: UM Batch Reports.

NOTE: You can use the STAR Audit Service to audit user requests for UM Worksheets. The Audit Service collects and stores information such as worksheet request date and time, the name of the user requesting the worksheet, and the criteria selected for the worksheet. For more information, see the *STAR Audit Service Reference Guide*.

UM SELECTED PATIENT TYPE REPORT (UMPTX)

The UM Selected Patient Type Report is designed to provide the UM Coordinator with a listing of patients for a specific patient type. This report was originally developed to list observation patients, but since each facility determines its own patient types for observation patients, this report option accommodates selection of any patient type prior to processing and printing the report. Because it allows patient type selection, this report is not limited to selection of observation patient types. The report allows two different sort options: nursing station and financial class. The selected patient types and sort option print in the header of the report. When you sort the report by nursing station, patients not assigned to a nursing station print at the beginning of the report.

The information on this report provides the UM Coordinator with a comprehensive listing of those patients who may need to be closely monitored to prevent the facility from incurring unnecessary reimbursement losses. This report may also be valuable to the Quality Assurance Department for identifying patients for possible QA review, as well as to the Admitting Department for use in determining bed utilization. This report can be printed on standard 8 1/2 by 11 paper.

The UM Selected Patient Type Report is requested on an as-needed basis from the UM Reports Menu. The patients who display on the report are those whose patient type matches a patient type selected prior to processing and printing the report. The report includes any patients considered active (inhouse patients). A patient is eligible to display on the report through the time his or her account has reached the number of suspense days as established in the Patient Type table. For example, if an I/P patient type is discharged on 6/5/99, and your facility has set suspense days for that patient type at 5, this patient may display on the report through 6/10/99.

NOTE: You can use the STAR Audit Service to audit user requests for this report. The Audit Service collects and stores information such as report request date and time, the name of the user requesting the report, and the criteria selected for the report. For more information, see the *STAR Audit Service Reference Guide*.

When the menu option, UM Selected Patient Type Report, is selected, this prompt displays:

Sort by Nursing Station(N) or Financial Class(F)--

You have the following entry options:

- Press **N** to indicate that the report is to be sorted by nursing station. It is not necessary to press ENTER after you enter **N**. Patients not currently in a bed do not display on the report.

- Enter **F** to indicate the report is to be sorted by financial class code. It is not necessary to press ENTER after you enter **F**.

Once you enter a sort option, this prompt displays:

Enter patient types to be included separated by ',' or '-' for list--

You have the following entry options:

- Enter the patient types to be included in the observation report if you know them, separating each patient type with a comma(,). You can enter upto 60 patient types for inclusion on this report. The selected patient types display in the header of the report.

- Press hyphen (-) followed by ENTER to display the Patient Type table for selection. You can select up to 60 patient types for inclusion on this report. The selected patient types display in the header of the report.

Once you enter or select the patient type(s) to be included on the report, this prompt displays:

Print Selected Patient Type Report? (Y/N)--

You have the following entry options:

- Enter **Y** for Yes to indicate the report is to be processed and printed. If you enter **Y**, this message displays:

  Processing!

  The message displays briefly, then you are returned to the prompt to enter your sort selection. Press period (.) followed by ENTER to return to the UM Reports menu.

- Enter **N** for No to indicate the report is not to be printed. After you enter **N**, you are returned to the prompt to enter your sort selection. Press period (.) followed by ENTER to return to the UM Reports menu.

The following is an example of the UM Selected Patient Type Report sorted by Nursing Station:

Figure 4.1 UM Selected Patient Type Report Sorted by Nursing Station (UMPTX)

```
Thu Jul 10, 1992 11:55 am    GENERAL HOSPITAL A                          Page 1
                               UM Selected Patient Type Report
Sort:  Nursing Station
Patient Types: OPO,I/P,O/P,SDS

Sta/Rm/Bed       Acct Number      Patient Name               Unit Number    FC
   P/T   Adm Date/time       Dis Date/Time      LOS/hr
      Admit Diagnosis                 Attending Physician
-------------------------------------------------------------------------------
1N/1118-02       92169-00002      DEMO,UTILIZATION MANAGEM    0000-9001-41   BLUE CROSS
   OPO   07/10/92 07:54 am                      3:59
      ABDOMINAL PAIN                SAMUELSON,DONALD

1N/1102-2        92206-00007      HEMPE,WILLY                 0000-9003-09   SELF PAY
   I/P   07/08/92 10:00 am                      2 days
      RABIES CONTACT                ADAIR,FRANKLIN B

End of Report
```

Field Explanations

STA/RM/BED
This is the nursing station, room, and bed for this patient. If the patient has been discharged, this field is blank. The patient is listed first on the report when the selected sort is nurse station.

ACCT NUMBER
This is the account number of the patient's current episode of care. This field accommodates up to 12 digits.

PATIENT NAME
This is the name of the patient and is displayed as LAST,FIRST MIDDLE. This field accommodates up to 25 characters and truncates any portion of the first or middle name that does not fall into the first 25 characters.

UNIT NUMBER
This is the unit number of the patient for this facility. This field accommodates up to 12 digits.

PT
This field contains the patient type for this patient's episode of care. The field displays the 3-character patient type code associated with this patient, but does not display the description.

FC
This field contains the patient's primary financial class for this episode of care. The field displays up to 10 characters or the financial class description, but not the code.

NOTE: For discharged patients, this field displays the financial class at the time of discharge. Financial class changes made after the patient is discharged are not reflected on this report.

ADM DATE/TIME
This field displays the patient's admission date and time for this episode of care.

DIS DATE/TIME
This field contains the discharge date and time for this patient's episode of care. If the patient has not been discharged, this field is blank.

LOS/HR
This field contains the patient's length of stay in hours. If the patient is discharged, this field is calculated using the discharge date and time minus the admission date and time. If the patient is not discharged, the LOS is calculated using the current date and time minus the admission date and time. If the patient type is outpatient, the LOS is displayed in hours and minutes. If the patient type is inpatient, the LOS is displayed in days.

ADMIT DIAGNOSIS
This field contains the admitting diagnosis for this patient. The field displays up to 25 characters of the free-form entry or the standard ICD description, but does not display the ICD code.

ATTENDING PHYS
This field contains the name of the attending physician and is displayed as LAST,FIRST MIDDLE. The field accommodates up to 20 characters and truncates any portion of the first or middle name that does not fall into the first 20 characters.

UM AVOIDABLE/NON-COVERED DAYS REPORT (UMDAYX)

The UM Avoidable/Non-Covered Days Report provides a listing of those patients whose UM Abstract contains data regarding avoidable and/or non-covered days. This information is helpful in reporting to the appropriate Medical Staff Committee and in determining the number of non-acute days incurred at the facility in a specified period of time.

NOTE: You can use the STAR Audit Service to audit user requests for this report. The Audit Service collects and stores information such as report request date and time, the name of the user requesting the report, and the criteria selected for the report. For more information, see the *STAR Audit Service Reference Guide*.

The UM Avoidable/Non-Covered Days Report is a demand report that allows selection of avoidable and/or non-covered day types, the report begin and end date, multiple sort options, the option to print information for discharged patients only, an option to print notes, and an option to suppress printing of the name of the Responsible Party to maintain confidentiality. All selected set-up entries print in the header of the report. This report prints on a wide-carriage (132-character) printer. When this option is selected from the UM Reports menu, this screen displays:

```
         General Hospital UM Avoidable/Non-Covered Days Report Processor
                                                 Mon Apr 05, 1999 10:31 am


( 1)Avoidable Day Type  :
( 2)Non-Covered Day Type:
( 3)Begin Date          :
( 4)End Date            :
( 5)Discharge Only      :
( 6)Confidential        :
( 7)Include Detail      :
( 8)Include Notes       :
( 9)Sort                :









Enter Avoidable Day Type Code(s) separated by ',', 'A' for all, or '-' for list-
- |
```

Field Explanations

1. AVOIDABLE DAY TYPE (TABLE LOOKUP)
This field is used to indicatewhich avoidable day type codes should be included on the report. When this field is accessed, the following prompt is displayed:

Enter Avoidable Day Type Code(s) separated by ',', 'A' for all, or '-' for list-

You have the following entry options:

- Enter the avoidable day type code(s), separating multiple codes with commas.
- Enter **A** to indicate the report should include all avoidable day types.
- Enter a hyphen (**-**) to display the Avoidable Day Type table and make your selections.
- Press ENTER to leave the field blank; no avoidable day types are included on the report.

2. NON-COVERED DAY TYPE (TABLE LOOKUP)
This field is used to indicate which non-covered day type codes should be included on the report. When this field is accessed, the following prompt is displayed:

Enter Non-Covered Day Type Code(s) separated by ',', 'A' for all, or '-' for list-- |

You have the following entry options:

- Enter the non-covered day type code(s), separating multiple codes with commas.
- Enter **A** to indicate the report should include all non-covered day types.
- Enter a hyphen (**-**) to display the Non-Covered Day Type table and make your selections.
- Press ENTER to leave the field blank; no non-covered day types are included on the report.

NOTE: You must make an entry in either the Avoidable Day Type or Non-Covered Day Type field. You can make entries in both fields.

3. BEGIN DATE
This field is used to indicate the beginning date for the report. The beginning date is based on the date the avoidable/non-covered episode began. This information is extracted from the Avoidable/Non-Covered Days screen of the UM Abstract. This field is used in conjunction with the next field, End Date, and the previous fields, Avoidable Day Type and Non-Covered Day Type. Completion of this field is required. When this field is entered, this prompt displays:

Enter begin date--

4. END DATE
This field is used to indicate the ending date for the report. The ending date is based on the date the avoidable/non-covered episode ends. This information is extracted from the Avoidable/Non-Covered Days screen of the UM Abstract. The End Date field is used in conjunction with the previous field, Begin Date. For example, if you are

reporting on avoidable/non-covered days for the month of May, you would enter a beginning date of 05/01/99 and an ending date of 05/31/99. The system then searches for any avoidable/non-covered days entry with a beginning or end date that falls between the begin date and end date specified on this screen. Therefore the listing on the report is inclusive of all avoidable/non-covered days that were incurred in the month of May.

NOTE: The system does not include non-covered days incurred in the specified time frame if the Day Types indicated are only avoidable and vice versa.

When this field is entered, this prompt displays:

Enter end date--

Completion of this field is required.

NOTE: If you run a Non-Covered Days Report for January (begin date 01/01 and end date 01/31) and one for February (begin date 02/01 and end date 02/28) and a patient has non-covered days beginning January 27 and ending February 5, this patient is included on both the January and February reports.

5. DISCHARGE ONLY

This field is used to indicate whether the report should contain only patients who have been discharged. When this field is entered, this prompt displays:

Discharged patients only? (Y/N)--

You have the following entry options:

- Enter **Y** to indicate the report should contain data only on patients who have been discharged. The report includes only discharged patients whose UM Abstract contains avoidable/non-covered day information that falls between the specified begin and end date.

- Enter **N** to indicate the report should contain all patients, not just those that have been discharged. Both in-house and discharged patients are included on the report if their UM Abstract contains avoidable/non-covered day information that falls between the specified begin and end date.

- Press ENTER and the system automatically enters **N** for No.

6. CONFIDENTIAL

This field is used to indicate whether the report should be confidential. The confidentiality refers to the name of the Responsible Party that displays on the report. When this field is entered, this prompt displays:

Print responsible party code only? (Y/N)--

You have the following entry options:

- Enter **Y** to indicate that this report is intended to be confidential and the display for Responsible Party should be the code only. If the Responsible Party entered for a patient was done so in a free-form format, this field is blank.

- Enter **N** to indicate that this report is not intended to be confidential and the display for the Responsible Party should be the code and name. If the Responsible Party entered for a patient was done so in a free-form format, this field contains only the name and not a code.

- Press ENTER and the system automatically enters **N** for No.

These print options are to assist the UM Coordinator and/or QA Coordinator in ensuring that confidential and sensitive information is maintained as such.

7. INCLUDE DETAIL
This field is used to indicate whether the report should include detailed patient information. When this field is entered, this prompt displays:

Print detail? (Y/N)--

You have the following entry options:

- Enter **Y** to indicate that the report should include detail information regarding the patient. Detail information is that which is included in the first two header lines of the report. Please see the report sample for additional information and field explanations.

- Enter **N** to indicate that the report should not include detail information regarding the patient. It should contain information found only in the third header line of the report. It is basically a listing of the avoidable/non-covered day entries that have occurred during the specified begin and end dates. Please see the report sample for additional information and field explanations.

- Press ENTER and the system automatically enters **N** for No.

8. INCLUDE NOTES
This field is used toindicate whether the report should include any additional notes that had been associated with the avoidable/non-covered day entry. When this field is entered, this prompt displays:

Include notes on report? (Y/N)--

You have the following entry options:

- Enter **Y** to indicate that notes should print on the report. The notes are extracted from the field of the same name in the Avoidable/Non-Covered Days screen of the UM Abstract.

- Enter **N** to indicate that the notes should not print on the report.

- Press ENTER and the system automatically enters **N** for No.

9. SORT
This field is used to indicate the sort option for the report. When this field is entered, this prompt displays:

Sort by 'C'ode, 'R'esp Party, 'F'in class, 'S'ervice, or 'N'urse station--

You have the following entry options:

- Enter **C** to indicate the report should be sorted by the UM avoidable day and/or the UM non-covered day code.

  NOTE: If both avoidable day types and non-covered day types are included in the report, avoidable day type codes are displayed first, followed by non-covered day type codes.

- Enter **R** to indicate the report should be sorted by the responsible party. This information is extracted from the field of the same name in the Avoidable/Non-Covered Days screen of the UM Abstract.

- Enter **F** to indicate the report should be sorted by the financial class code. This sort option should not be selected if you are not including patient detail on the report because the financial class does not display.

- Enter **S** to indicate the report should be sorted by hospital service. This sort option should not be selected if you are not including patient detail on the report because the hospital service does not display.

- Enter **N** to indicate the report should be sorted by nursing station. This sort option should not be selected if you are not including patient detail on the report because the nursing station does not display. Patients do not display when this sort option is selected if they are not currently in a nurse station.

Once you have completed the screen for the report set-up, this prompt displays:

Accept this screen? (Y/N)--

You have the following entry options:

- Enter **Y** to accept the information on the screen.

- Enter **N** to indicate the screen is not accepted. This prompt displays:

  Enter field number or '/' starting field number--

  You can update any field on the processor screen.

- Press period (.) followed by ENTER to abort the processing of this report and return to the UM Reports menu.

Once **Y** is entered, this message is displayed briefly before you are returned to the Reports Menu:

Processing!

The following is an example of the UM Avoidable/Non-Covered Days Report that is not confidential and that includes detail and notes:

Figure 4.2 UM Avoidable/Non-Covered Days Report - Not Confidential (UMDAYX)

```
Tue Apr 05, 1999  10:45 am                  GENERAL HOSPITAL A                              Page 1
                                  UM Avoidable/Non-Covered Days Report

Avoidable Day Type: 1,2,3,4,A,B,C          Begin  Date: 01/01/99            End Date: 01/31/99
Non-Covered Day Type: LOA,DDS,GRC,MED,SNF  Confidential: No                 Include Detail: Yes
Discharge Only: No                         Sort: Code                       Include Notes: Yes

Sta/Rm/Bed   Patient Name                Acct Number    Unit Number    Admit Dt   Disch Dt   FC        Ser
DRG                        LOS   Tot Charges       Avg Dly Chrg     #Days   Avoid/NCvd Chgs
Attending Physician     Responsible Party       Avoid/NCvd Type     Begin Dt   End Dt
    Notes
-------------------------------------------------------------------------------------------------------
2N 1118-01   DEVANEY,THEODORE           99010-00001    00009001234    01/15/99   01/30/99   BLUE CROSS  MED
127-CONGESTIVE HRT FAIL    15   $999,999,999.99   $50,000.00          3    $150,000.00
SAMUELSON,DONALD        SAMUELSON,DONALD        DDS-DENIED DAYS STAY 01/21/99   01/24/99
   PATIENT SHOULD NOT HAVE BEEN ADMITTED ON 01/15.  THE PHYSICIAN KNEW THIS AND THIS CASE IS BEING REFERRED TO
   ADMINISTRATION.  THE PATIENT HAD A KNOWN INFECTION AND THE PHYSICIAN KNEW SURGERY COULD NOT BE PERFORMED.  IT
   WILL TAKE A FEW DAYS TO GET ANOTHER BED AT THE SNF, BY WHICH TIME THE INFECTION WILL PROBABLY CLEAR UP AND THE
   PHYSICIAN WILL WANT TO GO AHEAD WITH THE PROCEDURE.

2N 1118-04   SMITHERS,ANGELA            99010-00006    00009001257    01/10/99   01/30/99   MEDICARE   MED
127-CONGESTIVE HRT FAIL    20   $999,999,999.99   $50,000.00          2    $100,000.00
SAMUELSON,DONALD        SAMUELSON,DONALD        DDS-DENIED DAYS STAY 01/28/99   01/30/99




Total cases for DDS: 2
```

Field Explanations

STA/RM/BED
This is the nursing station, room, and bed currently occupied by this patient. If the patient is not in a bed, this field is blank. If the patient has been discharged, the previous room and bed is displayed.

PATIENT NAME
This is the name of the patient and is displayed as LAST,FIRST MIDDLE. This field accommodates up to 25 characters and truncates the middle or first name as necessary.

ACCT NUMBER
This is the account number of the patient's current episode of care. This field accommodates up to 12 digits.

UNIT NUMBER
This is the unit number of the patient for this facility. This field accommodates up to 12 digits.

ADMIT DT
This field contains the admission date for this patient's episode of care.

DISCH DT
This field contains the discharge date for this patient's episode of care. If the patient has not been discharged, this field is blank.

FC
This field contains the patient's primary financial class for this episode of care. The field displays up to 10 characters or the financial class description, but not the code.

NOTE: For discharged patients, this field displays the financial class at the time of discharge. Financial class changes made after the patient is discharged are not reflected on this report.

SER
This field contains the current hospital service of record for this patient. The field displays the three-character service code, but not the description.

DRG
This field contains the provisional (predischarge) or final (post discharge) DRG for this patient. The field displays the three-digit DRG number concatenated by a hyphen (-) with up to 20 characters of the DRG description. This information is extracted from the DRG Assignment function. This field is blank if there is no provisional or final DRG.

LOS
This field contains the patient's current length of stay for this episode of care.

TOT CHARGES
This field contains the total charges for this patient. The charges displayed in this field are current, up to the time the report is processed.

AVG DLY CHRG
This field contains the average daily charges for this patient. This information is calculated by dividing the total charges by the patient's LOS.

#DAYS
This field contains the number of avoidable/non-covered days for this entry. This field is calculated by subtracting the begin date from the end date of the avoidable/non-covered day entry.

NOTE: If a report is printed for February and a patient had avoidable or non-covered days that spanned from January 27 to February 5, all nine days are included in the #DAYS field, not just the days in February.

AVOID/NCVD CHGS
This field contains the avoidable/non-covered day charges. This information is calculated by multiplying the number of avoidable/non-covered days by the average daily charges. This provides the facility an estimate of the charges incurred during an avoidable/non-covered day episode.

ATTENDING PHYS
This field contains the name of the attending physician and is displayed as LAST,FIRST MIDDLE. The field accommodates up to 24 characters and truncates the middle or first name as necessary.

RESPONSIBLE PARTY
This field contains information on the responsible party for this patient's entry. This information is extracted from the field of the same name in the Avoidable/Non-Covered Days screen of the UM Abstract. The information that displays in this field is controlled by whether you indicated that this is a confidential report. If this is a confidential report, this field contains only the code of the responsible party. If this is not a confidential report, this field contains both the name and code of the responsible party.

AVOID/NCVD TYPE
This field contains the avoidable/non-covered day type assigned for this patient. This information is extracted from the Avoidable/Non-Covered Days screen of the UM Abstract. The field displays the three-character code concatenated by a hyphen (-) with up to 10 characters of the description.

BEGIN DT
This field contains the date this avoidable/non-covered day episode began.

END DT
This field contains the date this avoidable/non-covered day episode ended. If an avoidable/non-covered day entry has no end date, and the beginning date is *within the report date range,* no date prints in this field. If an avoidable/non-covered day entry

has no end date, and the beginning date is *outside the report date range,* the patient does not print on the report.

NOTES
This field contains any notes that had been entered to provide additional information regarding this patient's avoidable/non-covered day entry. This information is extracted from the field of the same name in the Avoidable/Non-Covered Days screen of the UM Abstract. If no notes had been entered and/or the set-up for this report did not indicate to include notes, this field is blank. The field displays the complete note.

TOTAL NUMBER OF ACCOUNTS
This summary line displays the total number of accounts with avoidable/non-covered days that displayed on the report. This number will not always match the total accounts displayed because an account can have more than one avoidable/non-covered day entry.

TOTAL NUMBER OF DAYS
This summary line displays the total number of avoidable/non-covered days displayed on this report. This total represents the sum of the days that display in the #DAYS column.

TOTAL CHARGES FOR DAYS
This summary line displays the total charges for the avoidable/non-covered days. This total represents the sum of the charges that display in the AVOID/NCOVD CHGS column.

The following is an example of the UM Avoidable/Non-Covered Days Report that is confidential and does not include detail or notes:

Figure 4.3 UM Avoidable/Non-Covered Days Report - Confidential (UMDAYX)

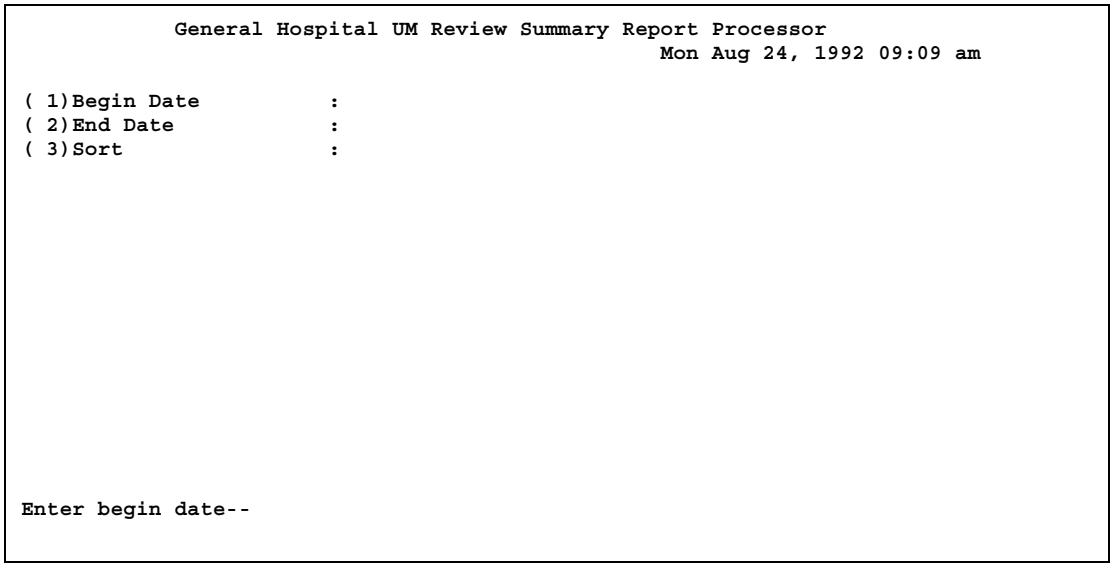
```
Tue Apr 05, 1999  10:45 am                  GENERAL HOSPITAL A                              Page 1
                                  UM Avoidable/Non-Covered Days Report

Avoidable Day Type: 1,2,3,4,A,B,C          Begin  Date: 01/01/99            End Date: 01/31/99
Non-Covered Day Type: LOA,DEL,GRC,MED,SNF  Confidential: Yes                Include Detail: No
Discharge Only: No                         Sort: Code                       Include Notes: No

Attending Physician     Responsible Party       Avoid/NCvd Type     Begin Dt   End Dt
-------------------------------------------------------------------------------------------------
SAMUELSON,DONALD        444                     DEL-DELAY IN DISCH  01/21/99   01/24/99

SAMUELSON,DONALD        1234                    DEL-DELAY IN DISCH  01/28/99   01/30/99


End of Report
```

UM REVIEW SUMMARY REPORT (UMSUMX)

The UM Review Summary Report is designed to provide statistical information on the number of reviews performed by the UM Department. This information is helpful in determining department productivity.

NOTE: You can use the STAR Audit Service to audit user requests for this report. The Audit Service collects and stores information such as report request date and time, the name of the user requesting the report, and the criteria selected for the report. For more information, see the *STAR Audit Service Reference Guide*.

The UM Review Summary Report is a demand report that allows selection of the report begin and end date as well as several sort options. All selected options print in the header of the report. This report can be printed on standard 8 1/2 x 11 paper for presentation to committees. However, this also limits the number of review types and reviewers that can display on the report. Therefore when you choose to sort by reviewer initials or financial class, the system prompts you to select a maximum of 6 review types. When you choose to sort by review type the system prompts you to enter up to six sets of reviewer initials. Regardless of the sort option selected, the report always displays a column titled *Other*, which contains the remaining number of reviews not included in the selected review types. This provides you with a total number of reviews even though you could only select six. When this report is selected from the UM Reports menu, the system displays this screen:



Field Explanations

1. BEGIN DATE
This field is used to indicate the beginning date for the report. The beginning date is based on the date the UM Review datawas entered. This information is extracted from

the Add/Edit Review screen of the UM Abstract. This field is used in conjunction with the next field, End Date. Completion of this field is required.

When this field is entered, this prompt displays:

Enter begin date--

2. END DATE
This field is used to indicate the ending date for the report. The ending date is based on the date the UM Review Data was entered. This information is extracted from the Add/Edit Review screen of the UM Abstract. The End Date field is used in conjunction with the previous field, Begin Date. For example, if you are reporting on reviews entered for the month of May, you would enter a beginning date of 05/01/92 and an ending date of 05/31/92. The system then searches for any review with a date that falls between the begin date and end date specified on this screen. Therefore, the listing on the report is inclusive of all reviews entered in the month of May. Completion of this field is required.

When this field is entered, this prompt displays:

Enter end date--

3. SORT
This field is used to indicate the sort option for the report. When this field is entered, this prompt displays:

Sort by 'R'eviewer, 'F'inancial Class or 'T'ype of Review--

You have the following entry options:

- Enter **R** to indicate the report should be sorted by the initials of the reviewer. This information is extracted from the INIT field of the Add/Edit Review screen of the UM Abstract. Once **R** is entered, the system automatically displays the UM Review Type table for selection of up to six codes to be included on the report.

- Enter **F** to indicate the report should be sorted by the financial class code of the patient. Once **F** is entered, the system automatically displays the UM Review Type table for selection of up to six codes to be included on the report.

- Enter **T** to indicate the report should be sorted by the type of review. This information is extracted from the Rev Type field of the Add/Edit Review screen of the UM Abstract. Once **T** is entered, the system displays this prompt:

  Enter up to six reviewer initials separated by ','--

Once you have completed the screen for the report set-up, this prompt displays:

Accept this screen? (Y/N)--

You have the following entry options:

- Enter **Y** to accept the information on the screen.
- Enter **N** to indicate the screen is not accepted. This prompt displays:

  Enter field number or '/' starting field number--

  You may update any field on the processor screen.
- Press period (.) followed by ENTER to abort the processing of this report and return to the UM Reports menu.

Once **Y** is entered, this message displays:

Processing!

The message displays briefly, and then you are returned to the Reports Menu.

The following is an example of the UM Review Summary Report sorted by reviewer:

Figure 4.4 UM Review Summary Report Sorted by Reviewer (UMSUMX)

```
   Wed Dec 13, 1995 04:49 pm          GENERAL HOSPITAL A                Page 1
                                   UW Review Summary Report

Begin Date: 11/01/95         End Date: 11/30/95       Sort: Reviewer

A-ADMISSION             E-CONTINUED STAY         C-DELEGATED
_____________________________________________________________________________
Reviewer: DB
                         _____________Review Type_____________
Financial Class           A       E       C                    Other   Total
=============================================================================
BLUE CROSS                 3       1       5                      9
MEDICARE                  10       8      12                     30
SELF PAY                     3       1       5                            9
_____________________________________________________________________________
TOTALS                    16      10      22                    0       48


Reviewer: JAS
                         _____________Review Type_____________
Financial Class           A       E       C                    Other   Total
=============================================================================
SELF PAY                   2               1                      3
_____________________________________________________________________________
TOTALS                     2               1                      3


Reviewer: KOK
                         _____________Review Type_____________
Financial Class           A       E       C                    Other   Total
=============================================================================
BLUE CROSS                 2       2       1                      5
MEDICARE                  12       6      11                     29
SELF PAY                   5       2       1                      8
_____________________________________________________________________________
TOTALS                    19      10      14                     42


End of Report
```

The header of this report contains the Begin Date, End Date, and Sort method, as specified on the UM Review Summary Report screen.

Field Explanations

REVIEWER
This field contains the initials of the person who performed the UM Review. Each reviewer included in the report prints in a separate section.

FINANCIAL CLASS
This field contains the patient's primary financial class for this episode of care. The field displays up to 10 characters or the financial class description, but not the code.

NOTE: For discharged patients, this field displays the financial class at the time of discharge. Financial class changes made after the patient is discharged are not reflected on this report.

REVIEW TYPE
The columns under Review Type contain the number of reviews for each review type. These columns are user-defined. You can include up to six review types. Examples include A - Admission, E - Continued Stay, and C - Delegated.

OTHER
This column contains the number of reviews in the system that were entered under review types other than the ones specified in the Review Types columns (up to six).

TOTAL
This column contains the total number of reviews.

The following is an example of the UM Review Summary Report sorted by financial class:

Figure 4.5 UM Review Summary Report Sorted by Financial Class (UMSUMX)

```
Wed Dec 13, 1995 04:34 pm          GENERAL HOSPITAL A                Page 1
                                UM Review Summary Report

Begin Date: 11/01/95         End Date: 11/30/95       Sort: Financial Class

A-ADMISSION             E-CONTINUED STAY         C-DELEGATED


_____________________________________________________________________________

Financial Class: BLUE CROSS
                          _____________Review Type_____________
Reviewer                   A      E      C                    Other   Total
=============================================================================
DB                         3      1      5                              9
KOK                        2      2      1                      1       6
_____________________________________________________________________________
TOTALS                     5      3      6                      1      15

Financial Class: MEDICARE
                          _____________Review Type_____________
Reviewer                   A      E      C                    Other   Total
=============================================================================
DB                        10      8      12                             30
KOK                       12      6      11                             29
_____________________________________________________________________________
TOTALS                    22     14      23                     0      59

Financial Class: SELF PAY
                          _____________Review Type_____________
Reviewer                   A      E      C                    Other   Total
=============================================================================
DB                         3      1      5                              9
JAS                        2             1                      1       4
KOK                        5      2      1                      1       9
_____________________________________________________________________________
TOTALS                    10      3      7                      2      22

End of Report
```

The header of this report contains the Begin Date, End Date, and Sort method, as specified on the UM Review Summary Report screen.

Field Explanations

FINANCIAL CLASS
This field contains the patient's primary financial class for this episode of care. The field displays up to 10 characters or the financial class description, but not the code. Each financial class included in the report prints in a separate section.

NOTE: For discharged patients, this field displays the financial class at the time of discharge. Financial class changes made after the patient is discharged are not reflected on this report.

REVIEWER
This column contains the initials of the person who performed the UM Review.

REVIEW TYPE
The columns under Review Type contain the number of reviews for each review type. These columns are user-defined. You can include up to six review types. Examples include A - Admission, E - Continued Stay, and C - Delegated.

OTHER
This column contains the number of reviews in the system that were entered under review types other than the ones specified in the Review Types columns (up to six).

TOTAL
This column contains the total number of reviews.

The following is an example of the UM Review Summary sorted by type of review:

Figure 4.6 UM Review Summary Sorted by Review Type (UMSUMX)

```
Wed Dec 13, 1995 05:10 pm          GENERAL HOSPITAL A                      Page 1
                                 UM Review Summary Report
Begin Date: 11/01/95          End Date: 11/30/95       Sort: Review Type
_____________________________________________________________________________

Review Type: ADMISSION
                              _____________Reviewers_____________
Financial Class           DB      JAS     KOK                        Other   Total
=============================================================================
BLUE CROSS                 3       0       2                                  5
MEDICARE                  10       0      12                                 22
SELF PAY                   3       2       5                                 10
_____________________________________________________________________________
TOTALS                    16       2      19                                 37


Review Type: DELEGATED
                              _____________Reviewers_____________
Financial Class           DB      JAS     KOK                        Other   Total
=============================================================================
BLUE CROSS                 5       0       1                                  6
MEDICARE                  12       0      11                                 23
SELF PAY                   5       1       1                                  7
_____________________________________________________________________________
TOTALS                    22       1      13                                 36


Review Type: CONTINUED STAY
                              _____________Reviewers_____________
Financial Class           DB      JAS     KOK                        Other   Total
=============================================================================
BLUE CROSS                 1       0       2                                  3
MEDICARE                   8       0       6                                 14
SELF PAY                   1       0       2                                  3
_____________________________________________________________________________
TOTALS                    10       0      10                                 20



End of Report
```

The header of this report contains the Begin Date, End Date, and Sort method, as specified on the UM Review Summary Report screen.

Field Explanations

REVIEW TYPE
This field displays the description of the selected review type. Each review type included in the report prints in a separate section.

FINANCIAL CLASS
This field contains the patient's primary financial class for this episode of care. The field displays up to 10 characters or the financial class description, but not the code.

NOTE: For discharged patients, this field displays the financial class at the time of discharge. Financial class changes made after the patient is discharged are not reflected on this report.

REVIEWERS
The columns under Reviewers contain the number of reviews done by each reviewer. These columns are user-defined, and you can include up to six reviewers.

OTHER
This column contains the number of reviews in the system that were entered by reviewers other than those specified in the Reviewers columns (up to six).

TOTAL
This column contains the total number of reviews.

UM DISCHARGE PLANNING REPORT (UMDISX)

The UM Discharge Planning Report provides a listing of those patients whose UM Abstract contains data regarding discharge planning. This information is helpful in reporting to the appropriate Medical Staff Committee and in determining whether discharge planning was started early enough in the patient stay to be effective.

NOTE: You can use the STAR Audit Service to audit user requests for this report. The Audit Service collects and stores information such as report request date and time, the name of the user requesting the report, and the criteria selected for the report. For more information, see the *STAR Audit Service Reference Guide*.

The UM Discharge Planning Report is a demand report that allows selection of the report begin and end date, multiple sort options, the option to print information on only discharged patients, and the option to include notes. All selected options display in the header of the report. The report prints on a wide carriage (132 character) printer. When UM Discharge Planning Report is selected from the UM Reports menu, this screen displays:

```
          General Hospital UM Discharge Planning Report Processor
                                                 Mon May 13, 2002 09:09 am

( 1)Begin Date          :
( 2)End Date            :
( 3)Discharge Only      :
( 4)Include Detail      :
( 5)Include Notes       :
( 6)Sort                :









Enter begin date--
```

Field Explanations

1. BEGIN DATE

This field is used to indicate the beginning date for the report. The beginning date is based on the date the discharge planning entry was made. This information is extracted from the Discharge Planning screen of the UM Abstract. This field is used in conjunction with the next field, End Date. When this field is entered, this prompt displays:

Enter begin date--

Completion of this field is required.

2. END DATE
This field is used to indicate the ending date for the report. The ending date is based on the date the discharge planning entry was made. This information is extracted from the Discharge Planning screen of the UM Abstract. The End Date field is used in conjunction with the previous field, Begin Date. For example, if you are reporting on discharge planning for the month of May, you would enter a beginning date of 05/01/92 and an ending date of 05/31/92. The system then searches for any discharge planning entry that falls between the begin date and end date specified on this screen. Therefore, the listing on the report is inclusive of all discharge planning done in the month of May. When this field is entered, this prompt displays:

Enter end date--

Completion of this field is required.

3. DISCHARGE ONLY
This field is used to indicate whether the report should contain data only on patients who have been discharged. When this field is entered, this prompt displays:

Discharged patients only? (Y/N)--

You have the following entry options:

- Enter **Y** to indicate the report should contain data only on patients who have been discharged. The report includes only discharged patients whose UM Abstract contains discharge planning information that falls between the specified begin and end date.

- Enter **N** to indicate the report should contain all patients, not just those that have been discharged. Both in-house and discharged patients are included on the report if their UM Abstract contains discharge planning information that falls between the specified begin and end date.

- Press ENTER and the system automatically enters **N** for No.

4. INCLUDE DETAIL
This field is used to indicate whether the report should include detailed patient information. When this field is entered, this prompt displays:

Print detail? (Y/N)--

You have the following entry options:

- Enter **Y** to indicate that the report should include detail information regarding the patient. Detail information is that which is included in the first two header lines of

the report. Please see the report sample for additional information and field explanations.

- Enter **N** to indicate that the report should not include detail information regarding the patient. A report does not include detail. It contains only information found in the third header line of the report. It is basically a listing of the avoidable/non-covered day entries that have occurred during the specified begin and end dates. Please see the report sample for additional information and field explanations.

- Press ENTER and the system automatically enters **N** for No.

5. INCLUDE NOTES

This field is used toindicate whether the report should include any additional notes that had been associated with the discharge planning entry. When this field is entered, this prompt displays:

Include notes on the report? (Y/N)--

You have the following entry options:

- Enter **Y** to indicate that notes should print on the report. The notes are extracted from the field of the same name in the Discharge Planning screen of the UM Abstract.

- Enter **N** to indicate that notes should not print on the report.

- Press ENTER and the system automatically enters **N** for No.

6. SORT

This field is used to indicate the sort option for the report. Subtotals for the option you choose are displayed on the report. For example, if you sort by code, totals for each code are printed on the report. When this field is entered, this prompt displays:

Sort by 'C'ode, 'R'eviewer, 'S'ervice, or 'N'urse station--

You have the following entry options:

- Enter **C** to indicate the report should be sorted by the UM Discharge Planning code.

- Enter **R** to indicate the report should be sorted by the initials of the reviewer entering the discharge planning data. This information is extracted from the field of the same name in the Discharge Planning screen of the UM Abstract.

- Enter **S** to indicate the report should be sorted by hospital service.

  NOTE: This sort option should not be selected if you are not including patient detail on the report because the hospital service does not display.

- Enter **N** to indicate the report should be sorted by nursing station. If the patient has been discharged, the patient is not included on the report when this sort option is selected.

  NOTE: This sort option should not be selected if you are not including patient detail on the report because the nursing station does not display, nor should this sort be used when you have selected to include discharged patients only.

Once you have completed the screen for the report set-up, this prompt displays:

Accept this screen? (Y/N)--

You have the following entry options:

- Enter **Y** to accept the information on the screen.
- Enter **N** to indicate the screen is not accepted. This prompt displays:

  Enter field number or '/' starting field number--

  You may update any field on the processor screen.
- Press period (.) followed by ENTER to abort processing this report and return to the UM Reports menu.

Once **Y** is entered, this message displays:

Processing!

The message displays briefly, and then you are returned to the Reports Menu.

The following is an example of the UM Discharge Planning Report that includes detail and notes:

Figure 4.7 UM Discharge Planning Report - Detail (UMDISX)

```
Mon Jun 03, 2002 05:21 pm                          Model Hospital A                                    Page 1
                                                UM Discharge Planning Report

Begin Date: 03/05/02                    End Date: 06/03/02
Discharge Only: No                      Include Detail: Yes
Include Notes: Yes                      Sort: Code

Sta/Rm/Bed    Patient Name                    Act Number    Unit Number    Admit Dt   D/P Date    D/P Code
  Rev   Disch Dt   Disposition           LOS    Acute Days   Referred From          Referred To
      Attending Physician      Primary Care Phy  Ser
   Notes
_____________________________________________________________________________________________________

           PROFFITT,UMA                         0204900004    000-00-2620   02/18/02    05/02/02    HOME HEALTH CARE
   KLP    02/18/02 *HOME(OUTPATIENT)       1      1           BAPTIST HOSPITAL
      COLEMAN,MICHAEL G                         PSY
    This is a very nice lady who will need home health once she is discharged from our facility.  There are numerous
contacts that need to be made and I will begin by calling Quality Home Health Care.

Total for Code 1 HOME HEALTH CARE: 1

            PRICE,ALLYSON                       0210500007    000-00-2798   04/15/02    05/02/02    SOCIAL SERVICES
   KLP    04/15/02 *HOME(OUTPATIENT)       1      1
      SMITH,MICHELE                             ERS
    This patient will need to have a lengthy consultation with our social services staff.  Likely, other family
members will need to be brought into this discussion as well.  Their needs are tremendous as they are on welfare,
food stamps and their living conditions are sub-optimal.

Total for Code 11 SOCIAL SERVICES: 1

ICU ICU-09    STANLEY,BRUCE                      0204900003    000-00-2619   02/18/02    05/06/02    FAMILY CARE
   KLP                                  105    105         REGIONAL HOSPITAL
      COLEMAN,MICHAEL G                         MED
    This patient will likely need good family support throughout their convalescence.  I will contact a family
therapist to ensure that the family support system remains strong.

            PROFFITT,UMA                        0204900004    000-00-2620   02/18/02    05/06/02    FAMILY CARE
   KLP    02/18/02 *HOME(OUTPATIENT)       1      1           BAPTIST HOSPITAL
      COLEMAN,MICHAEL G                         PSY
    This patient will need the support and help from family members at home. An exit conference will be schedule
with key family members to discuss the patient's care, expectations and follow up regime.  KP

Total for Code 3 FAMILY CARE: 2

Total number of Accounts: 3
Total number D/P Entries: 4

End of Report
```

Field Explanations

STA/RM/BED
This is the nursing station, room, and bed currently occupied by this patient. If the patient is not in a bed or has been discharged, this field is blank.

PATIENT NAME
This is the name of the patient and is displayed as LAST,FIRST MIDDLE. This field accommodates up to 25 characters and truncates the middle or first name as necessary.

ACT NUMBER
This is the account number of the patient's current episode of care. This field accommodates up to 12 digits.

UNIT NUMBER
This is the unit number of the patient for this facility. This field accommodates up to 12 digits.

ADMIT DT
This field contains the admission date for this patient's episode of care.

D/P DATE
This field contains the date the discharge planning information was entered in the Discharge Planning screen of the UM Abstract.

D/P CODE
This field contains the discharge planning code assigned for this patient. This information is extracted from the Discharge Planning screen of the UM Abstract. The field displays up to 20 characters of the description.

REV
This field contains the initials of the UM Coordinator who entered the discharge planning information. The field displays up to three characters.

DISCH DT
This field contains the discharge date for this patient's episode of care. If the patient has not been discharged, this field is blank.

DISPOSITION
This field contains the discharge disposition for this patient. If the patient hasnot been discharged or a disposition has not been entered, this field is blank. The field displays up to 20 characters of the description, but not the code.

LOS
This field contains the patient's current length of stay for this episode of care.

ACUTE DAYS
This field contains the number of acute days for this patient's episode of care. The information in this field is extracted from the Total Acute Days field of the UB Non-Covered Days Summary screen of the UM Abstract.

REFERRED FROM
This field contains the name of the location, facility, or person that referred this patient. This information is extracted from the Discharge Planning screen of the UM Abstract. The field displays the full 19 characters of the description, but not the code.

REFERRED TO
This field contains the location, facility or person to where this patient is being referred. This information is extracted from the Discharge Planning screen of the UM Abstract. The field displays the full 19 characters of the description, but not the code.

ATTENDING PHYS
This field contains the name of the attending physician and is displayed as LAST,FIRST MIDDLE. The field accommodates up to 20 characters and truncates the middle or first name as necessary.

PRIMARY CARE PHY
This field contains the name of the primary care physician for this patient. This information is extracted from the Medical Page of the MPI. If this information was not entered or is not available, this field is blank.

SER
This field contains the current hospital service of record for this patient. The field displays the three-character service code, but not the description.

NOTES
This field contains any notes that had been entered to provide additional information regarding this patient's discharge planning entry. This information is extracted from the field of the same name in the Discharge Planning screen of the UM Abstract. If no notes had been entered and/or the set-up for this report indicated notes should not print, this field is blank. The field displays the complete note.

TOTAL NUMBER OF ACCOUNTS
This summary line displays the total number of accounts with discharge planning information that displayed on the report. This number will not always match the total accounts displayed because an account can have more than one discharge planning entry.

TOTAL NUMBER OF D/P ENTRIES
This summary line displays the total number of discharge planning entries displayed on this report. This total represents the number of discharge planning entries done during the specified time frame.

The following is an example of the UM Discharge Planning Report that does not include detail or notes:

Figure 4.8 UM Discharge Planning Report - No Detail (UMDISX)

```
Tue Jun 04, 2002 04:56 pm                    Model Hospital A                                    Page 1
                                        UM Discharge Planning Report

Begin Date: 03/06/02                  End Date: 06/04/02
Discharge Only: No                    Include Detail: No
Include Notes: No                     Sort: Code

D/P Date   D/P Code              Rev   Disch Dt   Disposition                      Referred From       Referred To
_____________________________________________________________________________________________________________

05/02/02   HOME HEALTH CARE     KLP   02/18/02   *HOME(OUTPATIENT)                BAPTIST HOSPITAL

Total for Code 1 HOME HEALTH CARE: 1

05/02/02   SOCIAL SERVICES      KLP   04/15/02   *HOME(OUTPATIENT)

Total for Code 11 SOCIAL SERVICES: 1

05/06/02   FAMILY CARE          KLP                                           REGIONAL HOSPITAL
05/06/02   FAMILY CARE          KLP   02/18/02   *HOME(OUTPATIENT)           BAPTIST HOSPITAL

Total for Code 3 FAMILY CARE: 2

05/02/02   SKILLED NURSING FAC KLP

Total for Code 4 SKILLED NURSING FACILITY: 1

05/06/02   PSYCHIATRIC CARE     KLP

Total for Code 7 PSYCHIATRIC CARE: 1

05/02/02   HOSPICE              KLP   02/18/02   HOME HEALTH CARE ORGANIZ        BAPTIST HOSPITAL

Total for Code 9 HOSPICE: 1

04/30/02   DME CONSULT          KLP

Total for Code DMEC DME CONSULT: 1

04/30/02   REHABILITATION CONS KLP                                              NURSING HOME

Total for Code REHA REHABILITATION CONSULT: 1


Total number of Accounts: 8
Total number D/P Entries: 9

End of Report
```

UM CONTACT TO PHYSICIAN REPORT (UMPHYX)

The UM Contact to Physician Report provides a listing of those patients whose UM Abstract contains data regarding contact to the physician. This information is helpful in reporting to the appropriate Medical Staff Committee and in determining the number of times a physician was contacted by the UM Coordinator with regard to management of the patient.

NOTE: You can use the STAR Audit Service to audit user requests for this report. The Audit Service collects and stores information such as report request date and time, the name of the user requesting the report, and the criteria selected for the report. For more information, see the *STAR Audit Service Reference Guide*.

The UM Contact to Physician Report is a demand report that allows selection of the report begin and end date, multiple sort selection, the option to print information for discharged patients only, an option to suppress printing the physician's name to maintain confidentiality, and an option to print notes. All selected options print in the report header. This report prints on a wide carriage (132 character)printer. When this option is selected from the UM Reports menu, this screen displays:

```
        General Hospital UM Contact to Physician Report Processor
                                                Mon Aug 24, 1992 09:10 am

( 1)Begin Date          :
( 2)End Date            :
( 3)Discharge Only      :
( 4)Confidential        :
( 5)Include Detail      :
( 6)Include Notes       :
( 7)Sort                :









Enter begin date--
```

Field Explanations

1. BEGIN DATE

This field is used to indicate the beginning date for the report. The beginning date is based on the date the physician was contacted. This information is extracted from the Contact to Physician screen of the UM Abstract. This field is used in conjunction with the next field, End Date.

2. END DATE
This field is used to indicate the ending date for the report. The ending date is based on the date the physician was contacted. This information is extracted from the Contact to Physician screen of the UM Abstract. The End Date field is used in conjunction with the previous field, Begin Date. For example, if you are reporting on contact to physician for the month of May, you would enter a beginning date of 05/01/92 and an ending date of 05/31/92. The system then searches for any contact to physician entry with a date that falls between the begin date and end date specified on this screen. The listing on the report is inclusive of all contact to physician that was made in the month of May.

3. DISCHARGE ONLY
This field is used to indicate whether the report should contain data only on patients who have been discharged. When this field is entered, this prompt displays:

Discharged patients only? (Y/N)--

You have the following entry options:

- Enter **Y** to indicate the report should contain data only on patients who have been discharged. The report includes only discharged patients whose UM Abstract contains contact to physician information that falls between the specified begin and end date.

- Enter **N** to indicate the report should contain all patients, not just those who have been discharged. Both in-house and discharged patients are included on the report if their UM Abstract contains contact to physician information that falls between the specified begin and end date.

- Press ENTER and the system completes this field with **N** for No.

4. CONFIDENTIAL
This field is used to indicate whether the report is to remain confidential. The confidentiality refers to the name of the physician contacted that displays on the report. When this field is entered, this prompt displays:

Print physician code only? (Y/N)--

You have the following entry options:

- Enter **Y** to indicate that this report is intended to be confidential and the display for physician contacted should be the code only. If the physician contacted entered for a patient was done so in a free-form format, this field is blank.

- Enter **N** to indicate that this report is not intended to be confidential and the display for the physician contacted should be the code and name. If the physician contacted entered for a patient was done so in a free-form format, this field contains only the name and not a code.

- Press ENTER and the system completes this field with **N** for No.

These print options are to assist the UM Coordinator and/or QA Coordinator in ensuring that confidential and sensitive information is maintained as such.

5. INCLUDE DETAIL
This field is used to indicate whether the report should include detailed patient information. When this field is entered, this prompt displays:

Print detail? (Y/N)--

You have the following entry options:

- Enter **Y** to indicate that the report should include detail information regarding the patient. Detail information is that which is included in the first header line of the report. Please see the report sample for additional information and field explanations.

- Enter **N** to indicate that the report should not include detail information regarding the patient. A report that does not include detail contains only information found in the second and third header line of the report. A non-detail report is a listing only of the contact to physician entries that have occurred during the specified begin and end dates. Please see the report sample for additional information and field explanations.

- Press ENTER and the system completes this field with **N** for No.

6. INCLUDE NOTES
This field is used toindicate whether the report should include any additional notes that had been associated with the contact to physician entry. When this field is entered, this prompt displays:

Include notes on report? (Y/N)--

You have the following entry options:

- Enter **Y** to indicate that notes should print on the report. The notes are extracted from the field of the same name in the Contact to Physician screen of the UM Abstract.

- Enter **N** to indicate that notes should not print on the report.

- Press ENTER and the system completes this field with **N** for No.

7. SORT
This field is used to indicate the sort option for the report. When this field is entered, this prompt displays:

Sort by 'P'hysician, 'A'ttending Phys, 'F'in class, 'S'ervice, or 'I'nitials--

You have the following entry options:

- Enter **P** to indicate the report should be sorted by the physician contacted. This information is extracted from the field, Physician, in the Contact to Physician screen of the UM Abstract.

- Enter **A** to indicate the report should be sorted by the attending physician for this patient.

- Enter **F** to indicate the report should be sorted by the financial class code.

  NOTE: This sort option should not be selected if you are not including patient detail on the report because the financial class does not display.

- Enter **S** to indicate the report should be sorted by hospital service.

  NOTE: This sort option should not be selected if you are not including patient detail on the report because the hospital service does not display.

- Enter **I** to indicate the report should be sorted by the initials of the UM Coordinator entering the contact to physician information. This information is extracted from the INIT field on the Contact to Physician screen of the UM Abstract.

Once you have completed the screen for the report set-up, this prompt displays:

Accept this screen? (Y/N)--

You have the following entry options:

- Enter **Y** to accept the information on the screen.

- Enter **N** to indicate the screen is not accepted. This prompt displays:

  Enter field number or '/' starting field number--.

  You can update any field on the processor screen.

- Press period (.) followed by ENTER to abort processing of this report and return to the UM Reports menu.

The following is an example of the UM Contact to Physician Report that is not confidential and that includes detail and notes:

Figure 4.9 UM Contact to Physician Report - Not Confidential (UMPHYX)

```
Fri Jul 03, 1992  10:45 am                  GENERAL HOSPITAL A                                  Page 1
                                      UM Contact to Physician Report

Begin Date: 06/01/92            End Date: 06/30/92
Discharge Only: No                      Confidential: No
Include Detail: Yes                     Include Notes: Yes
Sort: Physician

Patient Name                 Acct Number    Unit Number    Admit Dt   Disch Dt   FC          Ser  P/T
   Attending Physician    Physician Contacted      Phys Type    Contact Dt   Resp Dt
   Contact Reason
  Action/Determination
Notes
-------------------------------------------------------------------------------------------------------
DEMO,UTILIZATION MANAGEME   92170-00001    00009001234    06/10/92   06/30/92   MEDICARE    MED  I/P
   SAMUELSON,DONALD       32-ADAIR,FRANKLIN P      CONSULTANT   06/21/92     06/24/92
   LOS CONCERN
   REF TO ATTENDING PHY
ATTENDING PHYSICIAN STATED HE IS AWARE OF SITUATION AND WILL ASSIST WITH ENSURING STAY IS MINIMIZED.

DEMO,UTILIZATION MANAGEME   92170-00001    00009001234    06/10/92   06/30/92   MEDICARE    MED  I/P
    SAMUELSON,DONALD       32-ADAIR,FRANKLIN P      CONSULTANT   06/28/92     06/30/92
    LOS CONCERN
    REF TO ATTENDING PHYREF TO DEPT CHAIRMANREF TO QA COMMITTEE
ATTENDING PHYSICIAN AGREED WITH REFERRALS NOTED ABOVE.



Total number of Contacts:  2

End of Report
```

Field Explanations

PATIENT NAME
This is the name of the patient and is displayed as LAST,FIRST MIDDLE. This field accommodates up to 25 characters and truncates the middle or first name as necessary.

ACCT NUMBER
This is the account number of the patient's current episode of care. This field accommodates up to 12 digits.

UNIT NUMBER
This is the unit number of the patient for this facility. This field accommodates up to 12 digits.

ADMIT DT
This field contains the admission date for this patient's episode of care.

DISCH DT
This field contains the discharge date for this patient's episode of care. If the patient has not been discharged, this field is blank.

FC
This field contains the patient's primary financial class for this episode of care. The field displays up to 10 characters or the financial class description, but not the code.

NOTE: For discharged patients, this field displays the financial class at the time of discharge. Financial class changes made after the patient is discharged are not reflected on this report.

SER
This field contains the current hospital service of record for this patient. The field displays the three-character service code, but not the description.

ATTENDING PHYS
This field contains the name of the attending physician and is displayed as LAST,FIRST MIDDLE. The field accommodates up to 20 characters and truncates the middle or first name as necessary.

PHYSICIAN CONTACTED
This field contains information on the physician contacted for this patient's entry. This information is extracted from the field, Physician, in the Contact Physician screen of the UM Abstract. The information that displays in this field is controlled by whether you indicated that this is a confidential report. If this is a confidential report, this field contains only the code of the physician contacted. If this is not a confidential report, this field contains both the name and code of the physician contacted.

PHYS TYPE
This field contains the physician type associated with the physician contacted in the previous field. This information is extracted from the field of the same name in the Contact to Physician screen of the UM Abstract. The field displays up to 10 characters of the physician type description, but not the code.

CONTACT DT
This field contains the date the physician was contacted.

RESP DT
This field contains the date (extracted from the Respond Date field in the Contact to Physician screen) the physician responded back to the UM Coordinator. If the physician has not responded back, this field is blank.

CONTACT REASON
This field contains the reason the physician was contacted. This information is extracted from the field of the same name in the Contact to Physician screen of the UM Abstract. The field displays the full 18-character description, but not the code. The field displays up to four contact reasons.

ACTION/DETERMINATION
This field contains the case action/determination for this contact. This information is extracted from the field of the same name in the Contact to Physician screen of the UM Abstract. The field displays the full 19-character description, but not the code. The field displays up to four action/determinations.

NOTES
This field contains any notes that had been entered to provide additional information regarding this contact to physician entry. This information is extracted from the field of the same name in the Contact to Physician screen of the UM Abstract. If no notes had been entered and/or the set-up of the report indicated notes should not print, this field is blank. The field displays the complete note.

TOTAL NUMBER OF CONTACTS
This summary line displays the total number of contacts made to physicians during the specified dates. This number will not always match the total accounts displayed because an account can have more than one contact to physician entry.

The following is an example of the UM Contact to Physician Report that is confidential and does not include detail or notes:

Figure 4.10 UM Contact to Physician Report - Confidential (UMPHYX)

```
Fri Jul 03, 1992  10:45 am                    GENERAL HOSPITAL A                                Page 1
                                          UM Contact to Physician Report

Begin Date: 06/01/92            End Date: 06/30/92
Discharge Only: No              Confidential: Yes
Include Detail: No              Include Notes: No
Sort: Physician

Patient Name                          Act Number     Unit Number     Admit Dt     Disch Dt   FC   Ser  P/T
       Attending Physician    Physician Contacted      Phys Type    Contact Dt   Resp Dt
       Contact Reason
      Action/Determination
-------------------------------------------------------------------------------------------------------------
       SAMUELSON,DONALD       32                       CONSULTANT   06/21/92     06/24/92
       LOS CONCERN
       REF TO ATTENDING PHY

      SAMUELSON,DONALD        32                       CONSULTANT   06/28/92     06/30/92
      LOS CONCERN
      REF TO ATTENDING PHYREF TO DEPT CHAIRMANREF TO QA COMMITTEE


Total number of Contacts:  2

End of Report
```

UM CONTACT TO ADVISOR REPORT (UMADVX)

The UM Contact to Advisor Report provides a listing of those patients whose UM Abstract contains data regarding contact to the physician advisor. This information is helpful in reporting to the appropriate Medical Staff Committee and in determining the number of contacts made to a physician advisor by a UM Coordinator.

NOTE: You can use the STAR Audit Service to audit user requests for this report. The Audit Service collects and stores information such as report request date and time, the name of the user requesting the report, and the criteria selected for the report. For more information, see the *STAR Audit Service Reference Guide*.

The UM Contact to Advisor Report is a demand report that enables selection of the report begin and end date, multiple sort selection, the option to print information for discharged patients only, the option to print notes, and an option to suppress printing of the physician's name to maintain confidentiality. All options print in the report header. This report prints on a widecarriage (132 character) printer. When this option is selected from the UM Reports menu, this screen displays:

```
        General Hospital UM Contact to Advisor Report Processor
                                                Mon Aug 24, 1992 09:12 am

( 1)Begin Date          :
( 2)End Date            :
( 3)Discharge Only      :
( 4)Confidential        :
( 5)Include Detail      :
( 6)Include Notes       :
( 7)Sort                :









Enter begin date--
```

Field Explanations

1. BEGIN DATE
This field is used to indicate the beginning date for the report. The beginning date is based on the date the physician advisor was contacted. This information is extracted from the Contact to Advisor screen of the UM Abstract. This field is used in conjunction with the next field, End Date.

2. END DATE
This field is used to indicate the ending date for the report. The ending date is based on the date the physician advisor was contacted. This information is extracted from

the Contact to Advisor screen of the UM Abstract. The End Date field is used in conjunction with the previous field, Begin Date. For example, if you are reporting on contact to advisor for the month of May, you would enter a beginning date of 05/01/04 and an ending date of 05/31/04. The system then searches for any contact to advisor entry with a date that falls between the begin date and end date specified on this screen. The listing on the report is inclusive of all contact to advisor that was made in the month of May.

3. DISCHARGE ONLY

This field is used to indicate whether the report should contain only data on patients who have been discharged. When this field is entered, this prompt displays:

Discharged patients only? (Y/N)--

You have the following entry options:

- Enter **Y** to indicate the report should contain data only on patients who have been discharged. The report includes only discharged patients whose UM Abstract contains contact to advisor information that falls between the specified begin and end date.

- Enter **N** to indicate the report should contain all patients, not just those that have been discharged. Both in-house and discharged patients are included on the report if their UM Abstract contains contact to advisor information that falls between the specified begin and end date.

- Press ENTER and the system completes this field with **N** for No.

4. CONFIDENTIAL

This field is used to indicate whether the report is to remain confidential. The confidentiality refers to the name of the physician advisor contacted that displays on the report. When this field is entered, this prompt displays:

Print physician code only? (Y/N)--

You have the following entry options:

- Enter **Y** to indicate that this report is intended to be confidential and the display for advisor contacted should be the code only.

- Enter **N** to indicate that this report is not intended to be confidential and the display for the advisor contacted should be the code and name.

- Press ENTER and the system completes this field with **N** for No.

These print options are to assist the UM Coordinator and/or QA Coordinator in ensuring that confidential and sensitive information is maintained as such.

5. INCLUDE DETAIL
This field is used to indicate whether the report should include detailed patient information. When this field is entered, this prompt displays:

Print detail? (Y/N)--

You have the following entry options:

- Enter **Y** to indicate that the report should include detail information regarding the patient. Detail information is that which is included in the first header line of the report. Please see the report sample for additional information and field explanations.

- Enter **N** to indicate that the report should not include detail information regarding the patient. A report that does not include detail contains only information found in the second and third header line of the report. A non-detail report is basically a listing of the contact to physician entries that have occurred during the specified begin and end dates. Please see the report sample for additional information and field explanations.

- Press ENTER and the system completes this field with **N** for No.

6. INCLUDE NOTES
This field is used toindicate whether the report should include any additional notes that had been associated with the contact to advisor entry. When this field is entered, this prompt displays:

Include notes on report? (Y/N)--

You have the following entry options:

- Enter **Y** to indicate that notes should print on the report. The notes are extracted from the field of the same name in the Contact to Advisor screen of the UM Abstract.

- Enter **N** to indicate that notes should not print on the report.

- Press ENTER and the system completes this field with **N** for No.

7. SORT
This field is used to indicate the sort option for the report. When this field is entered, this prompt displays:

Sort by 'P'hysician, 'A'ttending Phys, 'F'in Class, 'S'ervice, or 'I'nitials--

You have the following entry options:

- Enter **P** to indicate the report should be sorted by the physician advisor. This information is extracted from the Physician Advisor field in the Contact to Advisor screen of the UM Abstract.

- Enter **A** to indicate the report should be sorted by the attending physician for this patient.

- Enter **F** to indicate the report should be sorted by the financial class code.

  NOTE: This sort option should not be selected if you are not including patient detail on the report because the financial class does not display.

- Enter **S** to indicate the report should be sorted by hospital service.

  NOTE: This sort option should not be selected if you are not including patient detail on the report because the hospital service does not display.

- Enter **I** to indicate the report should be sorted by the initials of the UM Coordinator entering the contact to physician information. This information is extracted from the INIT field on the Contact to Advisor screen of the UM Abstract.

Once you have completed the screen for the report set-up, this prompt displays:

Accept this screen? (Y/N)--

You have the following entry options:

- Enter **Y** to accept the information on the screen.

- Enter **N** to indicate the screen is not accepted. This prompt displays:

  Enter field number or '/' starting field number--

  You can update any field on the processor screen.

- Press period (.) followed by ENTER to abort processing this report and return to the UM Reports menu.

Once **Y** is entered, this message displays:

Processing!

The message displays briefly, and then you are returned to the Reports Menu.

The following is an example of the UM Contact to Advisor Report that is not confidential and that includes detail and notes:

Figure 4.11 UM Contact to Advisor Report - Not Confidential (UMADVX)

```
Fri Jul 03, 1992  10:45 am          GENERAL HOSPITAL A                                Page 1
                              UM Contact to Advisor Report

Begin Date: 06/01/92             End Date: 06/30/92
Discharge Only: No               Confidential: No            Include Detail: Yes
Include Notes: Yes               Sort: Physician

Patient Name                Acct Number    Unit Number    Admit Dt   Disch Dt   FC          Ser  P/T
Rev   Attending Physician    Notice Dt   Denial Dt   Reinst Dt
Physician Advisor        Time   Contact Dt   Resp Dt
   Contact Reason
   Action/Determination
   Notes
-------------------------------------------------------------------------------------------------------
DEMO,UTILIZATION MANAGEME   92170-00001    00009001234    06/10/92   06/30/92   MEDICARE    MED  I/P
LTR   SAMUELSON,DONALD
4-GREEN,JOSEPH            2.50   06/28/92    06/29/92
   LOS CONCERN
   REF TO ATTENDING PHY
   ATTENDING PHYSICIAN WAS ADVISED OF REFERRAL TO PHYSICIAN ADVISOR AND UNDERSTANDS ISSUES.




Total number of Contacts:  1

End of Report
```

Field Explanations

PATIENT NAME
This is the name of the patient and is displayed as LAST,FIRST MIDDLE. This field accommodates up to 25 characters and truncates the middle or first name as necessary.

ACCT NUMBER
This is the account number of the patient's current episode of care. This field accommodates up to 12 digits.

UNIT NUMBER
This is the unit number of the patient for this facility. This field accommodates up to 12 digits.

ADMIT DT
This field contains the admission date for this patient's episode of care.

DISCH DT
This field contains the discharge date for this patient's episode of care. If the patient has not been discharged, this field is blank.

FC
This field contains the patient's primary financial class for this episode of care. The field displays up to 10 characters or the financial class description, but not the code.

NOTE: For discharged patients, this field displays the financial class at the time of discharge. Financial class changes made after the patient is discharged are not reflected on this report.

SER
This field contains the current hospital service of record for this patient. The field displays the three-character service code, but not the description.

REV
This field displays the initials of the UM Coordinator entering responsible for contacting the Physician Advisor. This information is extracted for the INIT field on the Contact to Advisor screen of the UM Abstract. The field displays up to 3 characters.

ATTENDING PHYS
This field contains the name of the attending physician and is displayed as LAST,FIRST MIDDLE. The field accommodates up to 20 characters and truncates the middle or first name as necessary.

PHYSICIAN ADVISOR
This field contains information on the physician advisor for this patient's entry. This information is extracted from the field of the same name in the Contact to Advisor screen of the UM Abstract. The information that displays in this field is controlled by whether you indicated that this is a confidential report. If this is a confidential report,

this field contains only the code of the physician advisor. If this is not a confidential report, this field contains both the name and code of the physician advisor.

CONTACT DT
This field contains the date the physician advisor was contacted. This information is extracted from the Contact DT field on the Contact to Advisor screen.

RESP DT
This field contains the date the physician advisor responded to the UM Coordinator. This information is extracted from the Contact DT field on the Contact to Advisor screen. If the physician has not responded, this field is blank.

CONTACT REASON
This field contains the reason the physician advisor was contacted. This information is extracted from the field of the same name in the Contact to Advisor screen of the UM Abstract. The field displays the full 18-character description, but not the code. The field displays up to four contact reasons.

ACTION/DETERMINATION
This field contains the case action/determination for this contact. This information is extracted from the field of the same name in the Contact to Advisor screen of the UM Abstract. The field displays the full 19-character description, but not the code. The field displays up to four action/determinations.

NOTES
This field contains any notes that had been entered to provide additional information regarding this patient's contact to advisor entry. This information is extracted from the field of the same name in the Contact to Advisor screen of the UM Abstract. If no notes had been entered and/or the set-up for this report indicated that notes should not print, this field is blank. The field displays the complete note.

TOTAL NUMBER OF CONTACTS
This summary line displays the total number of contacts made to physician advisors during the specified dates. This number will not always match the total accounts displayed because an account can have more than one contact to advisor entry.

The following is an example of the UM Contact to Advisor Report that is confidential and does not include detail or notes:

Figure 4.12 UM Contact to Advisor Report - Confidential (UMADVX)

```
Wed May 06, 1998 12:04 pm                          Model Hospital A                          Page 1
                                                UM Contact to Advisor Report

Begin Date: 04/01/98                                                    End Date: 04/30/98
Discharge Only: No                    Confidential: Yes                 Include Detail: No
Include Notes: No                     Sort: Physician

Rev   Attending Physician          Notice Dt      Denial Dt       Reinst Dt
Physician Advisor             Time     Contact Dt         Resp Dt
   Contact Reason
   Action/Determination
_____________________________________________________________________________________________

KOK   ADAIR,FRANK C
12                            .50      04/23/98           04/23/98
    ANCILLARY USAGE
    REF TO COMMITTEE

Total number of Contact to Advisor Entries: 1

End of Report
```

UM SPECIAL STUDY REPORT (UMSSX)

The UM Special Study Report is designed to provide a listing of those patients on whom a special study has been entered in the UM Module. Because each facility can define specific questions and responses for each special study, the main use of this report is to identify patients. For detailed and specific reports, you should use STAR SQL.

The UM Special Study Report is a demand report that allows selection of begin and end dates, the option to include discharged patients only, selection of sort options, and whether study detail should be included. All selection options print in the report header. This report requires full size (132-column) computer paper for printing.

NOTE: You can use the STARAudit Service to audit user requests for this report. The Audit Service collects and stores information such as report request date and time, the name of the user requesting the report, and the criteria selected for the report. For more information, see the *STAR Audit Service Reference Guide*.

When you select this option from the UM Reports menu, the system displays this screen:

```
             General Hospital UM Special Study Report Processor
                                                  Tue Mar 18, 1996 09:13 am

( 1)Date Type           : Discharge date
( 2)Begin Date          : 01/01/96
( 3)End Date            : 01/31/96
( 4)Discharge Only      : No
( 5)Study Detail        : Yes
( 6)Special Studies     : ER, 1A, 3B
( 7)Sort                : Patient Name









Accept this screen? (Y/N)-- [Y]
```

Field Explanations

1. DATE TYPE
This field allows you to select the type of date (admission, discharge, or study) in order to determine which patients are going to be included in the report.

When you access this field, the system displays the following prompt:

Select 'A'dmission, 'D'ischarge, or 'S'tudy date'--

Enter **A** for Admission, **D** for Discharge, or **S** for Study date.

2. BEGIN DATE
Enter the beginning admission, discharge, or study date, in the format MMDDYY. For example, if you enter 010196 and you selected discharge as the date type in the first field, the report includes all patients discharged on or after January 1, 1996.

3. END DATE
Enter the ending admission, discharge, or study date, in the format MMDDYY. For example, if you enter 063096 and you selected discharge as the date type in the first field, the report includes all patients whose discharge date is on or before June 30, 1996.

4. DISCHARGE ONLY
When you access this field, the system displays this prompt:

Discharged patients only? (Y/N)--

You have the following entry options:

- Enter **Y** if you want the report to contain data only on patients who have been discharged.
- Enter **N** for No if you want the report to contain all patients, not just those who have been discharged.

5. STUDY DETAIL
Use this field to indicate whether the report should contain all detail from the selected study. Study detail on the report means that responses for each patient are printed, as opposed to just a listing of those patients on whom the selected study had been entered.

When you access this field, the system displays the following prompt:

Include Study Detail? (Y/N)--

You can do one of the following:

- Enter **Y** for Yes to include in the report the responses for each patient's special study as well as a list of the questions at the beginning of the report.
- Enter **N** for No to indicate study detail should not print on the report. If detail is not included, the report contains only a list of the patients included in the study, but does not print the study questions or responses.

6. SPECIAL STUDIES
Use this field to indicate which special studies the report should include. When you access this field, the system displays the following prompt:

Enter table code--

You have two choices:

- Enter the code or codes of the special studies on which you want to report. You can add multiple special study codes.
- Enter a hyphen (-) to display the UM Special Study table for selection. You can select as many special studies as you need. When have made your selections, press ENTER. The system redisplays the UM Special Study Report Processor screen.

When you are done making your selections, the system displays the special study code(s) in this field.

NOTE: If you select multiple studies, all patients are printed for each study, separated by a page break. In addition, the special study questions are printed at the top of each page of the report.

7. SORT
When you access this field, the system displays this prompt:

Sort by 'P'atient Name, 'A'ccount Number or 'T'erminal Digit--

You can do one of the following:

- Enter **P** to have the report information sorted by the patient's last name.
- Enter **A** to have the report information sorted numerically by patient's account numbers.
- Enter **T** to have the report information sorted by terminal digit (based on the unit number of the patient).

When you complete these fields, the system displays this prompt:

Accept this screen? (Y/N)--

Press **N** for No to return to any of the fields to make changes. Press **Y** or ENTER for Yes to accept the screen. The system displays this message:

Processing!

The system displays this message briefly, then redisplays the Reports menu.

The following is an example of a UM Special Study Report that includes detail:

Figure 4.13 UM Special Study Report - Detail (UMSSX)

```
Thu Mar 21, 1996  10:45 am                GENERAL HOSPITAL A                                  Page 1
                                        UM Special Study Report
Date Type: S-StudyBegin Date: 01/01/96End Date: 03/15/96
Discharge Only: NoStudy Detail: Yes
Special Studies: ER
Sort: Patient Name

ER - DOA'S IN ER
 1   HOW DID THE PATIENT ARRIVE AT THE ER?
 2   TIME PATIENT ARRIVED AT THE ER
 3   WAS CPR INITIATED ON THIS PATIENT
 4   WHAT TIME WAS CPR INITIATED ON THIS PATIENT?
 5   WHAT TIME WAS CPR STOPPED ON THIS PATIENT?
 6   INDICATE PT'S B/P AT TIME OF ARRIVAL
 7   INDICATE THE PT'S O2 LEVEL AT TIME OF ARRIVAL
 8   DID RECORD INDICATE PUPILS AS FIXED AND DILATED UPON ARRIVAL?
 9   WAS ALCOHOL LEVEL OR DRUG SCREENING PERFORMED?
10   INDICATE ALCOHOL LEVEL IF SCREENING WAS DONE
11   INDICATE DRUGS FOUND POSITIVE IF DRUG SCREENING DONE
12   INDICATE TIME THE PT WAS PRONOUNCED DEAD
13   IF A RESIDENT PRONOUNCED THE PT, WAS AN ATTENDING PRESENT?
14   TIME PT'S REMAINS WERE PICKED UP TO TAKEN TO THE MORGUE
15   HAS THIS RECORD BEEN REVIEWED BY THE EMERGENCY MEDICINE COMMITTEE?

Patient Name                Acct Number    Unit Number    Admit Dt   Disch Dt   FC                Ser   Study Dt
--------------------------------------------------------------------------------------------------------------
RATES, WILL                 92170-00001    00009001234    02/26/96   02/27/96   MEDICARE          MED   02/27/96
 1. Ambulance
 2. 12:32am
 3. Unknown
 4.
 5.
 6. 100/50
 7.
 8. Yes
 9. No
10.
11.
12. 12:54am
13. Unknown
14.
15. Unknown
```

Field Explanations

PATIENT NAME
This is the name of the patient, which is displayed as LAST,FIRST MIDDLE. This field accommodates up to 25 characters and truncates the middle or first name as necessary.

ACCT NUMBER
This is the account number of the patient's current episode of care. This field accommodates up to 12 digits.

UNIT NUMBER
This is the unit number of the patient for this facility. This field accommodates up to 12 digits.

ADMIT DT
This field contains the admission date for this patient's episode of care.

DISCH DT
This field contains the discharge date for this patient's episode of care. If the patient has not been discharged, this field is blank.

FC
This field contains the patient's primary financial class for this episode of care. The field displays up to 10 characters of the financial class description, but not the code.

NOTE: For discharged patients, this field displays the financial class at the time of discharge. Financial class changes made after the patient is discharged are not reflected on this report.

SER
This field contains the current hospital service of record for this patient. The field displays the three-character service code, but not the description.

STUDY DT
This field contains the date the actual study was performed for each account.

The following is an example of the UM Special Study Report that does not include detail:

Figure 4.14 UM Special Study Report - No Detail (UMSSX)

```
Thu Mar 21, 1996  10:45 am                GENERAL HOSPITAL A                    Page 1
                                        UM Special Study Report
Date Type: S-StudyBegin Date: 01/01/96End Date: 03/15/96
Discharge Only: NoStudy Detail: No
Special Study: ER
Sort: Patient Name

Patient Name                Acct Number    Unit Number    Admit Dt   Disch Dt   FC                Ser   Study Dt
--------------------------------------------------------------------------------------------------------------
DEMI,CHARLES I              92170-00001    00009001234    01/15/96   01/20/96   MEDICARE          MED   01/17/96
DYER,RALPH A                92170-00001    00009001234    02/27/96   02/29/96   MEDICARE          MED   02/29/96
```

UM FAXING AUDIT REPORT (UMFAXX)

The UM Faxing Audit Report provides information on which UM Reviews have been faxed. Each time a UM Review is faxed, the following information is stored (for the number of days specified in the Fax Audit Retention parameter) and available for the UM Faxing Audit Report (UMFAXX, where the last X is the facility indicator):

- the date and time the fax was sent
- the ID code of the person who generated the fax
- the review number(s) and the patient and account number associated with the review
- to whom the fax was directed, including the fax number, company, and recipient
- any free text message added to the fax cover sheet

When you select this option from the UM Reports menu, the system displays the following screen:

```
            General Hospital UM Faxing Audit Report Processor
                                                Fri Apr 07, 2000 12:50 pm


( 1)Start Date               :
( 2)End Date                 :
( 3)Display/Print            :









Enter the begin date for the report--
```

Field Explanations

1. START DATE (6-N-R)
Enter the beginning date for the report in this field. If you want a report listing all UM Reviews faxed beginning on March 1, 2004, enter 3/1/04 in this field.

2. END DATE (6-N-R)
Enter the ending date for the report in this field. If you want a report listing all UM Reviews faxed ending on March 31, 2000, enter 3/31/00 in this field.

3. DISPLAY/PRINT (1-A-R)
Enter **D** to display the report on the screen or **P** to send the report to the default printer associated with the CRT. The default is D.

When you complete these fields, the system displays this prompt:

Accept this screen? (Y/N)--

Press **N** for No to return to any of the fields to make changes. Press **Y** or ENTER for Yes to accept the screen. The system displays this message:

Processing!

Following is an example of the UM Faxing Audit Report:

Figure 4.15 UM Faxing Audit Report (UMFAXX)

```
Fri Apr 07, 2000 02:22 pm      Model Hospital A                    Page:1

Start Date: 02/27/00
End Date:   02/28/00

Date/Time        Faxed by  Reviews         Patient Name      Account #
 Receiving Company              Receiving Person           Fax Phone
   Comment
--------------------------------------------------------------------------------
02/27/00 1109    #32266    6,7,8           ENGLISH,MARY    99327-00007
 BLUE CROSS                     LINDA DAY                  4043385101
   PATIENT WAS ADMITTED WITH FEVER OF 105.
   PATIENT IS EXPERIENCING DIZZINESS.

02/27/00 1120    #32266    6,7,8           ENGLISH,MARY    99327-00007
 MEDICARE                       SUSAN SMITH                4043385177
   HERE ARE THE REVIEWS YOU REQUESTED.
   FOR MORE INFORMATION, CONTACT LUNELLE SMITH
   AT 124/123-4788.

02/28/00 1121    #32266    6,7,8           ENGLISH,MARY    99327-00007
 COMPANY                        RECIPIENT                  4043385222

End of Report
```

Field Explanations

DATE/TIME
This field displays the date and time the review was spooled to the fax server.

FAXED BY
This field displays the ID code of the person who sent the fax.

REVIEWS
This field displays the review number(s) that were selected to be faxed.

PATIENT NAME
This field displays up to 25 characters of the patient's name in the format LAST,FIRST MIDDLE. The middle or first name is truncated if necessary.

ACCOUNT #
This field displays the account number (up to 12 digits) for the patient.

RECEIVING COMPANY
This field displays the name of the company to which the fax was sent, if the company was specified in the Fax to (Company) field when the fax was queued.

RECEIVING PERSON
This field displays the name of the person to whom the fax was sent, if the person was specified in the Fax to (Name) field when the fax was queued.

FAX PHONE
This field displays the fax number of the destination fax machine.

COMMENT
This field displays any comments that were entered in the Message field when the fax was queued.

Appendix A - INFORMATION WINDOWS

INTRODUCTION

The use of Information Windows enables the Utilization Management (UM) Coordinator to access additional patient information for determination of continued stay, resource utilization, and necessity of receiving acute care, without exiting the UM review functions.

You can display Information Windows if you meet the following criteria:

- You are using WEM on an IBM-compatible personal computer.
- Your PC and host ID computer are set up to enable the use of Information Windows.

For more information on using Information Windows, see the *WEM User's Guide*.

The following information applies to utilizing the window functionality:

- All information is accessed at the account number level.
- All information is display only.
- The information accessed via the window does not interfere with the UM information on the screen.
- To access the information windows, select **Tools > Information Windows** from the menu bar.
- To exit the information window, press the **ESC** key or close the window.

Information Windows displaying patients' MPI information, medical record abstract information, insurance information, physician information, and pharmacy profile information are available through the UM Module. The information is downloaded into the windows upon selection of a patient in these functions. During the download process, the system displays the following message:

Downloading Information Windows...Please Wait!

NOTE: Pharmacy information is only available when STAR Pharmacy is in the system network.

MPI INFORMATION

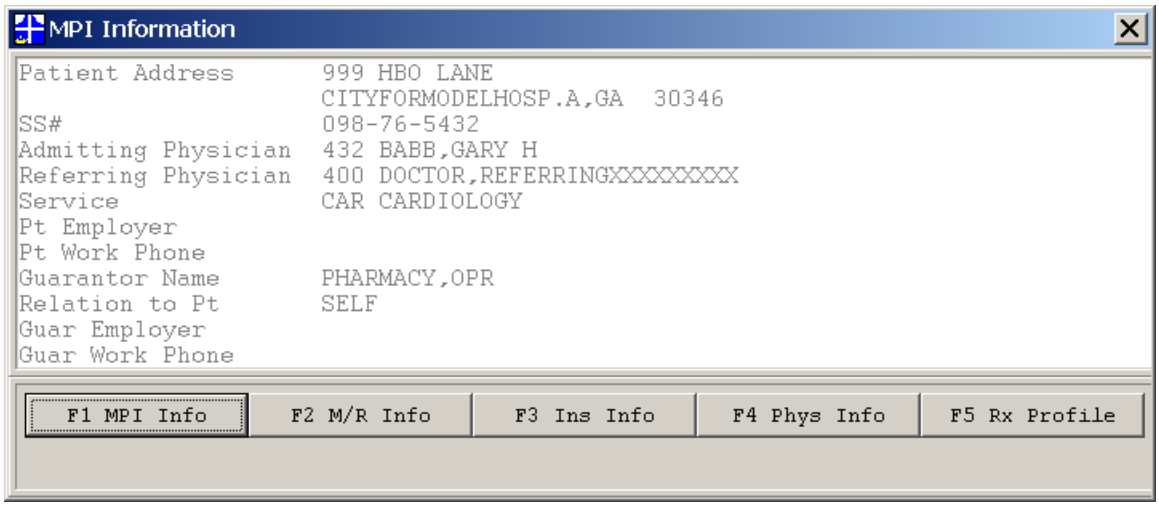
This window is accessed to view information from the MPI. When this window is selected, the following information displays if available:

- Patient's address
- Patient's social security number

  NOTE: Display of the social security number may be masked or partially masked, depending on your facility's settings.

- Admitting physician (code and description)
- Referring physician (code and description)
- Service (code and description)
- Patient's employer
- Patient's work phone number
- Guarantor's name
- Relation to patient - description
- Guarantor's employer
- Guarantor's work phone number

The following is a sample of the MPI Information Window that displays when accessed from a screen in the Utilization Management Module:



NOTE: Use the buttons on the bottom of the window to access the other Information Windows without exiting the Utilization Management Module.

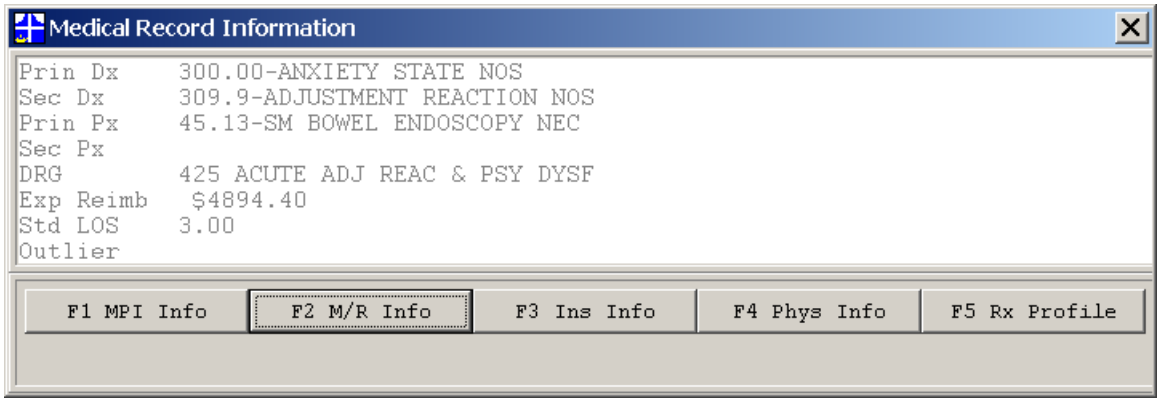
MEDICAL RECORD INFORMATION

This window is accessed to view information from the medical record abstract. When this window is selected, the following information displays if available:

- Principal Diagnosis (code and description)
- Secondary Diagnoses (code and description)
- Primary Procedure (code and description)
- Secondary Procedures (code and description)
- DRG number and description
- Exp. Reimbursement - displayed as $9,999,999.99
- DRG Standard LOS - displayed as 999.99
- Outlier Indicator - displayed as cost or stay or is blank
- Birthweight - display as lbs/oz and KG

NOTE: The header Birthweight does not display if the record does not contain this information.

The following is a sample of the Medical Record Information Window when accessed from a screen in the Utilization Management Module:



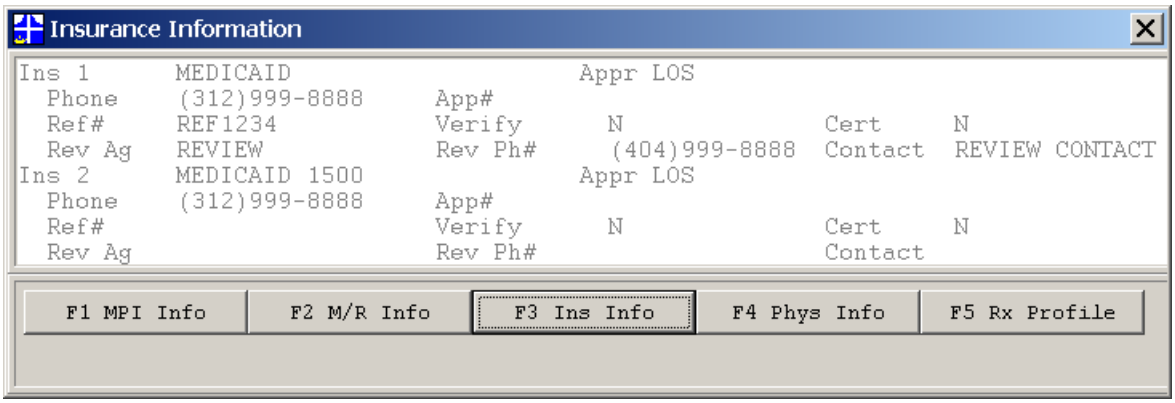
NOTE: Use the buttons on the bottom of the window to access the other Information Windows without exiting the Utilization Management Module.

INSURANCE INFORMATION

This window is accessed to view information from the insurance processor screen of the MPI. When you select this window, the following information for the primary and secondary insurance displays if available:

- Insurance name
- Approved Length of Stay - up to 3 digits
- Phone - area code and number
- Approval Number
- Reference Number
- Verification Done Indicator - a Y or N displays
- Certification Done Indicator - a Y or N displays
- Review Agency Name
- Review Agency phone number
- Review Agency Contact

The following is a sample of the Insurance Information Window when accessed from a screen in the Utilization Management Module:



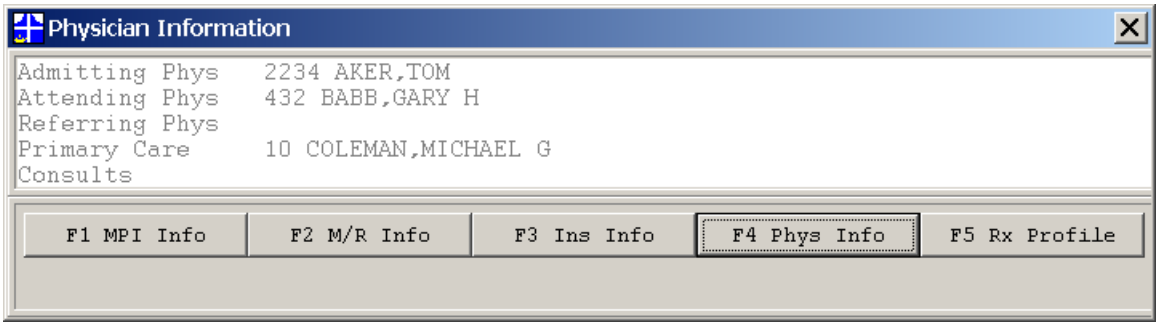
NOTE: Use the buttons on the bottom of the window to access the other Information Windows without exiting the Utilization Management Module.

PHYSICIAN INFORMATION

This window is accessed to view physician information for the selected patient. When you select this window, the following physician information displays if available:

- Admitting physician (code and description)
- Attending physician (code and description)
- Referring physician (code and description or freeform entry)
- Primary care physician (code and description or freeform entry)
- Consulting physicians (code and description)

The following is a sample of the Physician Information Window when accessed from a screen in the Utilization Management Module:



NOTE: Use the buttons on the bottom of the window to access the other Information Windows without exiting the Utilization Management Module.

RX PROFILE

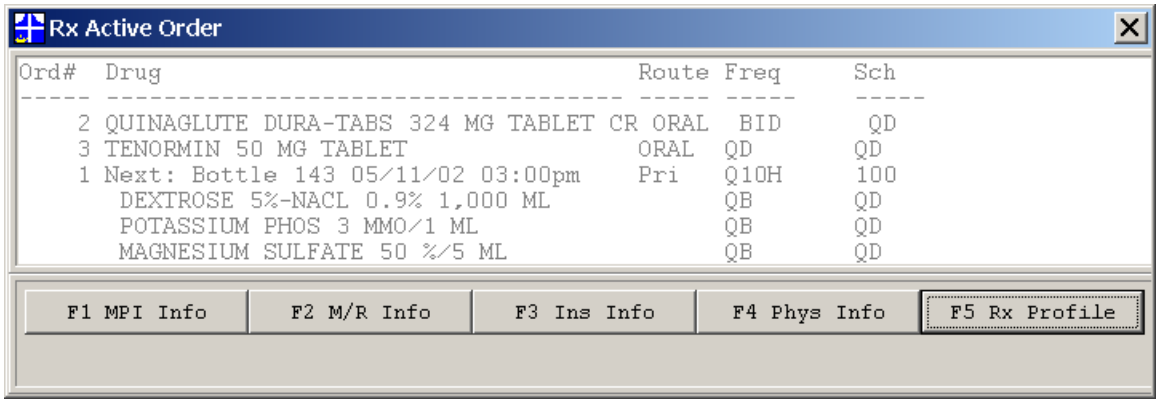
This window is accessed to view information from the pharmacy profile. When you select this window, the following information displays if available:

- Order number
- Drug
- Route
- Frequency
- Schedule

If the selected patient does not have any pharmacy orders, the following text displays in the RX Profile window:

No active orders for selected account.

The following is a sample of the RX Profile Information Window that displays when accessed from a screen in the Utilization Management Module:



NOTE: Use the buttons on the bottom of the window to access the other Information Windows without exiting the Utilization Management Module.

Index

■ Reader Comment Form ■

We value your suggestions for improving our documentation. Please use this form to evaluate the *Utilization Management Module* of the *STAR Patient Care Reference Guide* for Release 17.0.

Topic	Poor	Fair	Good	Excellent
Organization of information	❑	❑	❑	❑
Accuracy of information	❑	❑	❑	❑
Completeness of information	❑	❑	❑	❑
Clarity of information	❑	❑	❑	❑
Amount of overview information	❑	❑	❑	❑
Explanation of processes	❑	❑	❑	❑

Are there parts of this manual that could be made more helpful to you? Please explain.

Other Comments:

Thanks for your help in improving the documentation.

Your Name and Position _____

Hospital/Organization Name _____

Telephone Number _____

May we contact you? Yes or No (circle one)

■

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