McKESSON
Empowering Healthcare

STAR 2000™

STAR PATIENT CARE REFERENCE GUIDE
Medical Record Abstracting Module

Release 18.0
October 2012

C18000081

Copyright notice

Publication date

October 2012
Produced in Cork, Ireland

Product and version

STAR 2000 Release 18.0

Publication number

C18000081

Reader comments

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

STAR 2000 Documentation Team
McKesson
Mail Stop ATHQ-3302
5995 Windward Parkway
Alpharetta, GA 30005

Trademarks

CPT®

Preface

This volume of the *STAR Patient Care Reference Guide* provides a detailed explanation of the Medical Record Abstracting Module.

The book provides information on the following topics:

- entering diagnosis and procedure codes (ICD-9-CM and HCPCS)
- entering the official account of a patient's stay in the hospital
- entering information regarding a patient's care and stay via the Special Studies function
- M/R Maintenance
- M/R Abstracting Reports
- Core 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 by 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

Table of Illustrations

Introduction

Most healthcare facilities require some type of basic descriptive statistical reporting. This reporting may be required by the hospital, third party payors, accrediting agencies, or the state government, to name a few. Statistical reporting based on medical record information is facilitated by abstracting information from the medical record.

Abstracting is the act of extracting a predefined set of data from the patient's medical record for the purpose of data collection and reporting. Medical record abstracting can be performed while the patient is in the hospital (concurrently) or when the patient has been discharged (retrospectively).

Reporting requirements determine what type of patients need to be included in the abstracting process. For example, some facilities may only abstract inpatients and same day surgeries, while another may abstract all patient types (inpatients and outpatients).

The Medical Record Abstracting Module of the STAR Patient Care system provides a mechanism to perform online collection of abstract data. This process is facilitated by these system features:

- Data is integrated with patient information collected from the STAR Patient Care Admission/Registration process, eliminating repetitive data entry.
- Abstract information is stored online for easy retrieval and reporting.
- Up to six abstract types are defined for use with the module and are then associated with the patient type.
- The module provides for daily management and statistical reports as they relate to medical record abstracting.
- There is considerable flexibility in building the system using user-defined tables and parameters.

In summary, McKesson provides Medical Record Departments with a tool to manage effectively the functions and tasks associated with the abstracting process. This reference guide helps you to understand these functions, as well as how they work in conjunction with the DRG Assignment and Utilization Management Modules.

To further assist the hospital in processing the abstract, McKesson developed an interface between the STAR Patient Care Medical Record Abstracting Module and the 3M® Coding and Reimbursement System software from 3M Health Information Systems for character-based and GUI environments.

By definition, an encoder is an automated method of assigning ICD-9-CM codes to diagnosis and procedure descriptions. An encoder is used to improve the speed and accuracy of the coding process. This in turn has a positive impact on the hospital's billing process and cash flow. Many encoder products also offer reimbursement functionality to calculate DRGs and other reimbursement information.

To utilize the encoder interface, your facility must purchase the 3M Coding and Reimbursement System software from 3M Health Information Systems and the interface software from McKesson. Your account manager will assist you in this process.

Information on using the interface can be found in the chapter on M/R Abstracting. The interface can be accessed from both the Diagnosis and Procedure screens in this section.

Chapter 1 - HCPCS PROCEDURES

INTRODUCTION

Outpatient diagnoses and procedures were previously coded using only the ICD-9-CM coding scheme. However, in 1987, this changed when Medicare required that all outpatient surgical services submitted for reimbursement contain the Healthcare Common Procedure Coding System (HCPCS).

HCPCS codes are a combination of three coding levels:

1. CPT codes (Level I HCPCS codes), maintained by the American Medical Association (AMA)

2. Level II HCPCS codes, maintained by the Centers for Medicare and Medicaid Services (CMS)

3. Local codes, maintained by fiscal intermediaries (FI)

CMS publishes modifier codes to describe procedures more specifically. These two-digit modifiers can be collected and stored using this module.

The HCPCS Procedure function enables you to input HCPCS codes and modifiers for patients who have received outpatient surgical services (as defined by CMS), without going through the entire Medical Record Abstracting function. It also enables you to associate multiple procedures to the same episode. Procedures with the same date and time are considered part of the same episode. Thus, all procedures done during the same operative episode (that is, the same visit to the operating room or surgical suite, for example) should be entered with the same time and date. The major benefit of associating procedures to a common episode is that you only need to abstract episode detail information (pertaining to all procedures in one episode) one time. A patient may have multiple procedures per episode, and multiple episodes per visit.

When you select this function, the system displays the MPI Search screen. After you select a patient and the appropriate visit, the following screen is displayed:

```
               General Hospital HCPCS Procedures Processor
             Patent Info          Page  1 of  2 Sun Aug 05, 2007 10:39 pm
   Account No     Name                              Unit No        Corp No
   0720800004     ABUNDIS,SANFORD S                 000-00-4463    00004974
 1 Financial class          2 HCPCS Payor          3 Attending Physician
   S SELF PAY                                      4143 FILO,TEST DOC
 4 Service                  5 Admission Date       6 Birthdate  Admit Age
   MED MEDICALXX              07/27/07             03/17/29      78Y
 7 Sex       8 Discharge Date     9 Current LOS   10 Dsch Disposition
   MALE        07/27/07             1              *HOME(OUTPATIENT)
                           11 Final Accept Date   12 Initials









Enter field number or '/' starting field number--
                       next(/) or previous screen(/P) [/]
```

Field Explanations

1. FINANCIAL CLASS (TABLE LOOKUP)
The patient's financial class as assigned at the time of admission (or subsequently updated) displays in this field, or you can enter a new financial class by entering the financial class code if you know it, or by pressing hyphen (-) and ENTER to display the financial class code table for selection. Changes made to the financial class do not change the patient's insurance or MPI information. It is suggested that the business office or other appropriate department be contacted when the financial class is incorrect.

2. HCPCS PAYOR (DISPLAY ONLY)
This field displays the HCPCS Payor associated with the financial class that is entered in the Financial Class field. This field can be changed only by updating the financial class. Financial classes are associated with a HCPCS payor in the HCPCS Payor code table.

3. ATTENDING PHYSICIAN (TABLE LOOKUP)
This field contains the name of the attending physician entered during the admission sequence. When you access this field in the STAR Financials environment, the system displays a subscreen on which you can enter the name and address of a *new* attending physician.

NOTE: The screen enabling entry of an address only displays if the field *2nd Office Address* in the Hospital Facilities Options screen is set to Yes. Otherwise, only a new attending name and reclassification effective date is entered.

```
                    General Hospital HCPCS Procedures Processor
              Patent Info          Page  1 of  2 Fri Mar 17, 1995 12:00 pm
    Account No     Name                              Unit No        Corp No
    90030-00005    DOE,JOHN                          000-1048-47    0003029
   Current    1 Attending Physician         Office Address
                99 ZELLER,HECTOR C
   New        2 Attending Physician         Office Address
             ->
              3 Effective                4 By
                                           B C









Enter table code--
```

Subscreen Field Explanations

1. ATTENDING PHYSICIAN OFFICE ADDRESS (DISPLAY ONLY)
This field contains the name and address of the *current* attending physician.

2. ATTENDING PHYSICIAN OFFICE ADDRESS (26-A-R or TABLE LOOKUP)
This field is used to enter the name and address of a *new* attending physician. You can enter the table code for the new physician if you know it, or press hyphen (-) and ENTER to display the physician code table for selection. You can enter part of the physician's name or the letter(s) the name begins with followed by a hyphen (-) to limit the alphabetic table search.

3. EFFECTIVE DATE (25-AN-R)
This field prompts you to enter the effective date or the earliest reclassification date possible for the new attending physician. The earliest reclassification date allowed is either the admission date or the earliest reclassification date allowed according to the parameters set in STAR Financials. The default is the current date. Enter **E** followed by ENTER to automatically assign the earliest date allowed.

4. BY (DISPLAY ONLY)
This field is automatically completed with the initials of the person who signed on.

Impact

After you accept this subscreen, the following takes place:

- You are returned to the HCPCS Procedure Processor screen where the code and name of the new attending physician displays.

Field Explanations for HCPCS Procedure Screen cont.

4. SERVICE (TABLE LOOKUP)
If you are entering information in this field for the first time, enter the code identifying the hospital service the patient is using during this visit. Once this field contains an entry, the system automatically displays another screen, called the Service Tracker, whenever you access this field. The Service Tracker enables your facility to track all changes to the patient's hospital services during this visit. It keeps a record of every hospital service the patient has used so that none of this information is lost when changes are made. The information displayed on the Service Tracker depends on whether or not your facility is using Program Management.

NOTE: The Service Tracker retains the outpatient service information when an outpatient in bed is changed to an inpatient. It does not retain inpatient service information when an inpatient is changed to an outpatient.

If Program Management is not active, and the patient is (or was) in a bed, the following screen is displayed:

```
                  General Hospital HCPCS Procedures Processor
              Patent Info          Page  1 of  2 Tue Jun 04, 1996 04:39 pm
    Account No     Name                              Unit No        Corp No
    96-14100007    RAYMOND,LEE                       000002016      00002126
NO  SERVICE  (CODE)        START   LOS  SUB PHYSICIAN    (SPC)   DIAGNOSIS
 1  PSYCHIATRIC  (PSY)    06/01/96   3  1   ADAMS,WILHEL (PSYCH) No
 2  REHAB IP (RHBIP)      06/04/96   2  2   GENTER,ANNE D(PSYCH) No
 3


                          Enter episode start date
```

Subscreen Field Explanations

NO (DISPLAY ONLY)
As you enter each new service, the system assigns the next sequential number. If you enter a service with an earlier date than one already entered, the system resorts the entries in chronological order. The most recent one is what displays in the Service field on the HCPCS Procedures page.

SERVICE (CODE) (TABLE LOOKUP)
Enter the code for the service, if you know it, or enter a hyphen (-) to display the Service table for selection. When you make your entry, both the description and code are displayed on the screen.

START (DATE FORMAT)
Enter the date that this service is scheduled to start. To enter the current date, press ENTER or enter **T**.

LOS (DISPLAY ONLY)
This field displays the maximum length of stay (LOS) defined in the Service table for this service type.

SUB (1-N-O)
This field is used mainly by Canadian users. When you access this column, you are prompted to enter a subservice code, which is a number from zero to nine. There is no table or build function for subservice codes. Subservice codes are defined by the department or hospital and are used to further define the service. Subservice codes are passed to the CIHI with the first three service transfers that are not listed as the Main Service.

PHYSICIAN (TABLE LOOKUP)
This field enables you to associate a physician with the change of service. Once you enter a physician, you are prompted to complete the next column, (SPC).

(SPC) (TABLE LOOKUP)
This column enables you to associate a specialty with the physician entered in the previous column. Enter the physician's primary specialty code, or enter a hyphen (-) to display the valid specialty codes for the physician.

DIAGNOSIS (TABLE LOOKUP)
This column enables you to associate a diagnosis code with this service update entry. You have several entry options:

- Enter the diagnosis code directly into the field.
- Enter **U** and a hyphen (**-**) to display the entire Diagnosis Pointer table (in alphabetic order according to description). Select a code from this listing.
- Enter **U**, an alpha character or characters, and a hyphen (**-**) to display the pointer table that begins with the specific alpha character(s). Select a code from this listing.
- Enter a numeric digit(s) and a hyphen (**-**) to display the table from the diagnosis code table beginning with the specified number(s). Select a code from this listing.
- Enter a hyphen (**-**) to display the entire Diagnosis table in numeric order. Select a code from this listing.

If there is no diagnosis associated with this service, the field contains the entry No.

If Program Management is active, and the patient is (or was) in a bed, the following screen is displayed:

```
                  General Hospital HCPCS Procedures Processor
               Patent Info          Page  1 of  2 Tue Jun 04, 1996 04:39 pm
    Account No     Name                                Unit No        Corp No
    96-14100007    RAYMOND,LEE                         000002016      00002126
NO  CLINIC,UNIT,TEAM  (CODE)             PROGRAM  (CODE)            OFF SERVICE
    SERVICE  (CODE)           START    LOS SUB PHYSICIAN      (SPC)   DIAGNOSIS
 1  ACUTE EXTENDED CARE   (ACEAC)     PSYCH   (PSYCH)                 No
  PSYCHIATRIC   (PSY)       06/01/96    3  1
 2  REHAB IP   (RHBIP)                   PSYCH   (PSYCH)             No
  PSYCHIATRIC   (PSY)       06/04/96    2  2  3




                          Enter episode start date
```

Subscreen Field Explanations

NO
This field contains a system-assigned number as each service is added to the tracker.

CLINIC,UNIT,TEAM (TABLE LOOKUP)
Enter the Clinic,Unit,Team (CUT) code, or press hyphen (-) to display the CUT code table for selection. To override the existing CUT code, enter a new CUT code at the appropriate column number. To add a new service episode, press ENTER or the down arrow key to access the next sequential episode number.

PROGRAM (CODE) (DISPLAY ONLY)
If the medical service is linked to a program code, the program description and code are displayed in this field.

OFF SERVICE
A Yes or No is automatically displayed in this column to indicate whether or not the patient is off service (that is, in a bed that is not associated with the patient's service).

SERVICE (CODE) (TABLE LOOKUP)
Enter the code for the service, if you know it, or enter a hyphen (-) to display the Service table for selection. When you make your entry, both the description and code are displayed on the screen.

START (DATE FORMAT)
Enter the date that this service is scheduled to start. To enter the current date, press ENTER or enter **T**.

LOS (DISPLAY ONLY)
This field displays the maximum length of stay (LOS) defined in the Service table for this service type.

SUB (1-N-O)
This field is used mainly by Canadian users. When you access this column, you are prompted to enter a subservice code, which is a number from zero to nine. There is no table or build function for subservice codes. Subservice codes are defined by the department or hospital and are used to further define the service. Subservice codes are passed to the CIHI with the first three service transfers that are not listed as the Main Service.

PHYSICIAN (TABLE LOOKUP)
This field enables you to associate a physician with the change of service. Once you enter a physician, you are prompted to complete the next column, (SPC).

(SPC) (TABLE LOOKUP)
This column enables you to associate a specialty with the physician entered in the previous column. Enter the physician's primary specialty code, or enter a hyphen (-) to display the valid specialty codes for the physician.

DIAGNOSIS (TABLE LOOKUP)
This column enables you to associate a diagnosis code with this service update entry. You have several entry options:

- Enter the diagnosis code directly into the field.
- Enter **U** and a hyphen (**-**) to display the entire diagnosis pointer table (in alphabetic order according to description). Select a code from this listing.
- Enter **U**, an alpha character or characters, and a hyphen (**-**) to display the pointer table that begins with the specific alpha character(s). Select a code from this listing.
- Enter a numeric digit(s) and a hyphen (**-**) to display the table from the diagnosis code table beginning with the specified number(s). Select a code from this listing.
- Enter a hyphen (**-**) to display the entire diagnosis table in numeric order. Select a code from this listing.

If there is no diagnosis associated with this service, the field contains the entry No.

Impact

After you accept this subscreen, the following takes place:

- You are returned to the HCPCS Procedure Processor screen where the code and name of the new service are displayed. Continue editing the remainder of the fields on the HCPCS screen.

Field Explanations for HCPCS Procedure Screen cont.

5. ADMISSION DATE (DISPLAY ONLY)
The admission date entered during the admission sequence is displayed in this field, and it cannot be edited through this function. However, the admission date can be edited through the Change Admit/Discharge Date function.

6. BIRTHDATE, ADMIT AGE (10-AN-R)
The patient's birthdate entered during the admission sequence displays in this field. The birthdate can be edited, but the age is only updated as a result of a change to the birthdate. Dates can be entered in a variety of formats. Refer to the Information Entry Techniques chapter in the *STAR Patient Care Reference Guide*, *General Information Volume*.

7. SEX (1-A-R)
The sex of the patient entered during the admission sequence displays in this field. You can enter a new sex by entering **M** for Male or **F** for Female.

8. DISCHARGE DATE (DISPLAY ONLY)
If the patient has been discharged, the discharge date displays in this field but cannot be edited via this function. The discharge date can, however, be edited through the Change Admit/Discharge Date function.

9. CURRENT LOS (DISPLAY ONLY)
The current length of stay, based on the dates of admission and discharge, displays in this field. This field is display only and can only be updated by updating the admission and/or discharge date.

10. DSCH DISPOSITION (TABLE LOOKUP)
If the patient has been discharged, the discharge disposition displays in this field. This field cannot be edited if the patient has not been discharged, but is required for discharged patients. When you enter this field, the Disposition table displays for selection.

It is important to enter the appropriate disposition for the patient. Each disposition type is flagged in the Disposition table as either a final disposition or one that is not final. If a final disposition type is selected, the patient's discharge date and time are filed in the patient's record. If the disposition type selected is a type which is considered not final, the discharge date and time for this patient are not stored in the patient's record and the patient is still considered an active patient.

Some examples of a final disposition type are Against Medical Advice, Expired, and Home. If the disposition type is Expired, an X displays to the left of the patient's name on the MPI Name Search screens, and the patient cannot be admitted again.

11. FINAL ACCEPT DATE (DISPLAY ONLY)
This field contains the date the HCPCS code information is accepted as final. If the HCPCS information has not been accepted as complete, the field is left blank and you are prompted to accept the information as final prior to exiting the function.

12. INITIALS (DISPLAY ONLY)
This field displays the initials of the person who accepted the HCPCS information as final.

When you have completed these fields, press ENTER. The system displays the HCPCS Summary screen:

```
                  General Hospital HCPCS Procedures Processor
            HCPCS Procedures     Page  2 of  2 Thu Jun 26, 2003 03:55 pm
    Account No     Name                              Unit No        Corp No
    0124000004     TANNER,EDWARD                     000-00-2488    00002785
HCPCS Code/Description           Modifiers      Grp P-APC Rev  Grp Amt/P-APC Amt
  (1) 10001/DRAINAGE OF 2ND SKIN                  2        100  $363.00/    $0.00
  (2) 11900/INJECTION INTO SKIN                   0        100    $5.00/    $0.00
  (3) 11051/TRIM 2 TO 4 SKIN LES                  0        100    $5.00/    $0.00
                                          Total  --         $373.00/    $0.00
Select HCPCS to revise, add(A) a HCPCS, Code 3(E), View Charges(C), View PA APCs
(V)--             next screen (/) or previous screen (/P) [/]
```

The information on this screen is display only. If HCPCS codes were entered for this patient via the Outpatient Dispositioning function, those codes are displayed on this screen as well. This screen can contain up to 14 codes.

You can use the prompt on this screen to add, delete, or revise HCPCS codes. If the 3M Coding and Reimbursement System is activated, the prompt associated with this screen also enables you to enter an **E** to access the encoder. If your facility uses STAR Patient Accounting, you can also enter **C** to view the Patient Accounting charges posted to the patient's account. If your facility uses STAR Patient Accounting and the OPPS (Outpatient Prospective Payment System) interface to 3M APC Grouper Plus, you can enter **V** to view Patient Accounting APCs.

When HCPCS codes are on this screen or are added to this screen, the following information is displayed:

- The five-digit HCPCS code
- The technical description of the code as found in the HCPCS Table Maintenance function (updated annually with the AMA's media)

- All modifiers entered for this procedure on the Detail screen (without descriptions)
- The group number associated with the HCPCS code as found in the HCPCS Table Maintenance function (updated annually via a STAR STI if group number changes have been published by CMS)
- The preliminary APC (P-APC) code (without the description) returned from 3M's Coding and Reimbursement System and stored in STAR Medical Records
- The UB Revenue Code (without the description) that is associated with the HCPCS code via either the HCPCS Table Maintenance function or the HCPCS Revenue Code Assign function or that is returned from 3M's Coding and Reimbursement System
- A combined display of the expected reimbursement amount for this HCPCS code based on the payor and associated group number and the preliminary APC reimbursement amount from 3M's Coding and Reimbursement System. The APC information is blank until the APCfinder grouping is performed. This information is in column Grp Amt/P-APC Amt.
- The total expected reimbursement amount for all HCPCS codes for this patient

To add, edit, or delete a HCPCS code, select one of the following entry options:

- Enter the procedure number to revise or delete. The HCPCS Detail screen is displayed, which is explained in the next section.
- Enter **A** to add a procedure code. The HCPCS Detail screen is displayed, which is explained below.
- To add a new procedure using the STAR/3M Coding and Reimbursement System interface, enter **E**. When you return to STAR, the HCPCS procedure codes, code modifiers, procedure date, and primary surgeon are displayed. To update or add detail information, follow the steps detailed for adding, revising, and deleting a HCPCS code in the following sections.

NOTE: Since the character-based interface to the 3M Coding and Reimbursement System does not enable transmission and storage of procedure detail data (other than date, surgeon, and modifier), most detail data is lost when the encoder interface is re-accessed.

ADDING A HCPCS CODE

When you enter **A** to add a HCPCS code, the system displays the HCPCS Detail screen:

```
                  General Hospital HCPCS Procedures Processor
              HCPCS Procedures     Page  2 of  2 Mon Sept 10, 2001 10:02 am
    Account No     Name                                Unit No        Corp No
    0124000004     STONE,SALLY                         000003942      00004304
 1 Epis Date & Time      2 Procedure Code                    3 Modifier
->
 4 UB Revenue Code          5 ASC Group     6 Amount          7 Tissue Code

 8 Surgeon                                  9 Specialty

10 Anesth Code          11 Anesth Start Time  12 Anesth End Time 13 Anesth Dura

14 ASA-PS Class         15 Other Institution

16 Epis Location        17 Epis End Date/Time            18 Episode Duration

19 Rec Location         20 Rec Start Date/Time           21 Rec End Date/Time

22 Procedure Team Information     23 Prelim APC Code/Description

24 Prelim APC Weight              25 Prelim APC Payment Amt

Enter Episode date or '-' for available episodes, or `=` for the last entry used
[08/28/01 10 15]--
```

Field Explanations

1. EPIS DATE & TIME (CONDITIONAL: TABLE LOOKUP OR DATE/TIME FORMAT-R)
This field enables you to associate the procedure with an episode. The benefit of grouping procedures to an episode is that you need to enter episode detail only once.

NOTE: You cannot mark the abstract complete unless dates are entered for procedures.

You have the following entry options:

- If this is a new episode, enter the date and time. The default for the time is 7 a.m.
- If there are previous episodes (ICD-9-CM or HCPCS) on file for this patient visit, enter a hyphen (-) to display all episode dates and times previously entered, and select an entry from the listing.
- If you have just added a code, enter an equal sign (=) to bring forward previous detail data, such as episode location.

If you enter a date and time that is not within three days of the admission date, the system displays the following error message, indicating the specific admission date:

Error: Date must be within 3 days of admission date of 12/10/01!

If you enter a date and time that is after the discharge date, the system displays the following error message, indicating the specific discharge date:

Error: Date cannot be after discharge date of 01/26/02!

For example, if the patient's admission date is 12/10 and the discharge date is 01/26, you can enter a date between 12/07 and 01/26, including these dates.

2. PROCEDURE CODE (34-AN-R)
If you are revising a procedure, this field displays the procedure code and description that you selected from the previous screen.

NOTE: When you add HCPCS procedure codes, the codes with group numbers greater than 0 should be included in the first nine entered because only the first nine HCPCS procedures are sent to Patient Accounting to print on the bill. If you are using the Patient Accounting Reimbursement Module, the group numbers should be defined to determine expected reimbursement and to assist in determining "write off" adjustments. See the Tables, Masters, and Parameters Volume of the *STAR Financials Patient Accounting Reference Guide* for more information.

To add a new code or revise a code, enter a HCPCS code using one of the following entry options:

- Enter the HCPCS code if you know it.
- Enter **U** followed by a hyphen (**-**) to display the entire user-defined HCPCS procedure pointer table in alphabetic order. Make your selection from this table.
- Enter **U** followed by an alpha character or characters, then a hyphen (for example, **UA-**, **UBA-**, etc.) to display the pointer table that begins with the specified alpha character(s). For example, entering **UAN-** might cause the descriptions for Anesthesia, Angioplasty, and Anterior Chamber Injection to display if they have been built into the pointer table. Make your selection from this table.
- Enter a number (or numbers) and a hyphen to display the HCPCS code table by a range of specific codes. For example, if you know that the code you are searching for begins with 100, enter **100-** and all the codes beginning with 10000 display. Make your selection from this table.
- Enter a hyphen (**-**) to display the entire HCPCS procedure code table in numeric code order. Make your selection from this table.

NOTE: See the Impact statement for this screen.

3. MODIFIER (TABLE LOOKUP-O)
This field enables you to enter up to 5 modifier codes that further define the HCPCS code entered in the previous field.

NOTE: The cursor does not automatically stop at this field. You must access it by entering a slash (/) and the field number at the prompt. Since all HCPCS codes do not have modifiers, it is fewer keystrokes to access the subscreen when necessary versus having to enter and close it for every HCPCS code entered. Also, modifiers can be input on the encoder and sent back via the interface.

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

```
                General Hospital HCPCS Procedures Processor
              HCPCS Procedures     Page  2 of  2 Tue Jun 02, 1998 11:38 am
   Account No     Name                                Unit No        Corp No
   9806100015     DOE,JOHN                            000001152      00001299
 1 HCPCS Modifier # 1                2 HCPCS Modifier # 2

 3 HCPCS Modifier # 3                4 HCPCS Modifier # 4

 5 HCPCS Modifier # 5









Enter HCPCS modifier code, or "-" for table--
```

Enter a modifier code or a hyphen (-) to access the HCPCS Modifiers Code table for selection. Enter all modifiers sequentially, beginning with Modifier # 1.

If you need to delete a modifier, access the field and press ENTER. When you delete a modifier, all successive modifiers move up one field (e.g., if you delete Modifier # 3, Modifier # 4 moved to the Modifier # 3 field and Modifier # 5 moves to the # 4 field).

NOTE: For modifiers to be retained, both the subscreen above and the first HCPCS Procedures Processor screen must be accepted.

When modifiers are added for a procedure, *Entries Defined* displays in the Modifier field of the previous screen. Otherwise, the field is blank.

Field Explanations for HCPCS Detail Screen cont.

4. UB REVENUE CODE (TABLE LOOKUP-O)
If a revenue code is returned from the 3M Coding and Reimbursement System, it is displayed here automatically and can be edited if necessary.

If no revenue code is returned from the 3M Coding and Reimbursement System, the following processing applies:

- If you have associated UB revenue code(s) with this HCPCS code via the HCPCS Revenue Code Assign Maintenance function

  - and only one UB revenue code is associated with the HCPCS procedure code, that UB revenue code is automatically entered in this field upon returning to STAR.

  - and two or more UB revenue codes are associated with the HCPCS procedure code, then only those UB revenue codes are displayed for selection.

- If no UB revenue codes are associated with the HCPCS procedure code, then the UB Revenue Code table is displayed for you to make a selection.

If a HCPCS revenue code is not entered, the payment amount cannot be calculated and will not be displayed on the HCPCS screen.

5. ASC GROUP (DISPLAY ONLY)
This field displays the ASC group code associated with the selected HCPCS code. This field cannot be changed here. Change the Group Number field in the HCPCS Table Maintenance function if you want to change the ASC group.

6. AMOUNT (DISPLAY ONLY)
This field displays the expected reimbursement amount for this procedure based on the associated ASC group code and HCPCS payor code. Change the Group Number field in the HCPCS Table Maintenance function if you want to change the amount.

7. TISSUE CODE (TABLE LOOKUP-O)
This field identifies the pathological status of the tissue (if any) removed during this procedure. Enter the code or a hyphen (-) to access the Tissue code table for selection. Each procedure code in an episode has its own tissue type (if applicable).

8 SURGEON (TABLE LOOKUP-O)
This field enables you to enter the primary surgeon for this procedure. To enter the surgeon, perform one of these options:

- Enter the physician code.

- Enter the letter(s) the name begins with followed by a hyphen (**-**) to limit the search.

- Enter a hyphen (**-**) to display the Physicians table to select a physician from the table.

- Enter an equal sign (=) for the last physician entered.

- Press ENTER to enter the default response. The default for this field is the surgeon from the first ICD-9-CM procedure, if there is one, or it is the Admitting Physician for this visit.

- Enter **D** to delete the entry. The system will also delete the specialty.

NOTE: Entry of physician group codes is not allowed.

9. SPECIALTY (TABLE LOOKUP-O)
This field identifies the specialty associated with the surgeon. Enter the code directly, enter a hyphen (-) to select from the Specialty codes linked to this physician in the Physician table. Press ENTER to enter the default response. The default for this field is the Primary Specialty of this physician defined in the Physician table. When you delete the surgeon, the system also deletes the specialty.

10. ANESTH CODE (TABLE LOOKUP-O)
This field identifies the type of anesthesia used for this procedure. Enter the code or a hyphen (-) to access the Anesthesia code table for selection. Each procedure code in an episode has its own anesthesia code (if applicable).

11. ANESTH START TIME (TIME ENTRY-O)
This field enables you to enter the time the administration of the anesthesia began. Enter in HHMM format. Refer to the Information Entry Techniques chapter in the *STAR Patient Care Reference Guide, General Information Volume* for an explanation of time format field entry.

12. ANESTH END TIME (TIME ENTRY-O)
This field enables you to enter the time the administration of the anesthesia ended.

13. DURATION (DISPLAY ONLY)
This field displays the total duration time (in minutes) of the anesthesia and is automatically calculated based on the information entered in the Anesth Start Time and Anesth End Time fields

14. ASA-PS CLASS (3-AN-O)
This field enables you to associate an ASA-PS Class with the Anesthesia code. Enter the code or enter a hyphen (-) to access the ASA-PS Class code table for selection.

15. OTHER INSTITUTION (TABLE LOOKUP-O)
This field is used to indicate if this procedure was performed at another institution during the patient's stay at your facility. If this procedure was performed at another facility, enter the code or enter a hyphen (-) to access the Referring Facility/Institution code table for selection. If this procedure was not performed at another facility, leave this field blank.

16. EPIS LOCATION (TABLE LOOKUP-O)
This field identifies the room/location where the procedure(s) was performed. Enter the Revenue Center code, enter a hyphen (-) to access the Revenue Center code table for selection, or enter a number preceded by a hyphen (-).

17. EPIS END DATE/TIME (DATE/TIME FORMAT-O)
This field identifies the date and time this episode ended. It is possible for an episode to begin on one date and end on another. Therefore, the system does not default the date to the episode start date.

18. EPIS DURATION (DISPLAY ONLY)
This field is automatically calculated based on the information entered in the Epis Date & Time and Epis End Date/Time fields. The duration is displayed in minutes.

19. REC LOCATION (TABLE LOOKUP-O)
This field identifies the room/location where the patient recovered from the procedure episode. Enter the code, enter a hyphen (-) to access the Revenue Center code table for selection, or enter a number preceded by a dash.

20. REC START DATE/TIME (DATE/TIME FORMAT-O)
This field identifies the date and time the recovery began.

21. REC END DATE/TIME (DATE/TIME FORMAT-O)
This field identifies the date and time the recovery ended. It is possible for recovery to begin on one date and end on another. Therefore, the system does not default the date to the recovery start date.

22. PROCEDURE TEAM INFORMATION (SCROLLING SCREEN FORMAT-O)
This field enables you to identify other members of the operative/procedure team. When you access this field, the system displays a scrolling screen:

```
                  General Hospital Procedures Processor
                                              Wed Mar 20, 1996 10:44 am
   Account No     Name                              Unit No        Corp No
   89046-00001    WAINWRIGHT,ROBIN                  0001-0362-2    00001907
 1 Epis Date & Time     2 Procedure Code                        3 Modifier
   02/01/96 12:01am       05.24-PRESACRAL SYMPATHECTOMY         80
No       Procedure Team Member              Specialty             Type
1        ADAIR,FRANK K                      SURGICAL              SURGEON
2        ADAMS,JAY M                        FAMILY PRACTICE       ANESTHETIST
3        ALAHYAR,MARI                       INTERNAL MEDICINE     PHYS ADD









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

Subscreen Field Explanations

The first three fields are displayed only when they appear on this scrolling screen. For explanations, refer to the preceding discussion on the Procedures Detail screen.

NO (DISPLAY ONLY)
The system automatically assigns a number to each procedure team member as they are added.

PROCEDURE TEAM MEMBER (TABLE LOOKUP)
This column is for entry of any member of the team participating in the procedure/ operative episode. All entries in this field are associated with the episode. This means all procedure codes entered for this episode have these procedure team members associated with it. Enter a member using one of these options:

- Enter the physician code.
- Enter a hyphen (**-**) to display the Physicians table to select a physician from the table.
- Enter the letter(s) the name begins with followed by a hyphen (**-**) to limit the search.

SPECIALTY (TABLE LOOKUP)
This field identifies the specialty associated with the team member. Enter the code, or enter a hyphen (-) to select from the Specialty codes linked to this physician in the Physician table. Press ENTER to enter the default response. The default for this field is the Primary Specialty of this physician defined in the Physician table. When you delete the surgeon, the system also deletes the specialty.

TYPE (TABLE LOOKUP)
This field identifies the role or type of team member. Enter the code or a hyphen (-) to access the Physician Type table for selection. The Physician Type table should include entries such as Surgical Assistant, Surgical Resident, Anesthetist, Anesthesiologist, etc., to enable identification of the role each member had in this episode.

The options along the bottom of the screen enable you to navigate through the entry of information in the scrolling screen.

Key	Function
F1 Prev Page	Move to previous pages of entered information.
F2 Next Page	Move to additional pages of entered information.
F3 Insert	Enter additional lines of information between defined entries.
F4 Delete	Delete lines of information from between defined entries.
F6 Reset	Reset the screen, clearing all previously entered information.
F7 Exit	Accept your responses and exit the scrolling screen.

Once data is entered, the Procedure Team Information field on the HCPCS Procedure screen displays *Team Data Entered*.

Field Explanations for HCPCS Detail Screen cont.

23. PRELIM APC CODE/DESCRIPTION (DISPLAY ONLY)
This field displays the preliminary APC code and description returned from the 3M Coding and Reimbursement System and stored in STAR Medical Records.

24. PRELIM APC WEIGHT (DISPLAY ONLY)
This field displays the preliminary APC weight returned from the 3M Coding and Reimbursement System and stored in STAR Medical Records.

25. PRELIM APC PAYMENT AMT (DISPLAY ONLY)
This field displays the total of the Medicare payment for the preliminary APC code returned from the 3M Coding and Reimbursement System and stored in STAR Medical Records.

When you have completed all appropriate fields on the Procedures Detail screen, press ENTER. The system redisplays the HCPCS summary screen, and prompts you to accept the screen and accepts the HCPCS as final. Enter **Y** or press ENTER for Yes to accept the screen. The system displays another prompt:

Accept as Final HCPCS Codes? (Y/N) [N]--

Enter **Y** to accept the codes as final. Enter **N** or press ENTER for No; the system does not consider the codes as final.

Impact

- The first three HCPCS codes entered in the Medical Record Abstract **always** update the three Outpatient Dispositioning HCPCS Procedure Code fields.
- If HCPCS codes have not been entered in the Medical Record Abstract, entries in the Outpatient Dispositioning HCPCS Procedure Code fields update the Medical Record Abstract.
- HCPCS codes are stored internally in the same location for both Outpatient Dispositioning and Medical Record Abstracting; therefore, if the Medical Record Abstract contains any HCPCS procedure codes, you cannot add or edit HCPCS codes using the Outpatient Dispositioning function; you must use the Medical Record Abstract.

REVISING A HCPCS CODE

To revise a HCPCS code, enter the number to the left of the HCPCS code on the HCPCS Summary screen. The HCPCS Detail screen is displayed:

```
              General Hospital HCPCS Procedures Processor
            HCPCS Procedures     Page  2 of  2 Mon Sept 10, 2001 10:02 am
   Account No     Name                              Unit No        Corp No
   0124000004     STONE,SALLY                       000003942      00004304
 1 Epis Date & Time         2 Procedure Code                      3 Modifier

 4 UB Revenue Code          5 ASC Group     6 Amount         7 Tissue Code

 8 Surgeon                            9 Specialty

10 Anesth Code          11 Anesth Start Time  12 Anesth End Time 13 Anesth Duration

14 ASA-PS Class         15 Other Institution

16 Epis Location      17 Epis End Date/Time        18 Episode Duration

19 Rec Location       20 Rec Start Date/Time       21 Rec End Date/Time

22 Procedure Team Information     23 Prelim APC Code/Description

24 Prelim APC Weight              25 Prelim APC Payment Amt

Enter Episode date or '-' for available episodes--
```

For field explanations and entry options, refer to the preceding section, “ADDING A HCPCS CODE” on page 1-13.

When you have finished revising the HCPCS code, the system displays the following prompt:

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

Enter **Y** for Yes to accept your changes, **N** for No if you need to make further revisions, or enter **D** to delete the code.

When you are through deleting, revising, or adding procedures to the HCPCS Summary screen, press ENTER until this prompt is displayed:

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

Enter **Y** for Yes. The system displays another prompt:

Accept as Final HCPCS Codes? (Y/N) [N]--

Press ENTER to accept the default of **N** and the system does not consider the codes as final. Enter **Y** to accept the codes as final.

NOTE: Even if you choose not to accept the screen, the system does not delete the codes.

DELETING A HCPCS CODE

To delete a HCPCS code, select the code to delete from the HCPCS Summary screen. The system displays the HCPCS Detail screen. Press ENTER until the following prompt is displayed:

Delete? [N]--

Enter **Y** for Yes to delete the procedure. The system removes the procedure and redisplays the HCPCS Summary screen, where you can select another procedure to revise or delete, or you can add another procedure.

Impact

After you accept the HCPCS Summary screen, the following takes place:

- When HCPCS codes are accepted as final, an internal flag is set and/or a set of interface records is created for that night's processing (similar to those records created for the DRG Assignment function).
- When HCPCS codes are accepted as final, the Final Accept Date (Screen 1, Field 12) is completed by the system.
- The addition or deletion of a HCPCS code can affect the estimated reimbursement for this episode.

VIEWING STAR PATIENT ACCOUNTING CHARGES

If your facility uses STAR Patient Accounting, you can use the prompt on the HCPCS Procedures Summary screen to view the charges posted to a patient's account. Following are the screen and prompt:

```
                  General Hospital HCPCS Procedures Processor
            HCPCS Procedures     Page  2 of  2 Thu Jun 26, 2003 03:55 pm
    Account No     Name                                Unit No        Corp No
    0124000004     TANNER,EDWARD                       000-00-2488    00002785
HCPCS Code/Description           Modifiers      Grp P-APC Rev  Grp Amt/P-APC Amt
  (1) 10001/DRAINAGE OF 2ND SKIN                  2        100  $363.00/    $0.00
  (2) 11900/INJECTION INTO SKIN                   0        100    $5.00/    $0.00
  (3) 11051/TRIM 2 TO 4 SKIN LES                  0        100    $5.00/    $0.00
                                                Total  --         $373.00/    $0.00









Select HCPCS to revise, add(A) a HCPCS, Code 3(E), View Charges(C), View PA APCs
(V)--            next screen (/) or previous screen (/P) [/]
```

To view STAR Patient Accounting charges, enter **C** at the prompt:

Select HCPCS to revise, add(A) a HCPCS, Code 3(E), View Charges(C), View PA APCs (V)-- next screen (/) or previous screen (/P) [/]

This displays the charge information, as follows:

```
               General Hospital HCPCS Procedures Processor
                                                Fri Jun 27, 2003 12:37 pm
    Account No     Name                              Unit No        Corp No
    01155-00002    ANDERSON,LINDA                    10000422-1     00006192

Srv Date  Qty   UB Dpt   SIM Code and Description                ABN
          HCPCS Description                  HCPCS/Mod      HCPCS Conflict
06/04/03    1  110 RMB    1000 PRIVY ROOMY CHARGY
06/04/03    1  300 LAB    1210 ALBUMIN, SERUM
          ACETONE ASSAY                     8201027
06/04/03    1  300 LAB    9993 LAB PRO FEE
          ASSAY 17- KETOSTEROIDS            83586
06/04/03    1  301 LAB    1000 ACETAMINOPHEN
          ASSAY OF ACETAMINOPHEN            82003
06/04/03    1  301 LAB    1200 ACETONE SJK                         No
          ACETYLSALICYLIC ACID ASSAY        8201179
06/04/03    1  320 RAD    7300 XR CLAVICLE  73000                  App
06/04/03    1  720 ANS      12 EPIDURAL
          PATIENT RECORDED SPIROMETRY       94014475180



Press NL--
```

Field Explanations

SRV (SERVICE) DATE (DISPLAY ONLY)
This field contains the date the service was delivered.

QTY (DISPLAY ONLY)
This field contains the quantity of the item ordered for which the patient is charged.

UB (DISPLAY ONLY)
This field displays the UB-92 code related to this visit.

DPT (DISPLAY ONLY)
This field displays the code for the department where the service was rendered.

SIM CODE AND DESCRIPTION (DISPLAY ONLY)
This field contains the Service Item Master number and description.

ABN (DISPLAY ONLY)
This field displays data entered in STAR Patient Care. It indicates whether an Advanced Beneficiary Notification (ABN) form is necessary, based upon the patient type, plan, patient's diagnosis, and procedure code. This field may be blank or contain one of the following:

- **Yes:** An ABN is required and has been printed and signed by the patient for this charge.
- **No:** An ABN is required and has **not** been printed and signed by the patient for this charge; an override reason has been entered instead of a signed ABN form.

- **App:** An ABN is not required. The SIM item ordered has an approved diagnosis, or approved diagnoses have not been defined for this procedure in the STAR Medical Records HCPCS table.

HCPCS DESCRIPTION (DISPLAY ONLY)
This field contains the HCPCS description.

HCPCS/MOD (DISPLAY ONLY)
This field contains the HCPCS code and modifier (if present) associated with the charge.

HCPCS CONFLICT (DISPLAY ONLY)
If a HCPCS conflict has been identified, the system displays the type of conflict, the Correct Coding Edits (CCE) Indicator of Yes or No, and the HCPCS code that is identified as the conflict. Valid types of conflicts are as follows:

- **Dup** (Duplicate): Duplicate HCPCS charge
- **Excl** (Exclusive): Mutually exclusive with a previous charge
- **Comph** (Comprehensive): Comprehensive of a previous charge
- **Compt** (Component): Component of a previous charge

When you are viewing charges, use the slash (/) to move to the next page, or use slash P (/P) to return to the previous page. When you have viewed all the charges, press ENTER to return to the HCPCS Procedure Summary screen.

VIEWING STAR PATIENT ACCOUNTING APCS

If your facility uses STAR Patient Accounting and the OPPS (Outpatient Prospective Payment System) interface to 3M's APC Grouper Plus, you can use the prompt on the HCPCS Procedures Summary screen to view the account's Ambulatory Patient Classifications (APCs). Following are the HCPCS Procedure Summary screen and prompt:

```
                  General Hospital HCPCS Procedures Processor
            HCPCS Procedures     Page  2 of  2 Thu Jun 26, 2003 03:55 pm
   Account No     Name                              Unit No        Corp No
   0124000004     TANNER,EDWARD                     000-00-2488    00002785
HCPCS Code/Description          Modifiers      Grp P-APC Rev  Grp Amt/P-APC Amt
  (1) 10001/DRAINAGE OF 2ND SKIN                  2        100  $363.00/    $0.00
  (2) 11900/INJECTION INTO SKIN                   0        100    $5.00/    $0.00
  (3) 11051/TRIM 2 TO 4 SKIN LES                  0        100    $5.00/    $0.00
                                               Total  --         $373.00/    $0.00
Select HCPCS to revise, add(A) a HCPCS, Code 3(E), View Charges(C), View PA APCs
(V)--            next screen (/) or previous screen (/P) [/]
```

To view STAR Patient Accounting APCs, enter **V** at the prompt:

Select HCPCS to revise, add(A) a HCPCS, Code 3(E), View Charges(C), View PA APCs (V)-- next screen (/) or previous screen (/P) [/]

This displays the following screen:

```
                    General Hospital HCPCS Procedures Processor
                                                 Fri Jun 27, 2003 01:53 pm
    Account No     Name                               Unit No        Corp No
    0114300007     KESLER,CHARLENE                    000-00-2240    00002582

           Clm  OPPS       Rmb     From  To        Charge         Ins    Patient
       BS  Seq  Status     Use  BT Date  Date       Total     Payment    Deduct
Page:01
( 1)    1    2  NCalc/Errs Rmb   F 05/23 05/23     225.86
( 2)    1    1  NCalc/Errs Rmb   F 05/23 05/23   3,107.98

Select claim to be examined --
```

Field Explanations

ACCOUNT NO (DISPLAY ONLY)
This field displays the account number.

NAME (DISPLAY ONLY)
This field displays the patient's name.

UNIT NO (DISPLAY ONLY)
This field displays the patient's unit number.

CORP NO (DISPLAY ONLY)
This field displays the patient's corporate number.

BS (DISPLAY ONLY)
This field contains the number identifying the bill associated with this claim. For example, if this patient has three cycle bills, their sequence numbers (based on when they were produced) would be bill sequence 1, bill sequence 2, and bill sequence 3.

CLM SEQ (DISPLAY ONLY)
This field displays the claim sequence number identifying the claim.

OPPS STATUS (DISPLAY ONLY)
This field displays the current 3M OPPS status associated with an OPPS claim. This field is the same as the 3M OPPS Status field that displays on other screens in the interface processor. The values for the OPPS Status field are an abbreviated version of the values for the 3M OPPS Status field. The valid values for the OPPS Status field are:

- STAR Error—This status indicates the claim has not been queued to the 3M OPPS interface due to STAR errors affecting the 3M OPPS interface.

- Queued—This status indicates the claim has been queued and the results from 3M have not been applied.

- Calc—This status indicates the claim has been sent to 3M and reimbursement was calculated.

- Calc/Errors—This status indicates the claim has been sent to 3M, reimbursement was calculated, but the claim has errors that have not been excluded from FCR250. If the claim is processed by 3M again, reimbursement may change.

- Ncalc/Error—This status indicates the claim has been sent to 3M, reimbursement was not calculated due to the type of errors, and the claim has errors.

- 3M Log—This status indicates the claim could not be processed by 3M due to a data integrity problem, 3M did not return information for the claim, and the facility should review the 3M Log Reports to determine the problem.

RMB USE (DISPLAY ONLY)
This field displays the Reimbursement Use indicator. This indicator identifies the impact of the claim to reimbursement. The valid values for the Reimbursement Use indicator for a primary COB are RMB, Excl, and Extra. RMB indicates the claim is used in calculating reimbursement. Excl indicates the claim is not used in calculating reimbursement. Extra indicates the claim is associated with an adjustment or final bill sequence that is not being used to determine reimbursement or is associated with a late bill (although late bills should not be used). For a secondary COB, the Reimbursement Use indicator displays the value of Secondary. For a multi-bill claim, the Reimbursement Use indicator displays the value of Multi.

BT (DISPLAY ONLY)
This field displays the bill type associated with the bill. The valid values are A for Adjustment, C for Cycle, L for Late, and F for Final.

FROM DATE (DISPLAY ONLY)
This field displays the date on which charges began accruing on the claim's bill.

TO DATE (DISPLAY ONLY)
This field contains the billing cut-off date for this claim's bill.

CHARGE TOTAL (DISPLAY ONLY)
This field displays the total amount of charges on the claim.

INS PAYMENT (DISPLAY ONLY)
This field displays the total insurance payment that is estimated by 3M.

PATIENT DEDUCT (DISPLAY ONLY)
This field displays the patient deductible, which is calculated from the Total Patient Responsibility field estimated by 3M. The STAR system subtracts the Coinsurance from the Total Patient Responsibility to calculate the patient deductible.

At the prompt

Select claim to be examined --

Enter the number for the claim for which you want details. Doing so displays a screen similar to the following:

```
                    General Hospital HCPCS Procedures Processor
                                                Fri Jun 27, 2003 02:39 pm
    Account No     Name                              Unit No        Corp No
    0114300007     KESLER,CHARLENE                   000-00-2240    00002582

Clm/COB/Use:    1/1/Include             3M OPPS Status: 3M Errors/No reim calc

      Rev  HCPCS/Mod  HCPCS Description         Date          UOS      Total ERR
Page:01                      OPPS Charge Information
( 1)  300  82947      ASSAY, GLUCOSE, BLOOD QU  05/23/01        1      37.00 Yes
( 2)  300  8005101    ELECTROLYTE PANEL         05/23/01        1      35.00 Yes
( 3)  300  82553      CREATINE, MB FRACTION     05/23/01        1      70.00 Yes
( 4)  300  82565      ASSAY OF CREATININE       05/23/01        1      32.00 Yes
( 5)  300  84484      ASSAY OF TROPONIN, QUANT  05/23/01        1      62.97 Yes
( 6)  300  84520      ASSAY OF UREA NITROGEN    05/23/01        1      32.00 Yes
( 7)  300  85025      COMPLETE CBC W/AUTO DIFF  05/23/01        1      46.00 Yes
( 8)  450  99284      EMERGENCY DEPT VISIT      05/23/01        1     591.00
( 9)  480                                       05/23/01               81.82 Yes
(10)  730                                       05/23/01              130.63 Yes
(11)  730  93005      ELECTROCARDIOGRAM, TRACI  05/23/01        1     104.00
(12)  760  99234      OBSERV/HOSP SAME DATE     05/23/01        1     351.00

Enter choice--
                       next pg(/ or PG DN)  Search(TAB)
```

Field Explanations

ACCOUNT NO (DISPLAY ONLY)
This field displays the account number.

NAME (DISPLAY ONLY)
This field displays the patient's name.

UNIT NO (DISPLAY ONLY)
This field displays the patient's unit number.

CORP NO (DISPLAY ONLY)
This field displays the patient's corporate number.

CLM/COB/USE (DISPLAY ONLY)
These fields display the claim's sequence number, the insurance COB number, and a reimbursement use indicator. The reimbursement use indicator identifies the impact of the claim to reimbursement. The valid values for the reimbursement use indicator for

a primary COB are Include, Exclude and Extra. A value of Include indicates the claim is used in calculating reimbursement. A value of Exclude indicates the claim is not used in calculating reimbursement. A value of Extra indicates the claim is associated with an adjustment or final bill sequence that is not being used to determine reimbursement. A value of Extra is associated with claims for late bills although no late bills should be done for Medicare OPPS accounts. For a secondary COB, the reimbursement use indicator displays the value of Secondary. For a multi-bill claim, the reimbursement use indicator displays the value of Multi.

3M OPPS STATUS (DISPLAY ONLY)
This field displays the current status associated with an OPPS claim. This field is the same as the OPPS Status field that displays on other screens in the interface processor. The OPPS Status field displays an abbreviated version of the values for the 3M OPPS Status field. The valid values for the 3M OPPS Status field are

- Not queued due to errors—This status indicates the claim has not been queued due to STAR Errors that exist.
- Queued to 3M—This status indicates the claim has been queued and the results from 3M have not been applied.
- 3M Processed—This status indicates the claim has been sent to 3M, the results have been applied, and reimbursement was calculated.
- Processed but 3M Errors—This status indicates the claim has been sent to 3M and reimbursement was calculated, but the claim has errors. If the claim is processed by 3M again, reimbursement may change.
- 3M Errors/No reim calculated—This status indicates the claim has been sent to 3M, the results from 3M have been applied, reimbursement was not calculated due to the type of errors, and the claim has errors.
- Check 3M Log—This status indicates the claim could not be processed by 3M due to a data integrity problem, 3M did not return information for the claim, and the facility should review the 3M Log to determine the problem.
- OPPS Clm Proc Data Purged—The 3M OPPS status is not available because Claim Processing data was purged when the claim was purged.

REV (DISPLAY ONLY)
This column displays the UB revenue code for the service line.

HCPCS/MOD (DISPLAY ONLY)
This column displays the HCPCS code for the service line followed by one or two modifiers.

HCPCS DESCRIPTION (DISPLAY ONLY)
This column displays the description for the HCPCS.

DATE (DISPLAY ONLY)
This column displays the service date for the service line.

UOS (DISPLAY ONLY)
This column displays the quantity for the service line.

TOTAL (DISPLAY ONLY)
This column displays the charge total for the service line.

ERR (DISPLAY ONLY)
This column displays Yes if the 3M APC Grouper Plus Software identified edits for the service line that were not excluded under 3M OPPS Facility Parameters or if the service line was marked as denied or rejected by the 3M APC Grouper Plus Software.

At the prompt

Enter choice--

Enter the number for the charge for which you want details. Doing so displays a screen similar to the following:

```
                  General Hospital HCPCS Procedures Processor
                                              Fri Jun 27, 2003 02:39 pm
   Account No     Name                              Unit No        Corp No
   0114300007     KESLER,CHARLENE                   000-00-2240    00002582
 1 Rev Code    2 Service Date    3 UOS         4 Charge Total  5 Non-Covered
   300           05/23/01          1                 37.00
 6 HCPCS/Mod
   82947  ASSAY, GLUCOSE, BLOOD QUANT
 7 APC                                                          8 Weight
   19901 CLINICAL DIAGNOSTIC LABORATORY SERVICES
 9 Payment APC

10 Tot Clm Pmt 11 Ins Payment      12 Coinsurance      13 User Adjusted Coins

14 Pt Deduct   15 Remain Pt Ded    16 Min Unadj Coins  17 Nat Unadj Coins

18 Discount %  19 Discount Formula 20 Above Cap Pmt    21 Cost Outlier
                  1
22 Deny/Reject 23 Line Payment Ind 24 APC Service Ind  25 APC Payment Ind
                                      A-NOPPS             2-NOPPS
26 Payment Adj Flag  27 Packaged   28 Errors           29 Blood Deductible
   0-NONE                             1
View next charge line (Y/N) [Y]--
```

Field Explanations

NOTE: All fields are display only.

1. REV CODE
This column displays the UB revenue code for the service line.

2. SERVICE DATE
This column displays the service date for the service line.

3. UOS
This column displays the quantity for the service line.

4. CHARGE TOTAL
This column displays the charge total for the service line.

5. NON-COVERED
This column displays the non-covered amount for the service line. The non-covered amount can be a portion or all of the charge total.

6. HCPCS/MOD
This column displays the HCPCS code for the service line followed by one or two modifiers.

7. APC
This field displays the value for Procedure (HCPCS) APC and its 3M name is papc. This APC code is assigned per the HCPCS code. For some HCPCS codes, 3M has created special APCs and these five-digit codes begin with 19.

8. WEIGHT
This field displays the value for APC weight for the payment APC, and its 3M name is papcwt.

9. PAYMENT APC
This field displays the value for payment APC if it is different from the procedure APC. The 3M name is pay_papc. The payment APC can be different from the assigned APC. For some HCPCS codes, 3M has created special APCs and these five-digit codes begin with 19.

10. TOT CLM PMT
This field displays the value for Line Item Payment and its 3M name is li_payment.

12. COINSURANCE
This field displays the value for the Coinsurance Payment and its 3M name is li_coins. It is the estimated total of the coinsurance payment for the service line.

13. USER ADJUSTED COINS
This field displays the value for Reduced Adjusted Copayment (Hospital-Elected) and its 3M name is reduce_coins. A table of alternate coinsurance amounts can be maintained in 3M APC Grouper Plus.

14. PT DEDUCT
This field displays the patient deductible. It is the difference between the patient responsibility for the service line and the coinsurance for the service line.

15. REMAIN PT DED
This field displays the value for Remaining Deductible and its 3M name is rem_deduct. This field contains the remaining patient deductible after the patient deductible for this service line and for preceding service lines have been subtracted.

16. MIN UNADJ COINS
This field displays the value for Minimum Unadjusted Copayment, and its 3M name is min_coins.

17. NAT UNADJ COINS
This field displays the value for National Unadjusted Copayment, and its 3M name is natcoins.

18. DISCOUNT %
This field displays the value for Discount Percent, and its 3M name is dpercent. This value is determined when 3M estimates reimbursement for the service item.

19. DISCOUNT FORMULA
This field displays the value for Discounting Formula Applied, and its 3M name is discount. The field identifies a discounting formula used in 3M's estimate of reimbursement.

20. ABOVE CAP PMT
This field displays the value for Above Cap Payment, and its 3M name is above_cap. This number is determined when 3M estimates reimbursement for the service line.

21. COST OUTLIER
This field displays the value for Line Item Service Level Cost Outlier Payment and its 3M name is li_cost_outlier. This value is determined when 3M estimates reimbursement for the service item.

22. DENY/REJECT
This field is used if the line item has been denied or rejected.

- If the line item is non-covered, then this field contains "Ext/Denied" if the Non-Cov Line Item parameter in 3M OPPS Facility Parameters was D for Denied when the claim was formatted for the 3M OPPS Interface.

- If the line item is non-covered, then this field contains "Ext/Rej" if the Non-Cov Line Item parameter in 3M OPPS Facility Parameters was R for Rejected when the claim was formatted for the 3M OPPS Interface.

- If the 3M APC Grouper Plus Software marked the service line as denied/rejected, this field contains "Line."

- If the 3M APC Grouper Plus Software determined that the service line occurred on a day that was denied/rejected, this field contains "Day."

23. LINE PAYMENT IND
This field displays the value for Line Item Payment Indicator (3M name is li_payind) and an abbreviated description. For a current list of the codes, descriptions, and abbreviations, review the STAR Patient Accounting report FCR450, 3M OPPS Err Msg/Codes, which is produced under 3M OPPS Facility Parameters.

24. APC SERVICE IND
This field displays the value for Procedure (HCPCS) APC Service Indicator (3M name is papctype) and an abbreviated description. For a current list of the codes, descriptions, and abbreviations, review STAR Patient Accounting report FCR450, 3M OPPS Err Msg/Codes, which is produced under 3M OPPS Facility Parameters.

25. APC PAYMENT IND
This field displays the value for Procedure (HCPCS) APC Payment Indicator (3M name is ppayst) and an abbreviated description. For a current list of the codes, descriptions, and abbreviations, review STAR Patient Accounting report FCR450, 3M OPPS Err Msg/Codes, which is produced under 3M OPPS Facility Parameters.

26. PAYMENT ADJ FLAG
This field displays the value for Payment Adjustment Flag (3M name is pay_adjust) and an abbreviated description. For a current list of the codes, descriptions, and abbreviations, review STAR Patient Accounting report FCR450, 3M OPPS Err Msg/Codes, which is produced under 3M OPPS Facility Parameters.

27. PACKAGED
This field identifies the value for Packaging Flag (3M name is ancpk). “Packaged” is displayed for a packaged service, or “Day” is displayed for a service packaged into a per diem rate.

28. ERRORS
This field identifies the number of edits identified by the 3M APC Grouper Plus Software that were not excluded due to parameters under the 3M OPPS Facility Parameters.

29. BLOOD DEDUCTIBLE
This field displays the number of pints of blood that the plan does not cover.

The following prompt is displayed at the bottom of the screen:

View next charge line (Y/N) [Y]--

Enter **Y**, and information for the next charge line is displayed. Enter **N**, and you can select another claim for which to view information.

HCPCS PROCEDURES ON M/R ABSTRACT INQUIRY

When you are using the M/R Abstract Inquiry option, you can select to view the detail for HCPCS procedures.

The following is an example of the HCPCS Procedures screen that displays when you select the HCPCS Procedures option:

```
               General Hospital HCPCS Procedures Processor
                                                Sat Jun 28, 2009 12:42 am
    Account No     Name                          ICD Unit No        Corp No
    0808900001     ABUNDIS,SANFORD S             10  000-00-5337    00005963
HCPCS Code/Description          Modifiers          P-APC Rev  ASC Amt/P-APC Amt
  (1) 93799/CARDIOVASCULAR PROCE                       490    $0.00/    $0.00
  (2) 93799/CARDIOVASCULAR PROCE                       490    $0.00/    $0.00
  (3) 92950/HEART/LUNG RESUSCITA                       490    $0.00/    $0.00
  (4) 95953/EEG MONITORING/COMPU                       490    $0.00/    $0.00
  (5) 95954/EEG MONITORING/GIVIN                       490    $0.00/    $0.00
  (6) 95957/EEG DIGITAL ANALYSIS                       490    $0.00/    $0.00
                                          Total  --          $945.00/    $0.00









NEWLINE, or selection to view [NL] View Charges(C) or View PA APCs(V)--
```

The screen lists each HCPCS procedure for the account number, indicating the HCPCS code, the description, the modifiers, the ASC group number, the preliminary APC code, the UB Revenue Code, the estimated group reimbursement amount, and the preliminary APC reimbursement amount. The total estimated reimbursement amount for all procedures for the account is also included.

Press ENTER to exit the screen, or enter the number to the left of the HCPCS procedure code for which you want to review detail.

If you select to view detail, the system displays the HCPCS Detail screen as follows.

```
                General Hospital HCPCS Procedures Processor
                                              Fri Jun 27, 2009 05:10 pm
   Account No     Name                          ICD Unit No        Corp No
   01155-00002    ANDERSON,LINDA                10  10000422-1     00006192
 1 Epis Date & Time      2 Procedure Code                    3 Modifier
                           91055-GASTRIC INTUBATION FOR SMEA
 4 UB Revenue Code          5 ASC Group     6 Amount          7 Tissue Code
   490-Ambulatory Surgical                    $0.00
 8 Surgeon                                 9 Specialty

10 Anesth Code          11 Anesth Start Time  12 Anesth End Time 13 Anesth Dura

14 ASA-PS Class         15 Other Institution

16 Epis Location        17 Epis End Date/Time            18 Episode Duration

19 Rec Location         20 Rec Start Date/Time           21 Rec End Date/Time

22 Procedure Team Information     23 Prelim APC Code/Description

24 Prelim APC Weight              25 Prelim APC Payment Amt

Enter view modifiers(M), team information(T) or enter to continue--
```

Field Explanations

See the Field Explanations on page 1-13. You cannot edit while in the M/R Abstract Inquiry function, so all fields are display only.

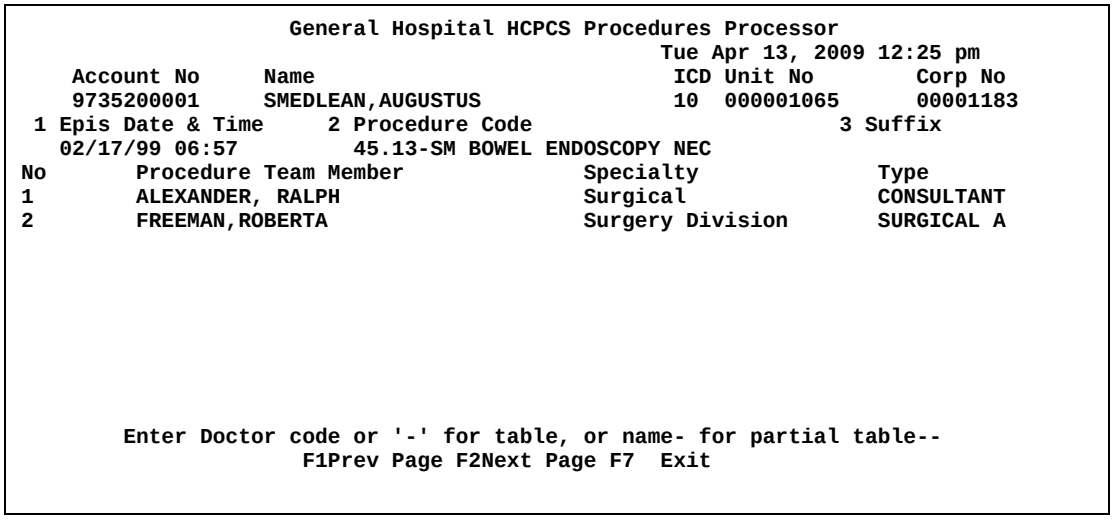
To view HCPCS modifiers, enter **M**. To view team information, enter **T**. To return to the summary screen, press ENTER.

If you enter **M**, the system displays a screen with up to five modifiers:

```
                  General Hospital HCPCS Procedures Processor
                                              Tue Apr 13, 2009 12:25 pm
   Account No     Name                          ICD Unit No        Corp No
   9735200001     SMEDLEAN,AUGUSTUS             10  000001065      00001183
 1 HCPCS Modifier # 1                2 HCPCS Modifier # 2
   32 MANDATED SERVICES                20 MICROSURGERY
 3 HCPCS Modifier # 3                4 HCPCS Modifier # 4
   21 PROLONGED EVAL/MGMT SERV         23 UNUSUAL ANESTHESIA
 5 HCPCS Modifier # 5
   24 UNRELATED EVAL/MGMT SERV









Press NL--
```

Press ENTER to return to the HCPCS Detail screen.

If you enter **T**, the system displays a screen that shows the team information:



```
                    General Hospital HCPCS Procedures Processor
                                                Tue Apr 13, 2009 12:25 pm
    Account No     Name                          ICD Unit No        Corp No
    9735200001     SMEDLEAN,AUGUSTUS             10  000001065      00001183
 1 Epis Date & Time     2 Procedure Code                        3 Suffix
   02/17/99 06:57         45.13-SM BOWEL ENDOSCOPY NEC
No       Procedure Team Member              Specialty              Type
1        ALEXANDER, RALPH                   Surgical               CONSULTANT
2        FREEMAN,ROBERTA                    Surgery Division       SURGICAL A









        Enter Doctor code or '-' for table, or name- for partial table--
                     F1Prev Page F2Next Page F7  Exit
```

To move to a previous page, press **F1**. To move to the next page, press **F2**. To return to the Detail screen, press **F7**.

Chapter 2 - MEDICAL RECORD ABSTRACTING

INTRODUCTION

This chapter contains screens, field explanations, and other documentation for usage of the base (US) product.

This function enables Medical Record department personnel to enter the official account of a patient's stay, known as the medical record abstract. Abstracting, an essential function of the Medical Record department, is enhanced by the DRG Monitoring and Utilization Management applications because information is integrated with the patient identification information collected through the STAR Patient Care system and other functions. As a result, the Medical Record staff is not required to reenter information previously recorded elsewhere in the system. In addition, since all abstract information is stored online, it is easily retrieved for reference and reporting needs.

The Medical Record Abstracting functions are accessed through options on the Abstracting & DRG Functions Input Options Menu. The following is a sample of this menu:

```
     General Hospital Abstracting & DRG Assignment Functions Processor
                                                  Thu Aug 09, 2007 10:11 pm
Abstracting & DRG Assignment Functions Input Options

            Option No.  Option
            ---------------------------------------
                1       DRG Simulation
                2       DRG Assignment
                3       Attestation Form
                4       Abstract Summary Form

                5       HCPCS Procedures
                6       M/R Abstracting
                7       M/R Special Study
                8       M/R Abstract Inquiry

                9       M/R Nosocomial Infections
               10       OP Disposition
               11       Pharmacy Nursing Functions
               12       Maintenance Functions
               13       Demand Reports
               14       Core Reports
Enter option number-
```

After selecting the M/R Abstracting option, you are prompted to select the appropriate patient through the MPI Search function. (Refer to the Admission chapter in the *STAR Patient Care Reference Guide, Patient Processing Module* for details regarding the MPI Search function.) After you select a patient, select the visit to be abstracted from the detailed list of all visits associated with that patient that the system displays (see below).

```
                General Hospital M/R Abstracting Processor
                                                  Thu Mar 19, 2009 03:42 pm
  No.          Name              Sex    BD    Room    Physician     SVC ICD Status
000005811      DONER,ABIGAIL      F  04/21/23

 No.   Acct#         Adm Date Dsch Date Type Attending Dr.    SVC FC Dsch Disptn
 1   0825500001     09/11/08 09/11/08  LIC  ADAMS,JAY K      ENT S  DSCH/XFER OT
 2   0824600003     09/02/08 09/02/08  ER   ADAMS,JAY K      MED S  *HOME(OUTPAT









Select visit--
```

If you select a visit for which an abstract has not been created, the system displays the following prompt:

Manual add to Abstract census? (Y/N)[Y]--

For information on automatic creation of an abstract, refer to the subsection M/R Abstract & DRG Census Criteria.

If you accept the default of Yes, the default abstract menu (defined in Patient Type Parameters) displays for this patient type, and the patient is now added to the abstract census. The system automatically assigns the default MR Abstract Census code to this abstract.

The screens that collectively comprise the abstract may differ in each facility. During installation, the hospital assigns one of six abstract types to each patient type with the Patient Type table. With the assistance of the McKesson representative, the abstract types can be modified to reflect the information collection needs for each identified patient type. When the abstracting function is accessed and a patient is selected from the MPI, the patient type of the patient determines which abstract type is displayed.

For example, the inpatient (IP) abstract may differ from the emergency room (ER) abstract. If an emergency room patient is selected, the abstract associated with the ER patient type is displayed, reflecting the information the hospital wants to collect for this patient type. If an inpatient is selected, the abstract associated with the IP patient type displays, reflecting the information the hospital wants to collect for this patient type.

This chapter contains examples of the six abstract types. The abstract types are:

- Inpatient Abstract
- Mental Health Abstract
- Series Outpatient Abstract
- Emergency Room Abstract
- Same Day Surgery (SDS) Abstract
- Outpatient Abstract

If the patient visit that you select from the MPI is an inpatient type, the following abstracting submenu may display, depending on what your facility has determined the abstract display to be:

```
                General Hospital Abstract Processor
                                                 Thu Mar 19, 2009 03:39 pm
   Account No     Name                          ICD    Unit No        Corp No
   0825500001     DONER,ABIGAIL                 9      000-00-5811    00006478
          Option No.  Option
          ------------------------------------
              1       Full Inpatient Abstract
              2       Patient Information
              3       Episode Information-1
              4       Episode Information-2
              5       User Defined Fields
              6       Consultations
              7       Diagnoses
              8       Procedures
              9       DRG Assignment
             10       Maternity/Newborn Information
             11       Death Classifications
             12       Specialty Units
             13       Blood Groups
             14       Special Studies
             15       History Audit
             16       Therapy Departments
Enter option number--
```

If you select the first option, Full Inpatient Abstract, up to 15 of the available screens of the entire abstract display sequentially for review and/or completion. On the menu shown above, options 2-16 are the screens contained in this abstract type. Each one of the screens can be accessed individually; you are not forced to page through the entire abstract to view one screen.

At the end of any abstract screen sequence, or before exiting this patient's abstract, you have the option to mark the abstract complete. If the abstract type you are marking as complete requires acceptance of a final DRG prior to completion (based on the DRG Required? parameter on the M/R Abstract & DRG Census Criteria screen), the system displays the following error message:

Error: Final DRG must be accepted before completion

The system displays this message briefly and then redisplays the menu screen for the patient's abstract.

The system does not allow you to accept the DRG as final or mark the abstract complete unless all procedure codes (both HCPCS and ICD-9-CM) also have dates entered.

When you attempt to mark an abstract complete for a patient who is not discharged and does not require a DRG, the system checks the Comp Abst Before Disch parameter associated with the abstract code. If the parameter is set to Yes, you can mark the abstract complete. If the parameter is set to No, the following message displays:

Error: Cannot mark abstract complete, patient is not discharged!

The message displays briefly, then returns to the current processing.

Once you mark an abstract complete, any changes, updates, or re-acceptance of an abstract screen causes the abstract to become incomplete, and the patient reappears on the Incomplete Abstract Report. Therefore, use the Abstract Inquiry option to view a patient's completed abstract.

NOTE: If you change or reaccept a special study that you have accessed through the separate M/R Special Study option on the Abstracting & DRG Input Options menu, the abstract does not become incomplete. However, modifying a special study accessed through the abstract does cause the patient's abstract to become incomplete.

The following pages contain examples of each screen in the abstract and each screen's field explanations. The display-only header fields, present on every screen, are described below and not repeated for each screen:

Header Field Explanations

ACCOUNT NO (DISPLAY ONLY)
This field displays the account number.

NAME (DISPLAY ONLY)
This field displays the patient’s name.

ICD (DISPLAY ONLY)
This field displays the ICD version used; 9 for ICD-9, 10 for ICD-10, or B for Both.

UNIT NO (DISPLAY ONLY)
This field displays the patient’s unit number.

CORP NO (DISPLAY ONLY)
This field displays the patient’s corporate number.

PATIENT INFORMATION SCREEN

The Patient Information screen displays patient demographic information that was entered during the admission sequence. All fields on this screen can be edited and all update the MPI.

After you select the Patient Information option, this screen displays:

```
           General Hospital Patient Information Processor
                                                Wed May 30, 2012 03:31 pm
    Account No     Name                          ICD    Unit No        Corp No
    11277-00002    CRANE, BOB                    10-9Dx 100008241      00002496
 1 Name                                          2 Entitle     3 Sex
   CRANE, BOB                                    ->               FEMALE
 4 Address Line 1              5 Address Line 2                  6 Phone
   456 ASPEN ST.                                                   (770)111-2222
 7 City              8 State          9 ZIP Code                10 County
   ROSWELL             GA               30075                     1 FULTON
11 Country                           12 Soc Sec Number
                                        123-99-1234
13 Birthdate   Age                   14 Admission Weight       15 Multiple Birth
   01/19/63    48Y
16 Mother's Name                     17 Geo.Cd/Census Tract    18 Marital Status
                                                                  S SINGLE
19 Race         20 Ethnicity          21 Nationality           22 Language
   1 CAUCASIAN
23 Abstract Code             24 Abstract Complete
   D



Press NL--
```

Field Explanations

ACCOUNT NO (DISPLAY ONLY)
This field displays the account number.

NAME (DISPLAY ONLY)
This field displays the patient's name.

ICD (DISPLAY ONLY)
This field displays the patient's unit number.

UNIT NO (DISPLAY ONLY)
This field displays the patient's unit number.

CORP NO (DISPLAY ONLY)
This field displays the patient's corporate number.

1. NAME (30-AN-R)
The patient's name displays as it was entered in the admission sequence, or you can edit this field by entering the patient's name in the format LAST,FIRST MIDDLE.

If you change the name, the following prompt is displayed after you accept the screen:

Retain `NAME,PREVIOUS` in the MPI? (Y/N)-- |
It will be available when searching the MPI and as an `Other Name`.

Enter **N** for No to simply change the name in the MPI.

Enter **Y** for Yes to retain the previous name in the Other Names section of the MPI Inquiry, MPI Revision, and MPI Review. Both names (old and new) are retained for use in searching. The individual whose name changed is displayed under the Changed section of the MPI Activity Report.

If you enter Y, an additional prompt is displayed:

Enter name type or `-` to list-- |

- Enter the appropriate code for the name type of the patient's previous name.
- Enter a hyphen (**-**). The system displays the Name Type table with the codes and descriptions for selection.

When you select a name type, an additional prompt for verification is displayed:

Retain `NAME,PREVIOUS` in the MPI
with a name type of `PREVIOUS`? (Y/N)-- |

Enter **Y**, and the name and name type are saved. Enter **N**, and the original prompt is repeated.

2. ENTITLE (4-A-O)
The patient's entitle is entered at the time of admission (or subsequently updated). Update this field by entering a new entitle. (Examples of entitles are Jr., III, MD, etc.)

3. SEX (1-A-R)
The patient's sex displays as it was entered in the admission sequence, or you can revise the sex by entering **M** for Male or **F** for Female.

4. ADDRESS LINE 1 (20-AN-R)
This is the first line of the patient's mailing address as it was entered in the admission sequence, or you can enter a new address.

5. ADDRESS LINE 2 (20-AN-O)
This is the second line of the patient's mailing address as it was entered in the admission sequence, or you can enter a new address.

6. PHONE (12-N-R)
The patient's phone number displays as it was entered in the admission sequence, or you can enter a new phone number by keying the area code and the phone number without the parentheses () and the hyphen (-). The system automatically enters the

parentheses around the area code and inserts a hyphen in the phone number. You can enter the phone number without the area code if it is a local number and the system automatically enters the area code.

7. CITY (15-A-O)
The patient's city displays as it was entered in the admission sequence. To update the city, you can enter a new one by keying one in freeform, or you can enter a ZIP code from the ZIP code table, which automatically fills in the City and State, and ZIP Code fields, or you can press the equal sign (=) key to enter the defaults.

8. STATE/PROV. (2-A-R)
The patient's state/province displays as entered at the time of admission (or subsequently updated). To update this field, you have three options:

- Enter the appropriate two-character abbreviation for the patient's state/province.
- Enter a hyphen (**-**) to display the table with the states/provinces to select from.
- Leave this field blank, and enter a code in the ZIP Code/Postcode field. This automatically completes the City and State/Province fields.

9. ZIP CODE/POSTCODE (9-N-R or 6-AN-R)
The patient's ZIP code/postcode displays as it was entered in the admission sequence. You can enter a new code by keying one in freeform, or you can press a hyphen (-) to display the ZIP Code/Postcode table for selection.

NOTE: If you select a code that is not associated in the table with the city and state/province entered in the previous fields, those fields may get updated with information associated with the new code.

You can also enter an equal sign (**=**) to enter the default code. If you enter a six-digit, alphanumeric Canadian postcode, it is displayed in an X9X 9X9 format.

10. COUNTY (2-N-R)
The patient's county displays as it was entered in the admission sequence (or subsequently updated). Enter the county code, if you know it, or enter a hyphen (-) to display the County Code table for selection.

11. COUNTRY (TABLE LOOKUP)
The patient's country is displayed as entered at the time of admission (or subsequently updated). Enter the code, or enter a hyphen (-) to display the Country code table for selection.

12. SOC SEC NUMBER (9-N-O)
The patient's social security number displays, or you can enter a new social security number without hyphens (-). The system displays the new numbers and automatically inserts the hyphens. If you enter a social security number already assigned to another patient, this message is displayed:

This SS# is assigned to XXXXXX,XXXX! Accept anyway? (Y/N)--

where XXXXXX,XXXX is the name of another patient.

Enter **Y** for Yes to accept the number or **N** for No to not accept it.

NOTE: Display of the social security number may be masked or partially masked, depending on your facility's settings.

13. BIRTHDATE (DATE FORMAT)
The patient's date of birth is displayed as entered in the admission sequence. Enter a new date to update this field. Dates can be entered in a variety of formats determined by the hospital when Patient Care was installed. Refer to the Information Entry Techniques chapter in the *STAR Patient Care Reference Guide, General Information Volume* for further details. The system automatically calculates the age.

AGE (DISPLAY ONLY)
The patient's age is automatically calculated based on the birth date subtracted from the admission date. The patient's age is always displayed in the abstract as the age at time of admission.

14. ADMISSION WEIGHT (5-C-O)
This field contains the weight of the patient if entered using the Nursing function Revise Patient. To enter the weight in pounds and ounces, separate the two by a slash (/); for example, if the patient weighs 8 pounds, 4 ounces, enter 8/4. To enter the weight in kilograms, enter the number followed by K; for example, if a patient weighs 4 kilograms, enter 4K. The field displays both weights regardless of which method you use. The system automatically converts increments of 16 ounces to pounds. For example, if you enter 7/16 (7 pounds, 16 ounces), the system displays 8 lbs 0oz/3.6kg.

15. MULTIPLE BIRTH (1-A-O)
Enter Yes if the patient was part of a multiple birth. Once the entry is selected, the Multiple Birth field will display as Yes or No.

16. MOTHER'S NAME (25-A-O)
The name of the patient's mother is displayed as entered in the admission sequence. Updates made to this field update the MPI. Enter a new name (usually the last name) by keying a freeform entry.

17. GEO.CODE/CENSUS TRACT/RESIDENCE CODE (TABLE LOOKUP)
This field contains the patient's geographic code/residence code as entered at time of admission (or subsequently updated). Enter the code or press hyphen (-) to display the Geographic Code/Census Tract/Residence Code table for selection.

18. MARITAL STATUS (2-N-R)
The patient's marital status is displayed as it was entered at the time of admission. Enter a new marital status by entering a marital status code, if you know it, or by entering a hyphen (-) to display the Marital Status code table.

19. RACE/ETHNIC ORIGIN (TABLE LOOKUP)
The patient's race/ethnic origin displays as it was entered in the admission sequence. Enter the code, if you know it, or enter a hyphen (-) to display the code table for selection.

20. ETHNICITY (TABLE LOOKUP-O)
The patient's ethnicity displays as it was entered in the admission sequence. Enter the code, if you know it, or enter a hyphen (-) to display the code table for selection. Once the entry is selected, the Ethnicity field displays up to 18 characters including code.

21. NATIONALITY (TABLE LOOKUP)
The patient's nationality is displayed as entered at the time of admission (or subsequently updated). Enter the code, or enter a hyphen (-) to display the Nationality code table for selection.

22. LANGUAGE (TABLE LOOKUP)
The patient's language displays as it was entered in the admission sequence. Enter the code, if you know it, or enter a hyphen (-) to display the code table for selection.

23. ABSTRACT CODE (DISPLAY ONLY)
This field displays the abstract census code that corresponds to this patient visit. If you change items that cause the patient to match a different abstract code, the system automatically updates the code in this field. The codes are defined in the MR Abstract and DRG Criteria functions.

NOTE: Once patients are in the census, the system does not remove them until the abstract is complete for them.

24. ABSTRACT COMPLETE (DISPLAY ONLY)
This field displays the date the abstract is marked complete. If the abstract is marked as complete and then edited, this date is removed. In that case, this field remains blank until the abstract is marked complete. The hospital can specify which patient types must have a final DRG accepted before the abstract can be marked complete (see M/R ABSTRACT & DRG CENSUS CRITERIA).

Impact

After you accept this screen, the following takes place:

- All changes made to any field on this screen update the MPI information.
- Name changes that are retained can now be used as search criteria in the MPI.

EPISODE INFORMATION-1 SCREEN

The Episode Information-1 screen displays additional patient information entered during the admission sequence. Many of the fields on this screen can be edited and most update the MPI. The fields that cannot be edited via the abstracting function are: Admission Date, Admission Time, Discharge Date, Discharge Time, LOS, and Total Charges.

When you select the Episode Information-1 option, the following screen displays:

```
            General Hospital Episode Information-1 Processor
                                              Tue Mar 17, 2009 09:16 am
    Account No     Name                          ICD    Unit No        Corp No
    0825500001     DONER,ABIGAIL                 9      000-00-5811    00006478
 1 Admission Date  2 Adm Time    3 Admitting Physician        4 Admit Service
   09/11/08          23:10         1 ADAMS,JAY K
 5 Admission Type             6 Admission Source      7 Service
   2 URGENT                     1 PHYS REF/NORMAL       ENT EAR NOSE THROAT
 8 Attending Physician        9 Referring Physician        10 Dsch Disposition
   1 ADAMS,JAY K                                           DSCH/XFER OTHER S
11 Discharge Physician       12 Discharge Date       13 Dsch Time     14 LOS
                                09/11/08                23:59            1
15 Financial cl    16 Total Charges   17 Main Service      18 Sub. Serv.
   S SELF PAY                         ENT EAR NOSE T
19 Most Resp. Physician        20 Phys. Spec.            21 2nd Cht/Reg #









Enter field number or '/' starting field number--
                      next(/) or previous screen(/P) [/]
```

Field Explanations

1. ADMISSION DATE (DISPLAY ONLY)
The admission date entered during the admission sequence is displayed in this field. You cannot update this information on this screen. To modify it, use the Revise Admission/Discharge Date and Time option.

2. ADM TIME (DISPLAY ONLY)
The admission time entered during the admission sequence is displayed in this field. You cannot update this information on this screen. To modify it, use the Revise Admission/Discharge Date and Time option.

3. ADMITTING PHYSICIAN (TABLE LOOKUP-R)
The name of the admitting physician entered during the admission sequence displays in this field, or you can enter a new admitting physician.

NOTE: When you are editing the Admitting or Attending Physician fields, the Admitting Privileges Status field from the Physician table applies. You may

see warnings about physicians you choose; however, you can always continue with whatever physician you find applicable.

When you edit this field in the STAR Financials environment, the system displays a subscreen showing the current admitting physician. You can update the current physician by using one of the following entry options:

- Enter the code for the new physician, if you know it.
- Enter a hyphen (**-**) to display the Physician table for selection.
- Enter part of the physician's name or the letter(s) beginning the name followed by a hyphen (**-**).

If you select a new physician, the system prompts you to enter the effective date or the earliest reclassification date possible for the new admitting physician. The default is the current date. This field is required if you are entering a new admitting physician.

The system automatically fills by By field of the subscreen with the initials of the person who signed on. Once you complete the subscreen, the system returns you to the Episode Information screen, where the code and name of the new admitting physician are displayed.

4. ADMIT SERVICE (TABLE LOOKUP)
The hospital service to which the patient was admitted upon arrival is displayed in this field. Enter a new admit service code, or enter a hyphen (-) to display the Hospital Services code table for selection.

5. ADMISSION TYPE (TABLE LOOKUP)
This field displays the admission type as entered at time of admission (or subsequently updated). Enter the code, or press hyphen (-) to display the Admission Type code table for selection.

6. ADMISSION SOURCE (TABLE LOOKUP)
This field displays the admission type as entered at time of admission (or subsequently updated). Enter the code, or press hyphen (-) to display the Admission Source code table for selection.

7. SERVICE (TABLE LOOKUP)
Initially, this field displays the service entered at time of admission (or subsequently updated). When you subsequently access this field to update information, a subscreen (called the Service Tracker) is displayed. This subscreen enables you to track all service changes and transfers for this patient. It maintains a list of all services assigned to this visit, and the length of stay for this service, in chronological order. When you accept the Service Tracker screen, you are returned to the Episode Information-1 screen, where the most recent entry in the Service Tracker is displayed in the Service field.

The following screen is a sample of the Service Tracker subscreen that displays if your facility is **not** using Program Management and the patient is not in a bed. A sample and explanation of the subscreen that displays if your facility is using Program Management follows this discussion.

```
              General Hospital  Episode Information-1 Processor
                                              Tue Mar 17, 2009 09:16 am
    Account No     Name                          ICD    Unit No        Corp No
    9332600002     KING,ADAM                     9      000000220      00000301
 NO  SERVICE  (CODE)            START    LOS SUB PHYSICIAN      (SPC) DIAGNOSIS
  1  ADULT PSYCHIATRIC (PSY)   10/18/95   26
  2  MEDICINE, GENERAL (MED)   11/13/95    4
  3  ADULT PSYCHIATRIC (PSY)   11/17/95    3  1  LEES,JACK R         304.62 0 2
  4  NEUROLOGY (NEU)           11/20/95    0  2  THOMPSON,DOCTOR     800.12   2









Accept screen? (Y/N) [Y]--
          F1Prev Page F3 Insert  F4 Delete  F6 Reset  F7  Exit   ?
```

This screen uses the scrolling screen processor. Use the function keys at the bottom of the screen to page through multiple screens (if there are any), insert a new entry between existing ones, delete an entry, reset a line entry, or exit from the Service Tracker. See the Scrolling Screen Processing subsection of the Information Entry Techniques chapter in the *STAR Patient Care Reference Guide, General Information Volume* for more information on using scrolling screens.

You can delete all but one service episode entry, since you must have at least one service associated with the patient's visit. The most recent entry in the tracker becomes the new and current service that displays in the Service field on the Episode Information-1 screen.

Subscreen Field Explanations

NO (DISPLAY ONLY)
This column identifies the sequence number of the entry. STAR automatically assigns the next sequential number when a new entry is made.

SERVICE (TABLE LOOKUP)
This column enables you to enter the new service, or correct the current service of the patient. You can overwrite the service using the same line number on which the service is listed. To indicate that the patient was transferred to a new service, press ENTER or the down arrow key to access the next sequential episode number. Select

the new service by entering the code, if you know it, or enter a hyphen (-) to display the Hospital Services code table for selection.

This column displays the description and corresponding code. If you delete the first entry, the system displays an error message indicating that the start date of the first service episode must be the admit date.

START DATE (DATE FORMAT)
This column enables you to identify the date this service became effective for this patient. The date entered must be between the admission and discharge dates. The first service entry must start on the admission date. When you want to insert a service transfer using the admission date as the start date, you must first change the start date of the first service to a later date. When a start date of a service episode is revised and when a new service transfer is inserted, all service episodes are re-sorted by start date.

LOS (DISPLAY ONLY)
This column displays the patient's length of stay (LOS) within this service. The LOS is calculated based on the difference between the start date of the previous entry and the start date of the current entry. For example, if the first service episode began on 11/01, and a service transfer took place on 11/10, then the LOS for the transferring service is nine (9).

SUB (1-N-O)
This field is used mainly by Canadian users. When you access this column, you are prompted to enter a subservice code, which is a number from zero to nine. There is no table or build function for subservice codes. Subservice codes are defined by the department or hospital and are used to further define the service. Subservice codes are passed to the CIHI with the first three service transfers that are not listed as the Main Service.

PHYSICIAN (TABLE LOOKUP)
This column enables you to associate a physician with the change of service. You only need to enter physicians in the Service Tracker if they are different from the Most Responsible Physician. Once you enter a physician, you are prompted to complete the next column, (SPC).

(SPC) (TABLE LOOKUP)
This column enables you to associate a specialty with the physician entered in the previous column. Enter the physician's primary specialty code, or enter a hyphen (-) to display the valid specialty codes for the physician.

DIAGNOSIS (TABLE LOOKUP)
This column enables you to associate a diagnosis code with this service update entry. To enter a code, execute one of these entry options:

- Enter the diagnosis code directly into the field.
- Enter **U** and a hyphen (**-**) to display the entire diagnosis pointer table (in alphabetic order, according to description). Select a code from this listing.

- Enter **U**, an alpha character or characters, and a hyphen (**-**) to display the pointer table that begins with the specific alpha character(s). Select a code from this listing.

- Enter a number(s) and a hyphen (**-**) to display the diagnosis code table from the specified number(s) forward. Select a code from this listing.

- Enter a hyphen (**-**) to display the entire diagnosis table in numeric order. Select a code from this listing.

When you access the Service field on the Episode Information screen and your system is live on Program Management and the patient is not in a bed, a more detailed Service Tracker subscreen is displayed. After you accept the Service Tracker screen, you are returned to the Episode Information-1 screen, where the updated service (if applicable) displays. The following screen is a sample of the Service Tracker subscreen:

```
        General Hospital  Episode Information-1 Processor
                                                 Tue Mar 17, 2009 09:16 am
    Account No     Name                          ICD   Unit No        Corp No
    9332600002     KING,ADAM                     9     000000220      00000301
 NO  CLINIC,UNIT,TEAM  (CODE)             PROGRAM  (CODE)          OFF SERVICE
    SERVICE  (CODE)           START    LOS SUB PHYSICIAN     (SPC)   DIAGNOSIS
  1  ACUTE ECT   (ACECT)              GENERAL PSYCHIATRY   (GNPSY)    No
   ADULT PSYCHIATRIC   (PSY) 10/18/95   33









Enter Clinic/Unit/Team code or `-` to list--
          F1Prev Page F3 Insert  F4 Delete  F6 Reset  F7  Exit   ?
```

NOTE: The Service Tracker retains the outpatient service information when an outpatient in bed is changed to an inpatient. It does not retain inpatient service information when an inpatient is changed to an outpatient.

Subscreen Field Explanations

NO (DISPLAY ONLY)
This column identifies the sequence number of the entry. STAR automatically assigns the next sequential number when a new entry is made.

CLINIC,UNIT,TEAM (TABLE LOOKUP)
Enter the Clinic,Unit,Team (CUT) code, or press hyphen (-) to display the CUT code table for selection. To override the existing CUT code, enter a new CUT code at the appropriate column number. To add a new service episode, press ENTER or the down arrow key to access the next sequential episode number.

PROGRAM (DISPLAY ONLY)
If the medical service is linked to a program code, the program description and code display in this field.

OFF SERVICE (DISPLAY ONLY)
A Yes or No is automatically displayed in this column to indicate whether or not the patient is off service (that is, in a bed that is not associated with the patient's service).

SERVICE (DISPLAY ONLY)
This column displays the service associated with the CUT entered previously. To perform a service transfer, you must enter a new CUT entry. To update the service, you must update the CUT entry.

START DATE (DATE FORMAT)
This column enables you to identify the date this service became effective for this patient. You must enter a date between the admission and discharge dates. The first service entry must start on the admission date. When you want to insert a service transfer using the admission date as the start date, you must first change the start date of the first service to a later date. When a start date of a service episode is revised and when a new service transfer is inserted, all service episodes are resorted by start date.

LOS (DISPLAY ONLY)
This column displays the patient's length of stay (LOS) within this service. The LOS is calculated based on the difference between the start date of the previous entry and the start date of the current entry. For example, if the first service episode began on 11/01, and a service transfer took place on 11/10, then the LOS for the transferring service is nine (9).

SUB (1-N-O)
This data element is mainly used by Canadian users. When you access this column, you are prompted to enter a subservice code, which is a number from zero to nine. There is no table for subservice codes. Subservice codes are defined by the department or hospital and are used to further define the service. Subservice codes are passed to the CIHI with the first three service transfers that are not listed as the Main Service.

PHYSICIAN (TABLE LOOKUP)
This column enables you to associate a physician with the change of service. You only need to enter physicians in the service tracker if they are different from the Most Responsible Physician. Once you enter a physician, you are prompted to complete the next column, (SPC).

(SPC) (TABLE LOOKUP)
This column enables you to associate a specialty with the Physician entered in the previous column. Enter the physician's primary specialty code, or enter a hyphen (-) to display the valid specialty codes for the physician.

DIAGNOSIS (TABLE LOOKUP)
This column enables you to associate a diagnosis code with this service update entry. You have several entry options:

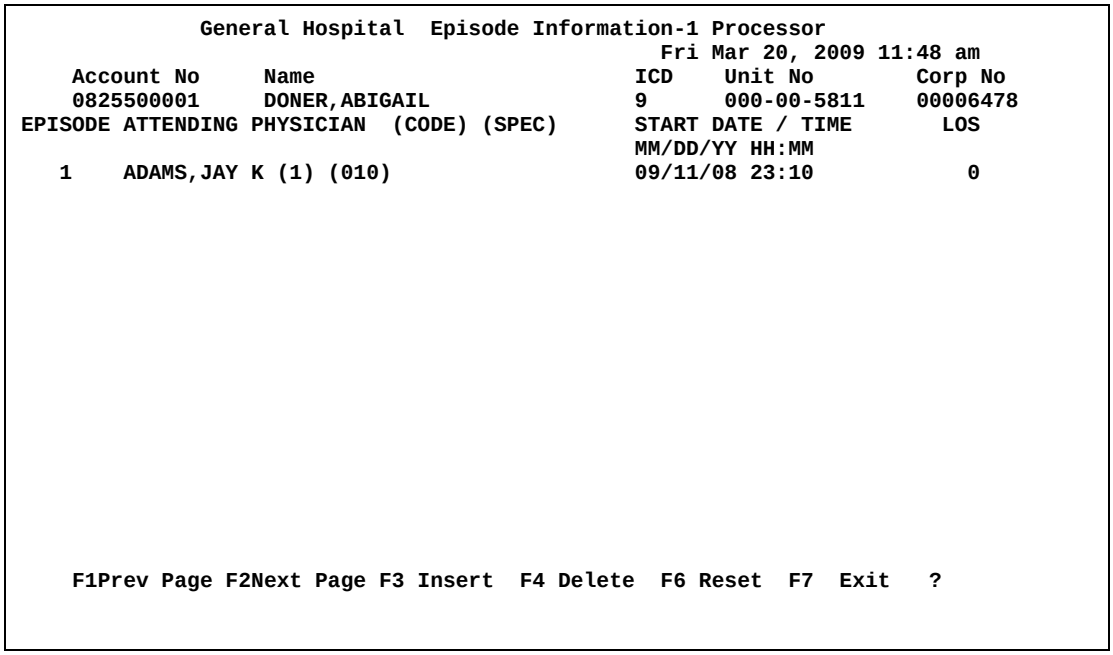
- Enter the diagnosis code directly into the field.
- Enter **U** and a hyphen (**-**) to display the entire diagnosis pointer table (in alphabetic order according to description). Select a code from this listing.
- Enter **U**, an alpha character or characters, and a hyphen (**-**) to display the pointer table that begins with the specific alpha character(s). Select a code from this listing.
- Enter a numeric digit(s) and a hyphen (**-**) to display the table from the diagnosis code table beginning with the specified number(s). Select a code from this listing.
- Enter a hyphen (**-**) to display the entire diagnosis table in numeric order. Select a code from this listing.

Episode Information-1 Field Explanations Cont.

8. ATTENDING PHYSICIAN (TABLE LOOKUP)
This field displays the name of the physician responsible for the patient's care during this visit. If the Hospital Facility Options and the specific physician parameters are set to accommodate multiple address processing, the following prompt is displayed when you access this field to update the information already in it:

Revise address information? (Y/N) [N]

The system automatically displays the Physician Tracker subscreen if the patient has been in a bed. This subscreen enables you to track all changes made to the attending physician for this patient. The following screen is a sample of the Physician Tracker subscreen:



NOTE: The Physician Tracker retains the outpatient physician when an outpatient in bed is changed to an inpatient. It does not retain inpatient information when an inpatient is changed to an outpatient.

This screen uses the scrolling screen processor. Use the function keys at the bottom of the screen to page through multiple screens (if there are any), insert a new entry between existing ones, delete an entry, reset a line entry, or exit from the Physician Tracker. See the Scrolling Screen Processing subsection of the Information Entry Techniques chapter in the *STAR Patient Care Reference Guide, General Information Volume* for more information on using scrolling screens.

Subscreen Field Explanations

EPISODE (DISPLAY ONLY)
This column identifies the sequence number of the entry. The system automatically assigns the next sequential number when a new entry is made.

ATTENDING PHYSICIAN (TABLE LOOKUP)
This field contains the name and Physician table code of the attending physician entered during the admission sequence, or subsequently updated. To edit this field, you can choose one of the following entry options:

- Enter the code for the new attending physician, if you know it.
- Enter a hyphen (**-**) to display the Physician table for selection.

- Enter part of the physician's name or the letter(s) beginning the name followed by a hyphen (**-**).

- To enter a name not in the table, enter a hyphen (**-**) followed by the name.

(SPEC) (TABLE LOOKUP)
This column enables you to associate a specialty with the physician entered in the previous column. Enter the physician's primary specialty code, or enter a hyphen (-) to display the valid specialty codes for selection.

START DATE OR START DATE/TIME (DATE OR DATE/TIME FORMAT)
Enter when the new attending physician will become or became responsible for the patient's care. This field accepts either a date or date and time, depending on the Phys Episodes setting in Admission and General Parameters. If the Phys Episodes parameter is set to Multiple per day, the following prompt is displayed:

Enter Start Date space Time, or 'T' space 'N' for current date and time.

You must enter both a date and time.

If the Phys Episodes parameter is set to At midnight (one per day), the following prompt is displayed:

Enter Start Date in the format MM/DD/YY or use a 'T' for today.

You must enter a date only.

The earliest reclassification date allowed is either the admission date or the earliest reclassification date allowed according to the parameters set in STAR Financials.

LOS (DISPLAY ONLY)
This column displays the length of stay (LOS) associated with this attending physician. The LOS is calculated based on the difference between the start date of the previous entry and the start date of the current entry.

Episode Information-1 Field Explanations Cont.

9. REFERRING PHYSICIAN (TABLE LOOKUP)
This field displays the physician who referred this patient to your facility, as entered at admission or subsequently updated. To update this field, you can use of the following entry options:

- Enter the code for the new physician, if you know it.

- Enter a hyphen (**-**) to display the Physician table for selection.

- Enter part of the physician's name or the letter(s) beginning the name followed by a hyphen (**-**).

- To enter a name not in the table, enter a hyphen (**-**) followed by the name.

10. DSCH DISPOSITION (TABLE LOOKUP)
This field displays the patient's discharge disposition, as entered at the time of discharge. To update this information, enter the code, if you know it, or enter a hyphen (-) to display the Discharge Status/Disposition code table for selection. The table displays the valid codes applicable for the patient type being abstracted. You cannot enter a discharge disposition on a patient that has not been discharged.

If you enter a discharge/disposition status that is flagged as an expired status, some of the existing patient data in the system may be automatically deleted as a result of the expiration status. When you enter an expired status, the following warning message displays:

Pending visit information will be cancelled! Continue? (Y/N) [N]--

Enter **Y** for Yes to continue with the expired discharge/disposition status. Enter **N** for No if you do not want to enter the expired status.

If you continue with the expired status, the following message displays:

Cancelling pending visit information

NOTE: The system calculates and enters the Date of Death in the patient's MPI information.

11. DISCHARGE PHYSICIAN (TABLE LOOKUP)
This field displays the physician responsible for discharging the patient, as entered at the time of discharge. To update this field, you can use of the following entry options:

- Enter the code for the new physician, if you know it.
- Enter a hyphen (**-**) to display the Physician table for selection.
- Enter part of the physician's name or the letter(s) beginning the name followed by a hyphen (**-**).
- To enter a name not in the table, enter a hyphen (**-**) followed by the name.

12. DISCHARGE DATE (DISPLAY ONLY)
If the patient has been discharged, this field displays the date. Otherwise, it is blank.

13. DSCH TIME (DISPLAY ONLY)
If the patient has been discharged, this field displays the time. Otherwise, it is blank.

14. LOS (DISPLAY ONLY)
This field displays the length of the patient's stay during this visit. LOS is calculated by subtracting the admission date from the discharge date. If the patient has not been

discharged, the current LOS is calculated by subtracting the admission date from the current date.

15. FINANCIAL CL (TABLE LOOKUP)
This field displays the patient's financial class as entered at admission, or subsequently updated. To update this field, enter the code, if you know it, or enter a hyphen (-) to display the Financial Classes code table for selection.

NOTE: Updating the financial class in the abstract does *not* update the MPI or insurance information. Changes in financial class should originate from the Patient Accounting/Billing system.

16. TOTAL CHARGES (DISPLAY ONLY)
This field displays the current total charges for this patient, including pharmacy and late charges. This information is updated online as charge information changes.

NOTE: Changes in the total charges do not automatically recalculate the DRG, or mark the DRG and/or abstract as incomplete.

17. MAIN SERVICE (TABLE LOOKUP)
When a patient is discharged, this field automatically displays the service listed in the Service Tracker that has the greatest length of stay (LOS). You can edit this field if necessary. When you access this field, the system automatically displays all services associated with this case in the Service Tracker subscreen. To select a service as the main service, enter the option number to the left of the service name.

18. SUB SERV (DISPLAY ONLY)
This field displays the subservice associated with the service entered in the Main Service field.

19. MOST RESP. PHYSICIAN (TABLE LOOKUP)
When a patient is discharged, this field automatically displays the physician listed in the Physician Tracker who was responsible for the patient during the longest time period, based on the patient's length of stay. You can edit this field if necessary. When you access this field, the system automatically displays a list of all attending physicians associated with this case. Enter the option number to the left of the physician name.

WARNING: This field does *not* autofill the next field, the specialty of the most responsible physician. That field (Phys Spec) must be manually updated by the user.

20. PHYS SPEC (TABLE LOOKUP)
This field enables you to identify the specialty of the physician selected in the previous field as the most responsible. You have the following entry options:

- Enter the Physician/Resource Specialty code, if you know it.
- Enter a hyphen (**-**) to display the Physician/Resource Specialty code table for selection.

- Press ENTER to accept the default of primary specialty associated with the physician in the Physician code table.

21. 2ND CHT/REG.# (12-C-0)
When the Newborn Admit function is used, this field displays the mother's unit number if this abstract belongs to a baby, or the baby's unit number if the abstract belongs to the mother. If the patient is neither a mother nor a baby, you can enter a second chart registration number for the patient.

Impact

After you accept this screen, changes made to most fields on this screen update the MPI information.

EPISODE INFORMATION-2 SCREEN

The Episode Information-2 screen shows additional patient information, some of which was entered during the admission sequence. Except for the Last Station field, all the fields on this screen can be edited.

When you select the Episode Information-2 option, the following screen is displayed:

```
               General Hospital Episode detail-2 Processor
                                                 Tue Mar 17, 2009 09:28 am
    Account No     Name                          ICD    Unit No        Corp No
    0825500001     DONER,ABIGAIL                 9      000-00-5811    00006478
 1 Transfer Service         2 Transferred From  3 Transferred To
->
 4 Re-admit        5 Pre-admit             6 Last Station      7 Coder

 8 Referral Reason   9 Referring Facility             10 Referred To

11 Incident Code  12 Incident Date             13 Arrival Mode

14 Date Ready For Dschg    15 Social Services  16 Discharge Planning

17 NJ/NY Z Code   18 Steri/Hyster Ind     19 Co-Pay Exception Code 20 Overflow









Enter hospital service--         |
```

Field Explanations

1. TRANSFER SERVICE (TABLE LOOKUP)
This field displays the type of service at the time of transfer, or you can enter a new transfer service. Enter the table code, if you know it, or enter a hyphen (-) to display the Hospital Service Code table for selection.

2. TRANSFERRED FROM (TABLE LOOKUP)
This field displays the location from which the patient was transferred, as entered at the time of admission, or subsequently updated. To update this field, enter a code for the facility, if you know it, or enter a hyphen (-) to display the Referring Institution/ Facility code table for selection. You can also make a freeform entry.

3. TRANSFERRED TO (TABLE LOOKUP)
This field displays the location to which the patient was transferred. To update this field, enter a code for the facility, if you know it, or enter a hyphen (-) to display the Referring Institution/Facility code table for selection. You can also make a freeform entry.

4. RE-ADMIT (TABLE LOOKUP)
This field enables you to identify the type of readmission for this patient, or to identify if this is not a readmission. Enter the code corresponding to the entry, if you know it, or enter a hyphen (-) to display the Re-Admission code table for selection.

5. PRE-ADMIT (TABLE LOOKUP)
This field enables you to identify the type of preadmission for this patient. Enter the code corresponding to the entry, if you know it, or enter a hyphen (-) to display the Pre-Admit code table for selection.

6. LAST STATION (DISPLAY ONLY)
This field displays the last nurse station where the patient was located. You cannot modify this field.

7. CODER (3-AN-O)
This field enables you to enter the code or initials of the person responsible for coding the diagnosis and procedures on the medical record. If the coding was done using the 3M Coding and Reimbursement System, the initials of the person who accessed 3M are automatically displayed here.

8. REFERRAL REASON (TABLE LOOKUP)
This field identifies the reason the patient was referred to your facility, as entered at the time of admission or subsequently updated. To modify this information, enter the code identifying the reason, if you know it, or enter a hyphen (-) to display the Reason for Referral code table for selection. Entries in this field update the Referral Reason field on the Mental Health screen, and vice versa.

9. REFERRING FACILITY (TABLE LOOKUP OR 19-C-O)
This field identifies the facility, institution, or person referring this patient to your facility, as entered at the time of admission, or subsequently updated. A referring facility may differ from the transferring facility in that the patient may be referred to your facility for care, but not physically transferred directly from another facility.

To modify this information, enter the code corresponding to the referring facility, or enter a hyphen (-) to display the Referring Institution/Facility code table for selection. You can also enter a freeform entry of up to 19 characters (you must type a hyphen before your freeform entry). Entries in this field update the Referred From field in the UM Discharge Planning function in the STAR Utilization Management Module.

10. REFERRED TO (TABLE LOOKUP)
This field identifies the facility, institution, or person to which this patient was referred upon leaving your facility. A referring facility may differ from the transferring facility in that the patient may be referred for follow-up care, but not physically transferred there directly from your facility. To modify this information, enter the code corresponding to the facility, or enter a hyphen (-) to display the Referring Institution/Facility code table for selection. You can also make a freeform entry.

11. INCIDENT CODE (TABLE LOOKUP)
This field displays the code identifying any incident that occurred to the patient during this visit. To modify this field, enter a new code, if you know it, or enter a hyphen (-) to display the Incident code table for selection.

12. INCIDENT DATE (DATE FORMAT)
This field enables you to associate a date with the code entered in the previous field.

13. ARRIVAL MODE (TABLE LOOKUP)
This field indicates how the patient arrived at your facility, as entered at the time of admission, or subsequently updated. To modify this field, enter the code identifying the patient's mode of arrival, if you know it, or enter a hyphen (-) to display the Arrival Modes table for selection. You can also make a freeform entry.

14. DATE READY FOR DSCHG (DATE FORMAT)
This field displays the date the patient should be ready for discharge. You can enter a new date, or leave the field blank. By using this information with the actual discharge date, your facility can compare how long patients stay past the time when they are ready to be discharged.

15. SOCIAL SERVICES (TABLE LOOKUP)
This field identifies social services received by the patient prior to discharge. Enter a new code, if you know it, or enter a hyphen (-) to display the Social Services code table for selection.

16. DISCHARGE PLANNING (TABLE LOOKUP)
This field displays a code identifying the type of discharge planning, if any, received by the patient prior to discharge. Enter a new code, if you know it, or enter a hyphen (-) to display the UM Discharge Planning code table for selection.

17. NJ/NY Z CODE (TABLE LOOKUP)
This field is only applicable to the states of New Jersey and New York. It is not a required field. Z Codes are trauma codes that indicate the place of injury. Enter a new code, or enter a hyphen (-) to display the New Jersey/New York Z Codes table for selection.

18. STERI/HYSTER IND (1-A-O)
This indicator is used primarily in New Jersey and New York. This field indicates if the Sterilization/Hysterectomy consent form has been signed. Enter **Y** for Yes, **N** for No, or leave the field blank.

19. CO-PAY EXCEPTION CODE (TABLE LOOKUP)
This indicator is used primarily in New Jersey and New York. This field contains the code identifying the reason the patient is exempt from co-payment. To modify this field, enter a new code, if you know it, or enter a hyphen (-) to display the UM Co-Pay Exception code table for selection.

20. OVERFLOW (TABLE LOOKUP)

This field is used mainly by Canadian facilities to identify areas of the abstract where an overflow of data exists. For example, if the patient has more than 15 diagnoses, the overflow type would be "diagnoses" to indicate there are more diagnoses entered in the abstract than can be placed in the CIHI interface. Enter the code, if you know it, or enter a hyphen (-) to display the Abstract Overflow code table for selection.

USER DEFINED FIELDS SCREEN

The User Defined Fields page contains up to 40 fields. Up to 20 of the fields are retained in the MPI and are brought forward with each subsequent visit. The remaining 20 fields are visit-specific. The MPI level fields are displayed first, followed by the Visit level fields. Each field can be defined by your hospital as yes/no, freeform, table-driven, or date format.

Based on parameters set by your facility in Table Maintenance (see the Tables appendix in the *STAR Patient Care Reference Guide, Patient Processing Module* for details), you are able to define the fields that display on this screen in the admission sequence including the label, question, code and description length, and whether or not the field is required. You maintain tables for the table-driven fields in the regular Table Maintenance function.

If your entries in Table Maintenance are accepted, the screen you set up displays in the admission sequence on the User Defined Fields page. The field labels on this screen are a result of the entries made on the Table processor. The same screen that displays in the admission sequence also displays in the abstracting function. These fields can be edited via the abstracting functions.

The following screen is an example of a User Defined Fields page that was set up during the admission sequence; it is displayed during the abstracting function:

```
              General Hospital User Defined Fields Processor
                                                 Fri Mar 20, 2009 12:12 pm
    Account No     Name                          ICD    Unit No        Corp No
    0825500001     DONER,ABIGAIL                 9      000-00-5811    00006478

User Defined Field                Response

BLOOD TYPE
MOTHER'S BLOOD TYPE
FATHER'S BLOOD TYPE
HIGH BLOOD PRESSURE
NUMBER OF CHILDREN                ONE
NUMBER OF SIBLINGS                TWO
CANCER IN FAMILY?                 YES
WHO?                              SISTER
DATE DIAGNOSED                    06/06/97
VISION PROBLEMS?
LAST CHEST XRAY                   01/01/99
LAST PHYSICAL                     01/02/99
ADDITIONAL INFORMAT               DOES NOT DRIVE
FAVORITE FRUIT                    MANGO
COUNTRIES VISITED
AMBULANCE SERVICE
Enter the patient's blood type, or - lookup--
               F1Prev Page F2Next Page F6 Reset  F7  Exit   ?
```

This screen is a scrolling screen. For information on using scrolling screens refer to the Information Entry Techniques chapter of the *STAR Patient Care Reference Guide, General Information Volume*.

CONSULTATIONS SCREEN

The Consultations screen is for entry of all physicians who consulted on this patient's case, along with the associated consultation dates and the specialties of the physicians. The specialty that is displayed is one defined in the Physician table, but you are able to edit the specialty. Consultations ordered through the STAR Patient Care Order Entry process, or those added through Revise Patient Nursing automatically display on this screen.

When a consult is added through Nursing, an indicator displays to the right of the physician name. This indicates which office address of the physician was selected at the time the consultation order was entered. This display only occurs if multiple address processing is being used at your facility.

You can enter consultation data directly on this screen at any time. Other than the Physician page in the MPI, STAR modules are not updated when consultants are added or deleted through the abstracting process.

The following is an example of a Consultations screen:

```
                  General Hospital Consultations Processor
                                                  Fri Mar 20, 2009 12:14 pm
    Account No     Name                          ICD    Unit No        Corp No
    0825500001     DONER,ABIGAIL                 9      000-00-5811    00006478

 No.   Consultant Physician            Date      Specialty              Type
(1 )   GABRIEL,JOHN A                  01/01/08  GP FAMILY PRACTICE     CNS









Select consultant to revise, or add(A) a new consultant--   |
                  next screen(/) or previous screen(/P) [/]
```

If there are no consultations, a message is displayed on the bottom of the screen stating this.

You have four choices:

- Enter the number corresponding to the consultant you wish to revise.
- Enter **A** to add a new consultant.

- Enter a slash (***/***) to move to the next screen.
- Enter a slash followed by P (***/P***) to move to the previous screen.

Add a Consultant

To add a consultant, enter **A**, and press ENTER. The system displays entry fields at the bottom of the Consultations screen, as in the following example:

```
                General Hospital Consultations Processor
                                                Fri Mar 20, 2009 12:14 pm
    Account No     Name                          ICD    Unit No        Corp No
    0825500001     DONER,ABIGAIL                 9      000-00-5811    00006478

 No.   Consultant Physician             Date      Specialty               Type
(1 )   GABRIEL,JOHN A                   01/01/08  GP FAMILY PRACTICE      CNS









 1 Consulting Physician          2 Date         3 Consultation Specialty
->
 4 Type


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

Field Explanations

1. CONSULTING PHYSICIAN (TABLE LOOKUP-R)
This field enables entry of the consulting physician. Add, delete or update a consultant as outlined above. This is a required field. To enter a consultant, execute one of these entry options:

- Enter the physician code.
- Enter a hyphen (**-**), apostrophe hyphen (’-), or backslash hyphen (\-) to select a physician, staff caregiver, or non-staff caregiver from a table listing.
- Enter letter(s) the name begins with followed by a hyphen (**-**) to limit the search.
- Enter a hyphen followed by a name to override the table and enter a freeform name

2. DATE (DATE)
Enter the date of the consultation. Enter an equal sign (=) to display the same date as the last consultation entered for this patient during this editing of the abstract. If you

enter a date that is before the patient's date of admission, the system displays the following prompt:

Date entered (mm/dd/yy) is prior to admission date. Continue? (Y/N) [Y]-

Enter **Y** for Yes or press ENTER to accept the date, or enter **N** for No to select another date.

If you enter a date that is after the discharge date, the system displays the following message and forces you to reenter the date:

Error: Date entered is past discharge date

3. CONSULTATION SPECIALTY (3-AN-O)
If you selected a consultant who is located in the Physician Code table, the specialty associated with that physician automatically displays in this field. You can retain that specialty or you can enter a new specialty by entering the specialty code if you know it, or by pressing hyphen (-) and ENTER to display the code table for selection.

4. TYPE (TABLE LOOKUP)
This field enables entry of the physician type to further define the role of this consultant. This is an optional entry field. Enter the code, or enter a hyphen (-) to display the Physician Types table for selection.

Once you accept the information, the consultant displays on the upper half of the screen.

Delete a Consultant

To delete a consultant, enter the number to the left of the consultant's name and press ENTER. Press ENTER again. The system displays a prompt asking you whether the consultant is to be deleted. Enter **N** or press ENTER for No to leave the consultant. Enter **Y** for Yes to delete the consulting information from the upper portion of the screen.

Revise a Consultant

To revise consultant information, enter the number to the left of the consultant's name and press ENTER. Enter the field number for which changes are to be made.

DIAGNOSES SCREEN

The Diagnoses screen is identical to the second screen of the DRG Assignment sequence. The system accepts entry of an Admitting, Reason, Nosocomial, Principal, and up to 14 ICD Secondary diagnosis codes.

NOTE: If diagnosis codes have been entered for the patient through Outpatient Dispositioning before any entries have been made in the abstract, those codes from Outpatient Dispositioning automatically display on the Diagnosis screen. However, future changes to the codes on the Outpatient Dispositioning screen do not update the abstract, nor do changes to the codes in the abstract update Outpatient Dispositioning.

Following are examples of the ICD-10 and ICD-9 Diagnoses Processor screens available once the US ICD-10 Effective Date is set. The ICD-10 Diagnoses Processor is the primary screen. The ICD-9 Diagnoses Processor is the secondary screen, and is accessed through the ICD-10 Diagnoses Processor.

ICD-10 Diagnoses Processor

```
                  General Hospital Diagnoses Processor
                                                Fri Mar 20, 2009 06:36 pm
   Account No     Name                          ICD    Unit No        Corp No
   0825500001     DONER,ABIGAIL                 10     000-00-5811    00006478
    ICD-10 Code      Description                   DRG Dx Tumor   Type POA/HAC
Admitting  F43.0     ACUTE STRESS REACTION                            Y
Principal  G30.9     ALZHEIMER'S DISEASE, UNSPECIFI
2ndary( 1) F41.1     GENERALIZED ANXIETY DISORDER                     W
      ( 2) D50.9     IRON DEFICIENCY ANEMIA, UNSPEC









Enter ICD-10 secondary(T), line to change, ICD-9(I), (*) for A,P,R,N options--
                  next screen(/) or previous screen (/P) [/]
```

ICD-9 Diagnoses Processor

```
                  General Hospital Diagnoses Processor
                                              Fri Mar 20, 2009 07:06 pm
    Account No     Name                        ICD    Unit No        Corp No
    0825500001     DONER,ABIGAIL               10     000-00-5811    00006478
     ICD-9 Code       Description                 DRG Dx Tumor   Type POA/HAC
 Admitting  789.01    ABDMNAL PAIN RT UPR QUAD                        Y
 Principal  003.0     SALMONELLA ENTERITIS
 2ndary( 1) 002.0     TYPHOID FEVER                                   N









Enter ICD-9 secondary(I), line to change, ICD-10(T), (*) for A,P,R,N options--
                  next screen(/) or previous screen (/P) [/]
```

From the ICD-10 Diagnoses screen, select one of the following entry options:

- Enter the line number of the secondary diagnosis code that you want to change.
- Enter **T** and follow the prompts to enter a new ICD-10 secondary diagnosis code.

  Enter a hyphen to display a list of ICD-10 diagnosis codes. Enter a slash (/) to move to the next page of the list of codes, or slash P (/P) to move to the previous page.
- Enter **I** to access the ICD-9 Diagnoses Processor screen, and enter **I** again to enter a new ICD-9 secondary diagnosis code.

  NOTE: From the ICD-9 Diagnoses Processor screen, you can return to the ICD-10 Diagnoses Processor screen, by entering **T**. All other options are the same for both screens.

  Enter a hyphen to display a list of ICD-9 diagnosis codes. Enter a slash (/) to move to the next page of the list of codes, or slash P (/P) to move to the previous page.
- Enter an asterisk (*****) to access a prompt for the A, P, R and N options:

  (A)dmitting Diagnosis, (P)rincipal Diagnosis, (R)eason for visit, (N)osocomial--
  next screen(/) or previous screen (/P) [/]

Enter **A** for an Admitting diagnosis code, **P** for a Principal diagnosis code, **R** for Reason for Visit diagnosis code, or **N** for Nosocomial Infection codes.

Field Explanations

ADMITTING (34-AN-O)
This field displays the current admitting diagnosis code and description, or you can enter a new admitting diagnosis. To enter a new admitting diagnosis, press **A** and ENTER, and the following prompt is displayed:

Enter Admitting diagnosis code-- |
`U-`ser DX code, `A-`dmit 2ndry DX codes, `-` for list

Select one of the following entry options:

- Enter the ICD diagnosis code if you know it.
- Enter **U** and a hyphen (-) to display the user-defined pointers that are set up with user-defined terminology that, when selected, display the corresponding ICD code. If you enter **U** and a letter followed by a hyphen (-), all the user-defined pointers that start with that letter are displayed. For example, you may only know the term Chest Pain and nothing more specific. If you enter **UC-**, all user-defined terms that begin with the letter C display. If Chest Pain is an option and you select it, the ICD code and the corresponding description automatically display in the Admitting Diagnosis field.
- Enter **A** and a hyphen (-) to display the secondary ICD diagnosis codes entered during the admission process. You can then select one of these codes to be used as the admitting diagnosis. Freeform diagnosis codes entered during admission are **not** displayed here for selection.
- Press hyphen (-) and ENTER to display a list of all the ICD diagnosis codes in numeric order. If you know the code you are searching for is in a specific group of codes, you can narrow the search by entering that group number. For example, you can enter 780- (the number and a hyphen) if you know the code is in the 780 group, and all codes that begin with 780 display in numeric order. This limits the ICD search and you can select from this list.

The following conditions may impact your Admitting diagnosis code entry:

- If you enter a diagnosis code in the 800 or 900 range, the system checks the Abstract Code associated with the patient and the E-code message parameter on the M/R Abstract and DRG Census Criteria table. If the E-code parameter is set to Yes, the following message is displayed:

  You have entered a code that requires an E-code

  The system displays this message briefly then returns to the current processing.

- If you enter an inactive ICD code (defined in ICD Table Maintenance) for the admitting diagnosis, the system displays the following error message:

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

If you enter **Y**, the following message is displayed briefly:

WARNING: ICD code is inactive

Then the following prompt is displayed:

Do you accept the XXX diagnosis? (Y/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:

  Error: This code valid for [sex] only--

  where [sex] is male or female.

- 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:

  Error: This code valid for patients ages # to # --

  where # is the lower or upper age number.

In the Type field, a type (or modifier) to the diagnosis code is required if the Diagnosis Type? field in the DRG Payors table is set to Yes. If it is not defined, you cannot make an entry in the Type field.

To edit or delete a type, select the line number for the code to access the Type field. Enter a hyphen (-) to access the Diagnosis Type table and select a type.

If the admitting diagnosis code was not entered in the Diagnoses screen but a valid ICD code was entered during admission, the code entered during admission defaults into the Admitting Diagnosis field on the Diagnoses screen in the M/R Abstracting and DRG Assignment functions and is transmitted to the encoder.

If the admitting diagnosis code was not entered in the Diagnoses screen and an *invalid* ICD code was entered during admission, no admitting diagnosis code is transmitted to the encoder.

REASON (34-AN-O)
This field displays the current Reason for Visit diagnosis code and description, or you can enter a new Reason for Visit diagnosis. To enter a new Reason for Visit diagnosis, press **R** and ENTER, and the following prompt is displayed:

Enter Reason for Visit diagnosis code--
`U-`ser DX code, `A-`dmit 2ndry DX codes, `-` for list

Select one of the following entry options:

- Enter the Reason for Visit diagnosis code if you know it.
- Enter **U** and a hyphen (-) to display the user-defined pointers that are set up with user-defined terminology that, when selected, display the corresponding ICD code. If you enter **U** and a letter followed by a hyphen (-), all the user-defined pointers that start with that letter display. For example, you may only know the term Chest Pain and nothing more specific. If you enter **UC-**, all user-defined terms that begin with the letter C display. If Chest Pain is an option and you select it, the ICD code and the corresponding description automatically display in the Reason for Visit field.
- Enter **A** and a hyphen (-) to display the secondary ICD diagnosis codes entered during the admission process. You can then select one of these codes to be used as the Reason for Visit. Freeform diagnosis codes entered during admission are **not** displayed here for selection.
- Press hyphen (-) and ENTER to display a list of all the ICD diagnosis codes in numeric order. If you know the code you are searching for is in a specific group of codes, you can narrow the search by entering that group number. For example, you can enter 780- (the number and a hyphen) if you know the code is in the 780 group, and all codes that begin with 780 display in numeric order. This limits the ICD search and you can select from this list.

NOSOCOMIAL (34-AN-O)
This field displays the current Nosocomial Infection code and description, or you can enter a new Nosocomial Infection code. To enter a new Nosocomial Infection code, press **N** and ENTER, and the following prompt is displayed:

Enter NNIS code or `-` for table lookup--

Select one of the following entry options:

- Enter the Nosocomial Infection code if you know it.
- Press hyphen (-) and ENTER to display a list of all the Nosocomial Infection codes in numeric order. If you know the code you are searching for is in a specific group of codes, you can narrow the search by entering that group number. For example, you can enter 780- (the number and a hyphen) if you know the code is in the 780 group, and all codes that begin with 780 display in numeric order. This limits the search and you can select from this list.

Once selected, you can enter multiple Nosocomial Infection codes and the following related information:

- Multidrug-resistant Organisms (MDRO) code
- ICD Procedure code
- NHSN operative category code, which identifies the eligible surgical site infection population

You can also identify the Procedure location of the surgical site infections as occurring during one of the following:

- **C** - Current IP admission
- **P** - Previous IP Admission at this hospital
- **D** - Previous IP Admission at a different hospital

PRINCIPAL (34-AN-O)
This field displays the current principal diagnosis code and description, or you can enter a new principal diagnosis. To enter a new principal diagnosis, press **P** and ENTER, and the following prompt is displayed:

Enter Principal diagnosis code-- |
`U-`ser DX code, `A-`dmit 2ndry DX codes, `P-`rincipal admit dx, `-` for list

You can select one of the options described previously in the Admitting explanation, and you also have the following additional option:

- Enter **P** followed by a hyphen (-) to default the principal diagnosis entered during admission.

The processing described for the Admitting field also applies to this field.

NOTE: The Principal Diagnosis field is automatically populated with the admitting diagnosis when the Adm to Prin Diag Default parameter for the patient's abstract census code is set to Yes. The Principal Diagnosis field is auto-populated the first time the abstract is accessed after the patient is discharged. Once the abstract is accessed, changes made in Admissions to the admitting diagnosis do not update the abstract.

In the Type field, a type (or modifier) to the diagnosis code is required if the Diagnosis Type? field in the DRG Payors table is set to Yes. If it is not defined, you cannot make an entry in the Type field.

To edit or delete a type, select the line number for the code to access the Type field. Enter a hyphen (-) to access the Diagnosis Type table and select a type.

NOTE: If there is no entry in this field and a primary DSM® code is entered on the Mental Health screen, the ICD code associated with that DSM code automatically populates this field.

SECONDARY (34-AN-O)
This field displays any current secondary diagnosis code(s) and description(s), or you can enter a new secondary diagnosis code. You can enter up to 14 secondary diagnosis codes. To enter a new secondary diagnosis, press **S** and ENTER, and select one of the options described above in the Admitting explanation. The options available here are identical.

NOTE: When additional DSM codes are added on the Mental Health screen, the associated ICD codes are automatically added here. Also, when a primary DSM code is added on the Mental Health screen and there is already a principal diagnosis code on this screen, the associated ICD code is added to this field.

In the Type field, a type (or modifier) to the diagnosis code is required if the Diagnosis Type? field in the DRG Payors table is set to Yes. If it is not defined, you cannot make an entry in the Type field.

To edit or delete a type, select the line number for the code to access the Type field. Enter a hyphen (-) to access the Diagnosis Type table and select a type.

To delete a secondary diagnosis code, select the number displayed to the left of the code and press ENTER. Press ENTER again to move through the next prompt. The following prompt displays:

Delete? (N) --

The default is **N** for No. Enter to **Y** for Yes to delete the code.

In the Type field, you can add a modifier (or type) to the diagnosis code if the Diagnosis Type? field on the DRG Payors table contains Yes.

To edit or delete a type, select the line number for the code to access the Type field. Enter a hyphen (-) to access the Diagnosis Type table and select a type.

ICD-10/ICD-9 CODE (DISPLAY ONLY)
The Code column contains the ICD diagnosis codes you entered in the admitting, principal, and/or secondary diagnosis code fields. ICD-10 Codes are displayed on the ICD-10 Diagnosis Processor screen. ICD-9 Codes are displayed on the ICD-9 Diagnosis Processor screen.

DESCRIPTION (DISPLAY ONLY)
The Description column contains the description of the ICD diagnosis code you entered.

DRG DX (DISPLAY ONLY)
The DRG DX column contains C/C if the diagnosis is a complication or comorbidity that affected the DRG calculation. Only one C/C displays at a time. If the displayed C/C is deleted, the next C/C (if there is one) is displayed by the next valid complication/ comorbidity code. This column may also contain SEC if it is a Secondary diagnosis code that affects the DRG calculation (that is, certain cardiac DRGs).

TUMOR IND. (DISPLAY ONLY)
The Tumor Ind. column identifies a diagnosis that could be related to a tumor. This is hospital-defined (see the ICD Maintenance section in this manual); Y or N is displayed.

TYPE (DISPLAY ONLY)
This column displays the type entered for this code.

To delete a principal or secondary diagnosis code, select the number to the left of the ICD code, or enter **P**. Once selected, press ENTER and the following prompt displays:

Delete? (N)--

The default is **N** for No; however, if you enter **Y** for Yes, the code is deleted.

POA/HAC (DISPLAY ONLY)
This field contains two indicators:

- **POA** - indicates diagnosis was present on admission
- **HAC** - indicates the diagnosis is a hospital acquired condition

NOTE: You cannot delete a code from this screen if this patient's DRG payor uses the 3M Coding and Reimbursement System for DRG assignment and reimbursement.

Impact

After you accept this screen, the following takes place:

- Changes made to the principal or secondary diagnosis could affect the DRG assignment.
- Changes made to the admitting diagnosis could affect the Admit DRG assignment.
- If you change the principal or secondary diagnosis, the system prompts you to accept the DRG (if the patient has been discharged) and whether to print the attestation.
- Once the codes are processed through the grouper (on STAR), they are resequenced so that those secondary diagnosis codes affecting the DRG are

placed at the top of the visit under the principal diagnosis, provided the Auto Resequence parameter is set to Yes in M/R Abstract and DRG Census Criteria.

PROCEDURES SCREEN

The Procedures screen is identical to the Procedures screen in the DRG Assignment sequence. You can enter up to 15 ICD procedure codes. The information updated here is also updated throughout the system.

The Procedures screen enables you to associate multiple procedures to the same episode. Procedures with the same date and time are considered part of the same episode. Thus, all procedures done during the same operative episode (that is, the same visit to the operating room or surgical suite, for example) should be given the same time and date. The major benefit of associating procedures to a common episode is that you only need to abstract episode detail information (pertaining to all procedures in one episode) one time. A patient may have multiple procedures per episode, and multiple episodes per visit.

NOTE: If ICD procedure codes have been entered for the patient through Outpatient Dispositioning before any entries have been made in the abstract, those codes from Outpatient Dispositioning will automatically display on the Procedures screen. However, future changes to the codes on the Outpatient Dispositioning screen do not update the abstract, nor do changes to the codes in the abstract update Outpatient Dispositioning.

Following are examples of the ICD-10 and ICD-9 Procedure Processor screens available once the US ICD-10 Effective Date is set, along with field explanations. The ICD-10 Procedure Processor is the primary screen. The ICD-9 Procedure Processor is the secondary screen, and is accessed through the ICD-10 Procedure Processor.

ICD-10 Procedure Summary

```
                  General Hospital Procedures Processor
                                                 Tue Mar 24, 2009 01:48 pm
    Account No     Name                         ICD    Unit No        Corp No
    0904200002     TONEY,TIM                    10     000-00-5885    00006552
ICD-10-PCS Code  Description                    Date/Time        Surgeon      AC
P  (1) HZ80ZZZ MEDICATION MANAGEMENT OF NICOTIN 02/11/09 07:00   ADAIR,CAR
   (2) 00160K0 0 Medical and Surgical|0 Central 02/11/09 07:00   TONGEN,LYLE
```

```
Select procedure to revise, View Charges(C), ICD-9(I), or add(A)--
                     next screen (/) or previous (/P) [/]
```

Field Explanations

[NO HEADING - LETTER]
There are six different code indicators that can display to the left of the ICD procedure code:

- **P** indicates the Principal procedure. The system considers the Principal procedure to be the first procedure entered. The **P** is displayed automatically.
- **M** indicates a Major procedure. A Major procedure may be more resource intensive than the other procedures and is the procedure being used in the calculation of the DRG. If the Principal procedure is the same as the Major procedure, only the **P** is displayed. The **M** displays after the codes are processed through the DRG grouper.
- **2** indicates an operative procedure that affects DRG assignment.
- **3** indicates an operative procedure that affects DRG assignment.
- **a** indicates a non-operative procedure that affects DRG assignment.
- **b** indicates a non-operative procedure that affects DRG assignment.

[NO HEADING - NUMBER]
This column displays the sequential number assigned to the code when it is added to this screen from the Procedure Detail screen. You select this number to access the Procedure Detail screen.

ICD-10-PCS CODE (DISPLAY ONLY)
This column displays the ICD-10-PCS procedure code entered on the ICD-10 Procedures Detail screen.

DESCRIPTION (DISPLAY ONLY)
This column displays the description associated with the ICD-10-PCS procedure code as found in the ICD-10-PCS maintenance file. You can alter the description when you are prompted for Alternate Descriptions on the DRG Assignment screen. The updated description is printed on the attestation form and abstract summary form.

DATE/TIME (DISPLAY ONLY)
This column displays the procedure date and time, which are used to group procedures together into episodes. All procedures that share the same date and time make up an episode. The patient can have multiple procedures pointing to the same episode date and time, since multiple procedures can be performed during a single visit to the operating room. The date and time are important because episode detail and procedure team information are stored at the episode level.

SURGEON (DISPLAY ONLY)
This column displays the primary surgeon associated with this procedure, as entered on the Procedure Detail screen.

AC (DISPLAY ONLY)
This column displays the anesthesia code entered on the Procedure Detail screen.

Once the codes are processed through the grouper (on STAR), they are resequenced so that those procedure codes affecting the DRG are all placed at the top of the list under the principal procedure, provided the Resequencing Parameter is defined in MR Abstract and DRG Census Criteria option.

The prompt displayed at the bottom of the screen gives you the following options:

- To update a procedure code and/or related information, or to delete a procedure code, select the option number to the left of the description. The Procedures Detail screen is displayed, enabling you to revise the information or delete the procedure. For details on deleting and revising a procedure, refer to the Procedure Detail Screen explanation below.

- To access the ICD-9 Procedure Processor screen from the ICD-10 Procedure Processor screen, enter **I**.

- To view the Patient Accounting charges posted to the patient's account, enter **C**. This option is valid only if your facility uses STAR Patient Accounting. For information on this option, see "VIEWING STAR PATIENT ACCOUNTING CHARGES" on page 1-23. The Charge screen is the same, whether you access it from the Procedures screen or HCPCS Procedures screen.

- To add a new procedure code, enter **A**. The Procedures Detail screen is displayed, enabling you to enter a new code and associated procedure information. Refer to the Procedure Detail Screen explanation below.

NOTE: If the STAR RES-Q OR Interface is active and the patient has OR cases assigned with post-operative information, the prompt also contains the option **S**, which enables you to select OR cases. Refer to the *STAR Patient Care, RES-Q OR Interface Guide* for further information.

Impact

After you accept this screen, the following takes place:

- Changes made to any of the procedure codes could affect the DRG assignment.

- Changes made to any of the procedure codes prompts the system to display the prompts accepting the DRG as final (if the patient has been discharged), and to print the attestation form and abstract summary form.

ICD-9 Procedure Summary

```
                  General Hospital Procedures Processor
                                              Tue Mar 24, 2009 01:32 pm
    Account No     Name                        ICD    Unit No        Corp No
    0904200002     TOMEY,TIM                   10     000-00-5885    00006552
       ICD-9-CM Code  Description     S Date/Time         Surgeon             AC
P  (1) 00.01 THER ULT HEAD & NECK VES   02/11/09 07:00    TONGEN,LYLE A        G
   (2) 00.02 THER ULTRASOUND OF HEART   02/11/09 07:00    TONGEN,LYLE A




Select procedure to revise, View Charges(C), ICD-10(T), or add(A)--
                      next screen (/) or previous (/P) [/]
```

Field Explanations

[NO HEADING - LETTER]
There are six different code indicators that can display to the left of the ICD procedure code:

- **P** indicates the Principal procedure. The system considers the Principal procedure to be the first procedure entered. The **P** is displayed automatically.

- **M** indicates a Major procedure. A Major procedure may be more resource intensive than the other procedures and is the procedure being used in the calculation of the DRG. If the Principal procedure is the same as the Major procedure, only the **P** is displayed. The **M** displays after the codes are processed through the DRG grouper.

- **2** indicates an operative procedure that affects DRG assignment.

- **3** indicates an operative procedure that affects DRG assignment.

- **a** indicates a non-operative procedure that affects DRG assignment.

- **b** indicates a non-operative procedure that affects DRG assignment.

[NO HEADING - NUMBER]
This column displays the sequential number assigned to the code when it is added to this screen from the Procedure Detail screen. You select this number to access the Procedure Detail screen.

ICD-9-CM CODE (DISPLAY ONLY)
This column displays the ICD-9-CM procedure code entered on the ICD-9 Procedures Detail screen.

DESCRIPTION (DISPLAY ONLY)
This column displays the description associated with the ICD-9-CM procedure code as found in the ICD-9-CM maintenance file. You can alter the description when you are prompted for Alternate Descriptions on the DRG Assignment screen. The updated description is printed on the attestation form and abstract summary form.

S (DISPLAY ONLY)
This column displays a code from the suffix field on the ICD-9 Procedures Detail screen.

DATE/TIME (DISPLAY ONLY)
This column displays the procedure date and time, which are used to group procedures together into episodes. All procedures that share the same date and time make up an episode. The patient can have multiple procedures pointing to the same episode date and time, since multiple procedures can be performed during a single visit to the operating room. The date and time are important because episode detail and procedure team information are stored at the episode level.

SURGEON (DISPLAY ONLY)
This column displays the primary surgeon associated with this procedure, as entered on the Procedure Detail screen.

AC (DISPLAY ONLY)
This column displays the anesthesia code entered on the Procedure Detail screen.

Once the codes are processed through the grouper (on STAR), they are resequenced so that those procedure codes affecting the DRG are all placed at the top of the list under the principal procedure, provided the Resequencing Parameter is defined in MR Abstract and DRG Census Criteria option.

The prompt displayed at the bottom of the screen gives you the following options:

- To update a procedure code and/or related information, or to delete a procedure code, select the option number to the left of the description. The Procedures Detail screen is displayed, enabling you to revise the information or delete the procedure. For details on deleting and revising a procedure, refer to the Procedure Detail Screen explanation below.

- To access the ICD-10 Procedure Processor screen from the ICD-9 Procedure Processor screen, enter **T**.

- To view the Patient Accounting charges posted to the patient's account, enter **C**. This option is valid only if your facility uses STAR Patient Accounting. For information on this option, see "VIEWING STAR PATIENT ACCOUNTING CHARGES" on page 1-23. The Charge screen is the same, whether you access it from the Procedures screen or HCPCS Procedures screen.

- To add a new procedure code, enter **A**. The Procedures Detail screen is displayed, enabling you to enter a new code and associated procedure information. Refer to the Procedure Detail Screen explanation below.

NOTE: If the STAR RES-Q OR Interface is active and the patient has OR cases assigned with post-operative information, the prompt also contains the option **S**, which enables you to select OR cases. Refer to the *STAR Patient Care, RES-Q OR Interface Guide* for further information.

Impact

After you accept this screen, the following takes place:

- Changes made to any of the procedure codes could affect the DRG assignment.

- Changes made to any of the procedure codes prompts the system to display the prompts accepting the DRG as final (if the patient has been discharged), and to print the attestation form and abstract summary form.

Procedure Detail Screen

The Procedure Detail screen is used to enter procedures, revise existing information displayed on the Procedure Summary screen, or to delete a procedure. Following are Procedure Detail screen examples and field definitions for both ICD-10 and ICD-9.

ICD-10 Procedure Detail

```
                General Hospital Procedures Processor
                                                Tue Mar 24, 2009 01:24 pm
   Account No     Name                          ICD    Unit No        Corp No
   0904200002     TOMEY,TIM                     10     000-00-5885    00006552
 1 Episode Date & Time        2 ICD-10-PCS Code
   02/11/09 07:00               HZ80ZZZ
 3 ICD-10-PCS Description
   MEDICATION MANAGEMENT OF NICOTINE REPLACEMENT
 4 Surgeon                    5 Specialty                  6 Tissue Code
   ADAIR,CAR                    020 Medical Division      ->
 7 Anesth Code                8 Anesthetist

 9 Anesth Start Time         10 Anesth End Time           11 Anesth Duration

12 ASA-PS Class              13 Other Institution        14 Procedure Team Info

15 Epis Location            16 Epis End Date/Time        17 Episode Duration

18 Rec Location             19 Rec Start Date/Time       20 Rec End Date/Time



Enter table code or `=` for previous code--
```

To remove the procedure, press ENTER until the following prompt is displayed:

Delete? [N]--

Enter **Y** for Yes. The system removes the procedure from the system and redisplays the Procedures Summary screen, where you can select or add another procedure.

Field Explanations

1. EPISODE DATE & TIME (CONDITIONAL: TABLE LOOKUP OR DATE/TIME FORMAT-R)
This field enables you to associate the procedure with an episode. The benefit of grouping procedures to an episode is that you need to enter episode detail only once.

NOTE: You cannot mark the abstract complete unless dates are entered for procedures.

You have the following entry options:

- If this is a new episode, enter the date and time.

- If there are previous episodes (ICD-9-CM or HCPCS) on file for this patient visit, enter a hyphen (-) to display all episode dates and times previously entered, and select an entry from the listing.

- If you have just added a code, enter an equal sign (=) to bring forward the previously entered date.

If you enter a date and time that is not within three days of the admission date, the system displays the following error message, indicating the specific admission date:

Error: Date must be within 3 days of admission date of 12/10/01!

If you enter a date and time that is after the discharge date, the system displays the following error message, indicating the specific discharge date:

Error: Date cannot be after discharge date of 01/26/02!

For example, if the patient's admission date is 12/10 and the discharge date is 01/26, you can enter a date between 12/07 and 01/26, including these dates.

NOTE: It is assumed that the episode date and time are the date and time that the episode *begins*. This field is used with the Epis End Date/Time field to calculate the episode's duration. The default time is 700am.

2. ICD-10-PCS CODE (TABLE LOOKUP-R)
If you are revising a procedure, this field displays the code selected from the Procedure Summary screen. To add to or revise this field, enter an ICD-10-PCS procedure code using one of the following entry options:

- Enter the ICD-10-PCS procedure code if you know it.

- Enter **U** followed by a hyphen (**-**) to display the entire procedure pointer table in alphabetic order. Make your selection from this table.

- Enter **U,** followed by an alpha character or characters, then a hyphen (for example, **UA-** or **UB-**) to display the pointer table that begins with the specific alpha character. For example, entering **UAN-** might cause the codes for anastomosis, anesthesia, or angioplasty to display if they have been built into the pointer table. Make your selection from this table.

- Enter a number (or numbers) and a hyphen to display the table by specific numeric range of codes. For example, if you know that the code you are searching for begins with 22, enter **22-** and all the codes beginning with 22.0 are displayed. Make your selection from this table.

- Enter a hyphen (**-**) to display the entire table in numeric code order, starting with 01.0. Make your selection from this table.

3. ICD-10-PCS DESCRIPTION (DISPLAY ONLY)
This field contains the description associated with the ICD-10-PCS code.

4. SURGEON (TABLE LOOKUP-R)
This field requires an entry of the primary surgeon associated with this procedure code.

To enter a surgeon, perform one of these entry options:

- Enter the physician code.
- Enter a hyphen (**-**) to displays the Physicians table to select a physician from the table.
- Enter the letter(s) the name begins with followed by a hyphen (**-**) to limit the search.
- Enter a **D** to delete the surgeon name and specialty if the surgeon is not required for this procedure code.

NOTE: This field does not allow the entry of a physicians group code.

5. SPECIALTY (TABLE LOOKUP-R)
This field enables entry of the surgeon's specialty. Press ENTER to accept the default of the Primary Specialty associated with this physician in the Physician table. Enter a hyphen (-) to access the Specialty codes linked to this physician in the Physician table, or take the default. The default response for this field is the Primary Specialty of this physician as defined in the Physician table. When you delete the surgeon, the system automatically deletes the specialty.

6. TISSUE CODE (TABLE LOOKUP-O)
This field identifies the pathological status of the tissue (if any) removed during this procedure. Enter the code or a hyphen (-) to access the Tissue code table for selection. Each procedure code in an episode has its own tissue type (if applicable).

7. ANESTH CODE (TABLE LOOKUP-O)
This field identifies the type of anesthesia used for this procedure. Enter the code or a hyphen (-) to access the Anesthesia code table for selection. Each procedure code in an episode has its own anesthesia code (if applicable).

8. ANESTHETIST (CONDITIONAL-O)
This field enables entry of the primary anesthetist or anesthesiologist for this procedure. To enter the anesthetist/anesthesiologist, perform one of these options:

- Enter the physician code.
- Enter a hyphen (**-**) to display the Physicians table to select a physician from the table.
- Enter the letter(s) the name begins with followed by a hyphen (**-**) to limit the search.

9. ANESTH START TIME (TIME ENTRY-O)
This field enables you to enter the time the administration of the anesthesia began.

10. ANESTH END TIME (TIME ENTRY-O)
This field enables you to enter the time the administration of the anesthesia ended.

11. ANESTH DURATION (DISPLAY ONLY)
This field displays the total duration time (in minutes) of the anesthesia and is automatically calculated based on the information entered in the Anesth Start Time and Anesth End Time fields.

12. ASA-PS CLASS (3-AN-O)
This field enables you to associate an ASA-PS (American Society of Anesthesia - Physical Status) Classification with the Anesthesia code. Enter the code or enter a hyphen (-) to access the ASA-PS Class code table for selection.

13. OTHER INSTITUTION (TABLE LOOKUP)
This field is used to indicate if this procedure was performed at another institution during the patient's stay at your facility. If this procedure was performed at another facility, enter the code or enter a hyphen (-) to access the Referring Facility/Institution code table for selection. If this procedure was not performed at another facility, leave this field blank.

14. PROCEDURE TEAM INFORMATION (TABLE LOOKUP-O)
This field enables you to identify any other members of the operative/procedure team. If this field is empty when you re-access the Procedure Detail screen after completing all other fields, you must enter a slash and the field number (/20) to access the scrolling screen.

When you access the Procedure Team Information field, the system displays a scrolling screen beneath the first three fields of the Procedure Detail screen for entry/ edits.

15. EPIS LOCATION (TABLE LOOKUP)
This field identifies the room/location where the procedure(s) was performed. Enter the Revenue Center code, enter a hyphen (-) to access the Revenue Center code table for selection, or enter a number preceeded by a dash.

16. EPIS END DATE/TIME (DATE/TIME FORMAT)
This field identifies the date and time this episode ended. It is possible for an episode to begin on one date and end on another. Therefore, the system does not default the date to the episode start date.

17. EPIS DURATION (DISPLAY ONLY)
This field is automatically calculated based on the information entered in the Epis Date & Time and Epis End Date/Time fields.

18. REC LOCATION (TABLE LOOKUP)
This field identifies the room/location where the patient recovered from the procedure episode. Enter the code, enter a hyphen (-) to access the Revenue Center code table for selection, or enter a number preceeded by a dash.

19. REC START DATE/TIME (DATE/TIME FORMAT-O)
This field identifies the date and time the recovery began.

20. REC END DATE/TIME (DATE/TIME FORMAT-O)
This field identifies the date and time the recovery ended. It is possible for recovery to begin on one date and end on another. Therefore, the system does not default the date to the recovery start date.

ICD-9 Procedure Detail

```
                General Hospital Procedures Processor
                                              Tue Mar 24, 2009 01:32 pm
   Account No     Name                        ICD    Unit No        Corp No
   0904200002     TOMEY,TIM                   10     000-00-5885    00006552
 1 Epis Date & Time     2 Procedure Code                        3 Suffix
   02/11/09 07:00         00.01-THER ULT HEAD & NECK VES       ->
 4 Surgeon                  5 Specialty                   6 Tissue Code
   TONGEN,LYLE A              120 Surgical
 7 Anesth Code              8 Anesthetist
   GENERAL                    10 COLEMAN,MICHAEL K
 9 Anesth Start Time       10 Anesth End Time           11 Anesth Duration

12 ASA-PS Class            13 Other Institution

14 Epis Location          15 Epis End Date/Time        16 Episode Duration

17 Rec Location           18 Rec Start Date/Time       19 Rec End Date/Time

20 Procedure Team Information


Enter procedure suffix--  |
```

To remove the procedure, press ENTER until the following prompt is displayed:

Delete? [N]--

Enter **Y** for Yes. The system removes the procedure from the system and redisplays the Procedures Summary screen, where you can select or add another procedure.

Field Explanations

1. EPIS DATE & TIME (CONDITIONAL: TABLE LOOKUP OR DATE/TIME FORMAT-R)
This field enables you to associate the procedure with an episode. The benefit of grouping procedures to an episode is that you need to enter episode detail only once.

NOTE: You cannot mark the abstract complete unless dates are entered for procedures.

You have the following entry options:

- If this is a new episode, enter the date and time.
- If there are previous episodes (ICD-9-CM or HCPCS) on file for this patient visit, enter a hyphen (-) to display all episode dates and times previously entered, and select an entry from the listing.
- If you have just added a code, enter an equal sign (=) to bring forward the previously entered date.

NOTE: If you are using the 3M Coding and Reimbursement Interface, STAR automatically defaults the episode time to 7:00 am because procedure time cannot be entered in 3M. You can update the episode date and time can be manually updated in this field.

If you enter a date and time that is not within three days of the admission date, the system displays the following error message, indicating the specific admission date:

Error: Date must be within 3 days of admission date of 12/10/01!

If you enter a date and time that is after the discharge date, the system displays the following error message, indicating the specific discharge date:

Error: Date cannot be after discharge date of 01/26/02!

For example, if the patient's admission date is 12/10 and the discharge date is 01/26, you can enter a date between 12/07 and 01/26, including these dates.

NOTE: It is assumed that the episode date and time are the date and time that the episode *begins*. This field is used with the Epis End Date/Time field to calculate the episode's duration. The default time is 700am.

2. PROCEDURE CODE (34-AN-R)

If you are revising a procedure, this field displays the code selected from the Procedure Summary screen. To add to or revise this field, enter an ICD-9-CM procedure code using one of the following entry options:

- Enter the ICD-9-CM procedure code if you know it.
- Enter **U** followed by a hyphen (**-**) to display the entire procedure pointer table in alphabetic order. Make your selection from this table.
- Enter **U,** followed by an alpha character or characters, then a hyphen (for example, **UA-** or **UB-**) to display the pointer table that begins with the specific alpha

character. For example, entering **UAN-** might cause the codes for anastomosis, anesthesia, or angioplasty to display if they have been built into the pointer table. Make your selection from this table.

- Enter a number (or numbers) and a hyphen to display the table by specific numeric range of codes. For example, if you know that the code you are searching for begins with 22, enter **22-** and all the codes beginning with 22.0 are displayed. Make your selection from this table.

- Enter a hyphen (**-**) to display the entire table in numeric code order, starting with 01.0. Make your selection from this table.

3. SUFFIX (1-C-O)
This field enables you to enter a suffix for this code.

4. SURGEON (TABLE LOOKUP-R)
This field requires an entry of the primary surgeon associated with this procedure code.

To enter a surgeon, perform one of these entry options:

- Enter the physician code.

- Enter a hyphen (**-**) to displays the Physicians table to select a physician from the table.

- Enter the letter(s) the name begins with followed by a hyphen (**-**) to limit the search.

- Enter a **D** to delete the surgeon name and specialty if the surgeon is not required for this procedure code.

NOTE: This field does not allow the entry of a physicians group code.

5. SPECIALTY (TABLE LOOKUP-R)
This field enables entry of the surgeon's specialty. Press ENTER to accept the default of the Primary Specialty associated with this physician in the Physician table. Enter a hyphen (-) to access the Specialty codes linked to this physician in the Physician table, or take the default. The default response for this field is the Primary Specialty of this physician as defined in the Physician table. When you delete the surgeon, the system automatically deletes the specialty.

6. TISSUE CODE (TABLE LOOKUP-O)
This field identifies the pathological status of the tissue (if any) removed during this procedure. Enter the code or a hyphen (-) to access the Tissue code table for selection. Each procedure code in an episode has its own tissue type (if applicable).

7. ANESTH CODE (TABLE LOOKUP-O)
This field identifies the type of anesthesia used for this procedure. Enter the code or a hyphen (-) to access the Anesthesia code table for selection. Each procedure code in an episode has its own anesthesia code (if applicable).

8. ANESTHETIST (CONDITIONAL-O)
This field enables entry of the primary anesthetist or anesthesiologist for this procedure. To enter the anesthetist/anesthesiologist, perform one of these options:

- Enter the physician code.
- Enter a hyphen (**-**) to display the Physicians table to select a physician from the table.
- Enter the letter(s) the name begins with followed by a hyphen (**-**) to limit the search.

9. ANESTH START TIME (TIME ENTRY-O)
This field enables you to enter the time the administration of the anesthesia began.

10. ANESTH END TIME (TIME ENTRY-O)
This field enables you to enter the time the administration of the anesthesia ended.

11. ANESTH DURATION (DISPLAY ONLY)
This field displays the total duration time (in minutes) of the anesthesia and is automatically calculated based on the information entered in the Anesth Start Time and Anesth End Time fields.

12. ASA-PS CLASS (3-AN-O)
This field enables you to associate an ASA-PS (American Society of Anesthesia - Physical Status) Classification with the Anesthesia code. Enter the code or enter a hyphen (-) to access the ASA-PS Class code table for selection.

13. OTHER INSTITUTION (TABLE LOOKUP)
This field is used to indicate if this procedure was performed at another institution during the patient's stay at your facility. If this procedure was performed at another facility, enter the code or enter a hyphen (-) to access the Referring Facility/Institution code table for selection. If this procedure was not performed at another facility, leave this field blank.

14. EPIS LOCATION (TABLE LOOKUP)
This field identifies the room/location where the procedure(s) was performed. Enter the Revenue Center code, enter a hyphen (-) to access the Revenue Center code table for selection, or enter a number preceeded by a dash.

15. EPIS END DATE/TIME (DATE/TIME FORMAT)
This field identifies the date and time this episode ended. It is possible for an episode to begin on one date and end on another. Therefore, the system does not default the date to the episode start date.

16. EPIS DURATION (DISPLAY ONLY)
This field is automatically calculated based on the information entered in the Epis Date & Time and Epis End Date/Time fields.

17. REC LOCATION (TABLE LOOKUP)
This field identifies the room/location where the patient recovered from the procedure episode. Enter the code, enter a hyphen (-) to access the Revenue Center code table for selection, or enter a number preceeded by a dash.

18. REC START DATE/TIME (DATE/TIME FORMAT-O)
This field identifies the date and time the recovery began.

19. REC END DATE/TIME (DATE/TIME FORMAT-O)
This field identifies the date and time the recovery ended. It is possible for recovery to begin on one date and end on another. Therefore, the system does not default the date to the recovery start date.

20. PROCEDURE TEAM INFORMATION (TABLE LOOKUP-O)
This field enables you to identify any other members of the operative/procedure team. If this field is empty when you re-access the Procedure Detail screen after completing all other fields, you must enter a slash and the field number (/20) to access the scrolling screen.

When you access the Procedure Team Information field, the system displays a scrolling screen beneath the first row of Procedure Detail screen fields for entry/edits:

```
                  General Hospital Procedures Processor
                                                Tue Mar 24, 2009 02:13 pm
   Account No     Name                          ICD    Unit No        Corp No
   0904200002     TOMEY,TIM                     10     000-00-5885    00006552
1 Episode Date & Time        2 ICD-10-PCS Code
  02/11/09 07:00               00160K0
No       Procedure Team Member              Specialty              Type
1        ADAIR,FRANK K                      SURGICAL               SURGEON
2        ADAMS,JAY M                        FAMILY PRACTICE        ANESTHETIST
3        ALAHYAR,MARI                       INTERNAL MEDICINE      PHYS ADD









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

Subscreen Field Explanations

The first two (ICD-10) or three (ICD-9) fields are display-only when they appear on the scrolling screen. For explanations, refer to the preceding discussion of the Procedures Details screen.

NO (DISPLAY ONLY)
The system automatically assigns a number to each procedure team member as they are added.

PROCEDURE TEAM MEMBER (TABLE LOOKUP)
This column is for entry of any member of the team participating in the procedure/ operative episode. All entries in this field are associated with the episode. This means all procedure codes entered for this episode have these procedure team members associated with it. Enter a member using one of these options:

- Enter the physician code.
- Enter a hyphen (**-**) to display the Physicians table to select a physician from the table.
- Enter the letter(s) the name begins with followed by a hyphen (**-**) to limit the search.

SPECIALTY (TABLE LOOKUP)
This field identifies the specialty associated with the team member. Enter the code, or enter a hyphen (-) to access the Specialty codes linked to this physician in the Physician table, or take the default. The default response for this field is the Primary Specialty of this physician as defined in the Physician table. When you delete the surgeon, the system automatically deletes the specialty.

TYPE (TABLE LOOKUP)
This field identifies the role or type of member. Enter the code or a hyphen (-) to access the Physician Type table for selection. The Physician Type table can include entries such as, Assistant 1, Assistant 2, Surgical Resident, Anesthetist, Anesthesiologist, etc., to enable identification of the role each procedure member has had in this episode.

Key	Function
F1Prev Page	Move to previous pages of entered information.
F2Next Page	Move to additional pages of entered information.
F3 Insert	Enter additional lines of information between defined entries.
F4 Delete	Delete lines of information from between defined entries.
F6 Reset	Reset the screen, clearing all previously entered information.
F7 Exit	Accept your responses and exit the scrolling screen.

The Procedure Team Information field contains the text "Team Data Entered."

When you have completed all appropriate fields on the Procedures Detail screen, press ENTER. The system displays the following prompt:

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

This prompt gives you these entry options:

- Enter **Y** or press ENTER for Yes to accept the screen. If you enter **Y**, the system stores your additions or changes and redisplays the Procedures Summary screen, where you can select another procedure to revise or delete, or add another procedure.

- Enter **N** for No to return to the Procedure Detail screen for additional revisions.

- Press **D** for Delete to delete the procedure. If you enter **D**, the system removes the procedure from the system and redisplays the Procedures Summary screen, where you can select another procedure to revise or delete, or add another procedure.

NOTE: Because the 3M Coding and Reimbursement System does not accommodate procedure detail information (for example, anesthesia, tissue, etc.), this information is lost when you add it on STAR and then access 3M. Procedure codes, surgeon, and procedure date are retained.

After you complete your additions or revisions and exit the Procedure Detail screen, the system redisplays the Procedure Summary screen with the following prompt:

Select procedure to revise, View Charges(C), ICD-9(I), or add(A)--
next screen (/) or previous (/P) [/]

You can revise or add another procedure by making the appropriate entry. To exit the Procedure Summary screen, press ENTER. The following prompt displays:

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

Enter **Y** or press ENTER for Yes to accept the screen and process the additions or changes you entered on the Procedure Detail screen. Enter **N** for No to return to the Procedure Summary screen for additional revisions.

DRG ASSIGNMENT RESULTS SCREEN

The DRG Assignment Results screen displays output from the DRG Groupers used for inpatient accounts. None of the fields on these screens can be edited. The DRG Assignment screens that display are determined by the other payor code(s) assigned to the account. See DRG Assignment Screens for Other Payor Codes in Chapter 4 of the *STAR Patient Care Reference Guide - Tables Volume*.

The following is an example of a STAR Medicare DRG Assignment Results screen. For DRGs calculated in STAR, when a principal diagnosis is entered, a Provisional DRG is calculated and displayed in Field 8 and Field 24. At the time of discharge, Provisional DRG changes to Final DRG indicating that this DRG can now be accepted for billing purposes. If any changes are made to the information regarding financial class, diagnoses, procedures, age, sex, transfer, or disposition of the patient information during the abstracting sequence, the DRG is recalculated and any changes are reflected on this screen and throughout the system.

```
              General Hospital DRG Assignment Processor
              DRG Results          Page  4 of  4 Thu Apr 09, 2009 01:25 pm
    Account No     Name                        ICD    Unit No        Corp No
    0827100005     BRADLEY,GROUPER             10     000-00-5937    00006675
 1 DRG Payor            2 Table No  3 Age    4 Sex     5 Dischg Disposition
   MEDICARE               21          84Y      FEMALE    SKILLED NURSING FACI
 6 Major Diagnostic Category                             7 FINAL ACCEPT DATE
   05 DISEASES/DISORDERS OF THE CIRCULATORY SYSTEM
 8 DRG/VER `FINAL`                       9 LOS    10 Std LOS  11 LOS Threshold
   221 V26.0 CARDIAC VALVE & OTH MAJ CARD  1          6.00        0.00
12 DRG Weight 13 Reimb.      14 Cost Threshold   15 Charges     16 Variance
      4.38690      20076.35       11637.82               0.00       20076.35
17 Principal Diagnosis               18 Complication/Comorbidity
   424.1  AORTIC VALVE DISORDER
19 Grouper Diagnosis 1               20 Grouper Diagnosis 2

21 Grouper Major Procedure           22 Outlier Indication
   35.22  REPLACE AORTIC VALVE NEC
23 Admit DRG                         24 Provisional DRG



Enter Alternate DRG's(A)/Standards(S)/Reimbursement(R)/HAC(H)--  |
                 next screen (/) or previous screen (/P) [/]
```

NOTE: If you are using the 3M Coding and Reimbursement System for this patient's payor, please refer to Chapter 9: RCS Update of the *STAR/3M Coding and Reimbursement Interface Reference Guide* for processing of this screen.

Field Explanations

1. DRG PAYOR (DISPLAY ONLY)
The DRG Payor is assigned in either the DRG Payor Table (if prior to Release 15.0) or in the Financial Classes Table.

NOTE: If this screen is being viewed through the Abstract Inquiry function, this field displays the information that was used the last time the DRG Assignment

screen was accessed in the M/R Abstracting or DRG Assignment character-based functions or the last time the DRG was calculated in GUI Abstracting.

2. TABLE NO (DISPLAY ONLY)
This field contains the current Rate Master table being accessed based on the patient's discharge date (or today's date if not discharged). (See DRG Rate Master Maintenance in the *STAR Patient Care Reference Guide, DRG Assignment Module*.)

NOTE: If this screen is being viewed through the Abstract Inquiry function, this field displays the information that was used the last time the DRG Assignment screen was accessed in the M/R Abstracting or DRG Assignment character-based functions or the last time the DRG was calculated in GUI Abstracting.

3. AGE (DISPLAY ONLY)
This field displays the patient's age at the time of admission as entered during the admission sequence, or reflects changes made to the birthdate while editing the MPI or abstract for this visit. The age is displayed in years only, and does not reflect months or days.

NOTE: If this screen is being viewed through the Abstract Inquiry function, this field displays *current* information rather than the information from the last calculation of the DRG.

4. SEX (DISPLAY ONLY)
This field displays the patient's sex as entered during the admission sequence, or reflects any change made during the abstracting process.

NOTE: If this screen is being viewed through the Abstract Inquiry function, this field displays *current* information rather than the information from the last calculation of the DRG.

5. DISCHG DISPOSITION (DISPLAY ONLY)
This field contains the patient's discharge disposition (if the patient has been discharged). If the patient is still in-house, this field remains blank and the system assumes the disposition of Home-Self Care in calculating the DRG.

NOTE: If this screen is being viewed through the Abstract Inquiry function, this field displays *current* information rather than the information from the last calculation of the DRG.

6. MAJOR DIAGNOSTIC CATEGORY (DISPLAY ONLY)
This field contains the Major Diagnostic Category into which this patient's DRG has been grouped.

NOTE: If this screen is being viewed through the Abstract Inquiry function, this field displays the information that was used the last time the DRG Assignment screen was accessed in the M/R Abstracting or DRG Assignment character-based functions or the last time the DRG was calculated in GUI Abstracting.

7. FINAL ACCEPT DATE (DISPLAY ONLY)
This field contains the date the DRG is accepted as final.

NOTE: If this screen is being viewed through the Abstract Inquiry function, this field displays the information that was used the last time the DRG Assignment screen was accessed in the M/R Abstracting or DRG Assignment character-based functions or the last time the DRG was calculated in GUI Abstracting.

8. DRG/VER PROVISIONAL (OR FINAL) (DISPLAY ONLY)
This field contains the current DRG number, version number (for DRG version 26 and later) and description calculated based on all the information collected. At the time of the patient's discharge, this field name changes to DRG FINAL, allowing the DRG to be accepted for billing.

NOTE: If this screen is being viewed through the Abstract Inquiry function, this field displays the information that was used the last time the DRG Assignment screen was accessed in the M/R Abstracting or DRG Assignment character-based functions or the last time the DRG was calculated in GUI Abstracting.

9. LOS (DISPLAY ONLY)
This field contains the patient's actual length of stay in the facility.

NOTE: If this screen is being viewed through the Abstract Inquiry function, this field displays *current* information rather than the information from the last calculation of the DRG.

10. STD LOS (DISPLAY ONLY)
This field contains the geometric length of stay associated with this particular DRG.

NOTE: If this screen is being viewed through the Abstract Inquiry function, this field displays the information that was used the last time the DRG Assignment screen was accessed in the M/R Abstracting or DRG Assignment character-based functions or the last time the DRG was calculated in GUI Abstracting.

11. LOS THRESHOLD (DISPLAY ONLY)
The number in this field indicates the number of days at which the DRG becomes a Stay Outlier. For example, for the DRG shown on the previous screen, when a LOS of 35 days is reached, the DRG becomes a Stay Outlier, indicating that the hospital may receive additional reimbursement on this case.

NOTE: Beginning with Grouper Version 15.0, effective October 1, 1997, CMS eliminated high stay outlier reimbursement; therefore, this field displays a value of zero.

If this screen is being viewed through the Abstract Inquiry function, this field displays the information that was used the last time the DRG Assignment screen was accessed in the M/R Abstracting or DRG Assignment character-based functions or the last time the DRG was calculated in GUI Abstracting.

12. DRG WEIGHT (DISPLAY ONLY)
This is the weight of the DRG as assigned by CMS (the Centers for Medicare and Medicaid Services). This weight is a value used as a multiplier in calculating a hospital's reimbursement for a particular DRG.

NOTE: If this screen is being viewed through the Abstract Inquiry function, this field displays the information that was used the last time the DRG Assignment screen was accessed in the M/R Abstracting or DRG Assignment character-based functions or the last time the DRG was calculated in GUI Abstracting.

13. REIMB. (DISPLAY ONLY)
This is the dollar amount of the calculated payment for this DRG for your facility.

NOTE: If this screen is being viewed through the Abstract Inquiry function, this field displays the information that was used the last time the DRG Assignment screen was accessed in the M/R Abstracting or DRG Assignment character-based functions or the last time the DRG was calculated in GUI Abstracting.

14. COST THRESHOLD (DISPLAY ONLY)
The number that is displayed in this field indicates the dollar amount that the system uses in determining whether this case should be considered as a possible cost outlier. If a patient's standardized costs are greater than the cost outlier threshold, the patient is passed through the calculations to determine if this is in fact a cost outlier.

NOTE: If this screen is being viewed through the Abstract Inquiry function, this field displays *current* information rather than the information from the last calculation of the DRG.

15. CHARGES (DISPLAY ONLY)
This field contains the dollar amount of all charges ordered for this patient and is updated online. For example, this amount would contain any Room and Bed Charges.

NOTE: If this screen is being viewed through the Abstract Inquiry function, this field displays *current* information rather than the information from the last calculation of the DRG.

16. VARIANCE (DISPLAY ONLY)
The number that displays in this field is the dollar difference between the accumulated total charges and the expected reimbursement. For example, Reimbursement minus Charges equals Variance.

NOTE: If this screen is being viewed through the Abstract Inquiry function, this field displays *current* information rather than the information from the last calculation of the DRG.

17. PRINCIPAL DIAGNOSIS (DISPLAY ONLY)
The Principal diagnosis that displays in this field is the current principal diagnosis entered on either the Diagnosis screen in the abstracting sequence, or the DRG Assignment function.

NOTE: If this screen is being viewed through the Abstract Inquiry function, this field displays *current* information rather than the information from the last calculation of the DRG.

18. COMPLICATION/COMORBIDITY (DISPLAY ONLY)
A complication is any condition that arises while the patient is in the hospital. A comorbidity is any condition that existed prior to the patient's admission to the hospital. If there is a complication/comorbidity (C/C) affecting this DRG, it displays in this field.

NOTE: If this screen is being viewed through the Abstract Inquiry function, this field displays the information that was used the last time the DRG Assignment screen was accessed in the M/R Abstracting or DRG Assignment character-based functions or the last time the DRG was calculated in GUI Abstracting.

19. GROUPER DIAGNOSIS 1 (DISPLAY ONLY)
A diagnosis displays in this field when a coronary DRG is involved with three conditions rather than just the primary and secondary.

NOTE: If this screen is being viewed through the Abstract Inquiry function, this field displays the information that was used the last time the DRG Assignment screen was accessed in the M/R Abstracting or DRG Assignment character-based functions or the last time the DRG was calculated in GUI Abstracting.

20. GROUPER DIAGNOSIS 2 (DISPLAY ONLY)
A diagnosis displays in this field when a coronary DRG is involved with three conditions rather than just the primary and secondary.

NOTE: If this screen is being viewed through the Abstract Inquiry function, this field displays the information that was used the last time the DRG Assignment screen was accessed in the M/R Abstracting or DRG Assignment character-based functions or the last time the DRG was calculated in GUI Abstracting.

21. GROUPER MAJOR PROCEDURE (DISPLAY ONLY)
The procedure that displays in this field is the procedure the grouper has determined to be the most resource intensive, and is being used in the calculation of the DRG.

NOTE: If this screen is being viewed through the Abstract Inquiry function, this field displays the information that was used the last time the DRG Assignment screen was accessed in the M/R Abstracting or DRG Assignment character-based functions or the last time the DRG was calculated in GUI Abstracting.

22. OUTLIER INDICATION (DISPLAY ONLY)
If the DRG surpasses the LOS Threshold, High Stay displays in this field. If the DRG surpasses Cost Threshold, Cost displays in this field. If both the LOS and the Charge Thresholds are surpassed, the one that pays the highest reimbursement is what displays in this field.

NOTE: Beginning with Grouper Version 15.0, effective October 1, 1997, CMS eliminated high stay outlier reimbursement.

If this screen is being viewed through the Abstract Inquiry function, this field displays the information that was used the last time the DRG Assignment screen was accessed in the M/R Abstracting or DRG Assignment character-based functions or the last time the DRG was calculated in GUI Abstracting.

23. ADMIT DRG (DISPLAY ONLY)
This field contains the DRG calculated based on the admitting diagnosis. If the admit diagnosis is updated, the Admit DRG is updated accordingly.

NOTE: If this screen is being viewed through the Abstract Inquiry function, this field displays the information that was used the last time the DRG Assignment screen was accessed in the M/R Abstracting or DRG Assignment character-based functions or the last time the DRG was calculated in GUI Abstracting.

24. PROVISIONAL DRG (DISPLAY ONLY)
This field displays the same DRG that is displayed in the DRG Provisional field until a change is made to the information which in turn changes the DRG. If the DRG changes, the previous DRG moves to this field and remains a Provisional DRG, while the new DRG displays in the DRG Provisional field.

NOTE: If this screen is being viewed through the Abstract Inquiry function, this field displays the information that was used the last time the DRG Assignment screen was accessed in the M/R Abstracting or DRG Assignment character-based functions or the last time the DRG was calculated in GUI Abstracting.

You are prompted to choose one of the following actions:

- press **A** if you want the Alternate DRGs screen to display
- press **S** if you want the DRG Standards screen to display
- press **R** if you want to view additional reimbursement information
- press **H** if you want to view Hospital Acquired Condition (HAC) details.

Alternate DRGs

If you press **A**, the Alternate DRGs screen displays:

```
                General Hospital DRG Assignment Processor
                                                Wed Jul 10, 1996 05:40 pm
 Account No   Name                              Age  Sex    Dischg Dispositn
 89046-00001  DOE,JOHN R                        38Y  MALE
 DRG Payor: MEDICARE                LOS: 21
              Diagnosis                    DRG  Weight  StdLOS  Reimbursement
  (1) 540.0 *AC APPEND W PERITONITIS       164  2.4065  11.20      7586.05
  (2) 401.0 *MALIGNANT HYPERTENSION        468  3.3045  12.50     10416.82
  (3) 574.11 *CHOLELIT/GB INF NEC-OBS      201  2.4875   9.00      7841.38









Select new Principal Diagnosis--
```

This screen displays the DRG, Weight, Standard Length of Stay (LOS), and the Reimbursement amount of all diagnoses entered as if they were the Principal diagnosis. You are prompted to select a new principal diagnosis. If you choose to enter a new principal diagnosis, the system automatically changes the display on the Diagnosis screen and recalculates the patient's DRG. This screen enables you to maximize the DRG reimbursement when appropriate.

Press ENTER after viewing this screen to return to the DRG Assignment screen.

NOTE: If this patient's payor uses 3M's Coding and Reimbursement System, you do not have the option to view Alternate DRGs.

Impact

After you accept this screen, the following takes place:

- Selection of a new principal diagnosis could affect the DRG assignment.
- Selection of a new principal diagnosis displays on the Diagnoses Processor screen.

DRG Standards

If you press **S**, the DRG Standards screen displays:

```
                General Hospital DRG Assignment Processor
              DRG Results          Page  4 of  4 Thu Apr 09, 2009 06:31 pm
    Account No     Name                          ICD    Unit No        Corp No
    0824600003     DONER,ABIGAIL                 9      000-00-5811    00006478
                              Hospital Comparisons

 1 Budget LOS      2 Total LOS       3 LOS Variance
     10.0              9.0               1.0
 4 Budget Charges  5 Total Charges   6 Charge Variance
     2947.74           4120.65           -1172.91
 7 Budget Cost     8 Total Cost      9 Cost Variance
     2358.19           3296.52           -1172.91

                                Payor Comparisons

10 LOS Threshold           11 Total LOS           12 LOS Variance
    26.00                      9.0                    17.00
13 Charge Threshold        14 Total Charges       15 Charge Variance
     19646.50                  4120.65                15525.85
16 DRG Cost Threshold      17 Total Cost          18 Cost Variance
     12129.75                  3296.52                8833.23

Press NL--
```

NOTE: If this patient's payor uses the 3M Coding and Reimbursement System, you do not have the option to view DRG Standards.

This screen displays the Hospital and DRG Payor comparisons for the patient's DRG. The payor comparisons (on the lower portion of the screen) are derived by comparing the patient's charges and LOS information against the reimbursement and LOS information held in the rate master for the patient's payor. (See Rate Master Maintenance in the *STAR Patient Care Reference Guide, DRG Assignment Module*.)

The Hospital Comparisons provide you with a mechanism to compare the patient's charge, cost, and length of stay information with hospital-specific standards. This budgeted information can be based on figures entered manually by the hospital or by averages accumulated by the system and averaged over a hospital-defined length of time. The patient's actual data is compared with these figures, and the variances are calculated. (See Budget Maintenance in the *STAR Patient Care Reference Guide, DRG Assignment Module*.)

Field Explanations

All the fields on this screen are display only. Fields 2, 5, and 8 represent the length of stay, total charges, and total costs associated with this episode of care. The length of stay is incremented by one day each night during processing and represents the current length of stay up until discharge. The Patient Charges and Cost fields are updated online and reflect all charge activity for the patient. The total charges in Field 5 are identical to the charge summary for the patient when accessed via the Patient

Care Charge Inquiry function. Total costs are derived using the Charge/Cost Ratios determined for each department (see Tables).

Fields 11, 14, and 17 are identical to Fields 2, 5, and 8, and are repeated for your convenience.

Fields 1, 4, and 7 are the budget or standard length of stay, charges, and cost information determined by the hospital for this particular DRG.

Fields 10, 13, and 16 are the length of stay, charge and cost thresholds set by Medicare for stay or cost outlier determinations for this particular DRG.

The six variance fields (3, 6, 9, 12, 15, and 18) are the mathematical differences between the respective two preceding fields. A negative number indicates that the patient has exceeded the standard or threshold for this DRG.

Pressing ENTER after viewing this screen returns you to the DRG Assignment screen.

Reimbursement Information

If you press **R** to view reimbursement information, the following screen is displayed:

```
                General Hospital DRG Assignment Processor
            DRG Results          Page  4 of  4 Thu Apr 09, 2009 06:31 pm
   Account No     Name                          ICD    Unit No        Corp No
   0824600003     DONER,ABIGAIL                 9      000-00-5811    00006478
                      DETAIL REIMBURSEMENT INFORMATION
( 1)Operating DRG Reimb      :  $2062.72
( 2)Capital DRG Reimb        :  $203.38
( 3)Operating Outlier Reimb. :  $14918.15
( 4)Capital Outlier Reimb.   :  $1538.59
( 5)Add-On Technology Reimb. :

( 6)Total                    :  $18722.84









Press NL--
```

NOTE: If the patient's payor uses the 3M Coding and Reimbursement System, you do not have the option to view Reimbursement Information.

This screen is for informational purposes only. The Reimbursement field on the DRG Results screen displays the total reimbursement for this patient (including outlier payments). For detailed information on what comprises this total, you can view this Detail Reimbursement Information screen.

Hospital Acquired Condition (HAC) Information

If you press **H** to view Hospital Acquired Condition (HAC) details, the following screen is displayed:

```
                General Hospital DRG Assignment Processor
              DRG Results          Page  4 of  4 Thu Apr 09, 2009 06:31 pm
    Account No     Name                          ICD    Unit No        Corp No
    0824600003     DONER,ABIGAIL                 9      000-00-5811    00006478
                          DETAIL OF HAC PROCESSING
( 1)HAC Required : Yes
( 2)HAC Status   : No HACs
( 3)Initial DRG  : 221 CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CAT
( 4)Initial Reimb: 20076.35









Press NL--
```

This screen displays the HAC details, including the HAC Processing Required indicator, the status of HAC Processing (demotions, DRG change), Initial DRG (DRG prior to HAC Processing), and Initial Reimb (reimbursement prior to HAC Processing). All the fields on this screen are display only.

Press ENTER after viewing this screen to return to the DRG Assignment screen.

If the patient has been discharged and changes were made to the information that affect DRG assignment (for example, diagnosis, procedure, sex age, disposition), when you exit the DRG Assignment screen, this prompt is displayed:

Accept Final DRG Assignment? (Y/N) [N]--

To accept the DRG as final, enter **Y** for Yes (do not press ENTER). This indicates to the system that this DRG is acceptable for billing. It also causes the date of the acceptance to display in the Final Accept Date field on the DRG Assignment screen.

The system does not allow you to accept the DRG as final unless all procedure codes (both HCPCS and ICD-9-CM) also have dates entered.

If you use the 3M's Coding and Reimbursement System for reimbursement calculation, the system does not allow you to accept the DRG as final if the field that displays the

DRG is blank. If you enter **Y** at the prompt when this field is blank, the system displays one of two messages:

- For visits that have DRGs calculated:

  Error: Final DRG is missing. Recalculate using a valid Code 3 product option.

  The system then displays the acceptance prompt again, and you must enter **N** or press ENTER. You must then reaccess 3M's Coding and Reimbursement System and select a 3M product option that calculates a DRG, then return to this screen and accept the DRG as final. If you are using multiple groupers, you must select a 3M product option that calculates a DRG both times STAR Patient Care accesses 3M's Coding and Reimbursement System.

- For visits that have APCs calculated:

  It is not necessary to mark the DRG as final when using APCfinder.

  The system then displays the acceptance prompt again, and you must enter **N** or press ENTER.

For more information on the 3M's Coding and Reimbursement System, refer to the *STAR Patient Care, STAR/3M Coding and Reimbursement Interface Guide.*

Whether or not you accept the DRG as final, after you respond to the previous prompt, the following prompt displays:

Enter Alternate Description for Diagnoses and/or Procedures? (Y/N) [N]--

An alternate description for the ICD-9-CM code is one that may be more acceptable to the physician responsible for completing the attestation form. The alternate description does not print on or affect any other reports, bills, or department functions. The alternate description only prints on the attestation and abstract summary forms for this patient. Once an alternate description is set up for a patient's episode, it remains there until it is removed or changed. Entering an alternate description on a patient's abstract does not change the ICD-9-CM description found in the maintenance function.

To enter an alternate description(s), press **Y** (do not press ENTER) to access the Diagnoses Processor screen. The system displays this prompt:

Select principal (P), or number (n), to enter alternate description--

Enter **P** or the number of the secondary diagnosis (to the left of the ICD-9-CM code). The system now displays this prompt:

Enter alternate description--

Enter the new description which is posted in place of the previous ICD-9-CM code description. You are then returned to this prompt:

Select principal (P), or number (n), to enter alternate description--

You can continue entering alternate descriptions or press ENTER to display this prompt:

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

Enter **N** for No to return to the prompt to select the principal diagnosis or code number for an alternate description. Once the screen is accepted, this message displays:

Filed!

The message displays briefly, then you are taken to the procedure processor screen.

To enter alternate descriptions for procedures, select the number to the left of the ICD-9-CM procedure code, and this prompt displays:

Enter alternate description for procedure--

Enter the new description which is posted in place of the previous ICD-9-CM code description and you are returned to this prompt:

Select number (n) to enter alternate description--

You can continue entering alternate descriptions or press ENTER and this prompt displays:

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

Press ENTER to accept the default of **N** for No to continue processing, and this message is displayed:

Print an (A)ttestation, an Abstract (S)ummary, or (B)oth forms? --

You have the following entry options:

- Enter **A** to print an attestation form. The following prompt displays:

  Indicate # of Primary copies, followed by # of Secondary copies (eg 1,2), or one copy of each [B]--

  For example, to print two copies for the primary payor and two copies for the secondary payor, enter **2,2**. If you want only one copy of each, press ENTER to accept the default of B for both.

NOTE: The maximum number of primary or secondary attestation forms that can be requested at one time is 99.

The following message displays:

Printing Attestation Form!

- Enter **S** to print an abstract summary form. The following message displays:

  Printing Abstract Summary form!

- Enter **B** to print both an attestation and an abstract summary form. The system displays the following prompt:

  Indicate # of Primary copies, followed by # of Secondary copies (eg 1,2), or one copy of each [B]--

  For example, to print two copies of the attestation form for the primary payor and one copy for the secondary payor, enter **2,1**. If you want only one copy of each, press ENTER to accept the default of B for both.

  NOTE: The maximum number of primary or secondary attestation forms that can be requested at one time is 99.

  The following messages display:

  Printing Attestation Form!

  Printing Abstract Summary form!

The system displays the *Printing* message, then displays this prompt:

Send an Attestation message? (Y/N) [N]--

This message is not displayed if the Medical Record Maintenance Option Electronic Signature parameter is set to No.

Press ENTER to accept the default of **N** for No and an electronic attestation is not sent. To send an electronic attestation, enter **Y** for Yes (do not press ENTER), and this prompt displays:

Enter physician code to send Attestation message--

Enter the code number of the physician to whom the attestation should be sent. If the selected physician does not have a secret code on file, or the secret code has expired, this message displays:

Error: Physician not available for Electronic Signature

Physicians are set up for electronic attestation in the Medical Records Maintenance option, Assign Phys Electronic Signature function.

The message displays briefly then returns you to the prompt to enter another physician code. You can enter a period (.) and press ENTER to terminate this process.

Once you select a physician whose code is on file, this screen displays:

```
                General Hospital DRG Assignment Processor
             DRG Results          Page  4 of  4   Thu Jul 11, 1996 10:49 am
      Account No    Name                              Unit No        Corp No
      90106-00003   ROGERS,ELLEN T                    0000-0000-67   00003191
1 DRG Payor            2 Table No  3 Age    4 Sex     5 Dischg Disposition
  MEDICARE               14          31Y      FEMALE    HOME - SELF CARE
6 Major Diagnostic Category                             7 FINAL ACCEPT DATE
  6  DISEASES/DISORDERS OF THE DIGESTIVE SYSTEM
           1         2         3         4         5         6         7
  12345678901234567890123456789012345678901234567890123456789012345678901234
01|                                                                          |
02|                                                                          |
03|                                                                          |
04|                                                                          |
05|                                                                          |
06|                                                                          |
07|                                                                          |
08|                                                                          |
09|                                                                          |
10|                                                                          |
11|                                                                          |
12|                                                                          |
`E`dit/`C`reate/`D`elete notes to the physician or `S`end message? (ECDS)--  |
```

This screen is used by the Medical Record Department to send notes or messages to the physician regarding the attestation. These notes display when the physician views the attestation via STAR Clinical Browser or Horizon*WP*® Physician Portal.

The prompt associated with this screen asks you to select one of the following entry options. (It is not necessary to press ENTER after you enter an option.)

- Enter **E** to edit notes
- Enter **C** to create notes
- Enter **D** to delete the notes
- Enter **S** to send the notes and/or attestation

If you enter **E** or **C** to edit or create notes, this screen displays:

```
                  General Hospital DRG Assignment Processor
            DRG Results          Page  4 of  4 Thu Jul 11, 1996 10:49 am
   Account No     Name                                Unit No        Corp No
   90106-00003    ROGERS,ELLEN T                      0000-0000-67   00003191
 1 DRG Payor            2 Table No  3 Age    4 Sex     5 Dischg Disposition
   MEDICARE               14          31Y      FEMALE    HOME - SELF CARE
 6 Major Diagnostic Category                             7 FINAL ACCEPT DATE
   6  DISEASES/DISORDERS OF THE DIGESTIVE SYSTEM
          1         2         3         4         5         6         7
   12345678901234567890123456789012345678901234567890123456789012345678901234
01|Please sign attestation by Friday.                                          |
02|                                                                            |
03|                                                                            |
04|                                                                            |
05|                                                                            |
06|                                                                            |
07|                                                                            |
08|                                                                            |
09|                                                                            |
10|                                                                            |
11|                                                                            |
12|                                                                            |
   F1           F2           F3      F4    F5          F6            F7    F10
   Delete Line  Insert Line  Center  Exit  Store Line  Restore Line  Pack  Help
```

This screen enables you to enter 12 lines of free-form text to send additional instructions or information to the receiving physician. The function keys at the bottom of the screen assist you with the various word processing functions available.

If you enter **D** for delete, the following prompt displays:

Are you sure you want to delete current notes? (Y/N) [N]--

Press ENTER to accept the default of **N** for No. If you enter **Y** for Yes, the notes are deleted.

If you enter **S** for send, the following prompt displays:

Are you sure you want to send this Attestation message to XXXX? (Y/N) [Y]--

where XXXX is the name of the selected physician.

Enter **Y** for Yes or press default to send the message. Enter **N** for No to skip sending the attestation message. If you accept the default, this message displays:

Sending Attestation Message!

The message displays briefly, then you are returned to the function where you started.

If an attestation is electronically signed and the diagnoses and/or procedures pertaining to that attestation are subsequently updated, the electronic signature and date are automatically removed from the file, and must either be electronically sent again and signed, or the physician can manually sign the attestation.

The message displays briefly, then you are returned to the abstracting process.

Impact

After you accept this screen, the following takes place:

- Alternate descriptions display on the Diagnoses Processor screen, and always print on the attestation and abstract summary forms for this episode for this patient until changed or removed.
- If the DRG is accepted as final (which can only take place if the patient is discharged), the system completes Field 7 on the DRG assignment screen with the date of acceptance.
- When the DRG is accepted as final, an internal flag is set and/or a set of interface records are created.
- Patients whose DRG is accepted as final are no longer included on the Unaccepted DRG Discharges Report.
- Patients whose DRG is accepted as final are included on the Final DRGs Accepted Report.
- Electronically transmitted attestation forms are now available for processing by the physician via STAR Clinical Browser or Horizon*WP* Physician Portal.

Output

- An attestation form is printed to the spooler or the default printer linked to the user's CRT, depending on the setting of the Abstract Facility Options parameter.
- An abstract summary form is printed to the spooler or the default printer linked to the user's CRT, depending on the setting of the Abstract Facility Options parameter.
- When the physician returns an electronic attestation, either signed or unaccepted, the attestation form prints in the Medical Record Department (at the printer associated with the report UFAFX). If the attestation is electronically signed, the form contains the signature and date and time of signing.
- If the attestation is not signed but is electronically returned as unaccepted, the unsigned attestation form prints in the Medical Record Department (at the printer associated with the report UFAFX), along with the medical record messages sent to the physician (if any), the Physician DRG unaccepted reasons (if any), and the physician message (if any).

MATERNITY/NEWBORN INFORMATION

The Maternity/Newborn Information function is used to collect information on newborns and their mothers. If the patient is over nine years old, the system displays the maternity screen. If the patient is less than nine years old, the system displays the newborn screen.

Maternity Screen

The following is an example of the screen that is displayed for the mother:

```
           General Hospital Maternity/Newborn Information Processor
                                                 Thu Apr 09, 2009 07:22 pm
    Account No     Name                          ICD    Unit No        Corp No
    2-00023-94     MEDU,SARA                     9      0000-000643    00000632
 1 Gravida         2 Parity     3 Prev Blood Trans.    4 Rubella Status
   1 pregnancies     1+0          No                     1 PREVIOUS POSITIVE
 5 VDRL Result     6 LMP Date   7 Gestation Period     8 Labour Onset Method
   Negative          06/01/95     38 weeks               2 ELECTIVE C-SECTION
 9 Prv Neo Dths   10 Prv Abort 11 Prev C-Sect  12 Prev Live   13 Prev Still
   0                 0            0              0              0
14 Delivery Place Type     15 Place Change Reason     16 Delivery Method
   6 PRIVATE HOSPITAL         1 CHANGE OF ADDRESS        8 ELECTIVE C-SECTION
17 Fetus/Labour            18 Delivery Date/Time      19 Delivery Person Status
   O OTHER CEPHALIC           95/01/10 09.33             2 GENERAL PRACT.
20 Delivery Facility Only  21 1st Labour Stage        22 2nd Labour Stage
   Yes                        08.50 hrs.mins             02.45 hrs.mins
23 Anaesthetic During Labour/Delivery   24 Anaesthetic Post Delivery
   4 GENERAL AND EPIDURAL/CAUDAL           4 GENERAL AND EPIDURAL/CAUDAL



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

Field Explanations

1. GRAVIDA (2-N-O)
Enter the number of total births including this patient visit. You can press ENTER to accept the default for this field, which is the number of previous births that were entered during the Admission process plus one.

2. PARITY (SPECIAL FORMAT-R)
Enter the parity in the following format: ## + ##. The first number you enter represents the number of viable births. The second number you enter represents the number of non-viable births. The two numbers totaled must be equal to or greater than the Gravida entry.

NOTE: You must enter the plus sign (+) between the two numbers.

3. PREV BLOOD TRANS. (1-A-O)
Enter **Y** if the patient has previously received a blood transfusion; otherwise, enter **N**.

4. RUBELLA STATUS (TABLE LOOKUP)
This field enables you to identify the status of the mother's Rubella testing. Enter the status code, if you know it, or enter a hyphen (-) to display the Rubella Status table for selection.

5. VDRL RESULT (1-A-O)
Indicate if the VDRL test was positive by entering **P**; enter **N** for negative. If a VDRL was not done, leave the field blank.

6. LMP DATE (DATE FORMAT)
If the last menstrual period (LMP) information was entered during the Admission process, this field is autofilled with the data. If the field is blank, or if you need to modify the existing date, enter the date that the patient's last menstrual cycle began.

7. GESTATION PERIOD (2-N-O)
Enter the number of weeks the patient has been pregnant. After you enter the number, the system appends your entry with the word "weeks." A warning message is displayed if you enter a number greater than 45; however, the entry can be accepted or revised.

8. LABOR ONSET METHOD (TABLE LOOKUP)
Specify the method, if any, by which labor was induced. Enter the code identifying the method, or enter a hyphen (-) to display the Labor Onset Method table for selection.

9. PRV NEO DTHS (2-N-O)
Enter the number of previous pregnancies that resulted in neonatal deaths. The number cannot be greater than the number entered in the Gravida field. A warning message is displayed when the number is greater than 10.

10. PRV ABORT (2-N-O)
Enter the number of previous pregnancies that were aborted. The number cannot be greater than the number entered in the Gravida field. A warning message is displayed when the number is greater than 10.

11. PREV C-SECT (2-N-O)
Indicate, in this field, the number of previous pregnancies that resulted in Cesarean Sections for the patient. The number cannot be greater than the number entered in the Gravida field. A warning message is displayed when the number is greater than 10.

12. PREV LIVE (2-N-O)
Enter the number of previous live births given by the patient. The number cannot be greater than the number entered in the Gravida field. A warning message is displayed when the number is greater than 10.

13. PREV STILL (2-N-O)
Enter the number of previous pregnancies that resulted in still births for the patient. The number cannot be greater than the number entered in the Gravida field. A warning message is displayed when the number is greater than five.

14. DELIVERY PLACE TYPE (TABLE LOOKUP-O)
Specify where the delivery took place. Enter the code identifying the place, or enter a hyphen (-) to display the Delivery Place Type table for selection.

15. PLACE CHANGE REASON (TABLE LOOKUP-O)
This field enables you to identify the reason a delivery did not occur in the planned location. For example, if a birth was to occur in a birthing room but actually took place in the operating room, you would enter in this field the code identifying the reason for this change. Enter the code, if you know it, or enter a hyphen (-) to display the Delivery Place Change Reason table for selection.

16. DELIVERY METHOD (TABLE LOOKUP)
This field identifies the method used for delivery. Enter the corresponding code, or enter a hyphen (-) to select from the available list of entries.

17. FETUS/LABOUR (TABLE LOOKUP)
You can specify in this field the presentation of the fetus before labour. Enter the corresponding code, or enter a hyphen (-) to select from the available list of entries.

18. DELIVERY DATE/TIME (DATE/TIME FORMAT)
This field indicates the baby's first admission date and time. The system prompts you for the date and time entries separately. Enter the date and then the time. For information on date and time entry techniques, refer to the *STAR Patient Care Reference Guide, General Information Volume*.

19. DELIVERY PERSON STATUS (TABLE LOOKUP)
Specify the status of the person who delivered the baby(ies). Enter the corresponding code, or enter a hyphen (-) to select from the available list of entries.

20. DELIVERY FACILITY ONLY (1-A-O)
Indicate if the patient used only the delivery facilities during the birth by entering **Y**; otherwise, enter **N**.

21. 1ST LABOR STAGE (SPECIAL FORMAT-R)
Enter the duration of the first stage of labor in the format HH:MM.

22. 2ND LABOR STAGE (SPECIAL FORMAT-R)
Enter the duration of the second stage of labor in the format HH:MM.

23. ANAESTHETIC DURING LABOUR/DELIVERY (TABLE LOOKUP)
Identify the type of anaesthetic administered to the patient during labor and delivery. Enter the code corresponding to the anaesthetic, or enter a hyphen (-) to display the Anaesthetic Type table for selection.

24. ANAESTHETIC POST DELIVERY (TABLE LOOKUP)
This field displays the code identifying any anaesthetic agent used during the labor and delivery stage of this birth. Enter the code, or enter a hyphen (-) to display the Anesthesia Type table for selection.

Newborn Screen

When the patient you are abstracting has been admitted using the Newborn Admission function or is younger than nine years old, the screen for entering the baby's information is displayed. If the baby's admission has been linked in the system via the Newborn Admission function, the mother's account number, name, and unit number are displayed on this screen and cannot be edited.

When you access the Maternity/Newborn Information page, the system displays the following prompt:

Enter patient info(I) or Special Factors(S)? (S/I) [I]--

When you enter **I** or press ENTER to enter patient information, the system displays the screen as follows. Following this section is an example of and field explanations for the Special Factors Screen that is displayed when you enter **S** (for special factors).

```
               General Hospital Newborn Information Processor
                                                  Thu Apr 09, 2009 07:22 pm
    Account No     Name                          ICD   Unit No        Corp No
    89046-00001    DOE,JANE R                    9     0001-0362-2    00001907
 1 Newborn indicator   2 Birth type    3 Birth status     4 Birth Wt
   LIVE BIRTH            SINGLE          TERM               8lbs 12oz/4.0kg
 5 Head Circum         6 Length        7 Jaundice         8 Examination/Hips
   0' 8"/20.32cm         1' 9/53.34cm    1 NO JAUNDICE      2 ABNORMAL HIP EXAM
 9 Apgar Codes                      10 C-Section Ind.
   Defined                             Yes
11 Resuscitation method                          12 Gestation period
   2 CPR                                            40
13 Delivery Place Type      14 Place Change Reason       15 Delivery Method
   1 HOSPITAL                  2 MOTHER'S CONDITION         3 REPEAT C-SECTION
16 Delivery Person Status   17 Feeding Type              18 Follow Up Care
   2 CERTIFIED MID-WIFE        2 BREAST                     2 CLINIC
19 Mother's Acct#           20 Mother's name             21 Mother's Unit#




Enter table code--
```

Field Explanations

1. NEWBORN INDICATOR (TABLE LOOKUP)
Enter the user-defined table code describing the baby's birth. For example, depending on how the table is defined, entering 1 may display LIVE BIRTH. If you do not know the code, enter a hyphen (-) to display the table for selection.

2. BIRTH TYPE (TABLE LOOKUP)
Enter the user-defined table code describing the birth type. For example, depending on how the table is defined, entering 1 may display MULTIPLE BIRTH. If you do not know the code, enter a hyphen (-) to display the table for selection.

3. BIRTH STATUS (TABLE LOOKUP)
Enter the user-defined table code describing the birth status. For example, depending on how the table is defined, entering 1 may display POST TERM. If you do not know the code, enter a hyphen (-) to display the table for selection.

4. BIRTH WT (5-C-O)
Enter the baby's weight at the time of birth in either pounds and ounces or in kilograms. To enter the weight in pounds and ounces, separate the two by a slash (/); for example, if the baby weighs 8 pounds, 4 ounces, enter 8/4. To enter the weight in kilograms, enter the number followed by K; for example, if the baby weighs 4 kilograms, enter 4K. The field displays both weights regardless of which method you use. The system automatically converts increments of 16 ounces to pounds. For example, if you enter 7/16 (7 pounds, 16 ounces), the system displays 8 lbs 0oz/3.6kg.

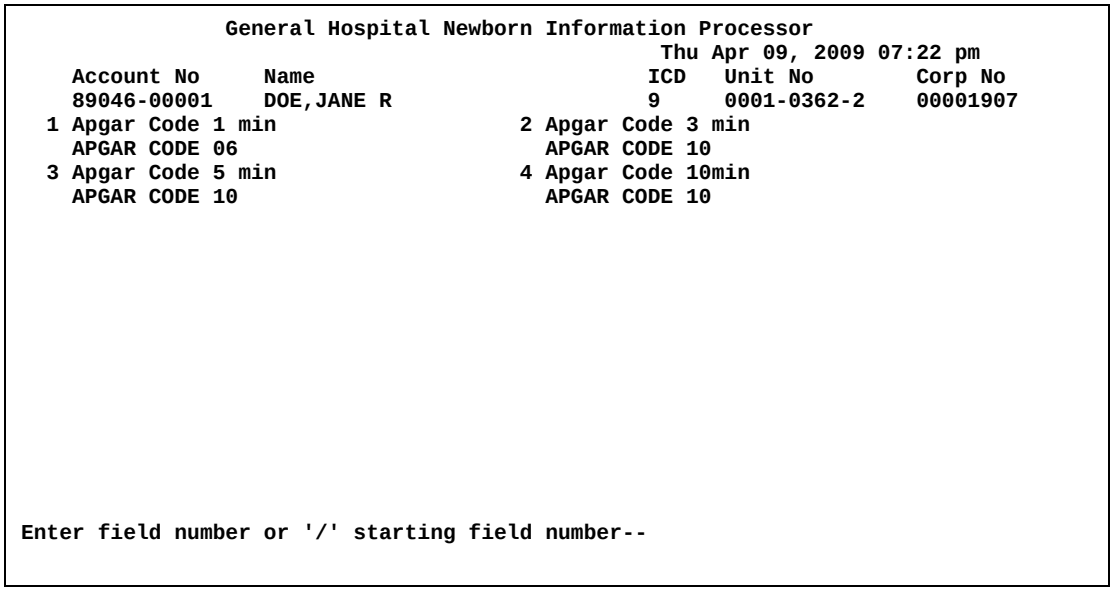
5. HEAD CIRCUM (6-C-0)
Enter the circumference of the baby's head at the time of birth in either feet and inches or in centimeters. To enter the measurement in feet and inches, separate the two numbers by a slash (/). For example, if the baby head measures 7 inches, enter 7. To enter the circumference in centimeters, enter the number followed by C. For example, if the measurement is 17.7 centimeters, enter 17.7C. The field displays both measurements regardless of which entry method is used.

6. LENGTH (6-C-O)
Enter the baby's length at the time of birth in either feet and inches or centimeters. To enter the measurement in feet and inches, separate the two numbers by a slash (/). For example, if the baby measures 22 inches, enter 0/22. to enter the length in centimeters, enter the number followed by C. For example, if the baby measures 54.5 centimeters, enter 54.5C. The field displays both measurements regardless of which entry method is used.

7. JAUNDICE (TABLE LOOKUP)
This field identifies the presence of jaundice at birth. Enter the code, if you know it, or enter a hyphen (-) to display the Presence of Jaundice table for selection.

8. EXAMINATION/HIPS (TABLE LOOKUP)
This field indicates the results of the examination of the baby's hips. Enter the code, if you know it, or enter a hyphen (-) to display the Examination of Hips table for selection.

9. APGAR CODES (TABLE LOOKUP)
When you access this field, the system displays the following subscreen to enable you to enter APGAR codes for 1 minute, 3 minutes, 5 minutes, and 10 minutes after birth.



Subscreen Field Explanations

1-4. APGAR X MIN (TABLE LOOKUP) (X=number of minutes)
These fields display the baby's APGAR scores. Enter a code in the field if you know it, or enter a hyphen (-) to display the APGAR Codes for Newborn table for selection.

NOTE: The APGAR Score (1 MIN) and APGAR Score (5 MIN) codes should not contain alphabetic characters if the APGAR information is to be used by TRENDSTAR®. TRENDSTAR allows only a numeric code.

Field Explanations for Newborn Screen cont.

10. C-SECTION IND. (1-A-O)
This field identifies whether or not the baby was delivered by C-section. Enter **Y** for Yes, or **N** for No.

11. RESUSCITATION METHOD (TABLE LOOKUP)
This field identifies the birth resuscitation method, if any, used at the time of the delivery of this baby. Enter the code or a hyphen (-) to display the Birth Resuscitation Method code table for selection.

12. GESTATION PERIOD (2-N-O)
This field is for entry of the number of weeks gestation for this newborn. If the baby was admitted using the Newborn Admission option, this information defaults from what was entered for the mother. To enter or update this information, enter a two-digit number. Editing this field updates the field of the same name on the mother's information screen. If you enter a number greater than 44, an error message is displayed to which you must respond.

Gestation entered is greater than 44. Accept?(Y/N)--

To continue with the value entered, enter **Y**. To delete the value and enter another value, enter **N**.

13. DELIVERY PLACE TYPE (TABLE LOOKUP)
This field enables entry of the code to identify the delivery location of this birth. If the baby was admitted utilizing the Newborn Admission option, this information defaults to what was entered for the mother. To edit this field, enter the code or enter a hyphen (-) to display the Delivery Place Types code table for selection. Editing this field in the baby's abstract updates the same field in the mother's abstract.

14. PLACE CHANGE REASON (TABLE LOOKUP)
This field enables entry of a reason as to why this baby was not delivered in the scheduled location. For example, if this was to be an in home delivery, but the baby was delivered at the hospital, this field can be used to indicate why a change in location occurred. To edit this field, enter the code or press hyphen (-) to display the Delivery Place Change Reason code table for selection.

15. DELIVERY METHOD (TABLE LOOKUP)
This field enables entry of the code to identify the method of delivery for this birth. If the baby was admitted using the Newborn Admission option, this information defaults to what was entered for the mother. To edit this field, enter the code or press hyphen (-) to display the Delivery Methods code table for selection. Editing this field in the baby's abstract updates the same field in the mother's abstract.

16. DELIVERY PERSON STATUS (TABLE LOOKUP)
This field identifies the status of the person primarily responsible for the delivery (for example, midwife, RN, or physician). If the baby was admitted in the Newborn Admission option, this information defaults from what was entered for the mother. To enter the information, enter the code or a hyphen (-) to display the Delivery Person Status code table for selection. Editing the information in this field, updates the field of the same name in the mother's abstract.

17. FEEDING TYPE (TABLE LOOKUP)
This field enables you to identify how the baby is being fed (for example, bottle, breast, or IV). Enter the code, if you know it, or a hyphen (-) to display the Feeding Type code table for selection.

18. FOLLOW UP CARE (TABLE LOOKUP)
This field identifies any follow up care the baby is to receive. Enter the code, if you know it, or a hyphen (-) to display the Follow Up Care table for selection.

19. MOTHER'S ACCT# (DISPLAY ONLY)
The mother's account number is displayed in this field if the baby's admission has been linked in the system via the Newborn Admission function. Otherwise, this field is blank and cannot be edited.

20. MOTHER'S NAME (DISPLAY ONLY)
This field displays the name of the mother associated with this baby as entered in the Newborn Admission sequence. Otherwise, this field is blank and cannot be edited.

21. MOTHER'S UNIT# (DISPLAY ONLY)
The mother's unit number displays in this field if the baby's admission has been linked in the system via the Newborn Admission function. Otherwise, this field is blank and cannot be edited.

In the case of a stillbirth, you can manually enter the mother's unit number. Stillborns are not admitted, but are added to the MPI through a manual add.

If you entered **S** at the prompt that was displayed when you accessed the Newborn Information page, the system displays this scrolling screen:

```
            General Hospital Maternity/Newborn Information Processor
                                                 Thu Apr 09, 2009 07:22 pm
     Account No     Name                         ICD   Unit No        Corp No
     2-00024-94     TARAS,BABY GIRL              9     0000-000644    00000633

Maternity Special Factors
 No.       Description
 1         29 PREMATURE LABOUR
 2         31 HIGH BLOOD PRESSURE
 3         25 DIABETES 4



                                      Special Factors
Page:01
( 1) 1-PRE-NATAL
( 2) 12-PER-NATAL
( 3) 25-DIABETES
( 4) 29-PREMATURE LABOR

                            Enter code or `-` to list--
     F1Prev Page F2Next Page F3 Insert  F4 Delete  F6 Reset  F7  Exit   ?
```

Special factors are conditions of the mother or delivery that influenced the delivery of the baby. Enter the code of the special factor(s), or enter a hyphen (-) to select from the available list of valid entries. These special factors print on the birth notification, and can be used for internal reviews.

DEATH CLASSIFICATIONS SCREEN

The Death Classifications screen enables you to add and edit classifications of death (as defined by the hospital in the Death Classifications table) for patients. Up to ten separate classifications can be entered for each patient.

This screen displays the patient's account number, name, unit number, and corporate number, and lists the death classification codes and descriptions. The screen also indicates whether or not the death was suicide-related.

If you access the Death Classifications option and the patient is not expired, the system displays the following message:

Patient is not expired!

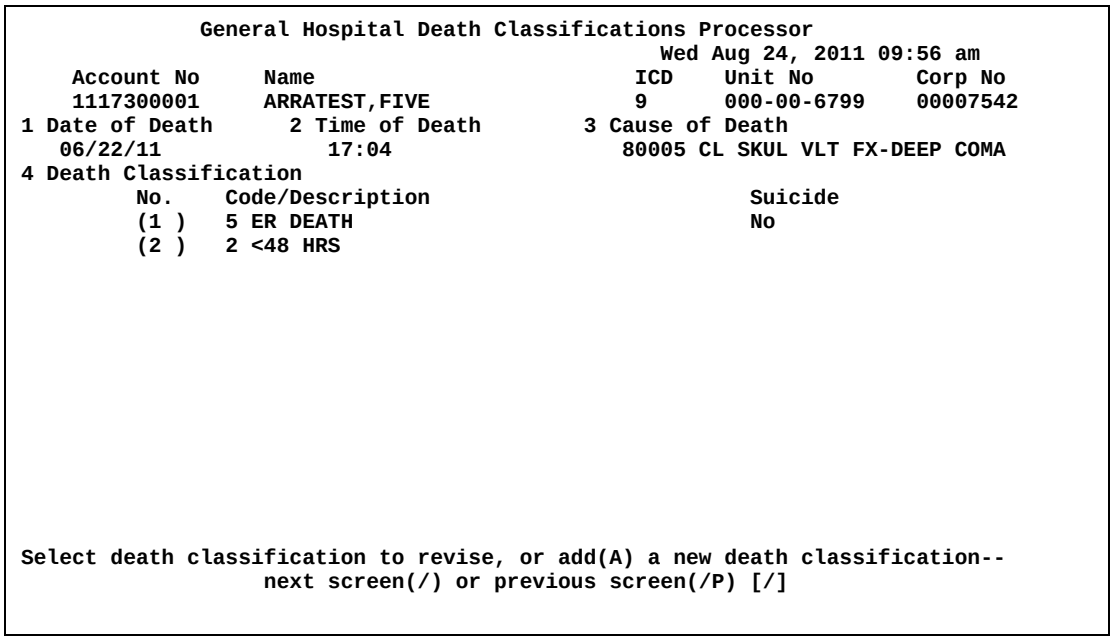
If you access the Death Classifications option for a patient with a previously entered death classification whose disposition has been changed to a non-expired status, the system displays the following message:

****Patient Not Expired****

If the patient has expired but no death classifications have been entered, the system displays the following message:

No Death Class Codes exist for this expired patient!

If the patient has expired and death classifications have been entered, the system displays this screen:



You can do one of the following:

- Select the classification you want to revise.
- Enter **A** to add an additional classification.
- Press ENTER, slash (***/***), or slash P (***/P***) to return to the menu screen.

Field Explanations

1. DATE OF DEATH (DISPLAY ONLY)
This field defaults to the discharge date. If revised in GUI Abstracting Expired Patient Information, the revision is displayed here.

2. TIME OF DEATH (DISPLAY ONLY)
The time of death as entered in GUI Abstracting Expired Patient Information.

3. CAUSE OF DEATH (DISPLAY ONLY)
This cause of death as entered in GUI Abstracting Expired Patient Information.

4. DEATH CLASSIFICATION CODE (DISPLAY ONLY)
This field contains a code describing the type of death. Death types are defined in the Death Classifications code table.

SUICIDE (DISPLAY ONLY)
This field indicates whether the death was suicide-related. Although this field appears to be associated with each death classification that is entered, only the last entry is stored.

To delete a death classification, enter the number to the left of the description and press ENTER until the following prompt is displayed:

Delete death classification code? (Y/N) [N]--

Enter **N** or press ENTER for No to keep the system from deleting the information. Enter **Y** for Yes to delete the death classification information.

Impact

After you accept this screen, the death classification information is available for reporting via the Core Reports function.

SPECIALTY UNITS SCREEN

The Specialty Units screen enables you to add and edit information that may have been entered on a specialty nursing unit if the patient was located there during this hospital stay. These entries can be captured automatically by the system if the facility has either Room and Bed Charging or simulation capabilities.

In addition to the charging/simulation process, the SIM must be set to support the process, and Specialty Units must be defined in the Room and Bed SIM. To automatically update abstracting, set up SIM items with Specialty Unit types. Updates made to abstracting display after Midnight Processing. Specialty Units are defined in a hospital-defined table. Additional information on this can be found in Medical Record Tables chapter of the *STAR Patient Care Reference Guide, Tables Volume*.

If you select the Specialty Units screen, and no specialty unit information has been entered, the system displays the screen with this message in the center:

No Specialty Units

This message is displayed briefly, and you are returned to the Specialty Units to either enter information or move on to the next screen.

If there is information present when you select this screen, the following screen is displayed:

```
                General Hospital Specialty Units 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

                    No.  Code/Description             No. of days    Death
                  (1 )   1 BURN UNIT                  23


Select specialty unit to revise, or add(A) a new specialty unit--
                    next screen(/) or previous screen(/P) [/]
```

This screen is very much like the Death Classifications screen in appearance. It displays the patient's account number, name, unit number, and corporate number, and it lists the specialty units and the number of days the patient spent in each specialty unit. It also indicates if the patient died on the specialty unit.

You can select the specialty unit you want to revise or delete, enter **A** to add a new specialty unit, or move to the next or previous screen.

If you select a specialty entry to revise, the system displays a subscreen at the bottom of the screen, and prompts you to enter the field number for which changes are to be made.

```
                General Hospital Specialty Units 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

                    No.  Code/Description             No. of days    Death
                  (1 )   1 BURN UNIT                  23




       1 Specialty Unit             2 No. of days          3 Death
         1 BURN UNIT                  23


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

Field Explanations

1. SPECIALTY UNIT (TABLE LOOKUP)
Enter the new or revised specialty unit in this field. Specialty units are included in the Specialty Unit table. Enter the table code if you know it, or enter a hyphen (-) to display the Specialty Unit table for selection. You can add multiple units. If the patient was located in a specialty unit that is set up in the SIM to automatically update the abstract, those units and days in the unit are displayed on this screen.

2. NO. OF DAYS (3-N-O)
Enter the new or revised number of days the patient spent in the specialty unit. This is a freeform field. Your entry cannot exceed the total length of stay for the patient, or the system displays an error message and does not accept the number of days entered.

If you are adding a specialty unit, the same screen displays, except that the Specialty Unit and No. of Days fields are blank. The procedures for adding a unit are the same.

NOTE: When the system is set up to automatically capture the number of days spent in a specialty unit (the facility has either Room and Bed Charging or simulation capabilities, the SIM is set to support the process, and Specialty Units are defined in the Room and Bed SIM), the calculations are performed as follows:

- If the charge is Not Timed, the system adds the actual quantity to the specialty unit for the patient (or subtracted from a credit).

- If the charge is Timed, the system adds one (1) to the specialty units for the patient for charges (or subtracts one (1) from a credit), instead of calculating and displaying minutes.

3. DEATH (1-A-O)
This field is used to indicate if the patient died on a specialty unit.

To delete a specialty unit, enter the number to the left of the description and press ENTER. Press ENTER again and the following prompt displays:

Delete? (N)--

Enter **N** or press ENTER for No to keep the system from deleting the information. Enter **Y** to delete the specialty unit information.

BLOOD GROUPS SCREEN

The Blood Groups screen enables you to add and edit information regarding blood usage. This information can be captured automatically by the STAR Patient Care Charge process if you define SIM items with a Blood Group type. Updates display in the abstract after Midnight Processing. Otherwise, the information can be entered manually. Blood Groups is a hospital-defined code table.

If no blood group information was entered and you select the Blood Groups screen, the following message displays in the center of the screen:

No Blood groups

If there is information present, the system displays the following screen:

```
                  General Hospital Blood Groups 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

                    No.  Code/Description             Quantity in units
                  (1 )   L LEUKPAC 005                6
                  (2 )   F FRESH PLA 005               2









Select blood group to revise, or add(A) a new blood group--
                     next screen(/) or previous screen(/P) [/]
```

This screen is very much like the Death Classifications and Specialty Units screens in appearance. It displays the patient's account number, name, unit number, and corporate number, and lists the blood groups and quantity of blood used for this patient during this particular visit.

Select the blood group you want to revise or delete, enter **A** to add a new blood group, or move to the next or previous screen.

If you select a blood group to revise, the system displays a subscreen at the bottom of the screen and prompts you to enter the field number for which changes are to be made.

```
                  General Hospital Blood Groups 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

                    No.  Code/Description             Quantity in units
                   (1 )   L LEUKPAC 005                24
                   (2 )   F FRESH PLA 005               2









   1 Blood Group                            2 Quantity in units
     L LEUKPAC 005                            24


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

Field Explanations

1. BLOOD GROUP (TABLE LOOKUP)
Enter the new or revised blood group in this field. Enter the table code if you know it, or press hyphen (-) and ENTER to display the blood group table for your selection. The code and the description are displayed.

2. QUANTITY IN UNITS (3-N-R)
Enter the quantity of blood in units for this blood group given to the patient during this visit. This is a freeform field and is not edited by the system.

If you add a blood group, the screen that displays for your entry is the same as the screen shown above, except that the Blood Group and Quantity in Units fields are blank. Follow the field explanations above, as entry of information is the same.

To delete a blood group entry, enter the number to the left of the description and press ENTER. Press ENTER again and the following prompt displays:

Delete? (N)--

Enter **N** or press ENTER for No. The information is not deleted. Enter **Y** to delete the blood group.

M/R SPECIAL STUDIES SCREEN

The Special Studies screen enables you to enter information in response to specific hospital- or department-defined questions regarding a patient's care and/or stay during this visit.

The special studies function is contained on the inpatient abstract menu. When you select the Full Inpatient Abstract option, the screen flow does not display the Special Studies screen. You must select the screen from the menu. This function is accessible also as a separate option, M/R Special Study, on the main abstracting menu. The separate option enables you to complete special study information on a patient without having to go through the M/R Abstracting function. Refer to *Chapter 3: M/R Special Study Function*.

When you revise special study information on a previously completed abstract, the system displays this prompt upon exiting the abstract:

Do you want to mark the abstract as complete? (Y/N)--

Enter **Y** for Yes to mark the abstract as complete or **N** for No.

NOTE: The system displays this prompt only when in the abstract. When you access the M/R Special Study option from the main abstracting menu, the status of the abstract remains unchanged.

If there are any special studies already associated with the patient's visit, the system displays them when you access the screen. A screen for a patient who has one or more special studies associated with this visit displays, similar to the following example:

```
                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









    Code   Description                    Date Entered       Init   Page:01
 ( 1)DG    DRUG USAGE                     02/14/96           N C




Enter special study to revise, add(A) a new special study--
```

You have two options:

- Select the special study to view, revise, or delete.
- Enter **A** to add a new special study.

If you enter **A** to add a new special study, or if there are *no* special studies associated with the patient when you access the screen, the system displays the following prompt:

Enter the MR Special Study Code or '-' to list--

This prompt provides two options:

- Enter the MR Special Study code if you know it.
- Enter a hyphen (-) and press ENTER to list the MR Special Study table for selection.

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.

When you select a special study to revise or you add a special study, the system displays a screen similar to the one below. (If you are accessing an existing study, the questions already have responses.) The study's questions are based on what is created in the MR 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 DRUGS?

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 the response field for the first question.

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 MR 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 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 MR Special Study table.

In response to the Date, Time, and Date/Time prompts, you have the option to enter any of the acceptable values as defined in the *Information Entry Techniques* chapter in the *STAR Patient Care Reference Guide, General Information Volume*. (For example, **T** for today and **N** for now.)

The special study screen scrolls, so you can use the arrow keys to move from one question to the next.

The system does not allow you to skip past those questions for which a response is required, as defined in the Special Study table. If you try to move past a question, 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 following table:

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. When you have completed the special study, press the F7 key. The system displays the following prompt:

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

You have three options:

- 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. If you exit a study that has the first response defined as *not* required, the special study code and description appear in the listing as if it had been defined. To remove it from the list, follow the steps in the next section to delete a special study.

- Press **N** for No if you do not want to accept the screen. The system returns your cursor to the first response field.

- 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

Follow these steps to delete a special study from the patient's record. You should be on the screen displaying the following prompt:

Enter special study to revise, add (A) a new special study--

1. Enter the option number to the left of the special study that you want to delete.The system displays the special study screen.

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 on this visit. You can continue deleting, adding, or revising special studies.

Impact

After you accept this screen, the special study information is available for reporting via the Core Reports function. The option is MR Special Study Report; the system report name is MRSSX.

NOTE: The main purpose of the MR 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.

THERAPY DEPARTMENTS

Therapy departments automatically display based on a patient's orders during the patient's stay. The first order for each therapy department logs a record which displays on this screen along with the associated activity type, if entered in the SIM.

The following is an example of the Therapy Departments screen:

```
                General Hospital Therapy Departments Processor
                                                Thu Apr 09, 2009 07:22 pm
     Account No     Name                         ICD  Unit No        Corp No
     3-00014-94     ADAMS,TESSA                  9    0000-000634    00000623

                    No.  Code/Description             Activity Type
                   (1 )   PT PHYSICAL THERAPY          2
                   (2 )   RT RESPIRATORY THERAPY       1









Select department to revise, or add(A) a new department--   |
                     next screen(/) or previous screen(/P) [/]
```

Select the therapy department you want to revise or delete by entering the line number for the department. Fields for the Therapy Department and Activity Type display at the bottom of the screen for editing.

Enter **A** to add a new therapy department. The following prompt displays:

Enter multiple therapy departments, separated by commas, or `-` for table--

You can enter multiple Therapy Departments, separated by commas, if you know the codes. Enter a hyphen (-) to select from a table listing of defined departments. You can make multiple selections from the table, up to a total of six entries. Each of the Therapy Department entries display on the subscreen separately for you to enter the corresponding Activity Type.

When you access the Therapy Department table while adding or revising an entry, the screen displays as follows:

```
                General Hospital Therapy Departments Processor
                                                Thu Apr 09, 2009 07:22 pm
     Account No     Name                         ICD  Unit No        Corp No
     3-00014-94     ADAMS,TESSA                  9    0000-000634    00000623
                    No.  Code/Description             Activity Type
                   (1 )   PT PHYSICAL THERAPY          2
                   (2 )   RT RESPIRATORY THERAPY       1









   1 Therapy Department                    2 Activity Type
  -> PT PHYSICAL THERAPY                     2
 Page:01                          Therapy Departments
 ( 1) ALSO UNKNOWN           ( 3) PHYSICAL THERAPY      ( 5) SPEECH THERAPY
 ( 2) OCCUPATIONAL           ( 4) RESPIRATORY THERAPY   ( 6) UNKNOWN

Enter choice--
```

Field Explanations

1. THERAPY DEPARTMENT (TABLE LOOKUP-R)
Enter the therapy department code directly, or enter a hyphen (-) to select from the Therapy Departments table.

NOTE: When you enter multiple therapy departments, the order in which they display for completion may not be the same as the order in which they were entered.

2. ACTIVITY TYPE (1-N-O)
You can enter a number from zero to nine that represents the activity type. The activity types and corresponding code numbers are previously defined by your hospital during the initial installation. Activity types can be used to further define the patient's visit to the therapy department.

To delete a therapy department, enter the number corresponding to the department. Press ENTER until the following prompt is displayed:

Delete? (N) --

Enter **Y** for Yes to delete it, or **N** or No to leave it.

When you accept this screen, you are returned to the abstracting menu.

MENTAL HEALTH ABSTRACT

If the visit you selected from the MPI was a mental health visit, the following abstract submenu is displayed, depending on what your facility has established.

```
                  General Hospital Abstract Processor
                                                 Thu Mar 19, 2009 03:14 pm
    Account No     Name                         ICD    Unit No        Corp No
    0904200002     TOMEY,TIM                    10     000-00-5885    00006552
            Option No.  Option
            ---------------------------------------
                1       Full Mental Health Abstract
                2       Patient Information
                3       Episode Information-1
                4       Episode Information-2
                5       User Defined Fields
                6       Consultations
                7       Diagnoses
                8       Procedures
                9       DRG Assignment
               10       Maternity/Newborn Information
               11       Death Classifications
               12       Specialty Units/Therapy Detail
               13       Blood Groups
               14       Special Studies
               15       Mental Health
               16       History Audit
Enter optio n number--
```

With the exception of the Mental Health screen, examples of these menu options are given previously in this section under the inpatient abstract type. The explanation of the Mental Health screen follows.

Mental Health Screen

The Mental Health screen enables you to record aspects of the patient's stay from legal to forensic, as well as medical.

If the patient type you are abstracting is an inpatient mental health patient type, then the following screen is displayed when you select the Mental Health screen menu option.

```
                  General Hospital Mental Health Processor
                                                  Mon Mar 23, 2009 02:18 pm
   Account No     Name                          ICD    Unit No        Corp No
   0904200002     TOMEY,TIM                     10     000-00-5885    00006552
 1 Prev Psych Admission     2 Prv Admit Dt  3 Legal Status   4 Legal Status Chg
   2 PSY ADMIT TYPE 2         06/05/08
 5 Employment Status        6 Financial Support       7 Education Level

 8 ECT Treatment            9 Community Agency       10 Mental Category

11 Referral Source         12 Referral Reason        13 Referred To

14 Method of Admission     15 Substance Taken        16 Forensic Patient
                                                        No
17 Primary DSM Code        18 Axis                   19 ICD9-CM

                                                     20 ICD10-CM

21 Additional DSM Codes



Enter field number or '/' starting field number--
                      next(/) or previous screen(/P) [/]
```

Field Explanations

1. PREV PSYCH ADM (TABLE LOOKUP)
This field indicates if the patient has had a previous psychiatric admission at any facility. This information may be entered at time of admission (or subsequently updated). Updates done in the abstract update the MPI. Enter the code, or enter a hyphen (-) to display the Previous Psychiatric Admission Types code table for selection.

2. PRV ADMIT DT (DATE FORMAT-O)
This field indicates the date of the patient's previous psychiatric admission. This information may be entered at time of admission and updated here. Updates done in the abstract update the MPI. Enter a date in an acceptable date format.

3. LEGAL STATUS (SPECIAL FORMAT-R)
You can indicate a legal status for the patient type you are abstracting. If there are no existing legal statuses when you access this field, the system displays the following prompt:

Assign a Legal Status? (Y/N) [N]--

If there is no legal status to assign, enter **N** or press ENTER for No.

To add legal status information, enter **Y**. The system displays a scrolling screen. This special screen enables you to add a status, revise an existing status, or just view the tracking of the patient's Legal Status classification.

If at least one legal status has previously been assigned to the patient, the system displays the screen automatically when you access the field.

```
                  General Hospital Mental Health Processor
                                                Mon Mar 23, 2009 02:18 pm
   Account No     Name                          ICD    Unit No        Corp No
   2-00025-94     PAGE,NADINE                   10     0000-000645    00000634
NUMBER  LEGAL STATUS       START DTE/TIME    LOS    EXP DTE/TIME    ACTUAL LOS
        CATEGORY            EXT. REVIEW REQ?  REVIEW DATE   REVIEW BY
        CONTACT              CONDITION        COMPLE DTE/TIME    COMPLETED BY
1       04-FOURTH LEGAL STAT  03/29/96 1743  5d     04/03/96 1743
        01-VOLUNTARY ADMISSION   Yes          03/31/96      ADAIR,FRANK K
        ALLEN,JOHN            4-CONDITION FIV  03/31/96 1045  ADAIR,FRANK K
2




                  Enter legal status code or '-' to list--
   F1Prev Page F2Next Page F3 Insert  F4 Delete  F6 Reset  F7  Exit   ?
```

Subscreen Field Explanations

NUMBER (DISPLAY ONLY)
The number in this column is automatically assigned by the system as each new Legal Status is entered.

LEGAL STATUS (TABLE LOOKUP)
This column enables you to enter the Legal Status. Enter the code or enter a hyphen (-) to display the Legal Status Definition code table for selection.

When you assign a new legal status, the system checks the Maximum/Visit flag in the Legal Status Definition table to determine how many times this status can be assigned to a patient per visit. If you assign a legal status that exceeds the maximum allowed per visit for this status, the system displays this warning:

Exceeds Legal Status Maximum/Visit, Assign Anyway? (Y/N)--

Enter **Y** to indicate that this status should be assigned. Enter **N** to indicate that this legal status should not be assigned.

The current legal status displays on the Mental Health screen (from which this subscreen was accessed).

START DTE/TIME (DATE/TIME FORMAT)
This column enables entry of the date and time this legal status went into effect. This information is used to calculate the information for the EXP DTE/TME field.

LOS (DISPLAY ONLY)
This column displays the length of stay (LOS) for this legal status definition, indicating the length of time that this status is in effect. The LOS is associated with the legal status code in the Legal Status Definition table.

EXP DTE/TIME (DISPLAY ONLY)
This column displays the expiration date and time of the current legal status. STAR calculates this field by adding the length of stay to the start date and time.

ACT LOS (DISPLAY ONLY)
This column displays the actual length of stay while the patient has this legal status. The system calculates this field by subtracting the current date and time from the start date and time of this legal status. The field is automatically calculated when you make an entry in the Compl Dte/Time field.

CATEGORY (DISPLAY ONLY)
This column displays the category code associated with this legal status. The category code is associated with the legal status in the Legal Status Definition table.

EXT REVIEW REQ? (1-A-O)
This column enables you to indicate whether or not an external review is required for this legal status. Enter Y for Yes or N for No.

REVIEW DATE (DATE FORMAT)
This column enables entry of the date and time the review is to take place.

REVIEW BY (TABLE LOOKUP)
This column enables entry of the external reviewer for this legal status. Enter the code or press hyphen (-) to display the Legal Status External Review By code table for selection.

CONTACT (TABLE LOOKUP)
This column enables you to enter the contact physician. To enter a physician, perform one of these entry options:

- Enter the physician code.
- Enter a hyphen (**-**) to display the Physicians table for selection.
- Enter the letter(s) physician's name begins with followed by a hyphen (**-**) to limit the search.
- Enter **R** to display a list of all physicians of record. Select a physician from this list.

CONDITION (TABLE LOOKUP)
This column enables you to enter the condition of the legal status. Enter the code or a hyphen (-) to display the Condition of Legal Status code table for selection.

COMPL DTE/TIME (DATE/TIME FORMAT)
This column enables you to enter the date and time this legal status was completed.

COMPLETED BY (TABLE LOOKUP)
The field enables you to identify a physician completing this legal status. To enter a physician, execute one of these entry options:

- Enter the physician code.
- Enter a hyphen (**-**) to display the Physicians table for selection.
- Enter the letter(s) the name begins with followed by a hyphen (**-**) to limit the search.
- Enter **R** to display a list of all physicians of record. Select a physician from this list.
- Press ENTER to default this field to the physician found in the Contact Physician field.

Once you have completed all the appropriate fields, press F7 to accept and exit the screen. You are returned to the Mental Health screen of the abstract.

Mental Health Screen Field Explanations cont.

4. LEGAL STATUS CHG (TABLE LOOKUP)
This field is used by Canadian facilities to enter a Legal Status applicable to the Canadian Institute for Health Information (CIHI) interface. By separating the Legal Status and Legal Status Change fields, you can enter codes more specific to your facility in the first field and an acceptable status for CIHI in this field. Enter the code or press hyphen (-) to display the Legal Status Changes code table for selection.

5. EMPLOYMENT STATUS (TABLE LOOKUP)
This field indicates the employment status of the patient. This information may be entered at time of admission and updated here (which updates the MPI). Enter the code or a hyphen (-) to display the Mental Health Employment Status table for selection.

6. FINANCIAL SUPPORT (TABLE LOOKUP)
This field indicates any financial support the patient is receiving. This information may be entered at time of admission and updated here (which updates the MPI). Enter the code or a hyphen (-) to display the Financial Support code table for selection.

7. EDUCATION LEVEL (TABLE LOOKUP)
This field indicates the education level of the patient. This information may be entered at time of admission and updated here (which updates the MPI). Enter the code or a hyphen (-) to display the Education Level code table for selection.

8. ECT TREATMENT (SPECIAL FORMAT)
If ECT treatments have been entered previously, the field contains "Entries Defined." If no treatments have been entered, the field is blank, and the system displays the following prompt:

Enter ECT Treatments? (Y/N) [N]--

If you do not want to enter any ECT treatments, enter **N** or press ENTER for No. Enter **Y** for Yes to access the screen to enter the treatment information. The following screen is an example:

```
                  General Hospital Mental Health Processor
                                              Mon Mar 23, 2009 02:18 pm
   Account No     Name                        ICD    Unit No        Corp No
   0904200002     TOMEY,TIM                   10     000-00-5885    00006552
NO.  ECT TYPE                    DATE       TIME       ANESTHESIA TYPE
     ELECTRODE POSITION          ORDERING PHYSICIAN         CONSENT     INIT
1    1 ELECTROSHOCK LEVEL1       03/23/09   09:00      G GENERAL
     1 EEG                       32 ADAIR,CAR               Yes         JJW
2




                  Enter ECT Treatment code or '-' to list--
   F1Prev Page F2Next Page F3 Insert  F4 Delete  F6 Reset  F7  Exit   ?
```

Subscreen Field Explanations

ECT TYPE (TABLE LOOKUP)
This column is for entry of ECT type code. Enter the code, if you know it, or enter a hyphen (-) to access the ECT table for selection.

DATE (DATE ENTRY)
This column is for entry of the date that the treatment was rendered.

TIME (TIME ENTRY)
This column is for entry of the time that the treatment was rendered. When you enter the time, you can enter it with or without am or pm (or a or p). For eight o'clock in the

morning, you could enter 8a, for example. If you enter the hour *without* the designation (for example, 8), the system displays an additional prompt:

"Am or Pm--"

Enter **A** or **P** to indicate morning or evening.

ANESTHESIA TYPE (TABLE LOOKUP)
This column identifies the type of anesthesia administered during ECT treatment. Enter the anesthesia code, if you know it, or enter a hyphen (-) to access the Anesthesia Codes table.

ELECTRODE POSITION (TABLE LOOKUP)
Entry in this field identifies the position of the electrodes for ECT treatment. Enter the code if you know it, or enter a hyphen (-) to access the Electrode Position table for selection.

ORDERING PHYSICIAN (TABLE LOOKUP)
This column is for entry of the physician ordering ECT treatment. To enter a physician, perform one of the following options:

- Enter the physician code.
- Enter a hyphen (**-**) to display the Physician table for selection.
- Enter the letter(s) the name begins with followed by a hyphen (**-**) to limit the search.
- Enter a hyphen followed by a name to override the table and enter a freeform name.
- Enter **R** to display a list of all physicians of record. Select a physician from this list.

CONSENT (1-A-R)
This column is used to indicate whether or not a signed consent was obtained for administering ECT treatment. Enter **N** for No if consent was not obtained, or **Y** for Yes if consent was obtained.

INIT (DISPLAY ONLY)
This field displays the initials of the person entering the information. This field cannot be edited.

Mental Health Screen Field Explanations cont.

9. COMMUNITY AGENCY (TABLE LOOKUP)
This field indicates any community agencies involved with the care of this patient. This information may be entered at time of admission and updated here (which updates the MPI). When you access this field, a screen is displayed with this prompt:

Enter delete(D) or add(A) a Community Agency--

If you press ENTER, no entry is made. To add an agency, enter **A**. The system displays the following prompt:

Enter community agency code--

Enter the code, if you know it, or a hyphen (**-**) to display the Community Agency code table for selection. This field allows multiple code selection to identify all community agencies that apply. If you display the table, you can enter a range of option numbers.

To delete an entry, enter **D**. The system prompts you to enter the option number of the community agency you want to delete. When you enter this number, the system displays the following prompt:

Delete NNNNN? (Y/N) [N]--

where NNNNN is the description of the community agency.

Enter **Y** to confirm the deletion.

10. MENTAL CATEGORY (TABLE LOOKUP)
This field indicates the mental category of the patient. Updates done in the abstract update the MPI. Enter the code or a hyphen (-) to display the Mental Category code table for selection.

11. REFERRAL SOURCE (TABLE LOOKUP)
This field indicates the source of this referral (who referred the patient to your facility). This information may be entered at time of admission and updated here (which updates the MPI). Enter the code or a hyphen (-) to display the Mental Health Referral Source code table for selection.

12. REFERRAL REASON (TABLE LOOKUP)
This field indicates the reason the patient was referred to your facility. This information may be entered at time of admission and updated here (which updates the MPI). Enter the code or a hyphen (-) to display the Reason for Referral code table for selection.

13. REFERRED TO (2-AN-O OR TABLE LOOKUP)
This field indicates the institution/facility to which the patient was referred upon leaving your facility. Enter the code or a hyphen (-) to display the Referring Institution/Facility code table for selection.

14. METHOD OF ADMISSION (1-N-O OR TABLE LOOKUP)
This field indicates how the patient was admitted. This information may be entered at time of admission and updated here (which updates the MPI). Enter the code or a hyphen (-) to display the Mental Health Admission Method code table for selection.

15. SUBSTANCES TAKEN (1-N-O)
This field identifies any substances (legal or illegal) being misused by the patient. If substances have been entered previously, *Entries Defined* is displayed in the field. If no substances have been entered, the following prompt is displayed:

Enter Substance Taken? (Y/N) [N]--

If you do not want to make an entry in this field, enter **N** for No or press ENTER to leave this field blank. To enter a substance or substances, enter **Y** for Yes. The following subscreen is displayed:

```
                  General Hospital Mental Health Processor
                                              Mon Mar 23, 2009 02:18 pm
  Account No     Name                        ICD    Unit No        Corp No
  2-00004-95     BOWLES,JAY                  10     0000-000934    00000924
NO.    SUBSTANCES TAKEN              CLASSIFICATION        INJECTED?    INIT
 1     4 COCAINE                     1 ILLICIT DRUGS       No           LTR
 2     5 SLEEPING PILLS              3 OVER COUNTER DRUG   No           LTR









            Enter substances taken code or '-' to list--
   F1Prev Page F2Next Page F3 Insert  F4 Delete  F6 Reset  F7  Exit   ?
```

Subscreen Field Explanations

SUBSTANCE TAKEN (TABLE LOOKUP)
This column is for entering the code that identifies the substance being misused. Enter the code or a hyphen (-) to display the Substances Taken code table for selection.

CLASSIFICATION (DISPLAY ONLY)
This column displays the classification that has been associated with the substance in the Substances Taken table. You cannot edit this information here.

INJECTED? (1-A-O)
This column identifies whether the substance was injected. Enter **N** for No or leave the field blank if it was not injected, or enter **Y** for Yes to indicate the substance was injected.

INIT (DISPLAY ONLY)
This field displays the initials of the person entering this information. The system automatically completes this field and it cannot be edited.

Mental Health Screen Explanations cont.

16. FORENSIC PATIENT (1-N-O)
This field indicates if this is a forensic patient (that is, a legal case). This information may be entered at time of admission and updated here (which updates the MPI). If forensic information has been entered, the field displays Yes. When you access this field, the system displays the following prompt:

Is patient a forensic patient? (Y/N) [N--

Enter **N** to indicate this is not a forensic patient or enter **Y** to indicate this is a forensic patient. If you enter **Y,** an additional screen is displayed enabling completion of additional information. The following is an example of this subscreen:

```
                    General Hospital Mental Health Processor
                                                 Wed Mar 18, 2009 03:36 pm
    Account No     Name                         ICD   Unit No        Corp No
    2-00004-95     BOWLES,JAY                   10    0000-000934    00000924
  1 Lawyer                          2 Phone
    DEWEY,DEWEY,& FORD              (404)848-4848
  3 Police Department Involved      4 Court Date
    DEKALB POLICE DEPT.               03/31/09









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

Subscreen Field Explanations

LAWYER (25-AN-O)
This field enables entry of the name of the patient's lawyer. This information may be entered at time of admission and updated here (which updates the MPI). To enter this information, enter the lawyer's name.

PHONE (7-N-O)
This field enables entry of the phone number of the patient's lawyer entered in the previous field. This information may be entered at time of admission and updated here (which updates the MPI). To enter this information, enter the phone number.

POLICE DEPARTMENT INVOLVED (25-AN-O)
This field enables entry of the name of the police department involved with this patient. This information may be entered at time of admission and updated here (which updates the MPI). To complete this field, enter the name of the police department.

COURT DATE (DATE ENTRY)
This field enables entry of the court date given to the patient by law enforcement officials. This information may be entered at time of admission updated here (which updates the MPI). Enter the court date in an acceptable date format.

Field Explanations for Mental Health cont.

17. PRIMARY DSM CODE (TABLE LOOKUP)
This field enables you to enter the primary DSM code for this patient's visit. Enter the code or a hyphen (-) to display the DSM Pointer table for selection.

The ICD code that is linked to the DSM code entered here is added to the Diagnosis screen's Secondary Diagnosis field, if there is already a principal diagnosis code on the Diagnosis screen. If there is not a principal diagnosis, the Principal Diagnosis field on the Diagnosis screen is automatically completed with the associated ICD code. If the DSM code entered here is later deleted, the associated ICD code is deleted from the Diagnosis screen.

18. AXIS (TABLE LOOKUP)
This field displays the Axis code associated with the DSM code entered in the Primary DSM Code field. Axis codes are attached to DSM codes in the DSM Pointer table. If the DSM code entered in the Primary DSM Code field does not have an Axis code associated with it in the DSM Pointer table, this field is blank but can be edited.

19. ICD-9-CM (DISPLAY ONLY)
This field displays the ICD-9-CM code associated with the DSM code. This association is done through the DSM Pointer table.

20. ICD-10-CM (DISPLAY ONLY)
This field displays the ICD-10-CM code associated with the DSM code. This association is done through the DSM Pointer table.

21. ADDITIONAL DSM CODES (1-A-O)
This field enables you to enter additional DSM codes on this patient. If additional codes have been entered previously, the field displays *Entries Defined*. The ICD-9-CM code(s) linked to the DSM code(s) entered here are added to the Diagnosis screen's Secondary Diagnosis field. When DSM codes are deleted from this field, the associated ICD-9-CM codes are deleted from the Secondary Diagnosis field on the Diagnosis screen.

When you access this field, the system displays the following prompt:

Enter or view additional DSM Codes? (Y/N) [N]--

If you do not want to enter DSM codes, enter **N** for No. If you want to enter codes, enter **Y** for Yes. The system displays the following subscreen:

```
                  General Hospital Mental Health Processor
                                                Mon Mar 23, 2009 02:18 pm
  Account No     Name                          ICD    Unit No        Corp No
  2-00004-95     BOWLES,JAY                    10     0000-000934    00000924
NO.    DSM Code                          Axis  ICD9-CM Code
 1     300.01 PANIC DISORDER             I     300.01-PANIC DISORDER
 2     304.10 BARBITURATE OR SIMILAR     I     304.10-BARBITURAT DEPEND-UNSPE









                  Enter DSM-III-R Code or '-' to list--
   F1Prev Page F2Next Page F3 Insert  F4 Delete  F6 Reset  F7  Exit   ?
```

Subscreen Field Explanations

DSM CODE (TABLE LOOKUP)
This column is for entry of DSM codes. Enter the DSM code or a hyphen (-) to display the DSM Pointer table for selection. Once the code is entered, the remainder of the fields associated with the code are automatically completed based on what had been entered in the DSM Pointer table.

AXIS (DISPLAY ONLY)
This column displays the axis associated with the DSM code entered. The axis is associated with the code through the DSM Pointer table.

ICD-9-CM (DISPLAY ONLY)
This column displays the ICD-9-CM mapped to the DSM code entered. The ICD-9-CM code is associated with the code via the DSM Pointer table.

HISTORY AUDIT SCREEN

The History Audit screen automatically captures activities that are performed on an abstract, as well as the name of the user who signed on when the activity occurred and the date when it occurred. This screen is for information purposes only, allowing you to view activities in an abstract, and cannot be edited. In GUI Abstracting, this information is displayed on the Abstract Audit Information form.

NOTE: The Audit History field of the M/R Abstract & DRG Census Criteria screen controls whether or not the system maintains a history of actions taken on accounts associated with a particular abstract code. For more information, refer to the M/R Abstract & DRG Census Criteria subsection in Chapter 4: M/R Maintenance of this manual.

The History Audit screen records the following activities:

- Abstract automatically added to the census
- Abstract completed
- Abstract incompleted
- Abstract manually added to the census
- Change of census code through the Update Abstract Census Code tool
- DRG finalized
- DRG unaccepted
- DRG recalculated
- Patient Type Change

The following screen is an example:

```
              General Hospital History Audit Processor
                                                Thu Apr 09, 2009 07:41 pm
    Account No     Name                        ICD    Unit No        Corp No
    0835000001     TOMEY,TIM                   9      000-00-5885    00006552
 No  Date and Time Action                          Name                Page:01
( 1) 04/09/09 0206 Abstract Complete               ***
( 2) 04/09/09 0206 DRG Final                       ***
( 3) 04/08/09 1448 Abstract Incomplete             Pritchett,Donald
( 4) 04/08/09 1447 Abstract Incomplete             Pritchett,Donald
( 5) 04/08/09 1447 DRG Recalculate                 Pritchett,Donald
( 6) 04/08/09 1446 Abstract Incomplete             Pritchett,Donald
( 7) 04/08/09 1446 DRG Recalculate                 Pritchett,Donald
( 8) 04/02/09 0206 Abstract Complete               ***
( 9) 04/02/09 0206 DRG Final                       ***
(10) 04/01/09 1750 DRG Unaccepted                  Pritchett,Donald
(11) 04/01/09 1750 Abstract Incomplete             Pritchett,Donald
(12) 04/01/09 1748 DRG Unaccepted                  Pritchett,Donald
(13) 04/01/09 1748 Abstract Incomplete             Pritchett,Donald
(14) 03/19/09 0206 Abstract Complete               ***
(15) 03/19/09 0206 DRG Final                       ***
(16) 03/18/09 2150 DRG Unaccepted                  Pritchett,Donald

Press NL
                        next pg(/ or PG DN)  Search(TAB)
```

Field Explanations

NO (DISPLAY ONLY)
The system assigns each action a number.

DATE AND TIME (DISPLAY ONLY)
The system captures the date and time the action occurred.

ACTION (DISPLAY ONLY)
This column contains a description of the action taken. The following list includes all predefined actions, along with their explanations:

Action	Description
Abstract Auto Add	When the patient is automatically included in the Abstract Census, based on the Abstract Census criteria defined by the user. The name of the clerk who admitted the patient also displays.
Abstract Complete	When the abstract is marked complete, either manually or automatically. This action is also displayed if the abstract had been completed, was changed, then marked complete again.
Abstract Incomplete	When the abstract was previously marked complete but then changes were made and the abstract was not marked complete again. This action is also displayed when a change is made to an abstract then not marked complete.
Abstract Manual Add	When the patient is manually added by a user to the Abstract Census.

Action	Description
Census Code Change -xxx to xxx	When a census code is changed using the Update Abstract Census Code tool (xxx to xxx indicates the original census code and the new census code.)
DRG Final	When a Final DRG is accepted as Final.
DRG Unaccepted	When a Final DRG is recalculated but not reaccepted as final, or when a change has occurred that could affect the DRG, but it is not marked final.
Patient Type Change -xxx to xxx	When the Patient Type is changed through Patient Processing. (xxx to xxx indicates the original patient type and the new patient type.)

NOTE: Actions such as removing an abstract from the census, or deleting an abstract, cannot create an entry on the History Audit screen. The audit is based on the existence of an abstract; STAR cannot post an action to an abstract that does not exist.

NAME (DISPLAY ONLY)
The system displays the name of the person signed on when the action was taken.

FULL SERIES OUTPATIENT ABSTRACT

If the visit you selected from the MPI was a series outpatient visit, the following abstracting submenu may display depending on what your facility has established as their abstract display.

```
              General Hospital M/R Abstract Processor
                                              Fri Apr 10, 2009 06:05 pm
   Account No     Name                          ICD    Unit No        Corp No
   89046-00001    DOE,JOHN R                    10     0001-0362-2    00001907
          Option No.  Option
          ---------------------------------------
              1       Full Series Outpatient Abstract
              2       Patient Information
              3       Episode Information-1
              4       Episode Information-2
              5       User Defined Fields
              6       Diagnoses
              7       Procedures
              8       HCPCS Procedures
              9       DRG Assignment
             10       Blood Groups
             11       History Audit



Enter option number--
```

Examples of each of the options on this menu are shown previously in this section under the inpatient abstract type. However, there are some screen variations which are explained on the following pages.

If you are using the Patient Processing Auto Re-registration of Series patients functionality, the system checks the re-admitted account against the current M/R Abstracting & DRG Census Criteria and assigns an abstract census code if applicable. The parameters (Retention, Auto Complete, 3M product, etc.) defined for the assigned census code will apply to the new account.

Additionally, the system automatically copies the following abstract data entered on the initial account to the subsequent re-registered account, if the data was entered on the initial series account and the re-admit account is assigned an abstract census code:

- Diagnosis from Admitting
- Admitting Complaint (GUI Abstracting)
- Principal Diagnosis code, description, detail
- Secondary Diagnosis codes, description, detail
- Coder Initials

- Admitting Physician
- Attending Physician
- Most Responsible Physician
- Delivering Physician
- Service
- Sub Service
- Blood Information
- Specialty Unit Information
- Corrected Patient Type
- Social Services
- Mental Health Information detail
- Legal Status Detail
- Substances Taken Detail
- DSM Codes

In addition, many abstract fields containing Patient Processing MPI data display on the re-registered account.

The new account will be in the incomplete abstract census and remain incomplete until the abstract is completed.

Episode Information-1 Screen

```
             General Hospital Series Outpatient Abstract Processor
              Episode Information  Page  2 of  9 Mon Mar 16, 2009 12:37 pm
    Account No     Name                          ICD    Unit No        Corp No
    0906900013     ADAMS,PHOEBE                  10     000-00-5912    00006589
 1 OP Admission Date  2 OP Admission Time     3 Discharge Date  4 Dsch Time
   03/10/09             16:58                   03/10/09          16:59
 5 Dsch Disposition   6 Service               7 Financial cl    8 LOS(Days/Hrs)
   *HOME(OUTPATIENT)    MED MEDICALXX           JA JULIE'S F      0/1
 9 Attending Physician                       10 Referring Physician
   1 ADAMS,JAY K                             ->
11 Most Resp. Physician                      12 Phys. Spec.

13 Main Service      14 Sub. Serv.           15 2nd Cht/Reg #









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

Field Explanations

1. OP ADMISSION DATE (DISPLAY ONLY)
The admission date entered during the admission sequence displays in this field. You cannot update this information on this screen. To modify it, use the Revise Admission/ Discharge Date and Time option.

2. OP ADMISSION TIME (DISPLAY ONLY)
The admission time entered during the admission sequence is displayed in this field. You cannot update this information on this screen. To modify it, use the Revise Admission/Discharge Date and Time option.

3. DISCHARGE DATE (DISPLAY ONLY)
This field displays the patient's discharge date for this visit. You cannot update this information on this screen, but you can update it by using the Revise Admission/ Discharge Date and Time option.

4. DSCH TIME (DISPLAY ONLY)
This field displays the patient's discharge time for this visit. You cannot update this information on this screen, but you can update it by using the Revise Admission/ Discharge Date and Time option.

5. DISCHARGE DISPOSITION (TABLE LOOKUP)
This field displays the patient's discharge disposition, as entered at the time of admission, or subsequently updated. Enter the code or a hyphen (-) to display the Discharge Status/Disposition table for selection. The table displays the valid codes applicable for the patient type being abstracted.

If you enter a discharge/disposition status that is flagged as an expired status, some of the existing patient data in the system may be automatically deleted as a result of the expiration status. When you enter an expired status, the following warning message displays:

Pending visit information will be cancelled! Continue? (Y/N) [N]--

Enter **Y** for Yes to continue with the expired discharge/disposition status. Enter **N** for No if you do not want to enter the expired status.

If you continue with the expired status, the following message displays:

Cancelling pending visit information

NOTE: The system calculates and enters the Date of Death in the patient's MPI information.

6. SERVICE (TABLE LOOKUP)
Initially, this field displays the service entered at time of admission (or subsequently updated). When you access this field to update this information, the Service Tracker subscreen is displayed. This subscreen enables you to track all service changes and transfers for this patient. The most recent entry in the Service Tracker is the service that displays in this field. After you accept the Service Tracker screen, you are returned to the Episode Information-1 screen where the updated service (if applicable) is displayed.

For details on using this Service Tracker screen, refer to the discussion regarding the Service field of the inpatient's Episode Information-1 screen.

7. FINANCIAL CL (TABLE LOOKUP)
This field displays the patient's financial class as entered at admission, or subsequently updated. To update this field, enter the code, if you know it, or enter a hyphen (-) to display the Financial Classes code table for selection.

NOTE: Updating the financial class in the Abstract does **not** update the MPI or insurance information. Changes in financial class should originate from the Patient Accounting/Billing system.

8. LOS (HRS)
This field displays the patient's length of stay (LOS) in hours.

9. ATTENDING PHYSICIAN (TABLE LOOKUP)
This field contains the name and address of the attending physician entered during the admission sequence. When you access this field in the STAR Financials environment, the system displays a subscreen on which you can enter the name and address of a *new* attending physician.

NOTE: The screen enabling entry of an address only displays if the field 2nd Office Address in the Hospital Facilities Options screen is set to Yes. Otherwise, only a new attending name and reclassification effective date are entered.

```
            General Hospital Series Outpatient Abstract Processor
               Episode Information  Page 2 of  9 Wed Mar 18, 2009 12:30 pm
 Account No     Name                      ICD        Unit No        Corp No
 90030-00005    DOE,JOHN                  9          000-1048-47    0003029
Current    1 Attending Physician         Office Address
             99 ZELLER,HECTOR C
New        2 Attending Physician         Office Address

           3 Effective                4 By
                                        B C









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

Subscreen Field Explanations

1. ATTENDING PHYSICIAN OFFICE ADDRESS (DISPLAY ONLY)
This field contains the name and address of the *current* attending physician.

2. ATTENDING PHYSICIAN OFFICE ADDRESS (26-A-R or TABLE LOOKUP)
This field is used to enter the name and address of a *new* attending physician. You can enter the table code for the new physician if you know it, or press hyphen (-) and ENTER to display the physician code table for selection. You can enter part of the physician's name or the letter(s) the name begins with followed by a hyphen (-) to limit the alphabetic table search.

3. EFFECTIVE DATE (25-AN-R)
This field prompts you to enter the effective date or the earliest reclassification date possible for the new attending physician. The earliest date allowed is either the admission date or the earliest reclassification date allowed according to the parameters set in STAR Financials. The default is the current date. Enter **E** to automatically assign the earliest reclassification date allowed.

4. BY (DISPLAY ONLY)
This field is automatically completed with the initials of the person who signed on.

Once you complete the subscreen for entering the attending physician, you are returned to the Episode Information screen where the code and name of the new attending physician displays.

Episode Information-1 Screen Field Explanations cont.

10. REFERRING PHYSICIAN (TABLE LOOKUP)
The referring physician entered during the admission sequence displays in this field. To enter a new referring physician, enter the physician's code number if you know it, or press hyphen (-) followed by ENTER to display the physician code table for selection. You can enter part of the physician's name or the letter(s) the name begins with followed by a hyphen to limit the search. You can also enter a hyphen followed by a physician's name to override the table.

11. MOST RESP. PHYSICIAN (TABLE LOOKUP)
When a patient is discharged, this field automatically displays the physician listed in the Physician Tracker who was responsible for the patient during the longest time period, based on the patient's length of stay. You can edit this field if necessary. When you access this field, the system automatically displays a list of all attending physicians associated with this case. Enter the option number to the left of the physician name.

12. PHYS. SPEC. (TABLE LOOKUP)
This field enables you to identify the specialty of the physician selected in the previous field as the most responsible. You have the following entry options:

- Enter the Physician/Resource Specialty code, if you know it.
- Enter a hyphen (-) to display the Physician/Resource Specialty code table for selection.
- Press ENTER to accept the default of primary specialty associated with the physician in the Physician code table.

13. MAIN SERVICE (TABLE LOOKUP)
When a patient is discharged, this field automatically displays the service listed in the Service Tracker that has the greatest length of stay (LOS). You can edit this field if necessary. When you access this field, the system automatically displays all services associated with this case in the Service Tracker subscreen. To select a service as the main service, enter the option number to the left of the service name.

14. SUB. SERV. (DISPLAY ONLY)
This field displays the subservice associated with the service entered in the Main Service field.

15. 2ND CHT/REG.# (12-C-O)
If this abstract belongs to a baby, the mother's unit number is displayed in this field. If this abstract belongs to a mother, the baby's unit number is displayed. If the patient is neither a mother nor a baby, you can enter a second chart registration number for the patient.

Episode Information-2 Screen

```
          General Hospital Series Outpatient Abstract Processor
              Episode detail-2     Page  3 of  9 Mon Mar 16, 2009 12:43 pm
   Account No     Name                          ICD    Unit No        Corp No
   0906900013     ADAMS,PHOEBE                  10     000-00-5912    00006589
 1 Departments
   Defined
 2 Arrival Mode             3 Admission Type          4 Admission Source
   ARR ARRIVAL BY BUS         12 ELECTIVE-BOOKED        10 ADMIT SOURCE
 5 Pre-admit                6 LMP Date                7 Coder
->
 8 Referring Facility       9 Referred To            10 Social Services

11 NJ/NY Z Code                      12 Overflow









Enter table code, or `-` for table--
```

Field Explanations

1. DEPARTMENTS (TABLE LOOKUP)
Enter the departments or areas the patient visited as a result of or during this visit. Enter the department code if you know it, or press hyphen (-) followed by ENTER to display the Department Location code table for selection. This field is automatically filled if the Visit Check-in function is used.

```
Page:01                      Department Locations           ##=Current Choices
( 1) CAR-CARDIOLOGY                       ( 3) EEG-EEG
( 2) ENT-EAR, NOSE, AND THROAT            ( 4) ER-EMERGENCY ROOM

Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
               end select(NL)  next pg(/ or PG DN)  Search(TAB)
```

2. ARRIVAL MODE (TABLE LOOKUP)
This field indicates how the patient arrived at your facility, as entered at the time of admission, or subsequently updated. To modify this field, enter the code identifying the patient's mode of arrival, if you know it, or enter a hyphen (-) to display the Arrival Modes table for selection. You can also make a freeform entry.

3. ADMISSION TYPE (TABLE LOOKUP)
Enter the code that specifies the type of admission. Enter the table code if you know it, or press hyphen (**-**) followed by ENTER to display the Admission Type code table for selection. The code and the admission type description display in this field.

4. ADMISSION SOURCE (TABLE LOOKUP)
Enter the code that specifies the source requesting admission for this patient. Enter the table code if you know it, or press hyphen (**-**) followed by ENTER to display the Admission Source code table for selection. The code and the source description display in this field.

5. PRE-ADMIT (TABLE LOOKUP)
This field enables you to identify the type of preadmission for this patient. Enter the code corresponding to the entry, if you know it, or enter a hyphen (-) to display the Pre-Admit code table for selection.

6. LMP DATE (25-AN-O)
Enter the date of the patient's last menstrual period (females only). Dates can be entered in a variety of formats. Refer to the Information Entry Techniques chapter in the *STAR Patient Care Reference Guide, General Information Volume* for details.

7. CODER (3-AN-O)
This field enables you to enter the code or initials of the person responsible for coding the diagnosis and procedures on the medical record. If the coding was done using the 3M Coding and Reimbursement System, the initials of the person who accessed 3M are automatically displayed here.

8. REFERRING FACILITY (TABLE LOOKUP OR 19-C-O)
This field identifies the facility, institution, or person referring this patient to your facility, as entered at the time of admission, or subsequently updated. A referring facility may differ from the transferring facility in that the patient may be referred to your facility for care, but not physically transferred directly from another facility. To modify this information, enter the code corresponding to the referring facility or enter a hyphen (-) to display the Referring Institution/Facility code table for selection. You can also make a freeform entry of up to 19 characters (you must type a hyphen before your freeform entry).

9. REFERRED TO (TABLE LOOKUP OR 19-C-O)
This field identifies the facility, institution, or person to which this patient was referred upon leaving your facility. A referring facility may differ from the transferring facility in that the patient may be referred for follow-up care, but not physically transferred there directly from your facility. To modify this information, enter the code corresponding to the facility, or enter a hyphen (-) to display the Referring Institution/Facility code table for selection. You can also make a freeform entry.

NOTE: Changes to this field also update the Referred To field in the Discharge Planning screen of the STAR Utilization Management Module.

10. SOCIAL SERVICES (TABLE LOOKUP)
This field identifies social services received by the patient prior to discharge. Enter a new code, if you know it, or enter a hyphen (-) to display the Social Services code table for selection.

11. NJ/NY Z CODE (TABLE LOOKUP)
This field is applicable only in the states of New Jersey and New York. The field is not required. Z Codes are trauma codes that indicate the *place of injury*. Select the appropriate code.

12. OVERFLOW (TABLE LOOKUP)
This field enables Canadian facilities to identify any areas of the abstract where an overflow occurred. For example, if the patient has more than 15 diagnoses, the overflow type would be "diagnoses" to indicate that there are more diagnoses entered in the abstract than can be placed in the CIHI interface. Enter the code, if you know it, or enter a hyphen (-) to display the Abstract Overflow code table for selection.

EMERGENCY ROOM PATIENT ABSTRACT

If the visit you selected from the MPI was an emergency room visit, the following abstracting submenu may display depending on what the facility has established as their abstract screen display:

```
              General Hospital M/R Abstract Processor
                                          Thu Mar 19, 2009 03:43 pm
   Account No     Name                          ICD    Unit No        Corp No
   0824600003     DONER,ABIGAIL                 9      000-00-5811    00006478
          Option No.  Option
          ---------------------------------------
              1       Full E/R Outpatient Abstract
              2       Patient Information
              3       Episode Information-1
              4       Episode Information-2
              5       User Defined Fields
              6       Consultations
              7       Diagnoses
              8       Procedures
              9       HCPCS Procedures
             10       DRG Assignment
             11       Death Classifications
             12       Blood Groups
             13       History Audit


Enter option number--
```

Examples of each of the options on this menu are shown previously in this section under the inpatient abstract type. However, there are some screen variations, which are explained on the following pages.

Episode Information-1 Screen

```
          General Hospital E/R Outpatient Abstract Processor
              Episode Information  Page  2 of 11 Fri Apr 10, 2009 05:18 pm
   Account No     Name                          ICD    Unit No        Corp No
   0824600003     DONER,ABIGAIL                 9      000-00-5811    00006478
 1 OP Admission Date  2 OP Admission Time     3 Discharge Date  4 Dsch Time
   09/02/08             11:26                  09/02/08          23:59
 5 Dsch Disposition   6 Service               7 Financial cl    8 LOS(Days/Hrs)
   *HOME(OUTPATIENT)    MED MEDICALXX          S SELF PAY        0/12
 9 Attending Physician                       10 Referring Physician
   1 ADAMS,JAY K                             ->
11 Most Resp. Physician                      12 Phys. Spec.

13 Main Service      14 Sub. Serv.           15 2nd Cht/Reg #









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

Field Explanations

1. OP ADMISSION DATE (DISPLAY ONLY)
The admission date entered during the admission sequence displays in this field. You cannot update this information on this screen. To modify it, use the Revise Admission/ Discharge Date and Time option.

2. OP ADMISSION TIME (DISPLAY ONLY)
The admission time entered during the admission sequence is displayed in this field. You cannot update this information on this screen. To modify it, use the Revise Admission/Discharge Date and Time option.

3. DISCHARGE DATE (DISPLAY ONLY)
This field displays the patient's discharge date for this visit. You cannot update this information on this screen, but you can update it by using the Revise Admission/ Discharge Date and Time option.

4. DSCH TIME (DISPLAY ONLY)
This field displays the patient's discharge time for this visit. You cannot update this information on this screen, but you can update it by using the Revise Admission/ Discharge Date and Time option.

5. DISCHARGE DISPOSITION (TABLE LOOKUP)
This field displays the patient's discharge disposition, as entered at the time of discharge, or subsequently updated. When you access this field, the Discharge Status/Disposition table is displayed for selection. The table displays the valid codes applicable for the patient type being abstracted.

If you enter a discharge/disposition status that is flagged as an expired status, some of the existing patient data in the system may be automatically deleted as a result of the expiration status. When you enter an expired status, the following warning message displays:

Pending visit information will be cancelled! Continue? (Y/N) [N]--

Enter **Y** for Yes to continue with the expired discharge/disposition status. Enter **N** for No if you do not want to enter the expired status.

If you continue with the expired status, the following message displays:

Cancelling pending visit information

NOTE: The system calculates and enters the Date of Death in the patient's MPI information.

6. SERVICE (TABLE LOOKUP)
Initially, this field displays the service entered at time of admission (or subsequently updated). When you access this field to update this information, the Service Tracker subscreen is displayed. This subscreen enables you to track all service changes and transfers for this patient. The most recent entry in the Service Tracker is the service that displays in this field. After you accept the Service Tracker screen, you are returned to the Episode Information-1 screen where the updated service (if applicable) is displayed.

For details on using this Service Tracker screen, refer to the discussion regarding the Service field of the inpatient's Episode Information-1 screen.

7. FINANCIAL CL (TABLE LOOKUP)
This field displays the patient's financial class as entered at admission, or subsequently updated. To update this field, enter the code, if you know it, or enter a hyphen (-) to display the Financial Classes code table for selection.

NOTE: Updating the financial class in the abstract does *not* update the MPI or insurance information. Changes in financial class should originate from the Patient Accounting/Billing system.

8. LOS (HRS)
This field displays the patient's length of stay (LOS) in hours.

9. ATTENDING PHYSICIAN (TABLE LOOKUP)
This field contains the name of the attending physician entered during the admission sequence. When you access this field in the STAR Financials environment, the system displays a subscreen on which you can enter the name and address of a *new* attending physician.

NOTE: The screen enabling entry of an address only displays if the field 2nd Office Address in the Hospital Facilities Options screen is set to Yes. Otherwise, only a new attending name and reclassification effective date is entered.

```
            General Hospital Series Outpatient Abstract Processor
               Episode Information  Page 2 of  9 Wed Mar 18, 2009 12:30 pm
 Account No     Name                      ICD        Unit No        Corp No
 90030-00005    DOE,JOHN                  9          000-1048-47    0003029
Current    1 Attending Physician         Office Address
             99 ZELLER,HECTOR C
New        2 Attending Physician         Office Address

           3 Effective                4 By
                                        B C









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

Subscreen Field Explanations

1. ATTENDING PHYSICIAN OFFICE ADDRESS (DISPLAY ONLY)
This field contains the name and address of the *current* attending physician.

2. ATTENDING PHYSICIAN OFFICE ADDRESS (26-A-R or TABLE LOOKUP)
This field is used to enter the name and address of a *new* attending physician. You can enter the table code for the new physician if you know it, or press hyphen (-) and ENTER to display the physician code table for selection. You can enter part of the physician's name or the letter(s) the name begins with followed by a hyphen (-) to limit the alphabetic table search.

3. EFFECTIVE DATE (25-AN-R)
This field prompts you to enter the effective date or the earliest reclassification date possible for the new attending physician. The earliest date allowed is either the admission date or the earliest reclassification date allowed according to the parameters set in STAR Financials. The default is the current date. Enter **E** to automatically assign the earliest reclassification date allowed.

4. BY (DISPLAY ONLY)
This field is automatically completed with the initials of the person who signed on.

Once you complete the subscreen for entering the attending physician, you are returned to the Episode Information screen where the code and name of the new attending physician displays.

Episode Information-1 Screen Field Explanations cont.

10. REFERRING PHYSICIAN (TABLE LOOKUP)
The referring physician entered during the admission sequence displays in this field. To enter a new referring physician, enter the physician's code number if you know it, or press hyphen (-) followed by ENTER to display the physician code table for selection. You can enter part of the physician's name or the letter(s) the name begins with followed by a hyphen to limit the search. You can also enter a hyphen followed by a physician's name to override the table.

11. MOST RESP. PHYSICIAN (TABLE LOOKUP)
When a patient is discharged, this field automatically displays the physician listed in the Physician Tracker who was responsible for the patient during the longest time period, based on the patient's length of stay. You can edit this field if necessary. When you access this field, the system automatically displays a list of all attending physicians associated with this case. Enter the option number to the left of the physician name.

12. PHYS. SPEC. (TABLE LOOKUP)
This field enables you to identify the specialty of the physician selected in the previous field as the most responsible. You have the following entry options:

- Enter the Physician/Resource Specialty code, if you know it.
- Enter a hyphen (-) to display the Physician/Resource Specialty code table for selection.
- Press ENTER to accept the default of primary specialty associated with the physician in the Physician code table.

You cannot edit this field if the Most Resp. Physician field is blank.

13. MAIN SERVICE (TABLE LOOKUP)
When a patient is discharged, this field automatically displays the service listed in the Service Tracker that has the greatest length of stay (LOS). You can edit this field if necessary. When you access this field, the system automatically displays all services associated with this case in the Service Tracker subscreen. To select a service as the main service, enter the option number to the left of the service name.

14. SUB. SERV. (DISPLAY ONLY)
This field displays the subservice associated with the service entered in the Main Service field.

15. 2ND CHT/REG.# (12-C-O)
If this abstract belongs to a baby, the mother's unit number is displayed in this field. If this abstract belongs to a mother, the baby's unit number is displayed. If the patient is neither a mother nor a baby, you can enter a second chart registration number for the patient.

Episode Information-2 Screen

```
          General Hospital E/R Outpatient Abstract Processor
              Episode detail-2     Page  3 of 11 Fri Apr 10, 2009 05:19 pm
   Account No     Name                          ICD    Unit No        Corp No
   0824600003     DONER,ABIGAIL                  9     000-00-5811    00006478
 1 Departments
->
 2 Arrival Mode             3 Admission Type         4 Admission Source
                              2 URGENT                 1 PHYS REF/NORMAL
 5 Date/Time Dr. Notif 6 Date/Time Dr. Arrived  7 Date/Time Patient Seen

 8 Triage Code          9 Admitted Ind.         10 Case Category Code

11 Visit Type         12 LMP Date              13 NJ/NY Z Code

14 Referring Facility      15 Referred To           16 Coder

17 Social Services                              18 Overflow




Enter department location code or first letter(s)`-` of description--          |
```

Field Explanations

1. DEPARTMENTS (TABLE LOOKUP)
Enter the departments or areas the patient visited as a result of or during this visit. Enter the department code if you know it, or press hyphen (-) followed by ENTER to display the Department Location code table for selection. This field is automatically filled if the Visit Check-in function is used.

```
Page:01                      Department Locations           ##=Current Choices
( 1) CAR-CARDIOLOGY                        ( 3) EEG-EEG
( 2) ENT-EAR, NOSE, AND THROAT             ( 4) ER-EMERGENCY ROOM

Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
               end select(NL)  next pg(/ or PG DN)  Search(TAB)
```

2. ARRIVAL MODE (13-A-O)
This field displays the arrival mode that was entered at the time of admission. You can update this field by entering the code that describes how the patient was brought to this facility, if you know it, or press hyphen (**-**) followed by ENTER to display the Arrival Mode code table for selection. You can override the table and enter an arrival mode freeform: enter a hyphen followed by the freeform entry.

3. ADMISSION TYPE (TABLE LOOKUP)
Enter the code that specifies the type of admission. Enter the table code if you know it, or press hyphen (-) followed by ENTER to display the Admission Type code table for selection. The code and the admission type description display in this field. This is a required field.

4. ADMISSION SOURCE (TABLE LOOKUP)
Enter the code that specifies the source requesting admission for this patient. Enter the table code if you know it, or press hyphen (-) followed by ENTER to display the Admission Source code table for selection. The code and the source description display in this field. This is a required field.

5. DATE/TIME DR. NOTIF (DATE/TIME)
Enter the date and time the doctor was notified of the patient's admission. Your facility can define "doctor" to be either the ER physician, the house physician, or the physician being called in.

6. DATE/TIME DR. ARRIVED (DATE/TIME)
Enter the date and time the doctor arrived to treat the patient. Your facility can define "doctor" to be either the ER physician, the house physician, or the physician being called in.

7. DATE/TIME PATIENT SEEN (DATE/TIME)
Enter the date and time the patient was actually seen by the physician.

8. TRIAGE CODE (TABLE LOOKUP)
Enter the code that best describes how critical the patient's condition was upon arrival. The values set up in the Triage Code table determine how this field is to be used. Enter the Triage code if you know it, or press hyphen (-) followed by ENTER to display the Triage Code table for selection. This is not a required field.

9. ADMITTED IND (1-A-R)
Enter **Y** or **N** to indicate whether or not the patient was admitted to the hospital from the emergency room. The default is **N** for No, or you can enter **Y** for Yes to indicate the patient was admitted.

10. CASE CATEGORY CODE (TABLE LOOKUP)
Enter the code that best describes the reason the patient came to the emergency room. The descriptions set up in the Case Category Code table determine how this field is to be interpreted. Enter the case category code if you know it, or press hyphen (-) followed by ENTER to display the Case Category Code table for selection. This is not a required field.

11. VISIT TYPE (TABLE LOOKUP)
Enter the code that best describes the type of visit for this patient. The descriptions defined in the Visit Type code table assist you in determining the appropriate response. Visit Types are usually descriptions such as Physician Visit in ER, Follow Up, Emergency Room, or Clinic Visit. Enter the visit type code if you know it, or press hyphen (-) followed by ENTER to display the Visit Type Code table for selection. This is not a required field.

12. LMP DATE (DATE)
Enter the date of the patient's last menstrual period (females only).

13. NJ/NY Z CODE (TABLE LOOKUP)
Z Codes are trauma codes that indicate the *place of injury*. Select the Z Code that corresponds with the code description. This is not a required field. This field is only applicable to the states of New Jersey and New York.

14. REFERRING FACILITY (TABLE LOOKUP OR 19-C-O)
This field identifies the facility, institution, or person referring this patient to your facility, as entered at the time of admission, or subsequently updated. A referring facility may differ from the transferring facility in that the patient may be referred to your facility for care, but not physically transferred directly from another facility. To modify this information, enter the code corresponding to the referring facility or enter a hyphen (-) to display the Referring Institution/Facility code table for selection. You can also make a freeform entry of up to 19 characters (you must type a hyphen before your freeform entry).

15. REFERRED TO (TABLE LOOKUP OR 19-C-O)
This field identifies the facility, institution, or person to which this patient was referred upon leaving your facility. A referring facility may differ from the transferring facility in that the patient may be referred for follow-up care, but not physically transferred there directly from your facility. To modify this information, enter the code corresponding to the facility or enter a hyphen (-) to display the Referring Institution/Facility code table for selection. You can also make a freeform entry.

NOTE: Changes to this field also update the Referred To field in the Discharge Planning screen of the STAR Utilization Management Module.

16. CODER (3-AN-O)
This field enables you to enter the code or initials of the person responsible for coding the diagnosis and procedures on the medical record. If the coding was done using the 3M Coding and Reimbursement System, the initials of the person who accessed 3M are automatically displayed here.

17. SOCIAL SERVICES (TABLE LOOKUP)
This field identifies social services received by the patient prior to discharge. Enter a new code, if you know it, or enter a hyphen (-) to display the Social Services code table for selection.

18. OVERFLOW (TABLE LOOKUP)
This field enables Canadian facilities to identify any areas of the abstract where an overflow occurred. For example, if the patient has more than 15 diagnoses, the overflow type would be “diagnoses” to indicate that there are more diagnoses entered in the abstract than can be placed in the CIHI interface. Enter the code, if you know it, or enter a hyphen (-) to display the Abstract Overflow code table for selection.

SAME DAY SURGERY PATIENT ABSTRACT

If the visit you selected from the MPI was a same day surgery (SDS) visit, the following abstracting submenu may display depending on what the facility has established as their abstract display:

```
              General Hospital M/R Abstract Processor
                                              Fri Apr 10, 2009 06:05 pm
   Account No     Name                          ICD    Unit No        Corp No
   89046-00001    DOE,JOHN R                    10     0001-0362-2    00001907
          Option No.  Option
          ----------------------------------------
              1       Full Same Day Surgery Abstract
              2       Patient Information
              3       Episode Information-1
              4       Episode Information-2
              5       User Defined Fields
              6       Consultations
              7       Diagnoses
              8       Procedures
              9       HCPCS Procedures
             10       DRG Assignment
             11       Death Classifications
             12       Blood Groups
             13       Special Studies
             14       History Audit


Enter option number--
```

Examples of each of the options on this menu are shown previously in this section under the inpatient abstract type, with the exception of the HCPCS Procedures, which are described in the HCPCS Procedures chapter in this manual. There are some screen variations, which are explained on the following pages.

Episode Information-1 Screen

```
            General Hospital Same Day Surgery Patient Abstract Processor
              Episode Information  Page  2 of  9 Fri Apr 10, 2009 05:32 pm
   Account No     Name                          ICD    Unit No        Corp No
   90044-00007    DOE,JOHN Q                    10     0000-1049-08   00003091
 1  OP Admission Date   2 OP Admission Time    3 Discharge Date    4 Dsch Time
   90044-00007
 5 Dsch Disposition     6 Service              7 Financial cl      8 LOS (Hrs)

 9 Attending Physician                        10 Referring Physician
   1 ADAMS,HAROLD R
11 Most Resp. Physician                       12 Phys. Spec.

13 Main Service        14 Sub. Serv.          15 2nd Cht/Reg









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

Field Explanations

1. OP ADMISSION DATE (DISPLAY ONLY)
The admission date entered during the admission sequence displays in this field. You cannot update this information on this screen. To modify it, use the Revise Admission/ Discharge Date and Time option.

2. OP ADMISSION TIME (DISPLAY ONLY)
The admission time entered during the admission sequence is displayed in this field. You cannot update this information on this screen. To modify it, use the Revise Admission/Discharge Date and Time option.

3. DISCHARGE DATE (DISPLAY ONLY)
This field displays the patient's discharge date for this visit. You cannot update this information on this screen, but you can update it by using the Revise Admission/ Discharge Date and Time option.

4. DSCH TIME (DISPLAY ONLY)
This field displays the patient's discharge time for this visit. You cannot update this information on this screen, but you can update it by using the Revise Admission/ Discharge Date and Time option.

5. DISCHARGE DISPOSITION (TABLE LOOKUP)
This field displays the patient's discharge disposition, as entered at the time of discharge, or subsequently updated. When you access this field, the Discharge Status/Disposition table is displayed for selection. The table displays the valid codes applicable for the patient type being abstracted.

If you enter a discharge/disposition status that is flagged as an expired status, some of the existing patient data in the system may be automatically deleted as a result of the expiration status. When you enter an expired status, the following warning message displays:

Pending visit information will be cancelled! Continue? (Y/N) [N]--

Enter **Y** for Yes to continue with the expired discharge/disposition status. Enter **N** for No if you do not want to enter the expired status.

If you continue with the expired status, the following message displays:

Cancelling pending visit information

NOTE: The system calculates and enters the Date of Death in the patient's MPI information.

6. SERVICE (TABLE LOOKUP)
Initially, this field displays the service entered at time of admission (or subsequently updated). When you access this field to update this information, the Service Tracker subscreen is displayed. This subscreen enables you to track all service changes and transfers for this patient. The most recent entry in the Service Tracker is the service that displays in this field. After you accept the Service Tracker screen, you are returned to the Episode Information-1 screen where the updated service (if applicable) is displayed.

For details on using this Service Tracker screen, refer to the discussion regarding the Service field of the inpatient's Episode Information-1 screen.

7. FINANCIAL CL (TABLE LOOKUP)
This field displays the patient's financial class as entered at admission, or subsequently updated. To update this field, enter the code, if you know it, or enter a hyphen (-) to display the Financial Classes code table for selection.

NOTE: Updating the financial class in the abstract does **not** update the MPI or insurance information. Changes in financial class should originate from the Patient Accounting/Billing system.

8. LOS (DISPLAY ONLY)
This field displays the patient's length of stay (LOS) in days and hours separated by a slash (/). For example, a LOS of 12 hours would display as 0/12 and an LOS of 50 hours would display as 2/2.

9. ATTENDING PHYSICIAN (TABLE LOOKUP)
This field contains the name of the attending physician entered during the admission sequence. When you access this field in the STAR Financials environment, the system displays a subscreen on which you can enter the name and address of a *new* attending physician.

NOTE: The screen enabling entry of an address only displays if the field 2nd Office Address in the Hospital Facilities Options screen is set to Yes. Otherwise, only a new attending name and reclassification effective date are entered.

```
            General Hospital Series Outpatient Abstract Processor
               Episode Information  Page 2 of  9 Wed Mar 18, 2009 12:30 pm
 Account No     Name                      ICD        Unit No        Corp No
 90030-00005    DOE,JOHN                  9          000-1048-47    0003029
Current    1 Attending Physician         Office Address
             99 ZELLER,HECTOR C
New        2 Attending Physician         Office Address

           3 Effective                4 By
                                        B C









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

Subscreen Field Explanations

1. ATTENDING PHYSICIAN OFFICE ADDRESS (DISPLAY ONLY)
This field contains the name and address of the *current* attending physician.

2. ATTENDING PHYSICIAN OFFICE ADDRESS (26-A-R or TABLE LOOKUP)
This field is used to enter the name and address of a *new* attending physician. You can enter the table code for the new physician if you know it, or press hyphen (-) and ENTER to display the physician code table for selection. You can enter part of the physician's name or the letter(s) the name begins with followed by a hyphen (-) to limit the alphabetic table search.

3. EFFECTIVE DATE (25-AN-R)
This field prompts you to enter the effective date or the earliest reclassification date possible for the new attending physician. The earliest date allowed is either the admission date or the earliest reclassification date allowed according to the parameters set in STAR Financials. The default is the current date. Enter **E** to automatically assign the earliest reclassification date allowed.

4. BY (DISPLAY ONLY)
This field is automatically completed with the initials of the person who signed on.

Once you complete the subscreen for entering the attending physician, you are returned to the Episode Information screen where the code and name of the new attending physician displays.

Episode Information-1 Screen Field Explanations cont.

10. REFERRING PHYSICIAN (TABLE LOOKUP)
The referring physician entered during the admission sequence displays in this field. To enter a new referring physician, enter the physician's code number if you know it, or press hyphen (-) followed by ENTER to display the physician code table for selection. You can enter part of the physician's name or the letter(s) the name begins with followed by a hyphen to limit the search. You can also enter a hyphen followed by a physician's name to override the table.

11. MOST RESP. PHYSICIAN (TABLE LOOKUP)
When a patient is discharged, this field automatically displays the physician listed in the Physician Tracker who was responsible for the patient during the longest time period, based on the patient's length of stay. You can edit this field if necessary. When you access this field, the system automatically displays a list of all attending physicians associated with this case. Enter the option number to the left of the physician name.

12. PHYS. SPEC. (TABLE LOOKUP)
This field enables you to identify the specialty of the physician selected in the previous field as the most responsible. You have the following entry options:

- Enter the Physician/Resource Specialty code, if you know it.
- Enter a hyphen (-) to display the Physician/Resource Specialty code table for selection.
- Press ENTER to accept the default of primary specialty associated with the physician in the Physician code table.

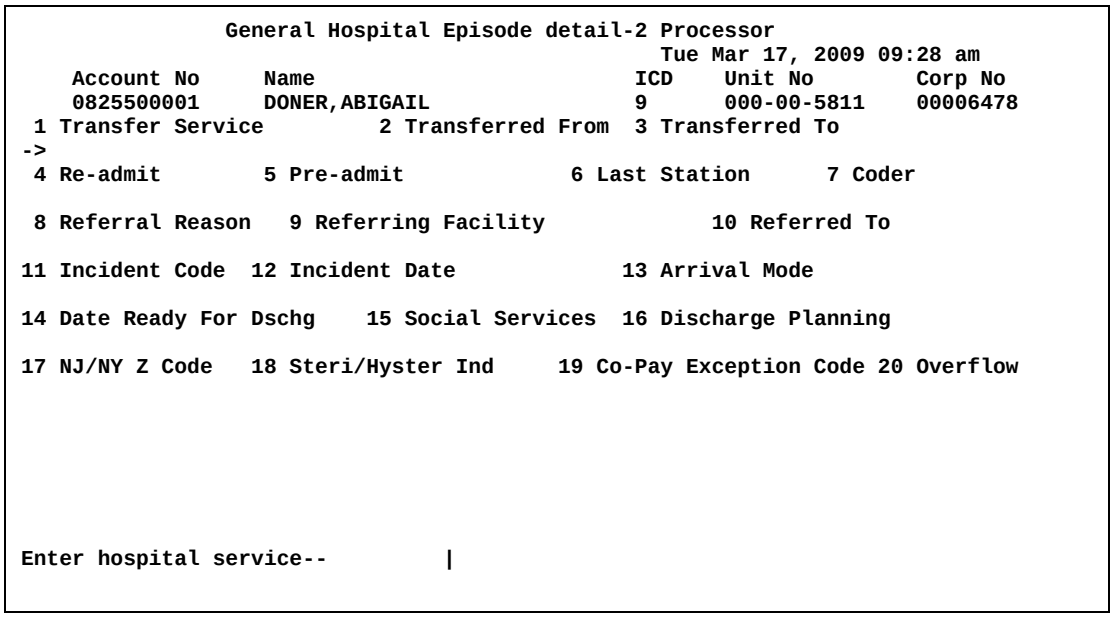
You cannot edit this field if the Most Resp. Physician field is blank.

13. MAIN SERVICE (TABLE LOOKUP)
When a patient is discharged, this field automatically displays the service listed in the Service Tracker that has the greatest length of stay (LOS). You can edit this field if necessary. When you access this field, the system automatically displays all services associated with this case in the Service Tracker subscreen. To select a service as the main service, enter the option number to the left of the service name.

14. SUB. SERV. (DISPLAY ONLY)
This field displays the subservice associated with the service entered in the Main Service field.

15. 2ND CHT/REG.# (12-C-O)
If this abstract belongs to a baby, the mother's unit number is displayed in this field. If this abstract belongs to a mother, the baby's unit number is displayed. If the patient is neither a mother nor a baby, you can enter a second chart registration number for the patient.

Episode Information-2 Screen



Field Explanations

1. TRANSFER SERVICE (TABLE LOOKUP)
This field displays the type of service at the time of transfer, or you can enter a new transfer service. Enter the table code, if you know it, or enter a hyphen (-) to display the Hospital Service table for selection.

2. TRANSFERRED FROM (TABLE LOOKUP)
This field displays the location from which the patient was transferred, as entered at the time of admission, or subsequently updated. To update this field, enter a code for the facility, if you know it, or enter a hyphen (-) to display the Referring Institution/ Facility code table for selection. You can also make a freeform entry.

3. TRANSFERRED TO (TABLE LOOKUP)
This field displays the location to which the patient was transferred. To update this field, enter a code for the facility, if you know it, or enter a hyphen (-) to display the Referring Institution/Facility code table for selection. You can also make a freeform entry.

4. RE-ADMIT (TABLE LOOKUP)
This field enables you to identify the type of readmission for this patient, or to identify if this is not a readmission. Enter the code corresponding to the entry, if you know it, or enter a hyphen (-) to display the Re-Admission code table for selection.

5. PRE-ADMIT (TABLE LOOKUP)
This field enables you to identify the type of preadmission for this patient. Enter the code corresponding to the entry, if you know it, or enter a hyphen (-) to display the Pre-Admit code table for selection.

6. LAST STATION (DISPLAY ONLY)
This field displays the last nurse station where the patient was located. You cannot modify this field.

7. CODER (3-AN-O)
This field enables you to enter the code or initials of the person responsible for coding the diagnosis and procedures on the medical record. If the coding was done using the 3M Coding and Reimbursement System, the initials of the person who accessed 3M are automatically displayed here.

8. REFERRAL TYPE (TABLE LOOKUP)
This field identifies the reason the patient was referred to your facility, as entered at the time of admission, or subsequently updated. To modify this information, enter the code identifying the reason, if you know it, or enter a hyphen (-) to display the Reason for Referral code table for selection.

9. REFERRING FACILITY (TABLE LOOKUP OR 19-C-O)
This field identifies the facility, institution, or person referring this patient to your facility, as entered at the time of admission, or subsequently updated. A referring facility may differ from the transferring facility in that the patient may be referred to your facility for care, but not physically transferred directly from another facility. To modify this information, enter the code corresponding to the referring facility or enter a hyphen (-) to display the Referring Institution/Facility code table for selection. You can also make a freeform entry of up to 19 characters (you must type a hyphen before your freeform entry).

10. REFERRED TO (TABLE LOOKUP OR 19-C-O)
This field identifies the facility, institution, or person to which this patient was referred upon leaving your facility. A referring facility may differ from the transferring facility in that the patient may be referred for follow-up care, but not physically transferred there directly from your facility. To modify this information, enter the code corresponding to the facility or enter a hyphen (-) to display the Referring Institution/Facility code table for selection. You can also make a freeform entry.

NOTE: Changes to this field also update the Referred To field in the Discharge Planning screen of the STAR Utilization Management Module.

11. INCIDENT CODE (TABLE LOOKUP)
This field displays the code identifying any incident that occurred to the patient during this visit. To modify this field, enter a new code, if you know it, or enter a hyphen (-) to display the Incident code table for selection.

12. INCIDENT DATE (DATE FORMAT)
This field enables you to associate a date with the code entered in the previous field.

13. ARRIVAL MODE (TABLE LOOKUP)
This field indicates how the patient arrived at your facility, as entered at the time of admission, or subsequently updated. To modify this field, enter the code identifying

the patient's mode of arrival, if you know it, or enter a hyphen (-) to display the Arrival Modes table for selection. You can also make a freeform entry.

14. DATE READY FOR DSCHG (DATE FORMAT)
This field displays the date the patient should be ready for discharge. You can enter a new date, or leave the field blank. By using this information with the actual discharge date, your facility can compare how long patients stay past the time when they are ready to be discharged.

15. SOCIAL SERVICES (TABLE LOOKUP)
This field identifies social services received by the patient prior to discharge. Enter a new code, if you know it, or enter a hyphen (-) to display the Social Services code table for selection.

16. DISCHARGE PLANNING (TABLE LOOKUP)
This field displays a code identifying the type of discharge planning, if any, received by the patient prior to discharge. Enter a new code, if you know it, or enter a hyphen (-) to display the UM Discharge Planning code table for selection.

NOTE: This field updates the Planning Code field in the Discharge Planning screen of the STAR Utilization Management Module.

17. NJ/NY Z CODE (TABLE LOOKUP)
This field is only applicable to the states of New Jersey and New York. It is not a required field. Z Codes are trauma codes that indicate the place of injury. Enter a new code, or enter a hyphen (-) to display the New Jersey/New York Z Codes table for selection.

18. STERI/HYSTER IND (1-A-O)
This indicator is used primarily in New Jersey and New York. This field indicates if the Sterilization/Hysterectomy consent form has been signed. Enter **Y** for Yes, **N** for No, or leave the field blank.

19. CO-PAY EXCEPTION CODE (TABLE LOOKUP)
This field contains the code identifying the reason the patient is exempt from co-payment. To modify this field, enter a new code, if you know it, or enter a hyphen (-) to display the UM Co-Pay Exception code table for selection.

20. OVERFLOW (TABLE LOOKUP)
This field is used mainly by Canadian facilities to identify any areas of the abstract where an overflow occurred. For example, if the patient has more than 15 diagnoses, the overflow type would be "diagnoses" to indicate that there are more diagnoses entered in the abstract than can be placed in the CIHI interface. Enter the code, if you know it, or enter a hyphen (-) to display the Abstract Overflow code table for selection.

OUTPATIENT ABSTRACT

If the visit you selected from the MPI was an outpatient abstract visit, the following abstracting submenu may display, depending on what the facility has established for its abstract display:

```
              General Hospital M/R Abstract Processor
                                              Fri Apr 10, 2009 05:29 pm
   Account No     Name                          ICD    Unit No        Corp No
   89046-00001    DOE,JOHN R                    10     0001-0362-2    00001907
          Option No.  Option
          ---------------------------------------
                1       Full Outpatient Abstract
                2       Patient Information
                3       Episode Information-1
                4       Episode Information-2
                5       User Defined Fields
                6       Consultations
                7       Diagnoses
                8       Procedures
                9       HCPCS Procedures
               10       Blood Groups
               11       History Audit


Enter option number--
```

Examples of each of the options on this menu are shown previously in this section under the Inpatient abstract type, with the exception of the HCPCS Procedures. For more information, refer to Chapter 1: HCPCS Procedures in this manual.

The Episode Information-1 screen for an Outpatient abstract is the same as the Episode Information-1 screen for a Same Day Surgery Abstract, explained earlier in this chapter. There are some variations on the Episode Information-2 screen for an Outpatient abstract, explained on the following pages.

Episode Information-2 Screen

```
             General Hospital Outpatient Abstract Processor
               Episode detail-2     Page  3 of  9 Fri Apr 10, 2009 05:34 pm
    Account No     Name                          ICD    Unit No        Corp No
    0907800004     TONEY,TEN                     10     000-00-5885    00006552
 1 Departments
->
 2 Arrival Mode             3 Admission Type          4 Admission Source
                              3 ELECTIVE                10 ADMIT SOURCE
 5 Pre-admit                6 LMP Date                7 Coder

 8 Referring Facility       9 Referred To            10 Social Services

11 NJ/NY Z Code                      12 Overflow









Enter department location code or first letter(s)`-` of description--          |
```

Field Explanations

1. DEPARTMENTS (TABLE LOOKUP)
Enter the departments or areas the patient visited as a result of or during this visit. Enter the department code if you know it, or press hyphen (-) followed by ENTER to display the Department Location code table for selection. This field is automatically filled if the Visit Check-in function is used.

```
Page:01                      Department Locations           ##=Current Choices
( 1) CAR-CARDIOLOGY                        ( 3) EEG-EEG
( 2) ENT-EAR, NOSE, AND THROAT             ( 4) ER-EMERGENCY ROOM

Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
               end select(NL)  next pg(/ or PG DN)  Search(TAB)
```

2. ARRIVAL MODE (TABLE LOOKUP)
This field indicates how the patient arrived at your facility, as entered at the time of admission, or subsequently updated. To modify this field, enter the code identifying the patient's mode of arrival, if you know it, or enter a hyphen (-) to display the Arrival Mode table for selection.

3. ADMISSION TYPE (TABLE LOOKUP)
Enter the code that specifies the type of admission. Enter the table code if you know it, or press hyphen (-) followed by ENTER to display the Admission Type code table for selection. The code and the admission type description display in this field.

4. ADMISSION SOURCE (TABLE LOOKUP)
Enter the code that specifies the source suggesting admission for this patient. Enter the table code if you know it, or press hyphen (-) followed by ENTER to display the Admission Source code table for selection. The code and the source description display in this field.

5. PRE ADMIT (1-A-R)
Enter **Y** for Yes, or enter **N** or press ENTER for No to indicate whether or not the patient was pre-admitted.

6. LMP DATE (DATE)
Enter the date of the patient's last menstrual period (females only).

7. CODER (3-AN-O)
This field enables you to enter the code or initials of the person responsible coding the diagnosis and procedures on the medical record. If the coding was done using the 3M Coding and Reimbursement System, the initials of the person who accessed 3M are automatically displayed here.

8. REFERRING FACILITY (TABLE LOOKUP OR 19-C-O)
This field identifies the facility, institution, or person referring this patient to your facility, as entered at the time of admission, or subsequently updated. A referring facility may differ from the transferring facility in that the patient may be referred to your facility for care, but not physically transferred directly from another facility. To modify this information, enter the code corresponding to the referring facility, or enter a hyphen (-) to display the Referring Institution/Facility code table for selection. You can also make a freeform entry of up to 19 characters (you must type a hyphen before your freeform entry).

9. REFERRED TO (CONDITIONAL: TABLE LOOKUP OR 25-AN-O)
This field identifies the facility, institution, or person to which this patient was referred upon leaving your facility. A referring facility may differ from the transferring facility in that the patient may be referred for follow-up care, but not physically transferred there directly from your facility. To modify this information, enter the code corresponding to the facility, or enter a hyphen (-) to display the Referring Institution/Facility code table for selection.

10. SOCIAL SERVICES (TABLE LOOKUP)
This field identifies social services received by the patient prior to discharge. Enter a new code, if you know it, or enter a hyphen (-) to display the Social Services code table for selection.

11. NJ/NY Z CODE (TABLE LOOKUP)
This field is only applicable to the states of New Jersey and New York. It is not a required field. Z Codes are trauma codes that indicate the place of injury. Enter a new code, or enter a hyphen (-) to display the New Jersey/New York Z Codes table for selection.

12. OVERFLOW (TABLE LOOKUP)
This field is used mainly by Canadian facilities to identify any areas of the abstract where an overflow occurred. For example, there are more diagnosis, procedures, or consultants entered in the abstract than can be place in the Canadian Institute for Health Information (CIHI) interface. Enter the code, if you know it, or enter a hyphen (-) to display the Abstract Overflow code table for selection.

At the end of any abstract screen sequence, or before exiting this patient's abstract, you have the option to mark the abstract complete. If the abstract type you want to mark as complete requires acceptance of a final DRG prior to completion (based on the DRG Required parameter on the M/R Abstract & DRG Census Criteria screen), the system displays the following error message:

Error: Final DRG must be accepted before completion

The system displays this message briefly, then redisplays the menu for the patient's abstract.

NOTE: The system does not allow you to accept the DRG as final or mark the abstract complete unless all procedure codes (both HCPCS and ICD-9-CM) also have dates entered.

Once you mark an abstract complete, any changes, updates, or re-acceptance of an abstract screen causes the abstract to become incomplete, and the patient reappears on the Incomplete Abstract Report. Therefore, use the Abstract Inquiry function to view a patient's completed abstract.

NOTE: If you change or reaccept a special study that you have accessed through the separate M/R Special Study option on the Abstracting & DRG Input Options menu, the abstract does not become incomplete. However, modifying a special study accessed through the normal abstract screen flow does cause the patient's abstract to become incomplete.

Impact

After you mark the abstract final, the following takes place:

- The patient's account is removed from the Incomplete Abstract Report during Midnight Processing.
- The patient's account is added to the Complete Abstracts Report.

Chapter 3 - M/R SPECIAL STUDY FUNCTION

INTRODUCTION

The Special Studies function enables you to enter information in response to specific hospital- or department-defined questions regarding a patient's care and/or stay during this visit.

This function is available as a separate option on the main abstracting menu, and is also contained within the regular inpatient abstract flow. The separate option enables you to complete special study information on a patient without having to go through the M/R Abstracting function.

M/R SPECIAL STUDY FUNCTION

The M/R Special Study function uses the MR 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 Abstract Census.

Special studies can be either specific hospital- or department-defined questions, or other requests for information regarding a patient's care and stay.

The screens in this function are the same as the special studies screens contained within the flow of the abstract. This function is located as a separate menu option for your convenience. It enables you to complete this information on a patient without having to go through the M/R Abstracting function.

Unlike the special studies function within the abstracting flow, the separate MR Special Studies option does not change the completion of the patient's abstract.

NOTE: The Special Studies function in M/R Abstracting is separate and distinct from the one found in the Utilization Management Module, and uses a different table. Refer to the *STAR Patient Care Reference Guide, Tables Volume* for additional information on setting up a special study using the MR Special Study table.

Information entered on the M/R Special Study screen can be reported via the Core Reports function. Select the MR Special Study Report option. The system report name is MRSSX.

Special Studies Screen

Follow these steps to enter special studies information on a patient's visit.

1. Select the M/R Special Study option from the Abstracting 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.

```
                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




    Code   Description                    Date Entered       Init   Page:01
 ( 1)HP    HISTORY & PHYSI                02/14/96           N C




Enter special study to revise, add(A) a new special study--
```

If the patient does not have associated special study information, the screen contains this prompt instead:

Enter the MR 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 options:

   - 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 MR Special Study Code or '-' to list--

   Go to Step 5.

5. Do one of the following:

   - Enter the MR Special Study code if you know it.

- Enter a hyphen (-) and press ENTER to list the MR Special Study - US 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!

This message is displayed 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 that the study's questions are based on what is created in the MR 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
CHIEF COMPLAINT PRESENT?

HISTORY OF PRESENT ILLNESS PRESENT?

PAST, SOCIAL, FAMILY HISTORY PRESENT?

RELEVANT PHYSICAL PRESENT?

REVIEW OF SYSTEMS PRESENT?

ADMITTING DIAGNOSIS PRESENT?

TREATMENT PLAN PRESENT?
```

This screen displays the questions associated with the special study code you selected. When you first access this screen, the cursor is on the response 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 MR Special Study table.

The table below lists the possible 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 Date, Time, and Date/Time prompts, you have the option to enter any of the acceptable values as defined in the Information Entry Techniques chapter in the *STAR Patient Care Reference Guide, General Information Volume*. (For example, **T** for today and **N** for now.)

The special study screen scrolls, so you can use the arrow keys to move from one question to the next.

The system does not allow you to skip past those questions for which a response is required, as defined in the Special Study table. If you try to move past a question, 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. When you have completed the special study, press the F7 key. The system displays the following prompt:

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

You have three options:

- 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. If you exit a study that has the first response defined as *not* required, the special study code and description appear in the listing as if it had been defined. 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 the following 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, the Special Study information entered is now available for reporting through Core Reports. The option is MR Special Study Report; the system report name is MRSSX.

NOTE: The main purpose of the MR 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.

Changes to the Medical Record Special Study table (in Medical Records and UM Table Maintenance) should be made carefully if patients have already been assigned a study because the answers will not correspond to the questions if the questions/question response formats are changed. Instead, a new study should be created.

Chapter 4 - M/R MAINTENANCE

Illustrations

INTRODUCTION

One of the options on the Abstracting & DRG main menu is the Maintenance Functions Input Options.

The following screen is an example of the Maintenance menu:

```
              General Hospital Maintenance Functions Processor
                                                  Fri Jun 25, 2004 01:33 pm
Maintenance Functions Input Options

            Option No.  Option
            ---------------------------------------
                1       ICD & HCPCS Maintenance
                2       DRG Rate Table Generation
                3       DRG Rate Master
                4       Concurrent Monitoring Parameters
                5       Calculate Budget Using Averages
                6       Budget Maintenance
                7       M/R Abstract & DRG Census Criteria
                8       Abstracting Facility Options
                9       Build/Print Abstract Deletion List
               10       Edit/Print Abstract Deletion List
               11       Delete Selected Abstracts
               12       Departmental Table Maintenance
               13       Electronic Signature Maintenance
               14       Encoder Interface
               15       SQL User Menu
               16       GUI Abstract Maintenance
Enter option number--
```

This menu is used to access the various criteria and parameters that control some of the functioning in the Abstracting and DRG Modules.

After you select the ICD & HCPCS Maintenance function, this submenu displays:

```
               General Hospital ICD & HCPCS Maintenance Processor
                                                  Fri Apr 10, 2009 10:48 am
ICD & HCPCS Maintenance Input Options

            Option No.  Option
            ---------------------------------------
                1       ICD-9-CM Maintenance
                2       ICD-10-CA Maintenance
                3       ICD-10-CCI Maintenance
                4       ICD-10-CM Maintenance
                5       ICD-10-PCS Maintenance

                6       HCPCS Table Maintenance
                7       HCPCS Revenue Code Assign
                8       HCPCS DPW Diagnostic Code Assignment









Enter option number--
```

The items on this menu are used to maintain the coding schemes currently in use in the Medical Record Department.

ICD-9-CM MAINTENANCE

For information on this function, see ICD-9-CM Maintenance in Chapter 2: High Level Tables of the *STAR Patient Care Reference Guide, Tables Volume*.

ICD-10-CA MAINTENANCE (CN ONLY)

This option is not available in the United States. For a description of it, please refer to the *STAR Patient Care Reference Guide, Tables Volume*.

ICD-10-CCI MAINTENANCE (CN ONLY)

This option is not available in the United States. For a description of it, please refer to the *STAR Patient Care Reference Guide, Tables Volume*.

ICD-10-CM MAINTENANCE

For information on this function, see ICD-10-CM Maintenance in Chapter 2: High Level Tables of the *STAR Patient Care Reference Guide, Tables Volume*.

ICD-10-PCS MAINTENANCE

For information on this function, see ICD-10-PCS Maintenance in Chapter 2: High Level Tables of the *STAR Patient Care Reference Guide, Tables Volume*.

HCPCS TABLE MAINTENANCE

For information on this function, see HCPCS Table Maintenance in Chapter 2: High Level Tables of the *STAR Patient Care Reference Guide, Tables Volume*.

HCPCS REVENUE CODE ASSIGN

HCPCS codes tend to be listed in ranges that apply to very similar procedures. The CPT codes are obtained from the AMA, and the associated UB revenue codes are not provided as part of the system at this time. To facilitate the assignment of these codes to each HCPCS code, the HCPCS revenue code assignment function enables you to first choose a revenue code from the UB revenue code table and then designate a range of HCPCS codes for which this revenue code is appropriate. If your facility is using STAR Patient Care to assign and capture HCPCS for printing the UB, these UB revenue codes are required fields. If a HCPCS code that does not have an associated UB revenue code is used, you have the option to enter the revenue code at the time the HCPCS code is entered. When you select this function, this screen displays:

```
            General Hospital HCPCS Revenue Code Assign Processor
                                                 Thu Feb 22, 1993 01:23 pm

( 1)Revenue Code : 490-AMBULATORY SURGICAL CARE

( 2)Starting Code: 10000
( 3)Ending Code  : 69999









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

Field Explanations

1. REVENUE CODE (3-N-R)
This field enables you to associate multiple revenue codes to a range of HCPCS codes. Enter the UB Revenue Code, or multiple codes separated by commas, or press hyphen (-) and ENTER to display the code table for selection.

You can enter up to 20 revenue codes to be associated with all HCPCS codes in the specified range. If you have already associated revenue codes with the HCPCS codes in the range, new code entries will be added to the existing codes. For example, if revenue code 490 was previously associated with the range 11000-36000, and you add revenue codes 360,110,490 and 500, the new codes will be added, and 490 will not be added again or deleted.

If only one revenue code has been assigned, the code and description display. If multiple codes are assigned, only the codes display, separated by commas. If more codes are assigned to the HCPCS code than can display in the field, the word *more* appears at the end of the line to indicate that additional codes exist.

2. STARTING CODE (5-N-R)
Enter the HCPCS code at the beginning of the range that will be covered by the UB Revenue Code that was entered.

3. ENDING CODE (5-N-R)
Enter the HCPCS code at the end of the range that will be covered by the UB Revenue Code that was entered.

Impact

After you accept this screen, the following occurs:

- When a HCPCS code is assigned, the associated UB Revenue Code displays on the HCPCS Procedure screen.

HCPCS DPW DIAGNOSTIC CODE ASSIGNMENT

This function enables you to define a range of HCPCS codes as DRG Payment Window (DPW) diagnostic codes.

When you select this function, the system displays the following screen:

```
        General Hospital HCPCS DPW Diagnostic Code Assignment Processor
                                                  Mon Sep 08, 2003 06:43 pm

( 1)DPW Diagnostic Code : Yes
( 2)Starting Code       : 93541
( 3)Ending Code         : 93552

Mark as DPW diagnostic procedure (Y/N)--
```

Field Explanations

1. DPW DIAGNOSTIC CODE (1-A-O)
This field indicates if the range of HCPCS codes identified on this screen contains valid DPW diagnostic codes.

When you access this field, the system displays the following prompt:

Mark as DPW diagnostic procedure (Y/N) --

To indicate that the range of codes is considered DPW diagnostic, enter **Y**. The system displays Yes in the DPW Diagnostic Procedure field in the HCPCS Table Maintenance screen.

If the range of codes is not considered DPW diagnostic, enter **N**. The system leaves the DPW Diagnostic Procedure field blank in the HCPCS Table Maintenance screen.

2. STARTING CODE (5-N-O)
This field contains the starting HCPCS code of the code range. Enter the starting HCPCS code.

NOTE: The system does not check the validity of the code entered here.

3. ENDING CODE (5-N-O)
This field contains the ending HCPCS code of the code range. Enter the ending HCPCS code.

NOTE: The system does not check the validity of the code entered here.

Impact

After you accept this screen, the system automatically updates the DPW Diagnostic Procedure field on the HCPCS Table Maintenance screen for the affected HCPCS code.

M/R ABSTRACT & DRG CENSUS CRITERIA

Since patients for whom DRGs are calculated are always abstracted, there is now *one census for both abstracting and DRG*. The parameters used to determine inclusion in the census are entered using the option M/R Abstract & DRG Census criteria, which is available on the Maintenance Functions menu in the character-based system. To determine which patients should display on DRG-related reports, the system checks the DRG Required parameter associated with the patient's abstract code. (This parameter is explained in the following discussion.) If a DRG is not required, then the patient does not display on the DRG-related reports.

NOTE: Creation of the census is done in real time on the system and not during Midnight Processing. The system compares the patient to the criteria for the first alphabetic census code and determines if there is a match. If so, that code is assigned to the patient. If not, the patient is compared to the next code until a match is made or all codes have been compared. Once a patient is compared to a code with no criteria defined in any of the four fields, the patient is assigned that census code and no more comparisons are made.

The option enables you to define the patient population to which an abstract code applies, based on the entries defined in the Patient Type, Financial Class, Medical Service, and Nursing Station fields. The system automatically creates an abstract on admission for patients meeting the established criteria.

NOTE: Once patients exist in the abstract census, they are not removed. For example, if you put patients into the census and later the station changes and the patients no longer meet abstract census codes, they remain in the census. If patients do not exist in the census, and something changes to cause them to meet a code, they will be added automatically. A patient's abstract census code can continue to change until the abstract has been marked complete.

Patients not included in the census criteria can be manually added at any time. For patients that are manually added, the system uses the default abstract census code to determine the parameters for these abstracts. Since these parameters define which patients require completed abstracts, these patients are listed on the Incomplete Abstract Report if they are discharged before the abstract is completed.

NOTE: If you use the Discharged Patient Change Patient Type function to change a patient type, the system checks the M/R Abstract & DRG Census parameters to determine if an abstract census code should be assigned or updated for the revised account.

When you select M/R Abstract & DRG Census Criteria from the Maintenance Functions menu, the system displays the following prompt:

Enter the Abstract Code, '-' for list, or 'D'efault--

This prompt gives you the following entry options:

- Enter an existing abstract code. The system displays the criteria screen for the selected code. Changes to the parameters and settings can be made as necessary.

  NOTE: Changes to an existing code do not affect patients with this code who have already been added to the census.

- Enter a hyphen (**-**) to display a current list of all abstract codes. This list is created when the first code is entered, and is automatically updated as codes are updated or added. The list is internal to the system and is not accessible to the user. (The default code does not display in the list.)

- Enter **D** to display the criteria screen containing the default parameters. When the release is loaded at your facility, a default abstract code with parameters is automatically created. However, the parameters can be updated as necessary. The code is used to determine the parameter settings that apply to abstracts that are manually added, or are in the census at the time of conversion. (The actual code is ***.)

  NOTE: You cannot enter anything into the Inclusion Criteria section of the DEFAULT abstract code, since you are essentially overriding the inclusion criteria with a manual addition.

- Enter a code that does not exist. You can enter up to four alphanumeric characters. The code should reflect the type of patient to which this abstract applies. For example, you might use the designation MCIP if you are creating a code that applies to Medicare inpatients.

When you enter a new code, the system displays the following prompt:

Add this code 'XXXX' (Y/N)?--

where XXXX is the new code.

You have two options:

- Enter **N** for No to indicate that the code should not be added.

- Enter **Y** for Yes to add the code. The system displays the Census Criteria screen:

```
     General Hospital M/R Abstract & DRG Census Criteria Processor
                                                Wed May 25, 2011 11:50 am

ABSTRACT PARAMETERS AND CONTROLS
 1 Abstract Code  2 Abstract Name               3 Retention    4 Audit History
   OP             OUTPATIENT                    9999           No
 5 DRG Required   6 DRG Complete  7 Abst Complete  8 Print HCPCS  9 Resequence
   No             0               0               Yes            No
10 E-Code Msg    11 Comp Before Disch             12 Default Bill Type
   Yes            Yes
13 Rev Codes/View Chrgs                      14 Prin DX Default  15 2nd Grouping
   All                                          No
16 Product Code     17 Calc OP DRG  18 2nd Product      19 APRDRG Payor/Product
   10 HCPCS/CPTFIND ->
20 GUI Abstract Form Flow                           21 POA Required?
   OP OP
22 Save Chg HCPCS in HIM Rev Codes           23 Inc Abst for ICD Change




For Outpatients, calculate a DRG on STAR?(Y/N)[N]-  |
                      next(/) or previous screen(/P) [/]
```

Field Explanations

ABSTRACT PARAMETERS AND CONTROLS

This section is used to define the parameters that control this abstract code.

1. ABSTRACT CODE (DISPLAY ONLY)
This field displays the user-defined code entered at the initial prompt. The code cannot be edited on this screen. To modify a code, you must delete it, then re-add it as it needs to be. If you delete a code, the system does not display the abstracts already assigned to that code; therefore, you should use the File as Deleted option.

2. ABSTRACT NAME (25-AN-R)
This field is for entry of the user-defined abstract name. The name should assist in identifying the patient population to which this code applies. For example, if the code applies to Medicare inpatients, the name may be Medicare Inpatients Only. Although you can reuse names, doing so is not advisable. You can change the name as often as you like even after the screen is filed. Completion of this field is required.

3. RETENTION (4-N-R)
The entry in this field indicates how long abstracts associated with this code are retained in the system after completion. All existing abstract data (in STAR Patient Care and STAR Patient Accounting) will be purged when the number of days entered in this field elapses after the abstract completion date.

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

WARNING! Retention controls how long abstracting data, diagnosis, procedure and DRG information is retained before it is deleted!, continue editing (Y/N)

You must enter a response.

- Enter **Y** to change the Retention parameter. If you enter **Y**, the following prompt displays:

  Enter # of days after abstract complete date to DELETE ALL ABSTRACT DATA--

  Enter a value between 0 and 9999 to indicate the number of days after a patient's abstract completion date. For example, if you want to retain information pertaining to Medicare inpatients for 20 years, the entry in this field would be 7300 (20 years x 365 days).

  When entering the number of retention days, consider the data that will be available for reports, such as SQL and TRENDSTAR.

- Enter **N** or press period (.) ENTER to exit the field and make no changes.

For abstract codes applying to outpatients or series patients, you may want to retain the information for only 10 years, in which case the entry in this field would be 3650. The Retention parameter applies to Abstract, DRG, and Special Studies information, if the patient is in the abstract census. You may want to refer to specific regulations in your state as a guide when completing this field. Once abstract and DRG information is purged from the system, it is no longer available for viewing or reporting.

NOTE: If you drastically reduce the retention value for one or more census codes, the number of abstracts to be purged during Midnight Processing will drastically increase. To manage the load of purging a vast number of abstracts, Midnight Processing only purges a maximum of 2,000 patients per facility per run. A message displays on the console log indicating when the system reaches the maximum limit. All abstracts over the first 2,000 will be purged in subsequent runs, until the system meets the new parameter setting.

4. AUDIT HISTORY (1-A-O)

The entry in this field indicates whether the system should maintain a history of actions taken on patients associated with this abstract code. Although completion of this field is optional, leaving it blank is equivalent to entering N (for No). It is strongly advised this parameter be set to YES, as the audit is very helpful to you and the McKesson support staff in determining what actions occurred on this patient's abstract. If you create an abstract code specific to contract or referral patients, it may not be necessary to maintain an audit, since abstracting and DRG activity may be minimal for these patients. The audit remains in STAR until the abstract is purged. (Refer to the explanation of the Retention field for information regarding purging.)

If you enter **Y**, the system maintains a record of the actions performed on this abstract, and displays that information in the History Audit screen. The field explanations for the

History Audit screen identifies the actions which create an entry into the audit. If you enter **N**, or leave the field blank, STAR does not maintain an audit record on patients with this abstract code.

5. DRG REQUIRED (1-A-O)
The entry in this field indicates whether patients with this abstract code require an accepted DRG in order to mark the abstract complete. Although completion of this field is optional, leaving the field blank is equivalent to entering **N** (for No). If you enter **Y**, an abstract (with this code) cannot be marked complete until the patient's DRG has been accepted as final. The system uses this parameter to determine which patients to display on such DRG reports as the DRG Admission Report, Unaccepted DRG Discharges Report, and the Regrouping Report. Patients whose abstract code has this parameter set to Yes are included on those DRG reports.

The parameter Abstract Auto Complete (discussed below) enables you to identify if these abstracts are automatically marked complete within a defined number of days after discharge. If the DRG Required field is set to Yes, and the abstract is set to Auto Complete, these abstracts will not auto-complete if the DRG does not have a final accept date. The system continues to check these nightly until such time a final DRG accept date is present.

6. DRG COMPLETE (3-A-O)
The entry in this field indicates whether STAR should automatically mark the DRG final within a defined number of days after the patient's discharge date. DRGs manually marked final are not refinalized by this parameter. This parameter only affects DRGs without a final accept date in abstracts associated with this abstract code. Although completion of this field is optional, the default entry is zero, which indicates the DRG should not auto-complete.

To set this field, enter a number from 1 to 999, or accept the default of zero. This identifies when STAR should automatically accept the DRG as final. For example, if you enter 100 in this field, STAR checks to see if patients with this abstract code have a final DRG 100 days past the discharge date. If the DRG does not have a final accept date, the system enters a final date, and the information is networked to STAR Financials. If there is no DRG to be marked final, the system bypasses the record and checks it during the next Midnight Processing. Any DRG number is considered to be valid; therefore, if the abstract contains DRG 470, it is marked final when the defined days have elapsed.

If a DRG is auto-completed, this action is displayed in the History Audit screen. Final DRG is the action, and it is accompanied by the date of completion and a blank, indicating that it was marked final. If both the Abstract Auto Complete and DRG Auto Complete are being set for an abstract code, the number of days in these parameters must be the same.

NOTE: If you drastically reduce the DRG auto-complete value for one or more census codes, the number of DRGs to be auto-completed during Midnight Processing will drastically increase. To manage the load of auto-completing a vast

number of DRGs, Midnight Processing only auto-completes a maximum of 2,000 patients per facility per run. A message displays on the console log indicating when the system reaches the maximum limit. All DRGs over the first 2,000 will be auto-completed in subsequent runs, until the system meets the new parameter setting.

7. ABST COMPLETE (3-A-O)
This field identifies whether the system automatically marks the abstract complete within a defined number of days after the patient's discharge date. Abstracts manually marked complete are not re-completed by this parameter. This parameter only affects abstracts (with this code) that are not complete when checked by the system. Although completion of this field is optional, the entry default is zero which indicates the abstracts do not auto-complete.

To set this field, enter a number from 1 to 999, or accept the default of zero. This indicates the number of days past discharge when the abstracts (associated with this code) are automatically marked complete. For example, if you have defined an abstract code pertaining to series patients, and do not abstract *every* series patient but abstract some, you may want to set this field to 30 days. STAR interprets this to mean that any abstract associated with this code that is currently incomplete will be automatically completed by the system 30 days after the patient's discharge date. The History Audit for a patient with this abstract code has the entry Complete Abstract, and it reflects the date of completion along with a blank to indicate that it was marked complete.

NOTE: If you drastically reduce the abstract auto-complete value for one or more census codes, the number of abstracts to be auto-completed during Midnight Processing will drastically increase. To manage the load of auto-completing a vast number of abstracts, Midnight Processing only auto-completes a maximum of 2,000 patients per facility per run. A message displays in the console log indicating when the system reaches the maximum limit. All abstracts over the first 2,000 will be auto-completed in subsequent runs, until the system meets the new parameter setting.

8. PRINT HCPCS (1-A-O)
The entry in this field indicates whether HCPCS codes print on the attestation form and abstract summary form for patients with this abstract code. If you enter **Y**, HCPCS code information prints on both the attestation form and abstract summary form. If you enter **N** or leave the field blank, HCPCS code information does not print on these forms.

9. RESEQUENCE (1-A-O)
The entry in this field indicates whether diagnosis and procedure codes are automatically resequenced. This applies to all patient's with this abstract code. Although completion of this field is optional, leaving the field blank is equivalent to entering **N**. If you enter **Y**, all diagnosis and procedure codes are resequenced based on the CMS (Medicare) Grouper resident in STAR. If this field is blank or contains No, the diagnoses and procedures will not be resequenced once the codes have been

processed through the CMS Grouper. Keep in mind the DRG calculated in STAR is based on all diagnoses and procedures. Therefore, if the abstract contains a diagnosis or procedure, which affects the DRG, but is not on the UB (because it was not resequenced to a higher position), the DRG calculated by the fiscal intermediary may differ, and the remittance advice may differ from the expected reimbursement.

If you are calculating the CMG or DRG and reimbursement utilizing 3M Coding and Reimbursement System, the diagnoses and procedures are not resequenced in the system (regardless of this parameter) since those codes do not pass through the CMS Grouper on STAR.

10. E-CODE MSG (1-A-O)
This field enables a warning message that displays when an ICD diagnosis code in the 800 or 900 range is entered. The default response is not to display the message.

When you enter a code in the 800 or 900 range on the Diagnosis screen of Medical Record Abstracting or DRG Assignment function, the system checks the Abstract Code associated with the patient and the E-Code Message parameter associated with the Abstract Code. If the E-Code Message parameter is set to No, no additional messages display. If the E-Code Message parameter is set to Yes, the following message displays:

You have entered a code that requires entry of an E-code

The message displays briefly, then returns to the current processing. You can accept the screen without entering an E-code.

11. COMP BEFORE DISCH (1-A-O)
This field enables abstracts to be marked complete before a patient has been discharged. It is recommended that this parameter be set to No if the DRG Required parameter is set to Yes.

12. DEFAULT BILL TYPE (4-C-O)
This field is accessible only if the code for 3M's APCfinder is entered in the Code 3 Product or Code 3 2nd Product field. It controls the default bill type that is sent to the 3M Coding and Reimbursement System when you are using APCfinder.

You have the following options:

- Leave the field blank. 13X is the bill type sent to the 3M Coding and Reimbursement System. This default gives you almost all of the CCI/OCE edits, and the few missing edits do not affect APC assignment.

- Enter **N** for None, and the STAR system does not send a bill type to the 3M Coding and Reimbursement System. The coder is prompted to enter a bill type when computing APCs.

- Enter a case-sensitive bill type code to be sent to the 3M Coding and Reimbursement System. Contact your 3M representative if you need a list of valid bill types.

13. REV CODES/VIEW CHRGS (TABLE LOOKUP-O)
This field is used to enter default revenue codes for this abstract code if your facility uses the GUI M/R Abstracting product. The revenue codes entered here are displayed as the default when STAR Patient Accounting charges are viewed in GUI M/R Abstracting; only charges assigned to these revenue codes are displayed for a patient with this abstract code. (You do have the option to override the default revenue codes in GUI M/R Abstracting and select others to view.)

This field is also used by the GUI M/R Abstracting View Pre-Bill Edits application. Only edits for charges that are assigned to the revenue codes entered here and that have a PBE Edit Category selected on the Abstracting Facility Options screen are displayed in the Charge Edits grid on the Pre-Bill Edits form.

NOTE: To access the Abstracting Facility Options screen and the PBE Edit Categories, access STAR Medical Records > Abstracting & DRG Assignment Functions > Maintenance Functions > Abstracting Facility Options. Options include Charge, Demographic, Insurance, and Medical Records.

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

Enter revenue dept codes separated by`,`, `-` to display table, or `=` All--

You can enter

- the revenue codes directly, each separated by commas,
- a hyphen (-) to display the UB Revenue Codes table and make your selections from there, or
- an equal sign (=) for all revenue codes.

NOTE: Use caution when assigning the default revenue codes. The more you assign, the longer it will take to retrieve the charge records when you are viewing charges in GUI M/R Abstracting.

This field is also used by the GUI M/R Abstracting View Pre-Bill Edits application. Only edits for charges that are assigned to the revenue codes entered here are displayed in the Charge Edits grid on the Pre-Bill Edits form. If a revenue code is removed from the Rev Codes/View Chrgs field, then it is removed from the Save Chg HCPCS in HIM Rev Codes field.

14. PRIN DX DEFAULT (1-A-O)
Indicate if the entry in the Admitting Diagnosis field (as assigned during the Admission process) should automatically default into the Principal Diagnosis field of the abstract

for patients with this abstract census code. Enter **Y** for Yes or **N** for No. The default is No.

NOTE: If this field is set to Yes, the admitting diagnosis automatically populates the Principal Diagnosis field in the abstract the first time the abstract is accessed after the patient is discharged (this also applies to accounts that are auto-discharged). This means that the user must go into the Diagnosis screen (or the Diagnosis/Procedure/HCPCS GUI form) of the abstract and accept the screen in order for the diagnosis globals to be updated with the defaulted Principal Diagnosis.

This is not an automated process; the abstract must be accessed for the globals to be updated and for the data to be stored. Once the abstract is accessed, changes made in Admissions to the admitting diagnosis do not update the abstract. The Admitting Diagnosis only automatically populates the Principal Diagnosis field if nothing has been entered on the abstract prior to the patient's discharge. The Admitting Multiple Diagnosis functionality is not affected by the Default functionality.

15. 2ND GROUPING (1-A-C)
This field is accessible only if your hospital is defined to use the multiple groupers. It allows you to control whether a second DRG grouping is performed.

Enter **Y** (Yes) or leave this field blank to set the system to perform both primary and secondary DRG Groupings. Enter **N** (No) to set the system to perform the primary DRG Grouping only.

16. PRODUCT CODE (TABLE LOOKUP OR 2-AN-C)
Identify the 3M Coding and Reimbursement System product option to be executed for this abstract code for the first grouping. Enter a hyphen and press ENTER to select the code from the table. If you do not have the STAR/3M encoder interface, leave this field blank.

When you access the 3M Coding and Reimbursement System via the interface, STAR checks the abstract code associated with the patient and the 3M Coding and Reimbursement product option associated with the abstract code.

If you use the STAR/3M Interface and leave this field blank, you are prompted to select a product option when the 3M Coding and Reimbursement System is accessed. You cannot leave this field blank or enter 00 (zero, zero) if you use multiple groupers.

17. CALC OP DRG (1-A-C)
This field is used only for outpatient abstracts to indicate whether the STAR MS-DRG Grouper should calculate a DRG for this outpatient census group.

Upon accessing this field, the following prompt is displayed:

For Outpatients, Calculate a DRG on STAR?(Y/N)[N]--

If you enter **Y**, an MS-DRG is calculated on STAR for this outpatient census group.

If you enter **N**, no MS-DRG is calculated on STAR for this outpatient census group.

18. 2ND PRODUCT (TABLE LOOKUP OR 2-AN-C)
This field is accessible only if your hospital is defined to use the multiple groupers. It allows you to perform two groupings when using the APCfinder product option with the 3M Coding and Reimbursement System interface.

Enter the code for the 3M Coding and Reimbursement System product option to be executed for this abstract code for the second grouping. Enter a hyphen and press ENTER to select the code from the table.

19. APRDRG PAYOR-PRODUCT (SPECIAL FORMAT-O)
When you access this field, the following prompt is displayed:

Enter Vendor APR-DRG payer code or `N` if None [N]-- |

If you are using the 3M All Patient Refined (APR) DRG software, enter **12** in this field.

Once you enter the APR-DRG payor code, the following additional prompt is displayed:

Enter the APR-DRG product code-- |

The following two options are available for the product code:

- **05** for DRGfinder without CPT
- **06** for DRGfinder with CPT

20. GUI ABSTRACT FORM FLOW (TABLE LOOKUP)
This field is used only if your department is using the GUI Abstracting product. To complete this field, you must first build your abstract forms and download the database. Then you must build your flows using the M/R Abstracting Form Flows (found under the GUI Abstract Maintenance option). Once you have completed these steps, associate one of the flows with this abstract code to indicate the form flow to be used for patients with this abstract code.

NOTE: This field must be defined with a form flow or no forms display when GUI Abstracting is opened.

The forms listed in the GUI Forms GOTO option are defined in the flow attached to the default (D) census code regardless of the census code assigned to the patient. The default (D) census code must be defined with a form flow for the GOTO option to list forms.

21. POA REQUIRED? (1-A-C)
This field is used to indicate whether Present on Admission processing is required for the DRG. This field is passed to the 3M Coding and Reimbursement System to indicate that POA is NOT required (exempt) for certain patient types/FC/S,services, station.

NOTE: This POA indicator is not stored anywhere on the account, it is used only to send to 3M to provide override settings with the third party grouping software.

Upon accessing this field, the following prompt is displayed:

POA Processing is Required for DRG ?(Y/N) [Y]-- |

If you enter **Y**, there is no override in 3M, and Present on Admission processing occurs per the 3M Configuration file.

If you enter **N**, a zero (0) is sent to 3M, via the Coding and Reimbursement Interface, indicating that Present on Admission processing is not required for this account. This "0" overrides setup in the 3M Configuration file for this account.

NOTE: Customers using the 3M Interface for processing Inpatient Psychiatric Facilities (IPF) or Long Term Care Hospitals (LTCH) groupers are advised to use this parameter.

22. SAVE CHG HCPCS IN HIM REV CODES (TABLE LOOKUP-O)
This field looks to the Rev Codes/View Chrgs field on this same screen. When the Rev Codes/View Chrgs field is set to specific revenue codes, this field prompts:

Enter rev codes to save chg HCPCS in HIM separated by`,`, `-` to display table, or (S)ame as Rev Codes/View Chrgs--

When the Rev Codes/View Chrgs field is set to All, this field forces you to select the revenue codes by prompting:

Enter rev codes to save chg HCPCS in HIM separated by `,` or `-` to display table--

When manually entering revenue codes that should save the charge level HCPCS/ modifiers in the HIM GUI Abstract, the revenue codes must be selected in the Rev Codes/View Chrgs field. If a revenue code is not listed in the Rev Codes/View Chrgs field, the system displays the following error message (where the x's are replaced by the revenue codes) and does not accept the current selection for Save Chg HCPCS in HIM Rev Codes.

Revenue codes xxx, xxx do not exist in Rev Codes/View Chrgs. Must re-enter!

NOTE: When manually entering in revenue codes, previously selected revenue codes must also be re-entered. The new list replaces the old list.

If the Rev Codes/View Chrgs field is BLANK, which defaults to All revenue codes, you cannot set the Save Chg HCPCS in HIM Rev Codes field. To enable access to the Save Chg HCPCS in HIM Rev Codes field, you must populate the Rev Codes/View Chrgs field with "All".

When using the dash lookup on the UB Revenue Code Table, only those revenue codes selected in the Rev Codes/View Chrgs field are displayed to highlight.

You can also enter an **S** for Same as Rev Codes/View Chrgs. When an S is entered, the system determines which revenue codes should save the charge level HCPCS/ modifiers in the HIM GUI Abstract based on the Rev Codes/View Chrgs field. Therefore, updates made to the Rev Codes/View Chrgs field in turn affect which revenue codes are used for Save Chg HCPCS in HIM Rev Codes.

Once revenue codes are highlighted, when exiting the field, if there are too many revenue codes than can fit in the field display, the field displays "Entries Defined". You must re-access the field in order to see the selected revenue codes.

PROCESSING FOR SAVE CHG HCPCS IN HIM REV CODES

This section defines the processing related to the Save Chg HCPCS in HIM Rev Codes field. In this field, you can highlight the revenue codes that are used to pull charge level HCPCS into the Medical Records Abstract in order to be edited and saved. The HCPCS/Modifier remains on the charge(s), but is also saved in STAR Medical Records at the point that the abstract is accessed for the account.

This process in GUI Abstracting includes the following steps.

1. Access the Charge HCPCS tab.

2. Click either the Move All to HCPCS or Move Selected to HCPCS button to move the Charge HCPCS into the (Medical Records) HCPCS tab.

3. Accept the abstract by clicking either **OK** or **Close**.

For any revenue code highlighted, when the GUI Abstract is accessed for the account, the system scans the account's charges. For any charge with a highlighted revenue code, if the charge has a HCPCS code/modifier, these HCPCS and modifiers, along with the UB Revenue Code and the Service Date, are pulled into the GUI Abstract in order to be edited and updated where needed and saved in the Medical Records Abstract.

If the charge with the HCPCS/modifiers also has a **Performing Physician**, it updates the Surgeon field in the GUI Abstract for the HCPCS/modifiers. Also, if the ancillary charge with the HCPCS/modifier does not have a Performing Physician, but a LINKED professional fee for the ancillary charge has a Performing Physician, this physician is used for the Surgeon for the HCPCS/modifiers copied from the ancillary charge. Ancillary and professional fee charge items are linked in the SIM (Service Item Master).

For any Performing Physician pulled into the Surgeon field of the GUI Abstract, the system also pulls the Primary Specialty from the Physician Table into the Specialty field of the abstract.

If the charge with the HCPCS/modifiers also has a **Service Time**, this pulls to the Charge HCPCS screen of the abstract. If the charge does not have a Service Time, the system uses the Procedure Time Default from the Abstracting Facility Options table (STAR Medical Records > Abstracting & DRG Assignment Functions > Maintenance Functions > Abstracting Facility Options). This default procedure time is used only for the charge level HCPCS/modifiers brought into the Charge HCPCS screen of the Abstract. The charge itself is not updated. The Service Time is needed in the Abstract since the charge level HCPCS cannot be saved as (Medical Records) HCPCS without a service time.

The system processes as follows for the **Episode information**. Episode information is built based on existing information when you are in the abstract.

NOTE: The system evaluates Episode information only for Charge HCPCS that are saved to the (Medical Records) HCPCS screen. Therefore, if a charge HCPCS is not saved as a (Medical Records) HCPCS, it is not used to build Episode information.

- If the charge level HCPCS/modifier has a Service Date, Service Time, and a Performing Physician, the Medical Records GUI Abstract is updated to have an episode with this Date, Time, and Physician.

- If the charge level HCPCS/modifier has a Service Date, Service Time, and a Performing Physician, but this is a duplicate to an episode that already exists in the Medical Records GUI Abstract, it is not added as a new episode.

- If the charge level HCPCS/modifier is missing either the Service Time (although since the default Procedure Time is used, the charge HCPCS should always have the Service Time) or the Performing Physician, the Episode information is not added to the Medical Records GUI Abstract.

- The charge level Service Date always updates the Date field in the Medical Records GUI Abstract for the HCPCS/modifier.

- The charge level Service Time (actual or defaulted) always updates the Time field in the Medical Records GUI Abstract for the HCPCS/modifier.

- If the charge has a Performing Physician or the linked professional fee has a Performing Physician if it does not exist on the ancillary charge, this updates the Surgeon field in the Medical Records GUI Abstract for the HCPCS/modifier.

- For any Performing Physician pulled into the Surgeon field of the Medical Records GUI Abstract, the system also pulls the Primary Specialty from the Physician Table into the Specialty field of the abstract.

The revenue codes must also be listed in the Rev Codes/View Charges field so that the Medical Records user can view and correct any Pre-bill Edits on these HCPCS/ modifiers pulled into the GUI Abstract. If a revenue code is removed from Rev Codes/ View Chrgs, then it is removed from Save Chg HCPCS in HIM Rev Codes.

If there is a duplicate HCPCS/modifier, Revenue Code, and Date between the HIM Abstract and the HCPCS/modifier, Revenue Code, and Service Date from the charge, the duplicate HCPCS/modifier is not pulled into the HIM Abstract. If only the HCPCS Code, Revenue Code, and Date/Service Date match between the HIM Abstract and the Charge, but one of the HCPCS has a modifier and the other does not, or they have different modifiers, then the charge level HCPCS/modifier will be pulled into the HIM Abstract. All modifiers are evaluated with the matching logic.

If there are two or more charges with the same HCPCS/modifier, Revenue Code, and Service Date, and the HIM Abstract has the same HCPCS/modifier, Revenue Code, and Date, the first occurrence of the duplicate is not added to the HIM Abstract, but the additional duplicates are added to the HIM Abstract. For example, if there are 3 charges with Rev Code 490, HCPCS 12345, for 01/05/2011, and the HIM Abstract also has Rev Code 490, HCPCS 12345, for 01/02/2011, the second and third occurrence of the information from the charge level are added to the HIM Abstract. This results in the same HCPCS/modifier, revenue code, and service date existing in the HIM Abstract three times. Medical Records could then either add the appropriate modifiers or remove the duplicates.

If there is a charge and an offsetting credit, the HCPCS information is not pulled into the HIM Abstract. Also, if there is a credit without an offsetting charge, the HCPCS information is not pulled into the HIM Abstract. This can occur if the credit was posted to the wrong account, or if the charge had already updated the HIM Abstract with the HCPCS information, and the credit came in after this was accepted. In this scenario, the HCPCS may need to be deleted from the abstract. This credit without an offsetting charge is reported on the Charge HCPCS After Abstract report (FCR360x).

Note that charge level HCPCS/modifiers copied into the GUI Abstract may include charges moved to an inpatient account due to DPW Processing, charges moved to an account due to Combine Billing, and newborn charges moved to the mother's account.

If the Charge HCPCS information is accessed again within the HIM Abstract, only charges entered since the charge information was last Marked as Reviewed are evaluated. Therefore, if charge level HCPCS/modifiers had already been pulled into the HIM Abstract, and Marked as Reviewed, these charges are not evaluated again. See documentation for the Charge HCPCS screen within GUI Abstracting. This also means that a credit may not have a corresponding charge, and that the HCPCS information from the original charge may need to be deleted from the GUI Abstract.

When a revenue code is selected to pull HCPCS information into Medical Records, the system takes from the charge the UB Revenue Code, the HCPCS and any HCPCS Modifiers, and the Service Date. See above for processing logic for the Service Date, Service Time, and Physician information.

These charge level HCPCS are added to any Medical Records HCPCS that already exist for the patient (following the logic outlined above). They do not replace them.

Once the HCPCS is stored in Medical Records, you can use the typical processing to add additional information for the HCPCS that may not exist at the charge level such as:

- Group #
- Surgeon
- Specialty
- Tissue Code
- Anesthesia Code
- Anesthesia Start
- Anesthesia End
- ASA-PS Class
- Other Institution

NOTE: Be careful when saving charge level HCPCS as Medical Records HCPCS. The system has a limit on the number of Medical Records HCPCS that can be stored (varies depending on the amount of data for the HCPCS, such as Anesthesia information). If all revenue codes are set to save in Medical Records, then your Laboratory, Radiology, and Pharmacy charge level HCPCS could easily exceed this limit. If the system cannot store all of the highlighted charge level HCPCS into the Abstract as Medical Records HCPCS, the following warning message is displayed:

HCPCS at the end of the list will not be saved due to length of the record. Would you like to edit the entries?

If you click **Yes**, the system returns to the HCPCS tab in order to delete those charge level HCPCS moved to the HCPCS screen that are not needed in the Abstract.

If you click **No**, the system stores what HCPCS can fit into the Abstract, and the remainder are not saved as Medical Records HCPCS. The system does not allow you to select which HCPCS to save.

Note also that HCPCS appearing on the UB claim are still determined by the UB Charge Control Parameters, and the setting of the HCPCS Proc field for

the revenue code. In this field, users indicate if the revenue code should pull HCPCS from the Charge, from Medical Records, or Both, and in what format.

23. INC ABST FOR ICD CHANGE (1-A-O)
This field indicates whether an account is included in the abstract if there is a change to the ICD indicator due to one of the following:

- Change to Financial Class, Insurance Carrier, and Insurance Plan
- Change to State Reporting discharge parameters which results in change to Discharge ICD Ind
- Change to Discharge date results in change to Discharge ICD Indicator

The following prompt is displayed:

Mark the Abstract as Incomplete with ICD changes? (Y/N) [Y]--

INCLUSION CRITERIA

This section defines which patients are associated with this abstract code. When a patient is admitted, STAR checks the patient type, medical service, financial class, and nurse station associated with the patient against what has been entered for this abstract code. If the patient meets **all** the established criteria, this abstract code is assigned to the patient. If the patient does not meet the criteria, STAR checks the patient information against the next code's criteria. If there are patients who do not meet the criteria for any abstract code, they are *not* included in the abstract and/or DRG census. If all fields are blank, *every* patient matches the abstract code.

NOTE: You cannot complete this section for the default abstract code. Using the default assumes that the patient's criteria do not match, but you want to override the criteria to include the patient in the Abstract/DRG census.

When you access one of the Inclusion Criteria fields, the system displays the appropriate table and the following prompt:

Enter choices (e.g. 1,7,5-9) or `-` choices to remove or `=` for All--
end select(NL) next pg(/ or PG DN) Search(TAB)

```
     General Hospital M/R Abstract & DRG Census Criteria Processor
                                                 Mon Nov 03, 2008 08:56 pm

INCLUSION CRITERIA
 1 Patient Types                              2 Services
   ADV,ALL,I/P,NII,OB,OPO,OPR,RES            ->
 3 Financial Class                            4 Stations
   DJ,M
 5 Edited By                                  6 Edited Date
   Fields,Dorothy                               10/13/05 1240









Enter service codes separated by `,`, `-` for table lookup, Partial Name`-`, or
`=` for All--
```

You can:

- Enter one choice, or enter multiple choices. To select more than one choice, you can enter the option numbers one by one or use one of the following methods:
  - Separated by commas: 1,5,7
  - Range: 1-9
  - Combination: 1,5,7-9
- Deselect a choice by entering a hyphen (-) followed by the option number.
- Enter an equal sign (**=**) to select all.

NOTE: For any of the four criteria, you have the option to leave the field blank. The system interprets the blank to mean that the patient does not have to have that data element in order to match the criteria. For example, if the Nurse Station field is blank, but the patient is in a bed, the system does not use the Nurse Station in determining whether the patient is assigned this abstract code.

1. PATIENT TYPES (TABLE LOOKUP-O)
This field enables you to identify the patient types associated with this abstract code. This field accesses the Patient Type table.

2. SERVICES (TABLE LOOKUP-O)
This field enables you to identify the hospital services associated with this abstract code. This field accesses the Hospital Service code table.

3. FINANCIAL CLASS (TABLE LOOKUP-O)
This field enables you to identify the financial classes associated with this abstract code. This field accesses the Financial Classes code table.

4. STATIONS (TABLE LOOKUP-O)
This field is used for entry of the nurse stations associated with this abstract code. This field accesses the Nurse Station code table. If this parameter is set to All, patients are required to have a station/room/bed assignment to match this criteria.

5. EDITED BY (DISPLAY ONLY)
This field displays the name of the person completing or editing this screen.

6. EDITED DATE (DISPLAY ONLY)
This field displays the date the completion or editing of this screen occurred.

NOTE: Since outpatients usually are not assigned a bed, they will never meet the criteria if you set the Stations field to All.

After you accept this screen, you are returned to the Maintenance Functions Input Options menu.

Impact

After you accept this screen, the following takes place during Midnight Processing:

- The system places the included patients on the Incomplete Abstract Report, when appropriate.
- The system automatically creates an abstract for those patients included in the census.

ABSTRACTING FACILITY OPTIONS

Abstracting Facility Options is located on the Abstracting & DRG Assignment Functions > Maintenance Functions menu. This option is used to set a default time to be used as the procedure time for both HCPCS and ICD procedures entered in GUI M/R Abstracting. (You can also indicate that no default should be used.) It is also used to determine how the unit number is sorted when terminal digit is selected as the sort option for a Chart Management or M/R Abstracting report and where the abstract summary forms and attestation forms print.

After you select Abstracting Facility Options, and a facility, if applicable, the following screen is displayed:

```
        General Hospital Abstracting Facility Options Processor
                                            Thu May 3, 2012

 1 Procedure Time Default                    2 Unit Number Sort
   None                                        Defined
 3 Abstract Summary Form                     4 DRG Attestation Form
   Spooler                                     Default
 5 PBE Edit Categories                       6 Edit PA Charges
   O,B,C,D,I,M,E,Z,L,U                         All Editable Fields
 7 FCR360 Days                               8 ICD-10 Discharge Eff Date
   30                                          05/01/2011
 9 GUI Abstract Charges/Late Charges      10 GUI Abstract Credits/Late Credits
   Yes                                       Yes
11 GUI Abstract Charge/Late Charge Inquiry
   No
12 Edited By                                13 Edited Date & Time
   New, Nancy                                  05/02/12 1445









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

Field Explanations

1. PROCEDURE TIME DEFAULT (TIME FORMAT-O)
If you are using GUI M/R Abstracting, enter a default time to be automatically entered as the procedure time (for both ICD and HCPCS procedures) when returning from the 3M or generic encoder. The time entered in this field is defaulted as the procedure time if a time is not returned from the 3M or generic encoder. Enter **N** (for None) or leave this field blank, and a procedure time is not defaulted.

2. UNIT NUMBER SORT (SPECIAL FORMAT-O)
This field determines how the unit number should be sorted when terminal digit is selected as the sort option for a report. Since each facility may have a different

breakdown of the unit number, the system must determine the length of each sequence of the facility's unit number in order to complete the terminal digit sort.

When you access this field, an additional screen is displayed:

```
                General Hospital Abstracting Facility Options Processor
                                                    Tue Jul 06, 2004 01:19 pm
Abstracting & Chart Management Unit Number Sort Option
( 1)Sort First   : 9
( 2)Sort Second  : 10
( 3)Sort Third   : 7
( 4)Sort Fourth  : 8
( 5)Sort Fifth   : 5
( 6)Sort Sixth   : 6
( 7)Sort Seventh : 3
( 8)Sort Eight   : 4
( 9)Sort Ninth   : 1
(10)Sort Tenth   : 2









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

This screen enables you to indicate the breakdown of the unit number for the purpose of terminal digit sorting on reports. For each section of the unit number, you must indicate the terminal digit number.

For example, if the unit number is six digits, you may want to set the sorting sequence as follows:

First:	5
Second:	6
Third:	3
Fourth:	4
Fifth:	1
Sixth:	2
Seventh:	
Eighth:	
Ninth:	
Tenth:	

This number sequence results in unit number 123456 being sorted as 56-34-12.

The following Abstracting reports have terminal digit sorting as an option:

- Discharges by DRG/MS-DRG (Detail)
- Discharges by Diagnosis (Detail)

- Discharges by Procedure (Detail)
- Discharges by HCPCS (Detail)
- Discharge Status/Disposition
- Mortality Report
- Discharges by Race

NOTE: This field is also available on the Chart Management Parameters screen, as terminal digit sorting is an option for several Chart Management reports. For more information, see the *STAR Patient Care Reference Guide, Chart Management Module*.

3. ABSTRACT SUMMARY FORM (1-A-R)
Indicate where the abstract summary form should print. Enter **S** for spooler or **D** for the CRT's default printer. The default is D.

4. DRG ATTESTATION FORM (1-A-R)
Indicate where the DRG attestation form should print. Enter **S** for spooler or **D** for the CRT's default printer. The default is D.

5. PBE EDIT CATEGORIES (1-A-O)
Indicate the categories of the non-charge edits displayed on the Pre-Bill Edit form in GUI M/R Abstracting. Enter an asterisk (*) for All categories or a hyphen (-) to select from the categories defined on the STAR Patient Accounting PBE Edit Category table.

NOTE: The Pre-Bill Edit Module requires additional implementation costs. See your Inside Sales Representative for more information.

6. EDIT PA CHARGES (1-A-O)
This field indicates the MR facility access level for the GUI PBE/ Edit PA charge function. Values are M for Modifiers only, A for All editable fields, or N for None.The default is N. If this field is left blank, the user is not allowed to edit any fields.

7. FCR360 DAYS (3-N-O)
This field indicates the number of days for PA charges to appear on the STAR Patient Accounting Charge HCPCS After Abstract report (FCR360x). Enter a number from 1 to 999 days. Default is 30 days.

The Charge HCPCS After Abstract report (FCR360x) is a daily report produced during Midnight Processing on STAR Patient Accounting. This report prints charges and credits that have been placed for the patient since the last time a user clicked the Mark as Reviewed button on the Charge HCPCS screen of the abstract. Therefore, if the user never clicks the Mark as Reviewed button within the abstract, but still moves charge HCPCS to the (Medical Records) HCPCS screen, and saves by clicking either the OK or Close button, charges/credits entered after this point are not reflected on the

Charge HCPCS After Abstract report (FCR360x). Only charges that have revenue codes that qualify to copy charge level HCPCS/modifiers into the abstract are reported.

The system produces a cumulative report based on the number of days set in this field. Once the Mark as Reviewed button has been clicked on the Charge HCPCS screen of the GUI Abstract, the system identifies new charges and credits with revenue codes set to update the abstract with the charge level HCPCS. The system keeps the account on the report for a length of the last charge/credit posting date on the report plus the number of days set in the FCR360 Days field.

Example:

For the following example, assume the FCR360 Days field is set to 30 days. If the account was abstracted and the Mark as Reviewed button was clicked on the Charge HCPCS screen, the system reports on charges and credits placed for the patient after this date that have a revenue code set to copy HCPCS/modifiers into the abstract.

- An account is abstracted on 1/1/2011 and the charge level HCPCS are moved to the HCPCS screen and the Mark as Reviewed button is clicked on the Charge HCPCS screen.
- A new charge is placed on 1/3/2011. This charge is on that night's FCR360x report.
- A new charge is placed on 1/4/2011. This charge is on that night's FCR360x report, along with the charge from 1/3/2011.
- The GUI Abstract is accessed on 1/7/2011, and the new charge level HCPCS are reviewed/moved, and the user clicks the Mark as Reviewed button.
- The charges from 1/3 and 1/4 drop off of the FCR360x report since they have now been reviewed.
- A new charge is placed on 1/8/2011. This charge is on that night's FCR360x report. This is now the only charge on the FCR360x report for the account since the charges for 1/3/2011 and 1/4/2011 have been reviewed previously.
- A new charge is placed on 1/9/2011. This charge is on that night's FCR360x report, along with the charge for 1/8/2011.
- If the GUI Abstract is not accessed again, and the charge level HCPCS are therefore not marked as reviewed, the account drops off of the report 30 days from the posting date of the last charge on the report, which is 30 days from 1/9/2011.
- If the account was dropped from the report 30 days from the last posting date on the report, and a charge/credit is then posted to the account, the account again appears on the report with any charges/credits that have a revenue code set to update the GUI Abstract with the charge level HCPCS, that have not been marked as reviewed.

8. ICD-10 DISCHARGE EFFECTIVE DATE (9-N-R)

This parameter is used to determine the date when all discharged accounts will begin to be coded using ICD-10 codes. This parameter is used for Abstracting/GUI Abstracting, and it is discharge based.

The date entered in this parameter must be ON or AFTER the facility USA ICD-10 Effective Date. The facility USA ICD-10 Effective Date field is edited so changes to this date may not be after the Discharge ICD-10 Effective Date.

This parameter is used in conjunction with the ICD 9 Exception Indicator on the Financial Class, Insurance Carrier, and Insurance Plan tables. Payors listed on those tables require an ICD9 code once the ICD-10 Discharge Effective Date has been met,

9. GUI ABSTRACT CHARGES/LATE CHARGES (1-A-O)

This parameter is used to give user access to the Charge/Late Charge functions in GUI Abstracting. When this field is accessed, the following prompt is displayed:

Allow access to the Charge/Late Charge Functions within the GUI Abstract(Y/N) [N]

- This field must be set to Yes to allow access to the Charge and Late Charge functions within the GUI Abstract and the HCPCS tab.
- If the field is set to No or left blank, then the function does not appear on the Charge Functions pop up screen. If none of the GUI Abstract charge functions are set to Yes, then when clicking the Charge Functions button on the HCPCS tab within GUI Abstracting, the system will give a pop up screen that states:

  Charge functions are not enabled for this facility

10. GUI ABSTRACT CREDITS/LATE CREDITS (1-A-)

This parameter is used to give user access to the Credits/Late Credits functions in GUI Abstracting. When this field is accessed, the following prompt is displayed:

Allow access to the Credits/Late Credits Functions within the GUI Abstract(Y/N) [N]

- This field must be set to Yes to allow access to the Credit and Late Credit functions within the GUI Abstract and the HCPCS tab.
- If the field is set to No or left blank, the function does not appear on the Charge Functions pop up screen. If none of the GUI Abstract charge functions are set to Yes, then when clicking the Charge Functions button on the HCPCS tab within GUI Abstracting, the system will give a pop up screen that states:

  Charge functions are not enabled for this facility

11. GUI ABSTRACT CHARGE/LATE CHARGE INQUIRY (1-A-)

This parameter is used to give user access to the Charge Inquiry and Late Charge Inquiry functions in GUI Abstracting. When this field is accessed, the following prompt is displayed:

Allow access to the Charge/Late Charge Inquiry Functions within the GUI Abstract(Y/N) [N]

- This field must be set to Yes to allow access to the Charge Inquiry and Late Charge Inquiry functions within the GUI Abstract and the HCPCS tab.
- If the field is set to No or left blank, the function does not appear on the Charge Functions pop up screen. If none of the GUI Abstract charge functions are set to Yes, then when clicking the Charge Functions button on the HCPCS tab within GUI Abstracting, the system will give a pop up screen that states:

  Charge functions are not enabled for this facility

12. EDITED BY (DISPLAY ONLY)

This field displays the name of the person who last updated this screen.

13. EDITED DATE & TIME (DISPLAY ONLY)

This field displays the date and time this screen was last updated.

BUILD/PRINT ABSTRACT DELETION LIST

As discussed in the previous section on M/R Abstract Census Criteria, the system automatically creates an abstract on those patients who meet the inclusion criteria. However, it may be necessary at times to delete an abstract. The Build/Print Abstract Deletion List function is used to delete an abstract and/or remove an abstract from the DRG Unaccepted Report. This function does not allow the deletion of abstracts that have a final DRG assigned or have been marked complete. You can delete abstracts on in-house or discharged patients.

To build or print the abstract deletion list, select this function from the Maintenance Functions Input Options menu. The system prompts you to enter the account number of the abstract to be deleted. When you enter a valid account number, it displays on the upper portion of the screen. You can continue entering account numbers until your list is complete. The screen resembles the following:

```
        General Hospital Build/Print Abstract Deletion List Processor
                                                Thu Feb 22, 1993 01:25 pm


 A9005-200001
 A9005-200002









Enter GENERAL HOSPITAL A account for Abstract deletion ('999')--
```

After you enter all necessary account numbers, press ENTER. The system prompts you to print the deletion list. If you press ENTER to accept the system default of **N** for No, the list is not printed. To print the list, enter **Y** for Yes. You are then returned to the Maintenance Functions Input Options menu.

Impact

After you accept this screen, the following takes place:

- The abstract deletion list is created.

The following is an example of the list displaying the abstracts to be deleted.

Figure 4.1 Build/Print Abstract Deletion List (ECPRTX)

```
 Wed Mar 14, 1993 01:17 pm      GENERAL HOSPITAL A                    Page 1
                            Abstracts to be Deleted

                                          Pat          Admit    Dsch    Deleter's
Account No.    Name                       Type         Date     Date    Initials
-------------------------------------------------------------------------------
90039-00004    SMITH,TOM                  I/P          02/08/90            LTR

90060-00001    ROTH,LEONARD               I/P          03/01/90            LTR

90023-00002    BENNETT,BARB               I/P          01/23/90            LTR

90024-00003    SIMON,SARAH                OPO          01/24/90 01/24/90   LTR

90018-00002    HARDING,JAMES              I/P          01/18/90            LTR

90025-00001    SCIOLLI,BUD                I/P          01/25/90            LTR

90025-00006    CHRISTIAN,COREY            OPO          01/25/90 01/25/90   LTR

Total Abstracts to be Deleted     =  7

                                End of Report
```

EDIT/PRINT ABSTRACT DELETION LIST

As discussed in the previous section on Build/Print Abstract Deletion List, you can identify accounts for which abstracts are to be deleted. However, it may be necessary to edit this list and remove accounts that are not to be deleted. To edit the deletion list, select this function from the Maintenance Functions menu.

When you select this option, the system prompts you to enter the account number to be edited. Once you enter the account number, the system prompts you either to edit or to remove it. You would actually use the editing function to change an account number. For example, if you entered account number 9001000001 but should have entered 900100010, this is where you would enter the correct number. The system registers the change.

To remove an account number from the deletion list, enter the account number at the first prompt, then enter **R**. The system briefly displays a message indicating that the account number has been deleted from the list.

You can continue entering account numbers to edit or remove. When you are done editing, press ENTER. The system prompts you to indicate whether or not you want to print the deletion list. To keep the system from printing the list, press ENTER to accept the default of **N** for No. Enter **Y** for Yes to print the list. You are then returned to the Maintenance Functions Input Options menu.

Impact

After you accept this screen, the following takes place:

- The Abstract Deletion list reflects any updates made.

DELETE SELECTED ABSTRACTS

This function is used to delete the abstracts that have been selected and placed on the deletion list. Even if an abstract is deleted, it can be manually added to the abstract census at a later date.

To delete the selected abstracts, select this function from the Maintenance Functions menu. The system prompts you to begin the deletion. Press ENTER to accept the default of **N** for No to keep from deleting the abstracts. Enter **Y** for Yes to start the deletion.

Impact

After you accept this screen, the following takes place:

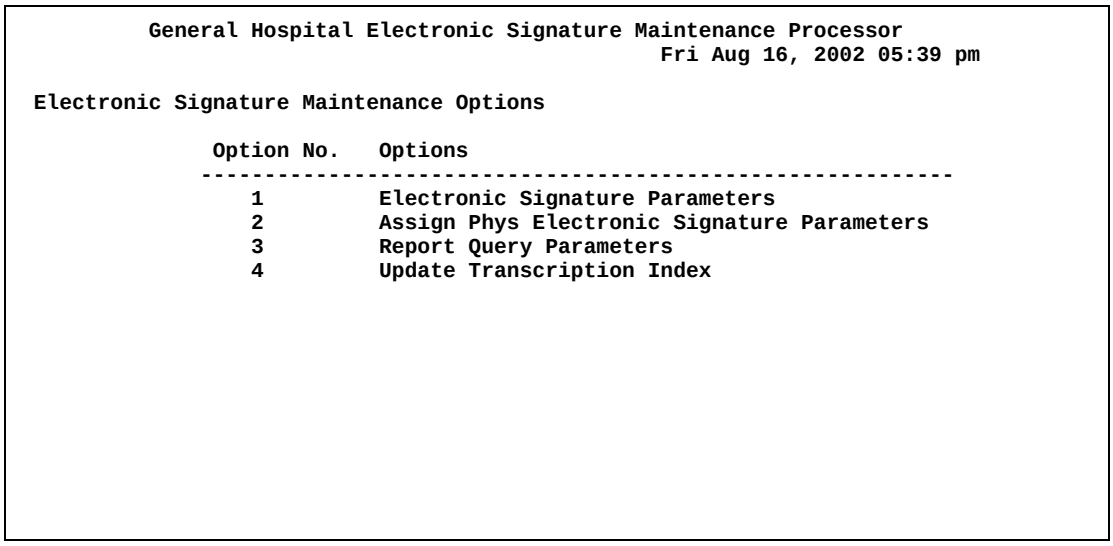
- All accounts on the list have the associated abstract deleted.
- No deleted accounts display on the incomplete abstract report.

ELECTRONIC SIGNATURE MAINTENANCE

This section describes the functions of Medical Record Maintenance, Electronic Signature Maintenance Options.

In the base system, the Assign Phy Electronic Signature option is located on the M/R Maintenance menu. If you do not utilize this menu, this function should be moved to another menu that is easily accessible.

When the option Electronic Signature Maintenance is selected from the Maintenance menu, this submenu displays:



Electronic Signature Parameters

The Electronic Signature Parameter screen is located on the Electronic Signature Maintenance menu in the base product. You have the option to put the function on the menu of your choice. The screen contains parameters that are required for the interface but are not specific to either Chart Management or STAR Clinical Browser/ Horizon*WP* Physician Portal.

The following is an example of the screen:

```
         General Hospital Electronic Signature Parameters Processor
                                                Sat Aug 25, 2001 01:21 pm

 1 Electronic Signature             2 Last Edit Date/Time     3 Last Edit Initials
   Yes                                10/31/94 0935             LTR
 4 Transcription Index Retention    5 Last Edit Date/Time     6 Last Edit Initials
   20                                 01/18/95 1229             VAH
 7 Transcription Interface Date     8 Last Edit Date/Time     9 Last Edit Initials
   08/22/94                           10/31/94 0935             LTR
10 Transcription Product           11 Last Edit Date/Time    12 Last Edit Initials
   SOFTMED TRANSCRIPTION              10/31/94                  VAH
13 Electronic Authentication Rpt   14 Last Edit Date/Time    15 Last Edit Initials
   Yes                                06/01/95 1539             VAH




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

Field Explanations

1. ELECTRONIC SIGNATURE (1-A-R)
This parameter indicates whether the prompt to electronically send attestations to physicians, appears in the M/R Abstracting and DRG Assignment functions. This does not require that physicians sign attestations electronically. When the field is entered, the following prompt is displayed:

Is electronic signature used for Attestation forms? (Y/N) [N]--

The following entry options are available:

Enter **N** for No, or press ENTER to indicate electronic signature is not used for attestation forms. If **N** is contained in the field, STAR does not display the prompt to send the attestation to the physician (in the M/R Abstracting and DRG Assignment functions).

Enter **Y** for Yes, to indicate that electronic signature can be used for attestation forms. If **Y** is contained in the field, STAR displays the prompt to send an attestation message to the selected physician via the M/R Abstracting and DRG Assignment functions. When selecting **Y** the staff in the Medical Record Department can generate an attestation message to the selected physician.

2. LAST EDIT DATE/TIME (DISPLAY ONLY)
Upon the completion of data entry in the Electronic Signature field, the system automatically completes this field with the current date and time.

3. LAST EDIT INITIALS (DISPLAY ONLY)
Upon the completion of data entry in the Electronic Signature field, the system automatically completes the field with the initials of the person performing the update.

4. TRANSCRIPTION INDEX RETENTION (4-N-R)
This parameter indicates the length of time the report header information is stored in STAR. The parameter does **not** control the length of time the complete report is stored in the transcription system. Information contained in the report header can be found in this document under the section, Technical Field Explanations. It is the report header information that enables the STAR Clinical Browser/ Horizon^{WP} Physician Portal and Chart Management Modules to be updated. When this field is entered, the following prompt is displayed:

How long is the transcription index retained?--

You can enter a number from 0 to 9999 to indicate the length of time the transcription index is retained. The purge clock begins the date the transcription report header is transmitted to STAR. When another report header is transmitted for this patient, the purge clock is reset. The index is retained by patient. When the index is purged, all report inquiries must be made to the transcription system to obtain a list of reports to view.

Suggested System Set-up:
The retention should coincide with the amount of time the full reports are maintained on the transcription system. Keep in mind that the longer the retention, the greater the utilization of CPU disk space.

5. LAST EDIT DATE/TIME (DISPLAY ONLY)
Upon the completion of data entry in the Transcription Index Retention field, the system automatically completes this field with the current date and time.

6. LAST EDIT INITIALS (DISPLAY ONLY)
Upon the completion of data entry in the Transcription Index Retention field, the system automatically completes this field with the initials of the person performing the update.

7. TRANSCRIPTION INTERFACE DATE (DATE ENTRY)
This field indicates the date the transcription interface went *live* at the facility. Although this field does not directly affect the processing of the interface, it is helpful for support of the interface. It enables McKesson to determine the date, report header information became available. When this field is entered, the following prompt is displayed:

Enter transcription interface live date--

8. LAST EDIT DATE/TIME (DISPLAY ONLY)
Upon the completion of data entry in the Transcription Interface Date field, the system automatically completes this field with the current date and time.

9. LAST EDIT INITIALS (DISPLAY ONLY)
Upon the completion of data entry in the Transcription Interface Date field, the system automatically completes this field with the initials of the person performing the update.

10. TRANSCRIPTION PRODUCT (30-AN-O)
This field indicates the transcription product being utilized with the interface. The field does not, in any way, affect the processing of the interface. It is helpful for support of the interface, as it enables McKesson to determine the transcription vendor.

This field allows the entry of 30 characters. The entry should be as clear as possible. For example, if you are utilizing SoftMed® Systems' ChartScript®, an entry would be *SoftMed/ChartScript*. The description should provide identification of both the vendor and product. When this field is entered, the following prompt is displayed:

Enter transcription product name--

11. LAST EDIT DATE/TIME (DISPLAY ONLY)
Upon completion of data entry in the Transcription Product field, STAR automatically completes this field with the current date and time.

12. LAST EDIT INITIALS (DISPLAY ONLY)
Upon completion of data entry in the Transcription Product field, STAR automatically completes this field with the initials of the person performing the update.

13. ELECTRONIC AUTHENTICATION RPT (1-A-R)
This field is used to indicate whether the system should maintain an index of those reports that have been electronically authenticated (i.e., signed) by the physician (via STAR Clinical Browser/ Horizon*WP* Physician Portal). This index is used to create the demand report, Electronic Authentication Report (found in the Chart Deficiency Reports submenu). The information in the index is retained until the Electronic Authentication Report is generated, at which time it is purged and starts over. If the Electronic Authentication Report is never generated, the index continues to grow and is never purged.

This report is helpful to the Transcription Department and the Deficiency Area as it indicates the reports (i.e., deficiencies) that have been electronically authenticated.

When this field is entered, the following prompt displays:

Enable the Electronic Authentication Report to be created? (Y/N) [N]--

Select one of the following entry options:

- Enter **N** for No, or press ENTER to indicate the system should not maintain an index of electronically authenticated reports. If you are not utilizing electronic signature in STAR Clinical Browser/ Horizon*WP* Physician Portal, No should be entered here. This prevents the system from maintaining the index.

- Enter **Y** for Yes to indicate the system should maintain an index. If **Y** is entered, it is important to note that the index is created and continues to grow until the report is generated.

14. LAST EDIT DATE/TIME (DISPLAY ONLY)
Upon the completion of data entry in the Electronic Authentication Rpt field, STAR automatically completes this field with the current date and time.

15. LAST EDIT INITIALS (DISPLAY ONLY)
Upon the completion of data entry in the Electronic Authentication Rpt field, STAR automatically completes this field with the initials of the person performing the update.

Assign Physician Electronic Signature Parameters

If you are not utilizing STAR Clinical Browser or Horizon*WP* Physician Portal for electronic signature of transcribed reports, it is not necessary to complete this screen.

The Assign Phys Electronic Signature Parameters function is used to enter a personal secret code and expiration date (of that code) for physicians who sign attestations or reports electronically. It is also used to identify which transcribed reports the physician has permission to sign electronically.

NOTE: In order to complete this parameter screen you first have to make sure you have built the necessary reports in the Physician Message Type table. For additional information on the Physician Message Type table, please refer to the *STAR Patient Care Reference Guide, Tables Volume*.

When the option Assign Phys Electronic Signature Parameters is selected, this prompt displays:

Enter physician code-- Enter '@' for all currently assigned, '' for all not currently assigned*

Select one of the following entry options.

- Enter the physician code that is to be added or updated by entering the physician code if you know it or by pressing hyphen (-) and ENTER to display the Physician Code table for selection, or you can enter the first letter(s) of the physician's last name followed by a hyphen (-) to display physicians whose name begins with the selected letter(s). This narrows the table search and you can select from this display.

- Enter an ampersand (@) and press ENTER to display all physicians with a password on file. Select from this display.

- Enter an asterisk (*) and press ENTER to display all physicians who do not have a password on file. Select from this display.

The following is an example of the screen:

```
      General Hospital Assign Phys Electronic Signature Parameters Processor
                                                  Sat Aug 25, 2001 06:14 pm

32 - ADAIR,FRANK
 1 Personal Secret Code     2 Expiration Date
   321                        05/21/2004
 3 Reports
   ANS-ANST NOTE
   CON-CONSULT
   CONS-Consultation Report









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

Field Explanations

1. PERSONAL SECRET CODE (15-AN-R)
This field is used for entry of the personal secret code for the physician to be used in STAR Clinical Browser and Horizon*WP* Physician Portal. The physician is prompted to enter the personal secret code prior to electronic signing of a report or attestation. The physician's personal secret code can be any combination of 15 alphanumeric characters. The code entered here can not be the same as the Secret Code entered in the Physician Parameters screen of the Physician table. When you enter a duplicate of the Secret Code, an error message is displayed and you are not allowed to use the code. When you enter this field, this prompt is displayed:

Enter physician's personal secret code--

2. EXPIRATION DATE (8-N-R)
This field is used for entry of an expiration date for the Personal Secret Code, to indicate the date when the code becomes invalid. After the expiration date has been reached, it is no longer possible for the physician to electronically sign reports, including attestations, via STAR Clinical Browser or Horizon*WP* Physician Portal. When you enter this field, the following prompt is displayed:

Enter expiration date--

NOTE: If you are entering a year beyond 2010, you must enter all four digits.

3. REPORTS (TABLE LOOKUP)
This field is used for entry of the report type(s) the physician electronically signs. This field accesses the Physician Message Types table. For additional information on this

table, please refer to the *STAR Patient Care Reference Guide, Tables Volume.* You can select as many codes as necessary, or enter **A** to select all.

From this field, STAR determines whether to automatically send the physician a message when the report type is available for signing.

NOTE: If the physician is currently utilizing the electronic attestation option, that Message Type should not be associated with the physician here. Attestations are not sent automatically but rather as determined per patient by the staff in the Medical Record Department; therefore, it does not require identification for automatic messaging.

If the report type is not identified, the physician does not have the option to electronically sign the report.

When this field is entered, this prompt displays:

Enter report codes separated by commas, or '-' for list, or All(A)--

You have the following entry options:

- Enter the report type codes separated by commas. You may enter up to 46 report types. The system only accepts message type codes that are associated with a System Event of Transcription.
- Enter a dash (-) to display the message types for selection. The only types to display for selection are those with a System Event of Transcription.
- Enter **A** to indicate that all Message Types should be added.

Report Query Parameters

The Report Query Parameters screen is part of Electronic Signature Maintenance located in M/R Maintenance. These parameters control various aspects of the query portion (viewing) of the transcription interface and are required to use the query portion.

```
            General Hospital Report Query Parameters Processor
                                                  Wed Apr 19, 1995 04:10 pm

Transcription Report Query Definition
 1 Number of Report Query Lines  2 Report Query Lines
   3                               TQ1
 3 Default Date Range (Days)     4 Account number required?
   7                               No
```

Field Explanations

1. NUMBER OF REPORT QUERY LINES (2-N-R)
This parameter indicates the number of query lines that have been defined in the STAR Communications Control Parameters. It is to be used for all transcription report queries when viewing and/or electronically signing. A minimum of three lines are required. Query lines are defined by McKesson during installation. When this field is entered, the following prompt is displayed:

Enter number of query lines--

2. REPORT QUERY LINES (78-AN-R)
This parameter indicates the names of the query lines that have been defined in the communications definitions, to be used for transcription report queries. Query lines are defined by McKesson during installation and are typically named TQ1, TQ2, and TQ3. When this field is entered, the following prompt is displayed:

Enter report query line communication definition(s) (separated by ',')--

3. DEFAULT DATE RANGE (2-N-R)
This parameter indicates the number of days prior to the current date to default the *Start Date* to when executing a two-step query in Physician Access/Physician View. This date range displays when **M** for More is entered from the View/Print Electronic Report options. When this field is entered, the following prompt is displayed:

Enter new number of days for the default date range (i.e. 7 for T-7)--

NOTE: STAR Clinical Browser and Horizon^{WP} Physician Portal do not use this parameter. Instead, the admission date of the selected encounter is defaulted.

4. ACCOUNT NUMBER REQUIRED (1-A-R)
This parameter indicates whether the transcription vendor requires the account number to be sent when executing a query to that system. When this field is entered, the following prompt is displayed:

Does transcription vendor require account number for report query (Y,N) [N]--

If the account number is sent, STAR must obtain all the account numbers for the patient and send them in the outbound message. This is time consuming.

NOTE: If you are using SoftMed, you should enter No to this prompt.

Update Transcription Index

The Update Transcription Index function allows you to remove an entry (report header) from a patient's transcription index on STAR. If a report is inadvertently associated with the wrong patient at the time of transcription, this mismatch can be corrected using this function.

When this option is selected, the MPI Search function is displayed to allow you to select a patient and visit. When a patient and visit are selected, a screen similar to the following is displayed, which contains all transcription index entries for the selected account number:

```
            General Hospital Update Transcription Index Processor
                                                  Tue Apr 20, 1999 01:27 pm
  No          Name             Sex    BD    Room    Physician     SVC   Status
9732400001    KENNEDY,THEODORE  M  09/09/64 3301-01 FRANKLIN,TODD PSY   MH  517
Page:01                                                    ##=Current Choices
Choice# Report Type              Date   Time  Adm Date  Dis Date  Elec Signed
( 1)   EC                       04/20/99 1327  11/20/97                No
( 2)   PM                       04/20/99 1327  11/20/97                No









Enter choices (eg. 1,3,5-9) or `-` choices to remove--
                                 end select(NL)
```

Field Explanations

CHOICE #
This field is the sequential number assigned by STAR to the transcription entry on this screen. Enter the Choice Number(s) at the prompt to select the index entry(ies) for deletion.

REPORT TYPE
This is the report type associated with the transcription index entry.

DATE
This is the date the entry was created in the index (usually the date the report was transcribed).

TIME
This is the time the entry was created in the index (usually the time the report was transcribed).

ADM DATE
This is the date the patient was admitted for the selected visit.

DIS DATE
This is the date the patient was discharged for this visit. If the patient has not been discharged, this field is blank.

ELEC SIGNED
This field indicates if the report has been electronically signed by the physician. If it has, a **Y** is displayed; if not, an **N** is displayed.

NOTE: A **Y** in this field does not prevent the entry from being deleted from the index.

At the prompt,

Enter choices (eg. 1,3,5-9) or `-` choices to remove--
end select(NL)

Enter the choice number(s) corresponding to the index entry(ies) you want to delete and press ENTER twice.

The following prompt is displayed:

Delete selected report headers? (Y/N)-- |

NOTE: You cannot retrieve the entry (report) after it has been deleted from the index.

To delete the selected entry(ies) from the index, enter **Y**. To abort the process, enter **N**.

If you enter **Y**, the message *Deletion Completed!* is displayed, the selected report (report header) is deleted from the transcription index, and the entry is no longer displayed in STAR Clinical Browser or Horizon^{WP} Physician Portal.

If you enter **N**, you are returned to the Transcription Index Processor to select a different entry.

ENCODER INTERFACE

The Encoder Maintenance function is located on the Abstracting & DRG Maintenance Options Menu. This function is used to maintain the encoder product.

After you select the Encoder Interface option, this submenu displays:

```
               General Hospital Encoder Interface Processor
                                                 Wed May 15, 1991 03:24 pm
Encoder Interface Input Options

            Option No.  Option
            ---------------------------------------
                1       Encoder Interface Status
                2       Encoder Parameters









Enter option number--
```

Encoder Interface Status

When you select the Encoder Interface Status option, this screen displays:

```
                 General Hospital Encoder Interface Status Processor
                                                 Wed May 15, 1991 03:24 pm



( 1)HSI Coder Status  : Inactive
( 2)Code 3 Status     : Active

















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

Field Explanations

1. HSI CODER STATUS
The HSI Coder Status field is no longer applicable.

2. CODE 3 STATUS
This field indicates the current status of the 3M Coding and Reimbursement product. When you access this field, the following prompt displays:

(A)ctivate or (I)nactivate Code 3--

Enter **A** to activate the encoder or **I** to inactivate the encoder.

When you press ENTER to exit this screen, the system displays a *Filed* message to indicate that your changes have been made.

Encoder Parameters

The Encoder Parameters are only used when using the Generic HL7® Encoder Interface. When you select the Encoder Parameters option, this screen displays:

```
              General Hospital Encoder Parameters Processor
                                                 Tue Apr 14, 1998 12:05 pm

( 1)Receiving Application    :
( 2)Receiving Facility       :
( 3)Edit by                  : Haines,Valerie
( 4)Edit date                : 09/04/97 1423









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

Field Explanations

1. RECEIVING APPLICATION (30-AN-C)
This field identifies the vendor's product receiving the HL7 message from STAR. This information is placed in the HL7 message MSH - 5. The vendor must provide the user with the information to be entered in this field.

NOTE: Users of QuadraMed Corporation's WinCoder+ should enter **CDS** here.

2. RECEIVING FACILITY (30-AN-C)
This field identifies the vendor receiving the HL7 message from STAR. This information is placed in the HL7 message MSH - 6. The vendor must provide the user with the information to be entered in this field.

3. EDIT BY (DISPLAY ONLY)
This field displays the name of the person who last updated these parameters.

4. EDIT DATE (DISPLAY ONLY)
This field displays the date these parameters were last updated.

GUI ABSTRACT MAINTENANCE

This option is essential only if you are using the GUI version of M/R Abstracting. This function gives you the ability to control the order in which the GUI forms (that is, the abstract screens) display.

When you select this option, the system displays a menu with three options:

```
              General Hospital Maintenance Functions Processor
                                                  Tue Apr 02, 1996 01:20 pm
GUI Abstract Maintenance Input Options

            Option No.  Option
            ---------------------------------------
                1       M/R Abstracting Form Flows
                2       M/R Abstracting Form Flow Copy
                3       GUT Database Management









Enter option number--
```

M/R Abstracting Form Flows

This option enables you to control the order in which the abstracting forms display, and to create as many flows as you need (per facility), as no flows are provided with the base STAR application. You can create a flow for each abstract code, or you can associate the same flow code to multiple abstract codes. Before you start adding flows, it is suggested you first map out the types of flow codes you want to create, and the forms you want to associate with each code. Prior to creating the flows, you must first build your abstract forms (using the GUI Tool) and download the forms and database into the system.

WARNING: Access to this function should be limited to those persons involved in maintenance functions within the Health Information Department.

When you select this option, the system displays this prompt:

Enter form flow code or first letters '-' to list--

You have these entry options:

- Enter an existing flow code. The system displays the screen for the selected code. You can make changes to the flow as necessary. However, these changes do not affect patients associated with the code prior to this change.

- Enter a hyphen (**-**) to display a current list of flow codes for selection.

- Enter a code that does not currently exist. You can enter up to 6 alphanumeric characters. **The first character must be a letter.** The code should reflect the type of patient to which this abstract applies. For example, if you are creating a flow that applies to Medicare inpatients, the code could be MCIP. When you enter a flow code that does not currently exist, this prompt is displayed:

  Add this flow XXXX (Y/N)?--

  where XXXX is the new flow code.

  Enter **Y** for Yes to enter the code. When you enter **Y**, the system displays the M/R Abstracting Forms Flow Processor screen displays. This is a sample of the screen:

```
              General Hospital M/R Abstracting Form Flows Processor
                                                  Thu Feb 29, 1996 12:38 pm
 MRA Abstracting Form Flow: IPA
  1 Flow     2 Description
    IPA        I/P ABSTRACT
  3 Death Class Screen                      4 Edit By           5 Edit Date/Time
                                              Smith,Bob           01/12/96 1147
 Enter field number or '/' starting field number--
```

NOTE: One flow should be defined with all forms so the Forms GOTO option can be used. The forms should also be linked to the default abstract census code (D) in the GUI Abstract Census Flow field, or nothing displays in GOTO. The forms built in the default flow are then available for selection under the GOTO option regardless of the census code assigned to the patient.

Field Explanations

FLOW (DISPLAY ONLY)
This field displays the flow code you entered at the initial prompt.

DESCRIPTION (50-AN-R)
This field enables you to enter the user-defined flow name. The name should be such that it clearly identifies the patient population to which this flow applies. For example, if the flow applies to Medicare inpatients, the flow name could be Medicare Inpatients Only. You can reuse flow names; however, it is not advisable. This is a required field.

DEATH CLASS SCREEN (TABLE LOOKUP)
This field enables you to indicate which form should be displayed when the disposition of the patient with this abstract flow is expired. The GUI version does not automatically include the Death Class screen as part of the abstract flow. To complete this field, enter a hyphen (-) to display all available Medical Record forms for selection.

EDIT BY (DISPLAY ONLY)
The system automatically completes this field with the name of the person creating or editing this flow code.

EDIT DATE/TIME (DISPLAY ONLY)
The system automatically completes this field with the date and time this flow code was created or edited.

When you complete this portion of the screen, press ENTER to display the existing form flow for this code. The following is a sample of this screen:

```
            General Hospital M/R Abstracting Form Flows Processor
                                                  Thu Feb 29, 1996 12:38 pm
 MRA Abstracting Form Flow: IPA
  1 Flow     2 Description
    IPA        I/P ABSTRACT
  3 Death Class Screen                      4 Edit By           5 Edit Date/Time
                                              Smith,Bob           01/12/96 1147

 Page:01                    Form
 ( 1) Patient Demographics
 ( 2) Patient Visit Information
 ( 3) Diagnosis and Procedure Information
 ( 4) Procedure Detail Information
 ( 5) Physician Information
 ( 6) Diagnosis and Procedure Information




Enter choice to edit, or add(A)--
```

Field Explanations

FLOW (DISPLAY ONLY)
This field displays the flow code entered at the initial prompt.

DESCRIPTION (DISPLAY ONLY)
This field displays the previously entered user-defined flow name. The name cannot be edited here.

DEATH CLASS SCREEN (DISPLAY ONLY)
This field displays the form selected for an expired patient with this flow.

EDIT BY (DISPLAY ONLY)
The system automatically completes this field with the name of the person creating or editing this flow code.

EDIT DATE/TIME (DISPLAY ONLY)
The system automatically completes this field with the date and time this flow code was created or edited.

FORM (TABLE SELECTION)
This field displays the forms already selected for inclusion in this abstract flow. The order in which they display here is the order they display when abstracting a patient with this flow code. You can, at any time, add or remove a form from a defined flow. The prompt associated with this forms subscreen gives you the following entry options:

- Enter the number to the left of the form to change or delete the form.
- Enter **A** to add to the current form flow.

When you enter **A**, the system displays the screen as follows:

```
              General Hospital M/R Abstracting Form Flows Processor
                                                  Thu Feb 29, 1996 12:39 pm
 MRA Abstracting Form Flow: IPA
  1 Flow     2 Description
    IPA        I/P ABSTRACT
                                          3 Edit By           4 Edit Date/Time
                                            Smith,Bob           01/12/96 1147

 Page:01                               Steps
 ( 1) Patient Demographic
 ( 2) Patient Visit Infor
 ( 3) Diagnosis and Proce
 ( 4) Procedure Detail In
 ( 5) Physician Informati
 ( 6) Diagnosis and Proce



Enter option # to add after (`B` for before first option) [End]--
```

The prompt displayed at the bottom of this screen gives you the following entry options:

- Enter the option number to the left of the form to indicate you want to add another form AFTER this form.
- Enter **B** to indicate you want to add this as the first form.
- Press ENTER to indicate the form is being added to the end of the list.

When you make your entry, the system displays the screen as follows:

```
             General Hospital M/R Abstracting Form Flows Processor
                                                  Thu Feb 29, 1996 12:39 pm
 MRA Abstracting Form Flow: IPA
  1 Flow     2 Description
    IPA        I/P ABSTRACT
  3 Death Class Screen                    4 Edit By           5 Edit Date/Time
                                            Smith,Bob           01/12/96 1147

  1 Form Name
 ->
  2 ICON                              3 Edit By           4 Edit Date









Enter form name--
```

Field Explanations

FLOW (DISPLAY ONLY)
This field displays the flow code entered at the initial prompt.

DESCRIPTION (DISPLAY ONLY)
This field displays the previously entered user-defined flow name. The name cannot be edited here.

DEATH CLASS SCREEN (DISPLAY ONLY)
This field displays the form selected for an expired patient with this flow.

EDIT BY (DISPLAY ONLY)
The system automatically completes this field with the name of the person creating or editing this flow code.

EDIT DATE/TIME (DISPLAY ONLY)
The system automatically completes this field with the date and time this flow code was created or edited.

FORM NAME (TABLE DISPLAY)
This field enables you to select the form to be included in the flow as indicated. Enter the form name, or hyphen (-) to display all forms for selection.

ICON (NOT USED)
This field is not used by the M/R Abstracting Module.

EDIT BY (DISPLAY ONLY)
The system automatically completes this field with the name of the person adding this form.

EDIT DATE/TIME (DISPLAY ONLY)
The system automatically completes this field with the date and time this flow code was added.

M/R Abstracting Form Flows Copy

The M/R Abstracting Form Flows Copy function enables you to copy one form flow to another. This provides a time-saving feature when one flow of forms is similar to another, existing flow. Once you copy an existing flow, you simple make the changes that make the new flow unique.

When you select this feature (and the associated facility), the system prompts you to enter the existing flow that you wish to copy. You can enter the flow code, or enter a hyphen (-) to display a list of the existing codes for selection.

When you enter the code, the system displays this prompt:

Enter new form flow description--

Enter up to a 50-character description for this new form flow. The system displays this prompt next:

Enter new flow code--

Enter the new code (up to 6 characters; the first character must be alphabetic) for this form flow. The system displays a message confirming that this flow was copied, and then redisplays the original prompt to enter the next form flow code to copy.

To revise the new form flow that you just copied, select the M/R Abstracting Form Flows function. Refer to the preceding subsection, M/R Abstracting Form Flows, for details.

GUT Database Management

Please refer to the *STAR Navigator User's Guide* for complete documentation of GUT Database Management.

Chapter 5 - M/R REPORTS

Illustrations

COMPLETE ABSTRACT REPORT

The Complete Abstract Report lists discharged patients whose medical record abstracts have been marked complete since the last time the report was generated. This report serves as an audit tool and displays those patients who have been identified as requiring an abstract through the MR Abstract Census Criteria.

The data elements that are included on this report are as follows:

- Discharge date
- Patient name
- Corporate number
- Unit number
- Account number
- Admission date
- Financial class
- Service
- Attending physician
- Total charges

The second page of the report displays a summary of the total charges by patient type, as well as grand total.

This report is generated as a by-product of Midnight Processing.

The following is an example of the Complete Abstract Report.

Figure 5.1 Complete Abstract Report - Page 1 (EMAOKX)

```
Thu Feb 22, 1993 05:05 am   GENERAL HOSPITAL A                    Page 1
           Complete Abstracts Report for the Patient Type I/P

Disch Date/
 Patient Name             MR#              Account#             Admission Date
 Financial Class          Service          Attend. Dr           Total Charges
--------------------------------------------------------------------------------

12/29/89
  JOHNSON,NATALIE A       100-00-03-25     1000028-4            12/26/89
  D-REGULAR MEDICARE      MED              HARRISON,WILLIAM T         945.80

  THOMAS,JAMES E          100-00-03-21     1000028-0            12/26/89
  G-BLUE CROSS OF GA      PED              WRIGHT,ALEXANDER         1,345.80

12/30/89
  CHAPMAN,SUSAN R         100-00-02-98     1000027-6            12/05/89
  D-REGULAR MEDICARE      MED              WRIGHT,ALEXANDER        10,034.85

  MORRISON,DIANE E        100-00-03-27     1000028-6            12/14/89
  D-REGULAR MEDICARE      OTH              HARRISON,WILLIAM T       5,125.00

  ROBINSON,JULIA C        100-00-03-22     1000028-1             12/21/89
  D-REGULAR MEDICARE      MED              SMITH,JOHN R             3,845.80

  WILSON,MICHAEL E        100-00-04-01     1000034-6             12/23/89
  G-BLUE CROSS OF GA      CCU              SMITH,JOHN R             8,845.80

Total Complete Abstracts for the Patient Type I/P:  6

                                End of Report
```

Figure 5.2 Complete Abstract Report - Page 2 (EMAOKX)

```
Thu Feb 22, 1993 05:05 am          GENERAL HOSPITAL A                Page 2
                                Complete Abstracts Report

Total Complete Abstract by Patient Type:          Total Charges:

             ADV:   1                                      .00
             CON:   1                                      .00
             DIA:   1                                 1,550.07
              ER:   4                                      .00
             I/P:  34                              1,641,927.12
             O/P:  29                                115,798.12
             OBV:   9                                 31,729.05
                  ____                                _________
    Grand Total :  87                              1,791,004.36
```

INCOMPLETE ABSTRACT REPORT BY PHYSICIAN

The Incomplete Abstract Report by Physician lists discharged patients whose medical record abstracts have not been marked complete. (Series patients who do not have a discharge date yet are also included in the report.) This report serves as an audit tool and displays those patients who have been identified as requiring an abstract through the MR Abstract Census Criteria.

The report is sorted by patient type and then by physician. The data elements that display on this report include the following:

- Patient name
- Corporate number
- Unit number (for example, Medical Record number)
- Account number
- Admission date
- Financial class
- Service
- Attending physician
- Total charges

The second page of the report displays a summary of the total charges by patient type, as well as a grand total.

This report is generated as a by-product of Midnight Processing.

The following is an example of the Incomplete Abstract Report by Physician.

Figure 5.3 Incomplete Abstract Report by Physician - Page 1 (MRINCDX)

```
Thu Mar 22, 1993 12:09 am                        GENERAL HOSPITAL A                                    Page 1
                              Incomplete Abstract Report by Physician

Attend Phys/
 Patient Name               Corp#    MR#         Account#     Adm.Date  F/C  Service  Disch Date       Total Charge
-------------------------------------------------------------------------------------------------------------------
-----

ADAIR,FRANK C

 ROBBINS,PAT                00002997 0000-1048-15 90019-00004  01/19/90   C     MED   01/19/90                .00
 ROBBINS,RHONDA             00003004 0000-1048-55 90033-00004  01/19/90   C     MED   01/19/90                .00

DERRICK,PAUL F

 KASHIN,DIANNE              00004623 0000-1048-22 90044-00004  01/19/90   S     MED   01/19/90                .00

FELDMAN,JOSEPH

 SMITH,RODNEY               00003043 0000-1048-59 90031-00001  01/31/90   S     MED    02/01/90               .00

Total Incomplete Abstract by Physician for the Patient Type ER: 4      Total Charges:            .00
```

Figure 5.4 Incomplete Abstract Report By Physician - Page 2 (MRINCDX)

```
Thu Mar 22, 1993 12:09 am                GENERAL HOSPITAL A                          Page 2
                              Incomplete Abstract Report by Physician

Total Incomplete Abstract by Patient Type:          Total Charges:

              ADV:   1                                       .00
              CON:   1                                       .00
              DIA:   1                                 1,550.07
               ER:   4                                       .00
              I/P:  34                                1,641,927.12
              O/P:  29                                  115,798.12
              OBV:   9                                   31,729.05

     Grand Total :  87                                1,791,004.36
```

INCOMPLETE ABSTRACT REPORT

The Incomplete Abstract Report lists discharged patients whose medical record abstracts have not been marked complete. (Series patients who do not have a discharge date yet are also included on the report.) This report serves as an audit tool and displays those patients who have been identified as requiring an abstract through the MR Abstract Census Criteria.

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 report is sorted by patient type and then discharge date. The data elements that display on this report include the following:

- Patient name
- Corporate number
- Unit number (medical record number)
- Account number
- Admission date
- Financial class
- Service
- Attending physician
- Total charges

The second page of the report displays a summary of the total charges by patient type, as well as the grand total.

This report is generated as a by-product of Midnight Processing, and may also be requested on demand via the Demand Reports menu. To print this report on demand, select this option from the Demand Reports menu. The system displays the following prompt:

Enter patient types separated by ',' or 'A'll [A]--

Enter the patient types if you know them, or press hyphen (-) followed by ENTER to display the patient type code table for selection. You can select as many patient types

as necessary from this table. Press ENTER to accept the default of **A** for all, and all patient types are included in the report.

Once you select the patient type(s), the system displays this prompt:

Enter beginning date for the report [Beginning]--

Enter the date to begin the report. The default is for the beginning of the file. Dates can be entered in a variety of formats. Refer to the Information Entry Techniques chapter in the *STAR Patient Care Reference Guide, General Information Volume* for further details.

When you enter the beginning date, the system displays this prompt:

Enter ending date for the report [Today]--

Enter the date the report is to end. The default is the date you are editing this information ("today"). Dates can be entered in a variety of formats. Refer to the Information Entry Techniques chapter in the *STAR Patient Care Reference Guide, General Information Volume* for further details.

Once you enter the ending date, the system displays this prompt:

Report Started!

The system displays this message briefly, then returns you to the Demand Reports menu.

The following is an example of the Incomplete Abstract Report.

Figure 5.5 Incomplete Abstract Report - Page 1 (MRINCX)

```
Thu Feb 22, 1993 05:06 am                    GENERAL HOSPITAL A                                    Page 1
                                  Incomplete Abstract Report for the Patient Type OBV

Disch Date/
 Patient Name          Corp#    MR#          Account#     Adm.Date  F/C  Service  Attnd.Dr            Total Charge
-------------------------------------------------------------------------------------------------------------------
---

01/16/90

 CLAYTON,MARCY        00311087 0000-0030-7  90-0160001-0 01/16/90   85    DRG    FAIRLEY,NORA L            240.70

01/18/90

 WEISENTHAL,HAILEY    00311085 0000-0095-0  90-0170000-7 01/17/90   50    MED    BACULI,BUENA E          1,671.47

01/22/90

 ABBOTT,BUDDY         00311151 0000-0109-9  90-0240000-3 01/22/90   80    CAR    ALLMON,THOMAS C         1,041.50
 ABBOTT,RONDA         00311111 0000-0057-0  90-0220000-4 01/22/90   85    CAR    ZELKO,JOHN R                .00

01/24/90

 GIOMMI,NANCY         00311121 0000-0071-1  90-0240000-6 01/24/90   80    ALT    MACK,JAMES A                .00

01/26/90

 ABBOTT,BUDDY         00311151 0000-0109-9  90-0290000-5 01/26/90   91    DIG    ANDERSON,ROSS W           538.50

01/30/90

 RAMBY,MORRIS         00311133 0000-0100-8  90-0300000-5 01/30/90   91    ESD    ALBERTS,PHILLIP S       1,697.88

02/01/90

 RAMBY,MORRIS         00311133 0000-0100-8  90-0320000-1 02/01/90   91    ESD    ALBERTS,PHILLIP S       3,159.20

02/06/90

 WEISENTHAL,RALPH     00311152 0000-0116-4  90-0370000-2 02/06/90   50    ENT    KALUZA,CHARLES         23,379.80

Total Incomplete Abstract for the Patient Type OBV: 9      Total Charges:    31,729.05

                              End of Report
```

Figure 5.6 Incomplete Abstract Report - Page 2 (MRINCX)

Thu Mar 22, 1993 12:09 am GENERAL HOSPITAL A Page 2
Incomplete Abstract Report

Total Incomplete Abstract by Patient Type:		Total Charges:
ADV:	1	.00
CON:	1	.00
DIA:	1	1,550.07
ER:	4	.00
I/P:	34	1,641,927.12
O/P:	29	115,798.12
OBV:	9	31,729.05
Grand Total :	87	1,791,004.36

ELECTRONIC ATTESTATION PENDING SIGNATURE

This report includes all patients on whom an attestation was electronically sent, but the attestation has not been sent back as signed or as unaccepted. Once the attestation for the account has been signed or returned, the patient is automatically removed from this report.

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 you select this report from the menu, the system displays the following prompt:

Sort by physician name(P), disch date(D), fin class(F), patient name(N), transmission date(T), or total charges(C)? [D]--

Select one of the sort options by entering the appropriate letter. The sort options are as follows:

- Enter **P** to sort alphabetically by the physician's last name
- Enter **D** or press ENTER for the default of sorting by the patient's discharge date
- Enter **F** to sort by the patient's financial class as found in the Medical Record Abstract and/or DRG Assignment function
- Enter **N** to sort alphabetically by the patient's last name
- Enter **T** to sort by the date the attestation was sent to the physician
- Enter **C** to sort by the patient's total charges (in descending order).

Once you select a sort option, the system displays this prompt:

Display or Print? (D/P) [D]--

This prompt asks you to choose whether to display the report on the screen or print the report at the default printer. To display the report, press ENTER to accept the default of **D** for display. The report begins processing. To print it, press **P** for print.

The following is an example of how the Electronic Attestation Pending Signature Report is displayed on the screen:

Figure 5.7 Electronic Attestation Pending Signature Report (screen)

```
Thu May 24, 1993 10:51 am                                          Page 1

                          GENERAL HOSPITAL A
                 Electronic Attestation Pending Signature Report
                          Sort: Discharge Date

#  Account #      Patient Name                    FC  Final DRG  Discharge Date
    Unit #          Physician Name                Trans Date     Total Charges
-------------------------------------------------------------------------------
1  90106-00007    TOST,LYNETTE                    M       no     04/16/90
    0000-0000-72    WOODBURN,ROBERT LOUIS         05/22/90        $.00

2  90115-00005    BISALLE,JOHN                    S       no     04/25/90
    0000-0001-08    LEES,JACK R                   05/22/90        $.00

3  90106-00003    ROGERS,ELLEN T                  18      no     05/15/90
    0000-0000-67    LEES,JACK R                   05/22/90        $1959983.50

4  90106-00003    ROGERS,ELLEN T                  18      no     05/15/90
    0000-0000-67    WOODBURN,ROBERT LOUIS         05/22/90        $1959983.50

Enter # to delete from report or Press NL for next screen [NL]--
```

Field Explanations

All fields are display only.

ACCOUNT #
This is the account number associated with this episode of care for this patient.

PATIENT NAME
This is the name of the patient for whom this attestation was sent.

FC
This is the financial class of the patient as found in either the Medical Record Abstracting and/or DRG Assignment function. If this was changed by the Medical Record Department, it may differ from the financial class stored in the MPI and business office.

FINAL DRG
This field indicates whether or not the DRG for this account has been accepted as final. Yes indicates that the DRG has been accepted as final, while No indicates that it is not final.

DISCHARGE DATE
The discharge date of this patient for this episode of care displays in this field.

UNIT #
This is the unit number (medical record number) for this patient.

PHYSICIAN NAME
This is the name of the physician to whom the electronic attestation was sent.

TRANS DATE
This is the date the electronic attestation was sent to the physician for signature.

TOTAL CHARGES
This shows the total charges for this patient.

The prompt at the bottom of the screen asks you to enter the number to delete from the report or to press ENTER to display the next screen. If you select a number to delete, this prompt displays:

Are you sure you want to delete #XX from this report? (Y/N) [N]--

where XX is the number to the left of the patient's name.

To keep the entry, press **N** or ENTER. To delete the entry, press **Y** for Yes.

The following is an example of a printed Electronic Attestation Pending Signature Report.

Figure 5.8 Electronic Attestation Pending Signature Report (print)

```
Thu May 24, 1993 10:51 am                                          Page 1

                          GENERAL HOSPITAL A
                Electronic Attestation Pending Signature Report
                          Sort: Discharge Date

#  Account #      Patient Name                    FC  Final DRG  Discharge Date
    Unit #          Physician Name                Trans Date     Total Charges
-------------------------------------------------------------------------------
1  90106-00007    TOST,LYNETTE                    M       no     04/16/90
    0000-0000-72    WOODBURN,ROBERT LOUIS         05/22/90        $.00

2  90115-00005    BISALLE,JOHN                    S       no     04/25/90
    0000-0001-08    LEES,JACK R                   05/22/90        $.00

3  90106-00003    ROGERS,ELLEN T                  18      no     05/15/90
    0000-0000-67    LEES,JACK R                   05/22/90        $1959983.50

4  90106-00003    ROGERS,ELLEN T                  18      no     05/15/90
    0000-0000-67    WOODBURN,ROBERT LOUIS         05/22/90        $1959983.50

End of Report
```

UNACCEPTED ELECTRONIC ATTESTATION

This report includes all patients whose attestation was electronically sent to the physician and then electronically sent back by the physician as unaccepted. When a new attestation message is sent to the physician for this account, the patient is automatically removed from this report.

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 you select this report from the menu, the system displays this prompt:

Sort by physician name(P), disch date(D), fin class(F), patient name(N), transmission date(T), or total charges(C)? [D]--

Select one of the sort options by entering the appropriate letter. The sort options are as follows:

- Enter **P** to sort alphabetically by the physician's last name
- Enter **D** or press ENTER for the default to sort by the patient's discharge date
- Enter **F** to sort by the patient's financial class as found in the Medical Record Abstract and/or DRG Assignment function
- Enter **N** to sort alphabetically by the patient's last name
- Enter **T** to sort by the date the attestation was sent back as unaccepted
- Enter **C** to sort by the patient's total charges (in descending order)

Once a sort option is selected, this prompt displays:

Display or Print? (D/P) [D]--

This prompts enables you to choose whether to display the report on the screen or print the report at the default printer. Press **D** or ENTER to display the report. If you enter **P,** the system displays this prompt:

Print associated messages on report? (Y/N) [N]--

To keep the system from printing the messages, press **N** or ENTER for No. To include the messages in the report, enter **Y** for Yes. When the messages are included, the report prints one page per patient entry.

The following is an example of how the Unaccepted Electronic Signature Report is displayed on the screen:

Figure 5.9 Unaccepted Electronic Attestation Report (screen)

```
Thu May 24, 1993 10:52 am                                          Page 1

                          GENERAL HOSPITAL A
                  Unaccepted Electronic Attestation Report
                          Sort: Discharge Date

#  Account #    Patient Name                    FC  Final DRG  Discharge Date
    Unit #        Physician Name                 Trans Date     Total Charges
-------------------------------------------------------------------------------
1  90106-00007  TESS,LYNETTE                    M       no     04/16/90
    0000-0000-72  ADAIR,FRANK C                 05/01/90        $.00

2  90106-00003  BOOTH,ELLEN T                   18      no     05/15/90
    0000-0000-67  COLEMAN,MICHAEL G             05/16/90        $1959983.50




Enter # to delete from report or Press NL for next screen [NL]--
```

Field Explanations

All fields are display only.

ACCOUNT #
This is the account number associated with this episode of care for this patient.

PATIENT NAME
This is the name of the patient for whom this attestation was sent.

FC
This is the financial class of the patient as found in either the Medical Record Abstracting or DRG Assignment function, or both. If the Medical Record Department changed the financial class, it may differ from that stored in the MPI and business office.

FINAL DRG
This field indicates whether or not the DRG for this account has been accepted as final. Yes in this field indicates that it has been accepted as final, No indicates that it has not.

DISCHARGE DATE
The discharge date of this patient for this episode of care displays in this field.

UNIT #
This is the unit number (medical record number) for this patient.

PHYSICIAN NAME
This is the name of the physician who returned the electronic attestation as unaccepted.

TRANS DATE
This shows the date the electronic attestation was returned by the physician as unaccepted.

TOTAL CHARGES
This shows the total charges for this patient.

The prompt at the bottom of the screen asks you to enter the number to delete from the report or to press ENTER to display the next screen. If you select a number to delete, this prompt displays:

Are you sure you want to delete #XX from this report? (Y/N) [N]--

where XX is the number to the left of the patient's name.

To keep the system from deleting the entry, press **N** or ENTER for No. To delete the patient entry, enter **Y** for Yes.

The field explanations for the printed report are the same as the field explanations previously described for the report that displays on the screen, with the exception of the following three items that display when the report is printed with messages included.

MEDICAL RECORD MESSAGE
This is the message sent by the Medical Record Department to the physician. If no message was sent, None displays here.

PHYSICIAN DRG UNACCEPTED REASONS
This shows the reason code(s) the physician selected from the code table to explain why the attestation was not signed.

PHYSICIAN MESSAGE
This is the message sent by the physician to the Medical Record Department. If no message was sent, None displays here.

The following is an example of an Unaccepted Electronic Attestation Report with messages included.

Figure 5.10 Unaccepted Electronic Attestation Report (print)

```
Thu May 24, 1993 10:52 am                                          Page 1

                          GENERAL HOSPITAL A
                  Unaccepted Electronic Attestation Report
                           Sort: Discharge Date

#  Account #    Patient Name                    FC  Final DRG  Discharge Date
    Unit #        Physician Name                 Trans Date     Total Charges
-------------------------------------------------------------------------------
1  90106-00007  TESS,LYNETTE                    M       no     04/16/90
    0000-0000-72  ADAIR,FRANK C                 05/01/90        $.00

2  90106-00003  BOOTH,ELLEN T                   18      no     05/15/90
    0000-0000-67  COLEMAN,MICHAEL G             05/16/90        $1959983.50

Medical Record Message:

PLEASE SIGN BY FRIDAY




Physician DRG Unaccepted Reasons:

DATA NOT COMPLETE

Physician Message:

NONE
```

SIGNED ELECTRONIC ATTESTATIONS PENDING FINAL DRG

This report includes all patients for whom an attestation was electronically signed by the physician, but whose DRG has not been accepted as final. Once the DRG is accepted as final, the patient is automatically removed from this report.

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 you select this report from the menu, the system displays this prompt:

Sort by physician name(P), disch date(D), fin class(F), patient name(N), signed date(T), or total charges(C)? [D]--

Select one of the sort options by entering the appropriate letter. The sort options are as follows:

- Enter **P** to sort alphabetically by the physician's last name
- Enter **D** or press ENTER to accept the default of sorting by the patient's discharge date
- Enter **F** to sort by the patient's financial class as found in the Medical Record Abstract and/or DRG Assignment functions
- Enter **N** to sort alphabetically by the patient's last name
- Enter **T** to sort by the date the attestation was signed
- Enter **C** to sort by the patient's total charges (in descending order)

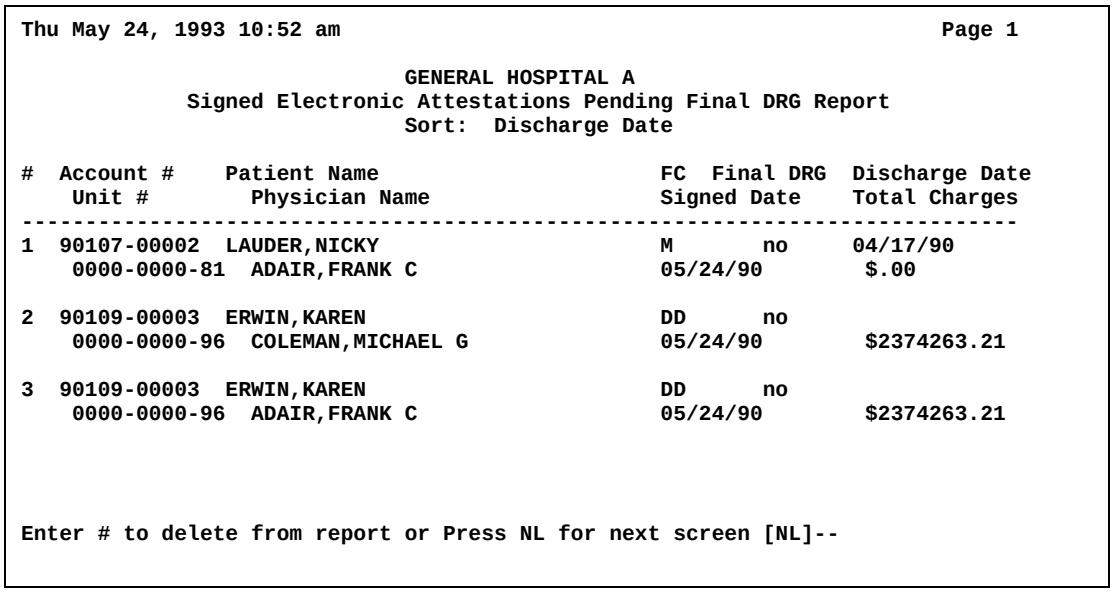
Once you select a sort option, the system displays this prompt:

Display or Print? (D/P) [D]--

Press **D** or ENTER to display the report on the screen, or press **P** to print it.

The following is an example of how the Signed Electronic Attestations Pending Final DRG Report is displayed on the screen:

Figure 5.11 Signed Electronic Attestations Pending Final DRG Report (screen)



```
Thu May 24, 1993 10:52 am                                          Page 1

                          GENERAL HOSPITAL A
            Signed Electronic Attestations Pending Final DRG Report
                          Sort:  Discharge Date

#  Account #    Patient Name                    FC  Final DRG  Discharge Date
    Unit #        Physician Name                 Signed Date    Total Charges
-------------------------------------------------------------------------------
1  90107-00002  LAUDER,NICKY                    M       no     04/17/90
    0000-0000-81  ADAIR,FRANK C                 05/24/90        $.00

2  90109-00003  ERWIN,KAREN                     DD      no
    0000-0000-96  COLEMAN,MICHAEL G             05/24/90        $2374263.21

3  90109-00003  ERWIN,KAREN                     DD      no
    0000-0000-96  ADAIR,FRANK C                 05/24/90        $2374263.21




Enter # to delete from report or Press NL for next screen [NL]--
```

Field Explanations

All fields are display only.

ACCOUNT #
This is the account number associated with this episode of care for this patient.

PATIENT NAME
This is the name of the patient for whom this attestation was sent.

FC
This is the financial class of the patient as found in either the Medical Record Abstracting or the DRG Assignment function. If this was changed by the Medical Record Department, it may differ from the financial class stored in the MPI and business office.

FINAL DRG
This field indicates whether or not the DRG for this account has been accepted as final. Yes in this field indicates that it has been accepted as final, No indicates that it has not.

DISCHARGE DATE
This field shows the discharge date of this patient for this episode of care.

UNIT #
This is the unit number (medical record number) for this patient.

PHYSICIAN NAME
This is the name of the physician who returned the electronic attestation as unaccepted.

SIGNED DATE
This is the date the electronic attestation was signed by the physician.

TOTAL CHARGES
This shows the total charges for this patient.

The prompt at the bottom of the screen asks you to enter the number to delete from the report or to press ENTER to display the next screen. If you select a number to delete, this prompt displays:

Are you sure you want to delete #XX from this report? (Y/N) [N]--

where XX is the number to the left of the patient's name.

To keep the system from deleting the entry, press **N** or ENTER for the default of No. To delete the patient entry, enter **Y** for Yes.

The following is an example of a printed Signed Electronic Attestations Pending Final DRG Report.

Figure 5.12 Signed Electronic Attestations Pending Final DRG Report (print)

```
Thu May 24, 1993 10:52 am                                          Page 1

                          GENERAL HOSPITAL A
            Signed Electronic Attestations Pending Final DRG Report
                          Sort:  Discharge Date

#  Account #    Patient Name                    FC  Final DRG  Discharge Date
    Unit #        Physician Name                 Signed Date    Total Charges
-------------------------------------------------------------------------------
1  90107-00002  LAUDER,NICKY                    M       no     04/17/90
    0000-0000-81  ADAIR,FRANK C                 05/24/90        $.00

2  90109-00003  ERWIN,KAREN                     DD      no
    0000-0000-96  COLEMAN,MICHAEL G             05/24/90        $2374263.21

3  90109-00003  ERWIN,KAREN                     DD      no
    0000-0000-96  ADAIR,FRANK C                 05/24/90        $2374263.21

End of Report
```

POINTER TABLE INACTIVE CROSS REFERENCE REPORT

This report lists Pointer Table codes that are linked to inactive ICD codes (diagnosis or procedure) or inactive HCPCS codes. You can print this report at any time. It prints to the default printer for the CRT.

Listed in the report are the pointer code, the pointer code description, and the attached inactive ICD indicator and ICD code or HCPCS code. The report is sorted alphabetically by the pointer code description.

The following is an example of a Pointer Table Inactive Cross Reference Report.

Figure 5.13 Pointer Table Inactive Cross Reference Report

```
Wed Mar 05, 2008 10:26 am     Model Hospital A                    Page 1
                    Pointer Table Inactive Cross Reference
                        ICD Diagnosis Pointer Table

Pointer Code       Pointer Description        ICD Ind       ICD Code
_____________________________________________________________________

947                *ACUTE ERYTHREMIA            9           07.0
                                               10          XXXXXXX

951                *ACUTE LEUKEMIA NOS                     208.0

931                *ACUTE LYMPHOID LEUKEMIA                204.0

942                *ACUTE MONOCYTIC LEUKEMI                206.0

936                *ACUTE MYELOID LEUKEMIA                 205.0

932                *CHR LYMPHOID LEUKEMIA                  204.1
```

ABSTRACT SUMMARY FORM

The abstract summary form is a summary of information entered in the abstract. It provides a convenient way to review a patient's visit information without having to go through the screens in either DRG Assignment or Medical Record Abstracting.

See the sample on the following page.

Figure 5.14 Abstract Summary Form (EPABFX)

```
Date: 06/21/09                  Model Hospital A                Page  : 1
Time: 11:57                  Abstract Summary Form              Report: MR

Patient:FITCHETT,AUBRY                          Address:900PEACHTREE RD
DOB:    01/01/92    Fin Class:MEDICARE                  WINDER
Sex:    MALE        Ins. Plan:BLUE CROSS                NC,30366
SS#:    227-77-9999 Guarantor:SELF              Phone #:(770)455-0101

Adm Date:02/01/02      Adm Source:ER                          Acct. #: 020320000
Adm Time:10:28         Adm Type:  ELECTIVE-PLANNED            Unit. #: 000002612
Dis Date:02/01/02      Trans From:                            Pt. Type:Regular I
Dis Time:11:17         Service:   PEDIATRICS                  Trans To:
LOS:     1             Dis Status:KARINAS DISPOSTION          Coder:   djf
Admitting DR:AKER,TOM                          Referring DR:COLEMAN,MICHAEL G
Attending DR:AKER,TOM                          Discharge DR:COLEMAN,MICHAEL G
ER Physician:ADAMS,JAY M                       Primary DR:  COLEMAN,MICHAEL G

DRG/260:   156   EGD PROC 0-17
Admit Diagnosis:     250.01   DMI WO CMP NT ST UNCNTRL
Principal Diagnosis: 005.0    STAPH FOOD POISONING
Secondary Diagnoses:
  900.82 DIFFERENT DESCRIPTION 2              002.9  PARATYPHOID FEVER NOS
  250.01 DMI WO CMP NT ST UNCNTRL             003.0  SALMONELLA ENTERITIS
  003.1  SALMONELLA SEPTICEMIA                003.20 LOCAL SALMONELLA INF NO
  001.0  CHOLERA D/T VIB CHOLERAE             003.21 SALMONELLA MENINGITIS
  001.1  CHOLERA D/T VIB EL TOR
  001.9  CHOLERA NOS
  002.0  TYPHOID FEVER
  401.9  HYPERTENSION NOS
  002.2  PARATYPHOID FEVER B
  002.3  PARATYPHOID FEVER C

Principal Procedure:                           Date:          Primary Surgeon:
  44.29  OTHER PYLOROPLASTY                    02/01/02       COLEMAN,MICHAEL G
Secondary Procedures:
  50.21  MARSUPIALIZAT LIVER LES               02/01/02       COLEMAN,MICHAEL G
  42.99  ESOPHAGEAL OPERATION NEC              02/01/02       COLEMAN,MICHAEL G
  88.74  DX ULTRASOUND-DIGESTIVE               02/01/02       COLEMAN,MICHAEL G
  42.99  ESOPHAGEAL OPERATION NEC              02/01/02       COLEMAN,MICHAEL G
  88.74  DX ULTRASOUND-DIGESTIVE               02/01/02       COLEMAN,MICHAEL G
  42.99  ESOPHAGEAL OPERATION NEC              02/01/02       COLEMAN,MICHAEL G
  88.74  DX ULTRASOUND-DIGESTIVE               02/01/02       COLEMAN,MICHAEL G
  28.5   EXCISION LINGUAL TONSIL               02/01/02       COLEMAN,MICHAEL G
  50.29  DESTRUC HEPATIC LES NEC               02/01/02       COLEMAN,MICHAEL G
  50.99  LIVER OPERATION NEC                   02/01/02       COLEMAN,MICHAEL G
  88.33  OTHER SKELETAL X-RAY                  02/01/02       TONGEN,LYLE A
  01.02  VENTRICL SHUNT TUBE PUNC              02/01/02       COLEMAN,MICHAEL G
  01.02  VENTRICL SHUNT TUBE PUNC              02/01/02       COLEMAN,MICHAEL G
  28.5   EXCISION LINGUAL TONSIL               02/01/02       COLEMAN,MICHAEL G
  40.19  LYMPHATIC DIAG PROC NEC               02/01/02       COLEMAN,MICHAEL G

HCPCS:                          Modifiers:     Date:      Surgeon:      Pre APC:
0003T CERVICOGRAPHY             47,59,80,DP,82 02/01/02   COLEMAN,MICHA
88172 CYTOPATHOLOGY EVAL OF FN                 02/01/02   COLEMAN,MICHA
43232 ESOPH ENDOSCOPY W/US FN                  02/01/02   COLEMAN,MICHA
0001T ENDOVAS REPR ABDO AO ANE                 02/01/02   COLEMAN,MICHA
33214 UPGRADE OF PACEMAKER SYS                 02/01/02   TONGEN,LYLE A
33216 REVISE ELTRD PACING-DEFI                 02/01/02   TONGEN,LYLE A
33218 REVISE ELTRD PACING-DEFI                 02/01/02   COLEMAN,MICHA
33220 REVISE ELTRD PACING-DEFI                 02/01/02   TONGEN,LYLE A
33233 REMOVAL OF PACEMAKER SYS                 02/01/02   COLEMAN,MICHA
33236 REMOVE ELECTRODE/THORACO                 02/01/02   COLEMAN,MICHA
33243 REMOVE ELTRD/THORACOTOMY                 02/01/02   COLEMAN,MICHA
```

```
Date: 06/21/09                Model Hospital A              Page  : 2
Time: 11:57                 Abstract Summary Form           Report: MR

Patient:FITCHETT,AUBRY                      Acct. #:0203200001


HCPCS:                          Modifiers:  Date:     Surgeon:      Pre APC:
33245 INSERT EPIC ELTRD PACE-D              02/01/02  COLEMAN,MICHA
33246 INSERT EPIC ELTRD/GENERA              02/01/02  COLEMAN,MICHA
33910 REMOVE LUNG ARTERY EMBOL              02/01/02  COLEMAN,MICHA
45379 COLONOSCOPY W/FB REMOVAL              02/01/02  COLEMAN,MICHA
45385 LESION REMOVAL COLONOSCO              02/01/02  COLEMAN,MICHA
76020 X-RAYS FOR BONE AGE                   02/01/02  COLEMAN,MICHA
82370 X-RAY ASSAY, CALCULUS                 02/01/02  COLEMAN,MICHA
75984 XRAY CONTROL CATHETER CH              02/01/02  COLEMAN,MICHA
49423 EXCHANGE DRAINAGE CATHET              02/01/02  COLEMAN,MICHA

Consultants:                                Date:         Specialty:
BASS,STATE                                  02/01/02      FAMILY PRACTICE
AKER,TOM                                    02/01/02      CARDIOLOGY
GABRIEL,JOHN A                              02/01/02      FAMILY PRACTICE
FREEMAN,ANNE                                02/01/02      Medical Division
ADAMS,JAY M                                 02/01/02      Medical Division
LEES,JACK R                                 02/01/02      CARDIOLOGY
*BAAB,FREMSTAD ETAL                         02/01/02      CARDIOLOGY
DEBVDOC,WITHAV                              02/01/02      Medical Division
KING,INGROUPTWO                             02/01/02      NEPHROLOGY
KING,INGROUPTHREE                           02/01/02      NEUROLOG - SURGERY


                              End of Report
```

NOTE: HCPCS codes and related information print on the form only if the Print HCPCS parameter (in M/R Abstract & DRG Census Criteria) for the patient's abstract code is set to **Yes**. The HCPCS codes that are included are those from Medical Records, not those from Order Entry (Charges).

Preliminary APC codes print for the HCPCS codes only if your facility is using 3M's APCfinder software.

CHARGE SUMMARY EXCEPTION REPORT (DCCERX)

The Charge Summary Exception Report prints at Midnight Processing. It is not available on demand from a Medical Record menu.

The Charge Summary Exception Report lists any charges, by account, for which a detail revenue center could not be determined. When the system is unable to determine the detail revenue center, charges cannot be accurately reflected in any cost/charge comparisons performed through Concurrent Monitoring.

Charges appear on this report under the following circumstances:

- The SIM item listed is attached to a FIM item that does not have a Detail Revenue Center assigned.
- The Detail Revenue Center contained in the FIM item has been deleted.
- The Detail Revenue Center does not contain the Major Revenue Center in the Detail Revenue Center table.

This report is used to troubleshoot Concurrent Monitoring issues and prevent additional errors for future charges from occurring. Charges for SIM items with a corresponding FIM item that contains an invalid Detail Revenue Center are not processed in the correct Revenue Center, which prevents accurate calculation of costs. Therefore, the Case Analysis by Major Revenue Center Report (DCRCX) does not accurately reflect costs/charges by Major Revenue Center.

Figure 5.15 Charge Summary Exception Report (DCCERX)

```
                              Model Hospital A                              Page 1
                    Charge Summary Exception Report For 06/14/95

                  Department                  SIM
    Account #     Code  Description           Code  Description
-----------------------------------------------------------------
Detail Revenue Center Overrides:
   9400700005    RXA  PHARMACY - A           301
   9400700005    RXA  PHARMACY - A           361
   9400700005    RXA  PHARMACY - A           377
   9400700005    RXA  PHARMACY - A           376
   9400700005    RXA  PHARMACY - A           304
   9400700005    RXA  PHARMACY - A           375
```

PROSPECTIVES CHARGE BALANCING REPORT (DCBALX)

The Prospectives Charge Balancing Report prints at Midnight Processing. It is not available on demand from a Medical Record menu.

The Prospectives Charge Balancing Report lists charges for accounts sent from a stand-alone ancillary/departmental system to STAR Patient Care, along with any charges generated by STAR.

This report is only for use by the Medical Records department in facilities that have the following:

- A financial system that uses a batch type of interface
- A foreign clinical system that does not interface their charges through STAR Patient Care

For example, this report would be used by a customer who has a batch non-STAR Financials system and a stand-alone foreign Pharmacy system that interfaces their charges directly to a foreign vendor. STAR Patient Care would not know of the charges, and, therefore, could not include them in concurrent monitoring comparisons.

NOTE: This would apply to any customer with a financial system, McKesson or foreign, that uses the a non-STAR Financials batch interface.

To insure that all the patient's charges are reflected, an external charge tape can be applied to STAR Patient Care to be included in concurrent monitoring totals.

This report is used to help balance charge totals between STAR Patient Care, the non-STAR Financials vendor, and the ancillary departmental system. It includes charge totals received on the external charge tape as well as STAR Patient Care charges by account.

Figure 5.16 Prospectives Charge Balancing Report (DCBALX)

```
                          Model Hospital A                                  Page 1
              Prospectives Charge Balancing Report for 06/14/95

Account #    Name                M* Csts   Ext Chgs  Ext Csts  R/B Chgs
Anc Chgs
-------------------------------------------------------------------------------
9333-400-001 JETT,BETH
   Beg Balance                      0.00      0.00      0.00 102,220.0
    0.00
   M* Chg Summary                   0.00                         190.00
    0.00
   Ext Chg Summary                            0.00      0.00       0.00
    0.00
   Total Daily Sum                  0.00      0.00      0.00    190.00
    0.00
   Beg Bal + Daily                  0.00      0.00      0.00 102,410.0
    0.00
   Ending Balance                   0.00      0.00      0.00 102,410.0
    0.00
   Patient Summaries                        Charges             Costs
```

CHARGE HCPCS AFTER ABSTRACT REPORT (FCR360X)

NOTE: The Charge HCPCS after Abstract report (FCR360x) is a daily report produced in Midnight Processing on the STAR Patient Accounting application.

The Charge HCPCS after Abstract report (FCR360x) prints charges and credits that have been placed for the patient after the charge level HCPCS/modifiers were marked as reviewed in the GUI Abstract by clicking the Mark as Reviewed button on the Charge HCPCS screen. Only charges that have revenue codes that qualify to copy charge level HCPCS/modifiers into the abstract are reflected on the report (See both Rev Codes/View Chrgs field and Save Chg HCPCS in HIM Rev Codes field under "M/R ABSTRACT & DRG CENSUS CRITERIA" on page 4-15 for more information.)

This report uses the FCR360 Days field on the Abstracting Facility Options screen to determine how many days of charge activity should be accumulated per account for the report.

The Medical Records department can use this report to re-access the GUI Abstract and the Charge HCPCS tab of the DIAG/PROC/HCPCS screen for the account in order to pull new HCPCS/modifiers into the abstract and to remove existing HCPCS from the abstract if warranted.

If a credit appears on the report without an associated charge, this could mean that the charge level HCPCS/modifier has already updated the Medical Records GUI Abstracting. If the new credit cancels the existing charge, Medical Records may need to delete the HCPCS/modifier in the GUI Abstract if it is no longer valid for the account.

The current Medical Records HCPCS that exist on the account as of the date/time the report is produced are also reflected on the report. If the new charge(s) have the same HCPCS/modifiers as what already exists in Medical Records, then the GUI Abstract need not be accessed and saved again in order to pull in these new charge level HCPCS/modifiers. However, if the new charge(s) have different HCPCS/modifiers as what already exists in Medical Records, then the GUI Abstract should be accessed and saved again in order to pull in these new charge level HCPCS/modifiers.

The system produces a cumulative report based on the number of days set in the FCR360 Days field. Once the charge level HCPCS have been Mark as Reviewed in the GUI Abstract, the system identifies new charges and credits with revenue codes set to update the abstract with the charge level HCPCS. The system keeps the account on the report a length of the last charge/credit posting date on the FCR360x report plus the number of days set in the Number of Days for Charge HCPCS After Abstract Rpt field.

If the field is set to 30 days and the account has been abstracted, and the Mark as Reviewed button was clicked on the Charge HCPCS screen, the system reports on charges and credits placed for the patient after this date that have a revenue code set to copy HCPCS/modifiers into the abstract.

Example:

- An account is abstracted on 1/1/2011 and the charge level HCPCS are moved to the HCPCS screen, and the Mark as Reviewed button is clicked on the Charge HCPCS screen.
- A new charge is placed on 1/3/2011. This charge is on that night's FCR360x report.
- A new charge is placed on 1/4/2011. This charge is on that night's FCR360x report, with the charge from 1/3/2011.
- The GUI Abstract is accessed on 1/7/2011, and the new charge level HCPCS are reviewed/moved, and the user clicks the Mark as Reviewed button.
- The charges from 1/3 and 1/4 drop off of the FCR360x report since they have now been reviewed.
- A new charge is placed on 1/8/2011. This charge is on that night's FCR360x report. This is now the only charge on the FCR360x for the account since the charges for 1/3/2011 and 1/4/2011 had already been reviewed.
- A new charge is placed on 1/9/2011. This charge is on that night's FCR360x report, along with the charge for 1/8/2011.
- If the GUI Abstract is not accessed again, and the charge level HCPCS are therefore not marked as reviewed, then the account will drop off of the report 30 days from the posting date of the last charge on the report, which is 30 days from 1/9/2011.

If the account had been dropped from the report 30 days from the last posting date on the report, if a charge/credit is then posted to the account, the account will again appear on the FCR360x report with any charges/credits that have a revenue code set to update the GUI Abstract with the charge level HCPCS, that have not been marked as reviewed.

If there is a charge and an offsetting credit, the HCPCS information is not pulled into the HIM Abstract. Also, if there is a credit without an offsetting charge, the HCPCS information is not pulled into the HIM Abstract. This can occur if the credit was posted to the wrong account, or if the charge had already updated the HIM Abstract with the HCPCS information, and the credit came in after this was accepted. In this scenario, the HCPCS may need to be deleted from the abstract. This credit without an offsetting charge is reported on the Charge HCPCS after Abstract report (FCR360x).

The report is sorted alphabetically by Patient Name. Within the account the secondary sort for the Charge HCPCS is Rev Code, and within Rev Code, the sort is by Service Date (oldest to newest). The Medical Records HCPCS print in the order they are listed in Medical Records.

The data elements that are included on this report are as follows:

- Patient Name
- Med Rec number (Med Rec #)
- Account number
- Financial Class (FC)
- Patient Type (PT)
- Charge Sequence number (Chg Seq)
- FIM Item
- FIM Description
- UB Revenue Code (Rev)
- Service Date (Srv Date)
- Posting Date (Post Date)
- HCPCS and Modifiers (HCPCS/Mods).

Following the charge data, the system lists the Medical Records HCPCS information that exists as of the date and time the report is produced. The reports lists:

- MED RECS HCPCS
- Rev (revenue code)
- Proc Date (procedure date)
- HCPCS/Mods (HCPCS and Modifiers)

Figure 5.17 Charge HCPCS After Abstract (FCR360X)

```
Date: 07/17/11                                    Model Hospital A
Time: 2:08                                  Charge HCPCS After Abstract


Patient Name                  Med Rec #   Account #      FC  PT
                              Chg Sq      FIM Item   Description                      Rev   Srv Date Post Date HC

DORIGHT,DUDLEY                000006135   A1113600004    O   I/P
                                  17      70330020   SURGICAL MONITORING              730   05/16/11 05/16/11  95
                                  12      70333101   BAER                             740   05/16/11 05/16/11  92
                                  13      70333130   EEG / BRAINMAPPING               740   05/16/11 05/16/11  95
                                  15      70333100   EEG                              740   05/16/11 05/16/11  95
                                  18      70311104   ECG PROFESSIONAL FEE             985   05/16/11 05/16/11  93
                                  19      70311105   RHYTHM STRIP PROFESSIONAL FEE    985   05/16/11 05/16/11  93
                                  14      70333112   EEG PRO FEE                      986   05/16/11 05/16/11  95
                                  16      70333112   EEG PRO FEE                      986   05/16/11 05/16/11  95

                                                                    MED REC HCPCS:   Rev   Proc Date          HC
                                                                                     730   05/16/11           95
                                                                                     740   05/16/11           92
                                                                                     740   05/16/11           95
                                                                                     985   05/16/11           93
                                                                                     985   05/16/11           93
                                                                                     986   05/16/11           95
                                                                                     986   05/16/11           95

                                                End of Report
```

ACCOUNTS TO BE REGROUPED (MRRGRP)

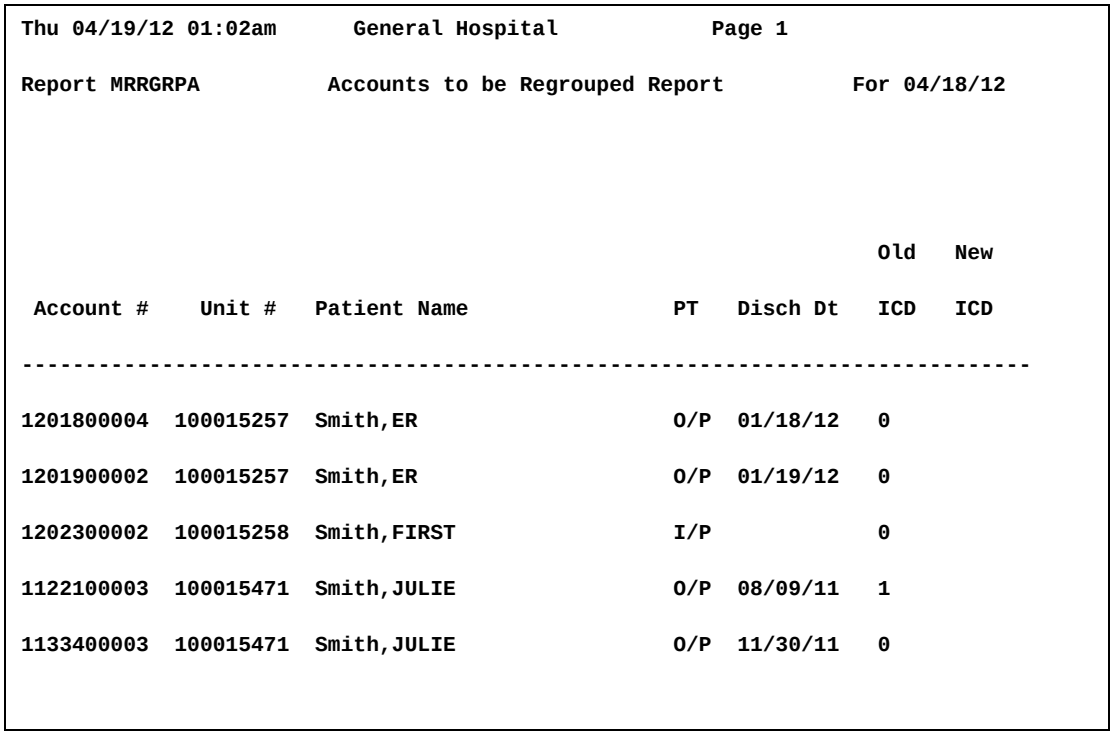
This report identifies accounts that require regrouping due to ICD Indicator change and codes/grouping that weren't required, and are now required. If there are no accounts to be reported, report will run with title and "blank" page.

This report lists all accounts that require regrouping

- Due to payor, MSDRG, HAC or ICD-9 flag change. If ICD Discharge Indicator changes from 10/9 or 9/10 to 10 or 9, both I-10 and I-9 coding and grouping data will remain stored in STAR and the account is not added to report.
- If STAR grouper changes to another STAR grouper (i.e.from current Medicare grouper to older Medicare used by a commercial plan), and it means a different rate master version needs to be used.

The Accounts to be Regrouped Report prints at Midnight Processing. It is not available on demand from a Medical Record menu.

Figure 5.18 Accounts to be Regrouped (MRRGRP)



```
Thu 04/19/12 01:02am      General Hospital            Page 1

Report MRRGRPA          Accounts to be Regrouped Report          For 04/18/12




                                                                  Old   New
 Account #    Unit #   Patient Name                PT   Disch Dt   ICD   ICD
-------------------------------------------------------------------------------
1201800004  100015257  Smith,ER                    O/P  01/18/12   0
1201900002  100015257  Smith,ER                    O/P  01/19/12   0
1202300002  100015258  Smith,FIRST                 I/P             0
1122100003  100015471  Smith,JULIE                 O/P  08/09/11   1
1133400003  100015471  Smith,JULIE                 O/P  11/30/11   0
```

Chapter 6 - CORE REPORTS

Illustrations

INTRODUCTION

The Core Reports function is usually located on the M/R Abstracting Functions Menu. Core Reports provide a tool with which to produce reports within the Medical Record Department without requiring the assistance of Data Processing. Each report has a heading that contains the report title, information on the selection criteria of the report, the date or period of time of the information on the report, and the date and time the report was printed. All selection criteria derived from tables (for example, financial class, service, race) are from the hospital's specific tables. Like other reports, Core Reports are facility specific.

NOTE: On any of the Core Reports, if you enter an equal sign (**=**) for All at the selection criteria prompt, the report includes filed as deleted codes in addition to all the active codes. For example, if you enter an equal sign (**=**) at the prompt for the Financial Class selection criteria, any patients who have filed as deleted financial classes print on the report as long as they meet the other selection criteria entered.

The Core Reports can be set up to print immediately on a printer in Medical Records or they can be spooled to be printed on demand on a high speed printer in Data Processing. This decision should be based on the availability of printers in the Medical Record Department, the type and size of paper in those printers, and the length of the reports being requested. Please consult the Data Processing department in your facility for assistance.

The purpose of the Core Reports function is to give the Medical Record Department a quick and easy way to obtain statistical and patient information from the Medical Record Abstracting Module. For more complex reporting needs, or for access to information not found in the Core Reports, the hospital should consider using the STAR Vista Reporting Module.

After you select the Core Reports option from the Abstracting & DRG functions menu, the following menu displays, listing the available reports:

```
                  General Hospital Core Reports Processor
                                                 Tue Sep 20, 2011 11:29 pm
Core Reports Input Options

            Option No.  Option
            ---------------------------------------
                1       Discharges by DRG
                2       Discharges by APRDRG
                3       Discharges by Diagnosis
                4       Discharges by Procedure
                5       Discharges by HCPCS
                6       Financial Class by Service
                7       Age and Sex by Service w/ LOS
                8       Age and Sex by Financial Class w/ LOS
                9       Discharge Status/Disposition Report
               10       MR Special Study Report
               11       Mortality Report
               12       Discharges by Race
               13       Combined HCPCS
               14       MR/HIM Productivity Report
               15       Post Payment Evaluation Options

Enter option number--
```

DISCHARGES BY DRG/MS-DRG REPORT (PRO1X)

This report is useful in determining the number of cases with a particular DRG within a specified time-frame. The selection criteria for the report can be set to display summary information or detailed patient information. The selection criteria also allow for selection of MSDRG or Classic (Non-MSDRG) codes, specific DRGs, specific financial classes, services, patient types, and physicians. Primary and secondary sort criteria are also available for the report.

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 patient detail is included, the report can be used as a resource for pulling records for patients with a particular DRG.

The report displaying Discharges by DRG/MS-DRG prints on wide bar (132 column) paper. The information on the report is based on data found in the abstract.

NOTE: In the character-based environment, the abstract does not have to be marked complete, nor does the DRG have to be marked as final as long as a provisional DRG is present in the abstract and the patient has been discharged. In GUI Abstracting, if the DRG is calculated by a system other than STAR, the DRG must be marked final for the account to print on this report.

To create this report, select the Discharges by DRG/MS-DRG option from the Core Reports menu. The Discharges by DRG Processor screen displays.

```
                    General Hospital Discharges by DRG Processor
                                                 Wed Apr 18, 2012 12:39 pm
( 1)ICD Indicator       : Both
( 2)DRG                 :
( 3)Financial Classes   :
( 4)Begin Discharge Date:
( 5)End   Discharge Date:
( 6)Service             :
( 7)MS-DRG              :
( 8)Patient Type        :
( 9)Physician           :
(10)Print Detail        :
(11)Primary Sort        :
(12)Primary Subtotals   :
(13)Secondary Sort      :









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

Field Explanations

1. ICD INDICATOR
When you access this field, the following prompt is displayed:

Report ICD10's (T), ICD9's (N), Both (T/N/B) [B]-- |

- Enter **T** to process the report with I-9 DRGs only
- Enter **N** to process the report with I-10 DRGs only
- Enter **B** to process the report with both I-9 and I-10s. If Both is selected, two reports will be processed: one for I-10 DRGs and one for I-9 DRGs.

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

Enter DRG(s), DRG range(s) separated by `,`, or T# for Top 10-35 DRGs, or `=` for All--

Enter an equal sign (=) or press ENTER for the default of All. You can also enter a single DRG, multiple DRGs, range(s) of DRGs, or a listing of the top DRGs in this field. Enter the DRG as either a single DRG number, multiple DRG numbers (each separated by a comma), or a range of numbers (for example, 015-030).

You must enter each DRG as a three-digit number, so include any leading zeros. When entering a range of DRGs, the first number must be less than the second

number. If you were to enter a range of 015-001, for example, the system would display this error message:

Invalid Entry!

To select all DRGs, the entry must be a range: 001-447.

If you want to select the top DRGs, enter **T** followed by a number in the range of 10 to 35. For example, if you enter **T25**, the report includes the top 25 DRGs.

3. FINANCIAL CLASSES
This field is for entering single, multiple, or all financial classes to be included in the report. When you access this field, the following prompt is displayed:

Enter financial class codes separated by `,`, `-` for table lookup, Partial Name `-`, or `=` for All [All]--

You can enter

- the financial class codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the financial class name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

When you select multiple financial classes, the report includes each financial class code in the header, up to two lines. The second line is appended with *+more* if there are more codes than can be listed in two lines.

4. BEGIN DISCHARGE DATE
Enter the beginning discharge date of those patients to be included in the report. For example, by entering 010199, the report includes all patients discharged on or after January 1, 1999. A date in the format MMDDYY is required. There is no default for this field.

5. END DISCHARGE DATE
Enter the ending discharge date of those patients to be included in the report. For example, if you enter 063099, the report includes all patients whose discharge date is on or before June 30, 1999. If you enter no date and press ENTER, the current date is displayed in this field, and the report ends with the last date of patient information in the database (usually the current date).

NOTE: A report for a specific time period (for example, a month, a quarter, or year) is completed much faster than one that is run against the entire database.

6. SERVICE
This field indicates which service codes are to be included on the report. When you access this field, the following prompt is displayed:

Enter service codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter

- the service codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the service name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

When you select multiple services, the report includes each service code in the header, up to two lines. The second line is appended with *+more* if there are more codes than can be listed in two lines.

7. MS-DRG
This field indicates which DRG code types are to be included on the report. When you access this field, the following prompt is displayed:

Print MS-DRG codes (Y/N) [Y]--

You can enter

- Y to include MS-DRG codes, or
- N to include only classic (non-MS-DRG) codes

8. PATIENT TYPE
This field indicates which patient types are to be included on the report. When you access this field, the following prompt is displayed:

Enter patient type codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter any combination of patient types. You can enter

- the patient type codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the patient type name followed by a hyphen, or

- an equal sign (=) or press ENTER for the default of all.

9. PHYSICIAN
This field indicates which physicians are to be included on the report. When you access this field, the following prompt is displayed:

Enter physician codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter

- the physician codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the physician name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

10. PRINT DETAIL
This field gives you the option of including patient detail on this report. Enter **Y** for Yes to include detail, which consists of the following patient-related information: account number, unit number, patient name, age and sex, admission date, and discharge date. Press **N** or ENTER for No, in which case only summary information prints.

11. PRIMARY SORT
This field allows you to select a primary sort (within DRG) for the report. Select the primary sort from the options that display when you access the field.

The primary sort options vary depending on whether you are printing a detail or a summary report. For the detail report, your options are discharge date, financial class, patient name, patient type, physician, service, terminal digit, or unit number. For the summary report, your options are financial class, patient type, physician, or service.

Each sort, except for discharge date, is by table code, not description.

NOTE: If you do not enter a primary sort, the system uses a default of physician.

12. PRIMARY SUBTOTALS (1-A-R)
This field allows you to indicate if subtotals for the primary sort should be included on the report. Enter **Y** or press ENTER for the default of Yes, and the subtotals are included. Enter **N**, and subtotals are not included.

NOTE: The report always includes totals for each DRG selected for the report.

In the sample reports that follow, the Detail report includes subtotals and the Summary report does not.

13. SECONDARY SORT
This field allows you to select a secondary sort (within DRG and primary sort) for the report. Select the secondary sort from the options that display when you access the field. This field is optional; if it is left blank, the report sorts by DRG and primary sort.

The secondary sort options vary depending on your primary sort and whether your report is detail or summary.

NOTE: If the primary sort is patient name, terminal digit, or unit number, the Secondary Sort field cannot be accessed.

After you complete these fields, this prompt displays:

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

Press **N** if you need to return to any of the fields to make changes. Press **Y** or ENTER for Yes to accept the screen. Once you accept it, this message displays:

Compiling and Printing

The system displays the message briefly, then returns you to the Core Reports menu.

Impact

After you accept this screen, the Discharges by DRG/MS-DRG Report prints at the assigned printer.

Output

Following are samples of the core report Discharges by DRG/MS-DRG:

- The first sample uses detail patient information and a primary sort of physician. It includes subtotals for the primary sort.
- The second sample uses summary information and a primary sort of financial class. It does not include subtotals for the primary sort.

Figure 6.1 Discharges by DRG/MS-DRG Report - Detail (PRO1X)

```
Mon Mar 10, 2008 11:48 am                          Model Hospital A                                                    Page 2
                                                  Discharges by MSDRG-Detail
                                                   Primary Sort: Physician
                                                 Secondary Sort: Discharge Date
Selection Criteria
-----------------
DRG/MS-DRG:    Top: 20
Financial:     All
Service:       All
Version:       MSDRG
Patient Type:  All
Physician:     All
Disch Dates    01/01/07 to 03/10/08

-------------------------------------------------------------------------------------------------------------------------
MS-DRG/Description

  Physician/Description             SVC P/T Acct#          Unit#          Patient Name   Age/Sex FC Adm Date Dis Dt MSDRG
-------------------------------------------------------------------------------------------------------------------------

293 HEART FAILURE & SHOCK W/O CC/MCC

      32 ADAIR,FRANK C              MED ER  07284-00015     000-00-5789     ENGLISH,ERIC M  45Y/M   S  10/11/07 10/11/07   Y

   Total for Physician     32 ADAIR,FRANK C: 1

      100 DOCTOR,ADMITTING ONEXXXXX NUR O/P 07304-00001     000-00-5507     TAYLOR,BEN J   22Y/F   S  10/31/07 10/31/07   Y

   Total for Physician    100 DOCTOR,ADMITTING ONEXXXXX: 1

      432 BABB,GARY H               MED OPS 08035-00004     000-00-5767     BRADLEY,CARRIE 66Y/F   M  02/04/08 02/04/08   Y

   Total for Physician    432 BABB,GARY H: 1

     1500 DEBVDOC,WITHAV            MED LOR 08036-00004     000-00-5904     FINE,AUGUSTUS  63Y/M   M  02/05/08 02/05/08   Y

   Total for Physician   1500 DEBVDOC,WITHAV: 1

   Total for DRG/MS-DRG 293 HEART FAILURE & SHOCK W/O CC/MCC: 4


      End of Report
```

Figure 6.2 Discharges by DRG/MS-DRG Report - Summary (PRO1X)

```
Tue Jul 02, 2007 05:07 pm                          Model Hospital A                                    Page 1
                                                Discharges by DRG/MS-DRG-Summary
                                               Primary Sort: Financial Class
                                                   Secondary Sort: None
Selection Criteria
-----------------
DRG:            Range 470
Financial:      All
Service:        All
Patient Type:   All
Physician:      All
Disch Dates     09/20/00 to 07/02/02
-------------------------------------------------------------------------------------------------------------------------
DRG/Description
Financial Class/Description                                                  Count
-------------------------------------------------------------------------------------------------------------------------

470 UNGROUPABLE

   B BLUE CROSS                                                               3
   M MEDICARE                                                                 1
   O OTHER COMMERCIAL                                                         5
   SP DALE'S SELF PAY                                                         6

   Total for DRG 470: 15



End of Report
```

DISCHARGES BY APRDRG REPORT (PRO15X)

The Discharges by APRDRG Report is useful in determining the number of cases with a particular APR-DRG within a specified time-frame. The selection criteria for the report can be set to display summary information or detailed patient information. The selection criteria also allow for selection of specific APR-DRGs, as well as specific financial classes, services, patient types, physicians, severity of illness indicators, and risk of mortality indicators. Primary and secondary sort criteria are also available for the report.

When patient detail is included, the report can be used as a resource for pulling records for patients with a particular APR-DRG.

The report displaying discharges by APR-DRG prints on wide bar (132 column) paper. The information on the report is based on data found in the abstract.

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*.

NOTE: In the character-based environment, the abstract does not have to be marked complete, nor does the APR-DRG have to be marked as final as long as a provisional APR-DRG is present in the abstract and the patient has been discharged. In GUI Abstracting, if the APR-DRG is calculated by a system other than STAR, the APR-DRG must be marked final for the account to print on this report.

To create this report, select the Discharges by APRDRG option from the Core Reports menu and a facility, if applicable. The Discharges by APRDRG Processor screen is displayed:

```
                  General Hospital Discharges by APRDRG Processor
                                                 Fri Jul 22, 2005 07:39 pm
( 1)APRDRG             :
( 2)Financial Classes  :
( 3)Begin Discharge Date:
( 4)End   Discharge Date:
( 5)Service            :
( 6)Patient Type       :
( 7)Physician          :
( 8)Severity of Illness :
( 9)Risk of Mortality  :
(10)Print Detail       :
(11)Primary Sort       :
(12)Primary Subtotals  :
(13)Secondary Sort     :









Enter DRG(s), DRG range(s) separated by `,`, or T# for Top 10-35 DRGs, or `=` fo
r All--
```

Field Explanations

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

Enter DRG(s), DRG range(s) separated by `,`, or T# for Top 10-35 DRGs, or `=` fo r All--

Enter an equal sign (=) or press ENTER for the default of All. You can also enter a single APR-DRG, multiple APR-DRGs, range(s) of APR-DRGs, or a listing of the top APR-DRGs in this field. Enter the APR-DRG as either a single APR-DRG number, multiple APR-DRG numbers (each separated by a comma), or a range of numbers (for example, 015-030).

You must enter each APR-DRG as a three-digit number, so include any leading zeros. When entering a range of APR-DRGs, the first number must be less than the second number. If you were to enter a range of 015-001, for example, the system would display this error message:

Invalid Entry!

To select all APR-DRGs, the entry must be a range: 001-447.

If you want to select the top APR-DRGs, enter **T** followed by a number in the range of 10 to 35. For example, if you enter **T25**, the report includes the top 25 APR-DRGs.

2. FINANCIAL CLASSES
This field is for entering single, multiple, or all financial classes to be included in the report. When you access this field, the following prompt is displayed:

Enter financial class codes separated by `,`, `-` for table lookup, Partial Name `-`, or `=` for All [All]--

You can enter

- the financial class codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the financial class name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

When you select multiple financial classes, the report includes each financial class code in the header, up to two lines. The second line is appended with *+more* if there are more codes than can be listed in two lines.

3. BEGIN DISCHARGE DATE
Enter the beginning discharge date of the patients to be included in the report. For example, by entering 010105, the report includes all patients discharged on or after January 1, 2005. A date in the format MMDDYY is required. There is no default for this field.

4. END DISCHARGE DATE
Enter the ending discharge date of the patients to be included in the report. For example, if you enter 063005, the report includes all patients whose discharge date is on or before June 30, 2005. If you enter no date and press ENTER, the current date is displayed in this field, and the report ends with the last date of patient information in the database (usually the current date).

NOTE: A report for a specific time period (for example, a month, a quarter, or year) is completed much faster than one that is run against the entire database.

5. SERVICE
This field indicates which service codes are to be included on the report. When you access this field, the following prompt is displayed:

Enter service codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter

- the service codes directly, each separated by commas,

- a hyphen (-) to do a table lookup,
- part of the service name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

When you select multiple services, the report includes each service code in the header, up to two lines. The second line is appended with *+more* if there are more codes than can be listed in two lines.

6. PATIENT TYPE
This field indicates which patient types are to be included on the report. When you access this field, the following prompt is displayed:

Enter patient type codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter any combination of patient types. You can enter

- the patient type codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the patient type name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

7. PHYSICIAN
This field indicates which physicians are included on the report. When you access this field, the following prompt is displayed:

Enter physician codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter

- the physician codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the physician name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

8. SEVERITY OF ILLNESS
This field indicates which levels of illness severity are included on the report. When you access this field, the following prompt is displayed:

Enter Severity of Illness codes (0-4) separated by `,` or `=` for All [All]--

You can enter

- a single code
- any combination of codes from 0 to 4, separated by commas
- an equal sign (=) or press ENTER for the default of all.

9. RISK OF MORTALITY
This field indicates which levels of mortality risk are included on the report. When you access this field, the following prompt is displayed:

Enter Risk of Mortality codes (0-4) separated by `,` or `=` for All [All]--

You can enter

- a single code
- any combination of codes from 0 to 4, separated by commas
- an equal sign (=) or press ENTER for the default of all.

10. PRINT DETAIL
This field gives you the option of including patient detail on this report. Enter **Y** for Yes to include detail, which consists of the following patient-related information: account number, unit number, patient name, age and sex, admission date, and discharge date. Press **N** or ENTER for No, in which case only summary information prints.

11. PRIMARY SORT
This field allows you to select a primary sort (within APR-DRG) for the report. Select the primary sort from the options that display when you access the field.

The primary sort options vary depending on whether you are printing a detail or a summary report. For the detail report, your options are discharge date, financial class, patient name, patient type, physician, service, terminal digit, or unit number. For the summary report, your options are financial class, patient type, physician, or service.

Each sort, except for discharge date, is by table code, not description.

NOTE: If you do not enter a primary sort, the system uses a default of physician.

12. PRIMARY SUBTOTALS (1-A-R)
This field allows you to indicate if subtotals for the primary sort should be included on the report. Enter **Y** or press ENTER for the default of Yes, and the subtotals are included. Enter **N**, and subtotals are not included.

NOTE: The report always includes totals for each APR-DRG selected for the report.

In the sample reports that follow, the Detail report includes subtotals and the Summary report does not.

13. SECONDARY SORT
This field allows you to select a secondary sort (within APR-DRG and primary sort) for the report. Select the secondary sort from the options that display when you access the field. This field is optional; if it is left blank, the report sorts by APR-DRG and primary sort.

The secondary sort options vary depending on your primary sort and whether your report is detail or summary.

NOTE: If the primary sort is patient name, terminal digit, or unit number, the Secondary Sort field cannot be accessed.

After you complete these fields, this prompt displays:

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

Press **N** if you need to return to any of the fields to make changes. Press **Y** or ENTER for Yes to accept the screen. Once you accept it, the following message is displayed:

Compiling and Printing

The system displays the message briefly and then returns you to the Core Reports menu.

Impact

After you accept this screen, the following takes place:

- The Discharges by APRDRG Report prints at the assigned printer.

Output

Following are samples of the core report Discharge by APRDRG:

- The first sample uses detail patient information and a primary sort of discharge date. It includes subtotals for the primary sort.

- The second sample uses summary information and a primary sort of physician. It does not include subtotals for the primary sort.

Figure 6.3 Discharges by APRDRG Report - Detail (PRO15X)

```
Fri Jul 22, 2005 03:01 pm                              Model Hospital A                                                    Page 1
                                                  Discharges by APRDRG-Detail
                                               Primary Sort: Discharge Date
                                              Secondary Sort: Financial Class
Selection Criteria
----------------------
APRDRG:             All
Financial:          All
Service:            All
Patient Type:       All
Physician:          All
Severity of Illness:All
Risk of Mortality:  All
Disch Dates         01/01/04 to 07/22/05
-------------------------------------------------------------------------------------------------------------------------------
APRDRG/Description
  Physician/Description     SOI/ROM SVC P/T Acct#           Unit#           Patient Name          Age/Sex FC Adm Date   Disch Date
-------------------------------------------------------------------------------------------------------------------------------

254 OTHER DIGESTIVE SYSTEM DIAGNOSES

       10 COLEMAN,MICHAEL G   1/1   MED I/P 0510400004      000-00-3445     FITCHETT,APRDRG       50Y/M   M  04/14/05   04/14/05

   Total for Discharge Date 04/14/05: 1

   Total for APRDRG 254 :1


349 MALFUNCTION, REACTION, COMPLIC OF ORTHOPEDIC DEVICE OR PROCEDURE

     2234 AKER,TOM            1/1   MED I/P 0510400006      000-00-3346     TEST,GUI ONE          97Y/F   M  04/14/05   04/14/05

   Total for Discharge Date 04/14/05: 1

   Total for APRDRG 349 :1


460 RENAL FAILURE

       32 ADAIR,FRANK C       2/2   MED I/P 0510500001      000-00-3394     TEST,JOHN 151         96Y/F   M  04/15/05   04/15/05
     2234 AKER,TOM            2/2   MED I/P 0510500002      000-00-3394     TEST,JOHN 151         96Y/F   M  04/15/05   04/15/05
      432 BABB,GARY H         2/2   MED I/P 0510500003      000-00-3394     TEST,JOHN 151         96Y/F   M  04/15/05   04/15/05

   Total for Discharge Date 04/15/05: 3

   Total for APRDRG 460 :3


End of Report
```

Figure 6.4 Discharges by APRDRG Report - Summary (PRO15X)

```
Fri Jul 22, 2005 08:44 pm                          Model Hospital A                                    Page 1
                                                Discharges by APRDRG-Summary
                                                   Primary Sort: Physician
                                                Secondary Sort: Financial Class
Selection Criteria
----------------------
APRDRG:             All
Financial:          All
Service:            All
Patient Type:       All
Physician:          All
Severity of Illness:All
Risk of Mortality:  All
Disch Dates         01/01/04 to 07/22/05
-------------------------------------------------------------------------------------------------------------------------
APRDRG/Description

-------------------------------------------------------------------------------------------------------------------------

254 OTHER DIGESTIVE SYSTEM DIAGNOSES

       10 COLEMAN,MICHAEL G        M MEDICARE                      1

   Total for APRDRG 254 :1


349 MALFUNCTION, REACTION, COMPLIC OF ORTHOPEDIC DEVICE OR PROCEDURE

     2234 AKER,TOM                 M MEDICARE                      1

   Total for APRDRG 349 :1


460 RENAL FAILURE

       32 ADAIR,FRANK C            M MEDICARE                      1
      432 BABB,GARY H              M MEDICARE                      1
     2234 AKER,TOM                 M MEDICARE                      1

   Total for APRDRG 460 :3



End of Report
```

DISCHARGES BY DIAGNOSIS REPORT (PRO2X)

This report is useful in determining the number of cases for the diagnosis codes specified (within a specified time-frame). The selection criteria for the report can be set to display summary information or detailed patient information. The selection criteria also allow for selection of specific diagnoses, as well as specific financial classes, services, patient types, and physicians. Primary and secondary sort criteria are also available for the report.

When patient detail is included, the report can be used as a resource for pulling patient records with a particular diagnosis.

The report prints on wide bar (132 column) paper. The information in this report is based on data found in the abstract. However, the abstract does not have to be marked complete in order for the information to be included on the report.

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*.

To create a report listing the discharges by ICD diagnosis codes, select this option from the Core Reports menu. The Discharges by Diagnosis Processor screen displays:

```
               General Hospital Discharges by Diagnosis Processor
                                                  Mon Jul 20, 2009 10:47 pm
( 1)ICD-10 Diagnosis    :
( 2)ICD-9 Diagnosis     :
( 3)Financial Classes   :
( 4)Begin Discharge Date:
( 5)End   Discharge Date:
( 6)Service             :
( 7)Patient Type        :
( 8)Physician           :
( 9)Print Detail        :
(10)Primary Sort        :
(11)Primary Subtotals   :
(12)Secondary Sort      :









Enter ICD10 Diagnosis, Diagnosis range(s) separated by `,`, or T# for Top 10-35
 Diagnosis, or `=` for All--[None]
```

If you select Criteria for both ICD-10 and ICD-9 codes, two reports are generated; one for ICD-9 codes and one for ICD-10 codes as shown in the following example:

```
             General Hospital View Spooled Reports Processor
                                                  Thu Jul 30, 2009 01:06 pm
Report : PRO2A  Discharges by Diagnosis (A)
Page:01

 Copy  Spooled      Last Printed   Pages     Comment
( 1) 07/30/09 1300  Not Printed        1      Discharges by ICD10 Diagnosis
( 2) 07/30/09 1300  Not Printed        1      Discharges by ICD9 Diagnosis









Enter choice--
```

Field Explanations

1. ICD-10 DIAGNOSIS
2. ICD-9 DIAGNOSIS
Access the first field to enter ICD-10 codes. Access the second field to enter ICD-9 codes. When you access either of these fields, the following prompt is displayed:

Enter Diagnosis, Diagnosis range(s) separated by `,`, or T# for Top 10-35 Diagnosis, or `=` for All--

Enter an equal sign (=) or press ENTER for the default of All. You can also enter a single diagnosis code, multiple diagnosis codes (each separated by commas), range(s) of codes (for example, 25000-25091), or a listing of the top diagnosis codes.

Decimal points are not required when entering the ICD-9-CM code numbers. When entering a range of code numbers, the first code must be less than the second number. Entering a range of 67694-650, for example, would cause the system to display the following error message:

Invalid Entry!

If you want to select the top diagnosis codes, enter **T** followed by a number in the range of 10 to 35. For example, if you enter **T25**, the report includes the top 25 diagnosis codes.

Accounts that do not contain any ICD-9-CM diagnosis codes and that meet the criteria range are included in the *No Diagnosis Code* section at the beginning of the report.

Once you enter the code(s), or range of codes, or top selection number, the system displays this prompt:

Include secondary diagnosis codes? (Y/N) [N]--

Enter **Y** for Yes to include secondary diagnosis codes in the report; the report also counts the patients under each one of those codes. Press **N** or ENTER for No include only the principal diagnoses.

3. FINANCIAL CLASSES
This field is for entering single, multiple, or all financial classes to be included in the report. When you access this field, the following prompt is displayed:

Enter financial class codes separated by `,`, `-` for table lookup, Partial Name `-`, or `=` for All [All]--

You can enter

- the financial class codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the financial class name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

When you select multiple financial classes, the report includes each financial class code in the header, up to two lines. The second line is appended with *+more* if there are more codes than can be listed in two lines.

4. BEGIN DISCHARGE DATE
Enter the beginning discharge date, in the format MMDDYY, of those patients to be included in the report. For example, if you enter 010199, the report includes all patients discharged on or after January 1, 1999. There is no default.

5. END DISCHARGE DATE
Enter the ending discharge date, in the format MMDDYY, of those patients to be included in the report. For example, if you 063099, the report includes all patients whose discharge date is on or before June 30, 1999. If you enter no date and you press ENTER, the system puts the current date in the field, and the report ends with the last date of patient information in the database (usually the current date).

NOTE: A report for a specific time period (for example, a month, a quarter, or a year) will be completed much faster than one that is run against the entire database.

6. SERVICE
This field indicates which service codes are to be included on the report. When you access this field, the following prompt is displayed:

Enter service codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter

- the service codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the service name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

When you select multiple services, the report includes each service code in the header, up to two lines. The second line is appended with *+more* if there are more codes than can be listed in two lines.

7. PATIENT TYPE
This field indicates which patient types are to be included on the report. When you access this field, the following prompt is displayed:

Enter patient type codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter any combination of patient types. You can enter

- the patient type codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the patient type name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

8. PHYSICIAN
This field indicates which physicians are to be included on the report. When you access this field, the following prompt is displayed:

Enter physician codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter

- the physician codes directly, each separated by commas,

- a hyphen (-) to do a table lookup,
- part of the physican name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

9. PRINT DETAIL
This field gives you the option of including patient detail on this report. Press **Y** for Yes to include detail, which consists of the following patient-related information: account number, unit number, patient name, age and sex, admission date, and discharge date. Press **N** or ENTER for No, in which case only summary information prints.

10. PRIMARY SORT
This field allows you to select a primary sort (within diagnosis code) for the report. Select the primary sort from the options that display when you access the field.

The primary sort options vary depending on whether you are printing a detail or a summary report. For the detail report, your options are discharge date, financial class, patient name, patient type, physician, service, terminal digit, or unit number. For the summary report, your options are financial class, patient type, physician, or service.

Each sort, except for discharge date, is by table code, not description.

NOTE: If you do not enter a primary sort, the system uses a default of physician.

11. PRIMARY SUBTOTALS (1-A-R)
This field allows you to indicate if subtotals for the primary sort should be included on the report. Enter **Y** or press ENTER for the default of Yes, and the subtotals are included. Enter **N**, and subtotals are not included.

NOTE: The report always includes totals for each diagnosis selected for the report.

In the sample reports that follow, the Detail report includes subtotals and the Summary report does not.

12. SECONDARY SORT
This field allows you to select a secondary sort (within diagnosis code and primary sort) for the report. Select the secondary sort from the options that display when you access the field. This field is optional; if it is left blank, the report sorts by diagnosis code and primary sort.

The secondary sort options vary depending on your primary sort and whether your report is detail or summary.

NOTE: If the primary sort is patient name, terminal digit, or unit number, the Secondary Sort field cannot be accessed.

After you complete these fields, this prompt displays:

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

Enter **N** if you need to return to any of the fields to make changes. Press **Y** or ENTER for Yes to accept the screen. Once you accept it, this message displays:

Compiling and Printing

The system displays the message briefly, then returns you to the Core Reports menu.

Impact

After you accept this screen, the Discharges by Diagnosis Report prints at the assigned printer.

Output

Following are samples of the core report Discharge by Diagnosis:

- The first uses detail patient information and a primary sort of physician. It includes subtotals for the primary sort.
- The second uses summary patient information, a primary sort of financial class, and a secondary sort of patient type. It does not include subtotals for the primary sort.

Figure 6.5 Discharges by ICD-10 Diagnosis Report - Detail (PRO2X)

```
Thu Jul 30, 2009 12:21 pm                          Model Hospital A                                                    Page 1
                                                Discharges by ICD10 Diagnosis-Detail
                                                      Primary Sort: Physician
                                                      Secondary Sort: None
Selection Criteria
-----------------
I10 Diagnosis: All
               Exclude Secondary Diagnosis
Financial:     All
Service:       All
Patient Type:  All
Physician:     All
Disch Dates    07/01/09 to 07/30/09
-------------------------------------------------------------------------------------------------------------------------------
ICD10 Diagnosis/Description
  Physician/Description             SVC P/T Acct#          Unit#          Patient Name          Age/Sex FC Adm Date   Disch Date
-------------------------------------------------------------------------------------------------------------------------------

No ICD10 Diagnosis Code

       1 ADAMS,JAY K                MED PAT 0916200004     000-00-6079    PAT,PATIENT           74Y/F   M  06/11/09 07/26/09
       1 ADAMS,JAY K                NUR NEW 0918700004     000-00-6106    SHW-PCONSTD,BABY GIRL 0D/F    M  07/06/09 07/06/09
       1 ADAMS,JAY K                NUR NEW 0920300003     000-00-6119    SHW-PCONSTD,BABY BOY  0D/M    M  07/22/09 07/22/09
       1 ADAMS,JAY K                MED O/P 0920300010     000-00-6120    SAKOWSKI,OP           65Y/M   S  07/22/09 07/22/09

   Total for Physician      1 ADAMS,JAY K: 4

      10 COLEMAN,MICHAEL K          CAR O/P 0918300002     000-00-6097    MERRITT,B             19Y/M   M  07/02/09 07/02/09
      10 COLEMAN,MICHAEL K          CAR O/P 0918300003     000-00-6098    MERRITT,C             63Y/M   O  07/02/09 07/02/09
      10 COLEMAN,MICHAEL K          CAR ER  0918300004     000-00-6099    MERRITT,D             28Y/F   O  07/02/09 07/02/09
      10 COLEMAN,MICHAEL K          CAR O/P 0918300005     000-00-6100    MERRITT,E             69Y/F   JA 07/02/09 07/02/09
      10 COLEMAN,MICHAEL K          MLK ER  0918300006     000-00-6101    MERRITT,F             57Y/F   M  07/02/09 07/02/09
      10 COLEMAN,MICHAEL K          MLK O/P 0918300007     000-00-6102    MERRITT,G             47Y/M   O  07/02/09 07/02/09
      10 COLEMAN,MICHAEL K          CAR O/P 0918900001     000-00-6064    MERRITT,MDAMB NOVALUE 32Y/F   S  07/08/09 07/08/09
      10 COLEMAN,MICHAEL K          MED ALL 0919000002     000-00-6108    TONEY,CHAMPUS         39Y/M   O  07/09/09 07/09/09
      10 COLEMAN,MICHAEL K          CAR O/P 0919400001     000-00-6111    MERRITT,OR REASON     43Y/F   S  07/13/09 07/13/09
      10 COLEMAN,MICHAEL K          CAR O/P 0919400002     000-00-6112    MERRITT,OR PRINICPAL  98Y/M   S  07/13/09 07/13/09
      10 COLEMAN,MICHAEL K          CAR O/P 0919400003     000-00-6113    MERRITT,OR ADMITTING  37Y/M   S  07/13/09 07/13/09
      10 COLEMAN,MICHAEL K          CAR O/P 0919400004     000-00-5842    MERRITT,ADMIT DX      20Y/M   S  07/13/09 07/13/09
      10 COLEMAN,MICHAEL K          ENT OP  0920400001     000-00-6121    MERRITT,H             28Y/F   O  07/23/09 07/23/09
      10 COLEMAN,MICHAEL K          CAR DIA 0920400002     000-00-6122    MERRITT,RECURRING     98Y/M   M  07/16/09 07/23/09
      10 COLEMAN,MICHAEL K          EMR ER  0920400003     000-00-6123    MERRITT,I             31Y/F   JA 07/23/09 07/23/09
      10 COLEMAN,MICHAEL K          CAR OPS 0920500001     000-00-6125    MERRITT,ACCIDENT      39Y/F   S  07/24/09 07/24/09

   Total for Physician     10 COLEMAN,MICHAEL K: 16

      32 ADAIR,CAR                  CAR I/P 0917600002     000-00-6083    SHW-DRG,PASSTHRU-C    69Y/F   M  06/25/09 07/13/09
      32 ADAIR,CAR                  CAR I/P 0918100001     000-00-6092    SHW-PCONSTD,SIX       59Y/M   M  06/30/09 07/22/09
      32 ADAIR,CAR                  CAR I/P 0918200002     000-00-6086    SHW-PCONSTD,TWO       59Y/F   M  06/30/09 07/01/09
      32 ADAIR,CAR                  MED O/P 0918200003     000-00-6095    SHW-OPPS,PCONSTD      59Y/M   M  07/01/09 07/01/09
      32 ADAIR,CAR                  CAR I/P 0918200005     000-00-6084    SHW-PCONSTD,ONE       59Y/F   M  07/01/09 07/01/09
      32 ADAIR,CAR                  CAR I/P 0918300008     000-00-6074    SHW-DRG,PASSTHRU-A    59Y/F   M  07/02/09 07/02/09
      32 ADAIR,CAR                  CAR I/P 0918300009     000-00-6086    SHW-PCONSTD,TWO       59Y/F   M  07/02/09 07/02/09
      32 ADAIR,CAR                  MED I/P 0918300010     000-00-5980    ACCIDENT,AMY          59Y/F   M  07/02/09 07/02/09
```

Figure 6.6 Discharges by ICD-9 Diagnosis Report - Detail (PRO2X)

```
Thu Jul 30, 2009 12:21 pm                          Model Hospital A                                                    Page 1
                                                Discharges by ICD9 Diagnosis-Detail
                                                      Primary Sort: Physician
                                                     Secondary Sort: None
Selection Criteria
-----------------
ICD9 Diagnosis:All
               Exclude Secondary Diagnosis
Financial:     All
Service:       All
Patient Type:  All
Physician:     All
Disch Dates    07/01/09 to 07/30/09
-------------------------------------------------------------------------------------------------------------------------------
ICD9 Diagnosis/Description
  Physician/Description             SVC P/T Acct#          Unit#          Patient Name          Age/Sex FC Adm Date   Disch Date
-------------------------------------------------------------------------------------------------------------------------------

No ICD9 Diagnosis Code

        1 ADAMS,JAY K               MED PAT 0916200004     000-00-6079    PAT,PATIENT           74Y/F   M  06/11/09 07/26/09

   Total for Physician      1 ADAMS,JAY K: 1

       10 COLEMAN,MICHAEL K         CAR O/P 0918300003     000-00-6098    MERRITT,C             63Y/M   O  07/02/09 07/02/09
       10 COLEMAN,MICHAEL K         CAR ER  0918300004     000-00-6099    MERRITT,D             28Y/F   O  07/02/09 07/02/09
       10 COLEMAN,MICHAEL K         CAR O/P 0918300005     000-00-6100    MERRITT,E             69Y/F   JA 07/02/09 07/02/09
       10 COLEMAN,MICHAEL K         MLK ER  0918300006     000-00-6101    MERRITT,F             57Y/F   M  07/02/09 07/02/09
       10 COLEMAN,MICHAEL K         MLK O/P 0918300007     000-00-6102    MERRITT,G             47Y/M   O  07/02/09 07/02/09
       10 COLEMAN,MICHAEL K         CAR O/P 0918900001     000-00-6064    MERRITT,MDAMB NOVALUE 32Y/F   S  07/08/09 07/08/09
       10 COLEMAN,MICHAEL K         CAR O/P 0919400004     000-00-5842    MERRITT,ADMIT DX      20Y/M   S  07/13/09 07/13/09
       10 COLEMAN,MICHAEL K         ENT OP  0920400001     000-00-6121    MERRITT,H             28Y/F   O  07/23/09 07/23/09
       10 COLEMAN,MICHAEL K         CAR DIA 0920400002     000-00-6122    MERRITT,RECURRING     98Y/M   M  07/16/09 07/23/09
       10 COLEMAN,MICHAEL K         EMR ER  0920400003     000-00-6123    MERRITT,I             31Y/F   JA 07/23/09 07/23/09
       10 COLEMAN,MICHAEL K         CAR OPS 0920500001     000-00-6125    MERRITT,ACCIDENT      39Y/F   S  07/24/09 07/24/09

   Total for Physician     10 COLEMAN,MICHAEL K: 11

   Total for No ICD9 Diagnosis Code: 12


0010 CHOLERA D/T VIB CHOLERAE

       10 COLEMAN,MICHAEL K         CAR O/P 0918300002     000-00-6097    MERRITT,B             19Y/M   M  07/02/09 07/02/09

   Total for Physician     10 COLEMAN,MICHAEL K: 1

       32 ADAIR,CAR                 CAR I/P 0918800001     000-00-5777    EVERY,FIELD           59Y/M   M  07/07/09 07/07/09

   Total for Physician     32 ADAIR,CAR: 1

   Total for ICD9 Diagnosis 0010: 2

0060 AC AMEBIASIS W/O ABSCESS
```

DISCHARGES BY PROCEDURE REPORT (PRO3X)

This report is useful in determining the number of cases found in a specific procedure code (within a specified time-frame). The selection criteria for the report can be set to display summary information or detailed patient information. The selection criteria also allow for selection of specific procedures, as well as specific financial classes, services, patient types, and physicians. Primary and secondary sort criteria are also available for the report.

When patient detail is included, the report can be used as a resource for pulling patient records with a particular procedure.

NOTE: If an account contains multiple procedures with the same code, the report lists the account only once.

The report displaying discharges by procedure prints on wide bar (132 column) paper. The information on the report is based on data found in the abstract. However, the abstract does not have to be marked complete for the information to be included on the report.

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*.

To create a report listing the discharges by the ICD-9-CM procedure code, select this option from the Core Reports menu. The Discharges by Procedure Processor screen is displayed:

```
              General Hospital Discharges by Procedure Processor
                                                    Mon Jul 20, 2009 10:53 pm
( 1)ICD10-10 Procedure  :
( 2)ICD-9 Procedure     :
( 3)Financial Classes   :
( 4)Begin Discharge Date:
( 5)End   Discharge Date:
( 6)Service             :
( 7)Patient Type        :
( 8)Physician           :
( 9)Print Detail        :
(10)Primary Sort        :
(11)Primary Subtotals   :
(12)Secondary Sort      :









Enter ICD10 Procedures, Procedure range(s) separated by `,`, or T# for Top 10-35
      Procedures, or `=` for All--[None]
```

If you select Criteria for both ICD-10 and ICD-9 codes, two reports are generated; one for ICD-9 codes and one for ICD-10 codes as shown in the following example:

```
            General Hospital View Spooled Reports Processor
                                                Tue Aug 04, 2009 09:26 pm

Report : PRO3A  Discharges By Procedure (A)

Page:01



 Copy  Spooled      Last Printed   Pages     Comment
( 1) 08/04/09 2126  Not Printed        1      Discharges by ICD10 Procedure
( 2) 08/04/09 2126  Not Printed        1      Discharges by ICD9 Procedure









Enter choice--
```

Field Explanations

1. ICD-10 PROCEDURE
2. ICD-9 PROCEDURE
Access the first field to enter ICD-10 codes. Access the second field to enter ICD-9 codes. When you access either of these fields, the following prompt is displayed:

Enter Procedures, Procedure range(s) separated by `,`, or T# for Top 10-35 Procedures, or `=` for All--

Enter an equal sign (=) or press ENTER for the default of All. You can also enter a single procedure code, multiple procedure codes (each separated by commas), range(s) of codes (for example, 570-5799), or a listing of the top procedure codes.

Decimal points are not required when entering the ICD-9-CM code numbers. When entering a range of code numbers, the first code must be numerically less than the second number. If you enter 3500-352, for example, the system displays this error message:

Invalid Entry

If you want to select the top procedure codes, enter **T** followed by a number in the range of 10 to 35. For example, if you enter **T25**, the report includes the top 25 procedure codes.

Accounts that do not contain any ICD-9-CM procedure codes and that meet the criteria range are included in the *No Procedure Code* section at the beginning of the report.

Once you enter the code(s), or range of codes, or top selection number, the system displays this prompt:

Include secondary Procedure codes? (Y/N) [N]--

Enter **Y** for Yes to include in the report secondary codes; the report also counts the patients under each one of those codes. Press **N** or ENTER for No include only the principal procedures.

3. FINANCIAL CLASSES
This field is for entering single, multiple, or all financial classes to be included in the report. When you access this field, the following prompt is displayed:

Enter financial class codes separated by `,`, `-` for table lookup, Partial Name `-`, or `=` for All [All]--

You can enter

- the financial class codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the financial class name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

When you select multiple financial classes, the report includes each financial class code in the header, up to two lines. The second line is appended with *+more* if there are more codes than can be listed in two lines.

4. BEGIN DISCHARGE DATE
Enter the beginning discharge date, in the format MMDDYY, of those patients to be included in the report. For example, if you enter 010199, the report includes all patients discharged on or after January 1, 1999. There is no default.

5. END DISCHARGE DATE
Enter the ending discharge date, in the format MMDDYY, of those patients to be included in the report. For example, if you enter 063099, the report includes all patients whose discharge date is on or before June 30, 1999. If you enter no date and you press ENTER, the system puts the current date into the field, and the report ends with the last date of patient information in the database (usually the current date).

NOTE: A report for a specific time period (for example, a month, a quarter, or a year) will be completed much faster than one that is run against the entire database.

6. SERVICE
This field indicates which service codes are to be included on the report. When you access this field, the following prompt is displayed:

Enter service codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter

- the service codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the service name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

When you select multiple services, the report includes each service code in the header, up to two lines. The second line is appended with *+more* if there are more codes than can be listed in two lines.

7. PATIENT TYPE
This field indicates which patient types are to be included on the report. When you access this field, the following prompt is displayed:

Enter patient type codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter any combination of patient types. You can enter

- the patient type codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the patient type name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

8. PHYSICIAN
This field indicates which physicians are to be included on the report. When you access this field, the following prompt is displayed:

Enter physician codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter

- the physician codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the physican's name followed by a hyphen, or

- an equal sign (=) or press ENTER for the default of all.

NOTE: The physician that is accessed is the surgeon who performed the procedure.

9. PRINT DETAIL
This field gives you the option of including patient detail on this report. Press **Y** for Yes to include detail, which consists of the following patient-related information: account number, unit number, patient name, age and sex, admission date, and discharge date. Press **N** or ENTER for No, in which case only summary information will print.

10. PRIMARY SORT
This field allows you to select a primary sort (within procedure code) for the report. Select the primary sort from the options that display when you access the field.

The primary sort options vary depending on whether you are printing a detail or a summary report. For the detail report, your options are discharge date, financial class, patient name, patient type, physician, service, terminal digit, or unit number. For the summary report, your options are financial class, patient type, physician, or service.

Each sort, except for discharge date, is by table code, not description.

NOTE: If you do not enter a primary sort, the system uses a default of physician.

11. PRIMARY SUBTOTALS (1-A-R)
This field allows you to indicate if subtotals for the primary sort should be included on the report. Enter **Y** or press ENTER for the default of Yes, and the subtotals are included. Enter **N**, and subtotals are not included.

NOTE: The report always includes totals for each procedure selected for the report.

In the sample reports that follow, the Detail report includes subtotals and the Summary report does not.

12. SECONDARY SORT
This field allows you to select a secondary sort (within procedure code and primary sort) for the report. Select the secondary sort from the options that display when you access the field. This field is optional; if it is left blank, the report sorts by procedure code and primary sort.

The secondary sort options vary depending on your primary sort and whether your report is detail or summary.

NOTE: If the primary sort is patient name, terminal digit, or unit number, the Secondary Sort field cannot be accessed.

After you complete these fields, this prompt displays:

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

Press **N** if you need to return to any of the fields to make changes. Press **Y** or ENTER for Yes to accept the screen. Once you accept it, this message is displayed briefly:

Compiling and Printing

The system then returns you to the Core Reports menu.

Impact

After you accept this screen, the Discharges by Procedure Report prints at the designated printer.

Output

Following are samples of the core report Discharges by Procedure:

- The first uses detail patient information, ICD10 codes, a primary sort of physician, and no secondary sort. It includes subtotals for the primary sort.
- The second uses detail patient information, ICD9 codes, a primary sort of physician, and no secondary sort. It includes subtotals for the primary sort.

Figure 6.7 Discharges by Procedure Report - ICD10 Detail (PRO3X)

```
Tue Aug 04, 2009 09:26 pm                          Model Hospital A                                                    Page 1
                                          Discharges by ICD10 Procedure-Detail
                                                 Primary Sort: Physician
                                                 Secondary Sort: None
Selection Criteria
-----------------
I10 Procedure: All
               Exclude Secondary Procedures
Financial:     All
Service:       All
Patient Type:  All
Physician:     All
Disch Dates    07/01/09 to 08/04/09

-------------------------------------------------------------------------------------------------------------------------
ICD10 Procedure/Description
  Physician/Description            SVC P/T Acct#          Unit#          Patient Name         Age/Sex FC Adm Date   Disch Date
-------------------------------------------------------------------------------------------------------------------------

0016070 Bypass Cerebral Ventricle to Nasopharynx with Autologous Tissue Substitute, Open Approach

       10 COLEMAN,MICHAEL K        MED LTC 0919500001      000-00-6097     TONEY,LTC            51Y/M   S  07/14/09 07/14/09

   Total for Physician     10 COLEMAN,MICHAEL K: 1

   Total for ICD10 Procedure 0016070: 1

00160J1 Bypass Cerebral Ventricle to Mastoid Sinus with Synthetic Substitute, Open Approach

                                MED O/P 0919400001      000-00-5851     KESLER,TESTA         65Y/F   S  07/13/09 07/13/09

   Total for Physician      0 : 1

   Total for ICD10 Procedure 00160J1: 1


End of Report
```

Figure 6.8 Discharges by Procedure Report - ICD9 Detail (PRO3X)

```
Tue Aug 04, 2009 09:26 pm                          Model Hospital A                                                    Page 1
                                                Discharges by ICD9 Procedure-Detail
                                                     Primary Sort: Physician
                                                     Secondary Sort: None
Selection Criteria
-----------------
ICD9 Procedure:All
               Exclude Secondary Procedures
Financial:     All
Service:       All
Patient Type:  All
Physician:     All
Disch Dates    07/01/09 to 08/04/09

-------------------------------------------------------------------------------------------------------------------------------
ICD9 Procedure/Description
  Physician/Description             SVC P/T Acct#          Unit#          Patient Name          Age/Sex FC Adm Date   Disch Date
-------------------------------------------------------------------------------------------------------------------------------

No ICD9 Procedure Code

       10 COLEMAN,MICHAEL K         MED LTC 0919500001     000-00-6097    TONEY,LTC             51Y/M   S  07/14/09 07/14/09

   Total for Physician     10 COLEMAN,MICHAEL K: 1

      432 BABB,GARY H               MED O/P 0919400001     000-00-5851    KESLER,TESTA          65Y/F   S  07/13/09 07/13/09

   Total for Physician    432 BABB,GARY H: 1

   Total for No ICD9 Procedure Code: 2
```

DISCHARGES BY HCPCS REPORT (PRO14X)

This report is useful in determining the number of cases found for a specific HCPCS code (within a specified time-frame). You can also select HCPCS code ranges or "Top 10-35" HCPCS codes. The selection criteria for the report can be set to display summary information or detailed patient information. The selection criteria also allow for selection of specific modifiers and preliminary APCs, as well as specific financial classes, services, patient types, and physicians. Primary and secondary sort criteria are also available for the report.

When patient detail is included, the report can be used as a resource for pulling patient records with a particular HCPCS procedure.

NOTE: If an account contains multiple HCPCS procedures with the same code, the report lists the account only once.

The report displaying discharges by HCPCS prints on wide bar (132 column) paper. The information on the report is based on data found in the abstract. However, the abstract does not have to be marked complete for the information to be included on the report.

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*.

To create a report listing the discharges by the HCPCS code, select this option from the Core Reports menu. The Discharges by HCPCS Processor screen is displayed:

```
                  General Hospital Discharges by HCPCS Processor
                                                  Fri Jun 13, 2003 04:54 pm
( 1)HCPCS               :
( 2)Modifiers           :
( 3)Preliminary APCs    :
( 4)Financial Classes   :
( 5)Begin Discharge Date:
( 6)End   Discharge Date:
( 7)Service             :
( 8)Patient Type        :
( 9)Physician           :
(10)Print Detail        :
(11)Primary Sort        :
(12)Primary Subtotals   :
(13)Secondary Sort      :









Enter HCPCS, HCPCS range(s) separated by `,`, or T# for Top 10-35 HCPCS, or `=`
for All--
```

Field Explanations

1. HCPCS
This field is for entering single, multiple, or all HCPCS codes to be included in the report. When you access this field, the following prompt is displayed:

Enter HCPCS, HCPCS range(s) separated by `,`, or T# for Top 10-35 HCPCS, or `=` for All--

You can enter

- a single HCPCS code
- multiple HCPCS codes, each separated by commas
- a range (or ranges) of codes (for example, 31300-31420)
- **T** followed by a number from 10-35 to list the top HCPCS codes (for example, if you enter **T25**, the report includes the top 25 HCPCS codes)
- an equal sign (=) or press ENTER for the default of all.

When you select multiple HCPCS codes, the report includes each HCPCS code in the header, up to two lines. The second line is appended with *+more* if there are more codes than can be listed in two lines.

Accounts that do not contain any HCPCS procedure codes and that meet the criteria range are included in the *No Procedure Code* section at the beginning of the report.

2. MODIFIERS
This field is for entering single, multiple, or all HCPCS modifiers to be included in the report. When you access this field, the following prompt is displayed:

Enter Modifiers codes separated by `,`, `-` for table lookup, Partial Name`-` , or `=` for All--

You can enter

- the modifier codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the modifier description followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

NOTE: The default of all includes HCPCS codes with no modifiers.

3. PRELIMINARY APCS

This field is for entering single, multiple, or all preliminary APCs to be included in the report. When you access this field, the following prompt is displayed:

Enter APC(s), `-` for table lookup, APC range(s) separated by `,`, or `=` for All--

You can enter

- the APCs directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- a range (or ranges) of codes (for example, 00018-00027)
- an equal sign (=) or press ENTER for the default of all.

NOTE: If your facility does not use APCs (via 3M's APCfinder or another product), you should use the default of all. Using the default of all includes on the report all HCPCS codes that do not have preliminary APCs assigned.

If you enter specific APCs, the report is limited so that it includes only the HCPCS codes that are assigned to the specific APCs you entered.

4. FINANCIAL CLASSES

This field is for entering single, multiple, or all financial classes to be included in the report. When you access this field, the following prompt is displayed:

Enter financial class codes separated by `,`, `-` for table lookup, Partial Name `-`, or `=` for All [All]--

You can enter

- the financial class codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the financial class name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

When you select multiple financial classes, the report includes each financial class code in the header, up to two lines. The second line is appended with +*more* if there are more codes than can be listed in two lines.

3. BEGIN DISCHARGE DATE
Enter the beginning discharge date, in the format MMDDYY, of those patients to be included in the report. For example, if you enter 010103, the report includes all patients discharged on or after January 1, 2003. There is no default.

4. END DISCHARGE DATE
Enter the ending discharge date, in the format MMDDYY, of those patients to be included in the report. For example, if you enter 063003, the report includes all patients whose discharge date is on or before June 30, 2003. If you enter no date and you press ENTER, the system puts the current date into the field, and the report ends with the last date of patient information in the database (usually the current date).

NOTE: A report for a specific time period (for example, a month, a quarter, or a year) will be completed much faster than one that is run against the entire database.

5. SERVICE
This field indicates which service codes are to be included on the report. When you access this field, the following prompt is displayed:

Enter service codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter

- the service codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the service name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

When you select multiple services, the report includes each service code in the header, up to two lines. The second line is appended with *+more* if there are more codes than can be listed in two lines.

6. PATIENT TYPE
This field indicates which patient types are to be included on the report. When you access this field, the following prompt is displayed:

Enter patient type codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter any combination of patient types. You can enter

- the patient type codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,

- part of the patient type name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

7. PHYSICIAN
This field indicates which physicians are to be included on the report. When you access this field, the following prompt is displayed:

Enter physician codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter

- the physician codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the physican's name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

NOTE: The physician that is included on the report is the surgeon who performed the HCPCS procedure.

8. PRINT DETAIL
This field gives you the option of including patient detail on this report. Press **Y** for Yes to include detail, which consists of the following patient-related information: account number, unit number, patient name, age and sex, admission date, and discharge date. Press **N** or ENTER for No, in which case only summary information will print.

9. PRIMARY SORT
This field allows you to select a primary sort (within HCPCS code) for the report. Select the primary sort from the options that display when you access the field.

The primary sort options vary depending on whether you are printing a detail or a summary report. For the detail report, your options are discharge date, financial class, modifier, patient name, patient type, physician, service, terminal digit, or unit number. For the summary report, your options are financial class, modifier, patient type, physician, or service.

Each sort, except for discharge date, is by table code, not description.

NOTE: If you do not enter a primary sort, the system uses a default of physician.

10. PRIMARY SUBTOTALS (1-A-R)
This field allows you to indicate if subtotals for the primary sort should be included on the report. Enter **Y** or press ENTER for the default of Yes, and the subtotals are included. Enter **N**, and subtotals are not included.

NOTE: The report always includes totals for each HCPCS procedure selected for the report.

In the sample reports that follow, the Detail report includes subtotals and the Summary report does not.

11. SECONDARY SORT
This field allows you to select a secondary sort (within HCPCS procedure code and primary sort) for the report. Select the secondary sort from the options that display when you access the field. This field is optional; if it is left blank, the report sorts by HCPCS procedure code and primary sort.

The secondary sort options vary depending on your primary sort and whether your report is detail or summary.

NOTE: If the primary sort is patient name, terminal digit, or unit number, the Secondary Sort field cannot be accessed.

After you complete these fields, this prompt is displayed:

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

Press **N** if you need to return to any of the fields to make changes. Press **Y** or ENTER for Yes to accept the screen. Once you accept it, this message is displayed:

Compiling and Printing

The system displays the message briefly, then returns you to the Core Reports menu.

Impact

After you accept this screen, the Discharges by HCPCS Report prints at the designated printer.

Output

Following are samples of the core report Discharges by HCPCS:

- The first uses detail patient information, a primary sort of physician, and no secondary sort. It includes subtotals for the primary sort.

- The second uses summary information, a primary sort of financial class, and a secondary sort of patient type. It does not include subtotals for the primary sort.

Figure 6.9 Discharges by HCPCS Report - Detail (PRO14X)

```
Tue Jun 17, 2003 02:16 pm                          Model Hospital A                                                    Page 1
                                                Discharges by HCPCS-Detail
                                                  Primary Sort: Physician
                                                  Secondary Sort: None
Selection Criteria
-----------------
HCPCS:         All
Modifiers:     All
Pre-APCS:      All
Financial:     All
Service:       All
Patient Type:  All
Physician:     All
Disch Dates    12/17/02 to 06/17/03
-------------------------------------------------------------------------------------------------------------------------------
HCPCS/Description
  Physician/Description         SVC P/T Acct#           Unit#         Patient Name         FC Disch Date  Modifiers      Pre APC
-------------------------------------------------------------------------------------------------------------------------------

No Procedure Code

        8 TONGEN,LYLE A         MED O/P 0235400002      000-00-3356   CURNICK,MICHAEL      O  12/20/02   47,GA,80,47,47
        8 TONGEN,LYLE A         CAR O/P 0314700001      000-00-3726   RUTHERFORD,TUESDAY   SP 05/27/03

   Total for Physician      8 TONGEN,LYLE A: 2

     1234 FREEMAN,ANNE          MED O/P 0236400002      000-00-3361   ANDERSON,STAR        F  12/30/02   47,GA,80,47,47
     1234 FREEMAN,ANNE          SUR OPS 0236400004      000-00-3363   ANDERSON,OPIE        M  12/30/02   47,GA,80,47,47
     1234 FREEMAN,ANNE          ER  O/P 0301900001      000-00-3370   MARTY,ANN            SP 01/19/03   47,GA,80,47,47

   Total for Physician   1234 FREEMAN,ANNE: 3

   Total for No HCPCS Code: 5


0002T ENDOVAS REPR ABDO AO ANEURYS

     2040 SILVA,ABBI            MED O/P 0311900012      000-00-3695   CURNICK,MOLLY        M  04/29/03

   Total for Physician   2040 SILVA,ABBI: 1

   Total for HCPCS 0002T: 1


00124 ANESTH, EAR EXAM

     1234 FREEMAN,ANNE          MED ALL 0315800001      000-00-3651   TATE,BETTY           M  06/07/03

   Total for Physician   1234 FREEMAN,ANNE: 1

   Total for HCPCS 00124: 1

End of Report
```

Figure 6.10 Discharges by HCPCS Report - Summary (PRO14X)

```
Tue Jun 17, 2003 03:58 pm                          Model Hospital A                                    Page 1
                                                 Discharges by HCPCS-Summary
                                               Primary Sort: Financial Class
                                               Secondary Sort: Patient Type
Selection Criteria
-----------------
HCPCS:         All
Modifiers:     All
Pre-APCS:      All
Financial:     All
Service:       All
Patient Type:  All
Physician:     All
Disch Dates    01/29/03 to 06/17/03
-------------------------------------------------------------------------------------------------------------------------
HCPCS/Description
Financial Class/Description       Patient Type                      Count
-------------------------------------------------------------------------------------------------------------------------

No Procedure Code

   B BLUE CROSS                   ER Emergency Room                  5
   B BLUE CROSS                   I/P Regular Inpatient Admission    8
   B BLUE CROSS                   O/P Regular Outpatient Admission   12
   O OTHER COMMERCIAL             ER Emergency Room                  4
   O OTHER COMMERCIAL             I/P Regular Inpatient Admission    20
   O OTHER COMMERCIAL             SER Series                         2
   SP DALE'S SELF PAY             ER Emergency Room                  32
   SP DALE'S SELF PAY             I/P Regular Inpatient Admission    42
   SP DALE'S SELF PAY             O/P Regular Outpatient Admission   44
   SP DALE'S SELF PAY             OPB Outpatient in Bed              8
   SP DALE'S SELF PAY             OPT Outpatient Pre Admission Testi 2
   SP DALE'S SELF PAY             SER Series                         13

   Total for No HCPCS Code: 192


00530 ANESTH, PACEMAKER INSERTION

   M MEDICARE                     O/P Regular Outpatient Admission   1
   SP DALE'S SELF PAY             ER Emergency Room                  3
   SP DALE'S SELF PAY             O/P Regular Outpatient Admission   2

   Total for HCPCS 00530: 6


76020 X-RAYS FOR BONE AGE

   M MEDICARE                     O/P Regular Outpatient Admission   1

   Total for HCPCS 76020: 1

End of Report
```

FINANCIAL CLASS BY SERVICE REPORT (PRO4X)

This report provides information regarding the number of patients discharged by service, in up to 15 financial classes. The report displays the total number of patients in each service (within the time-frame specified) and the total number of days. This is then followed by the cumulative average length of stay (LOS) for patients in the service. This report does not provide detailed patient information; thus, it is useful mainly for statistical reporting.

The Financial Class by Service Report prints on wide bar (132 column) paper. The information on the report is based on data found in the abstract. However, the abstract does not have to be marked complete in order for the information to be included on the report.

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*.

This report was previously known as the Expected Payment Source by Service Report.

To create this report, select this option from the Core Reports menu. The Financial Class by Service Processor screen displays:

```
            General Hospital Financial Class by Service Processor
                                                    Tue Jul 02, 2002 01:47 pm
( 1)Service             : All
( 2)Financial Classes   : 99,B,C,D,A,H,44,KE,L,K,M,O,S2,PK,S1
( 3)Begin Discharge Date: 12/01/01
( 4)End   Discharge Date: 12/31/01
( 5)Patient Type        : All









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

Field Explanations

1. SERVICE

This field indicates which service codes are to be included on the report. When you access this field, the following prompt is displayed:

Enter service codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter

- the service codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the service name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

When you select multiple services, the report includes each service code in the header, up to two lines. The second line is appended with *+more* if there are more codes than can be listed in two lines.

2. FINANCIAL CLASSES
This field enables you to include a single financial class or multiple (up to 15) financial classes in the report. When you access this field, the following prompt is displayed:

Enter financial class codes separated by `,`, `-` for table lookup, or Partial Name`-`--

You can enter

- the financial class codes directly, each separated by commas,
- a hyphen (-) to do a table lookup, or
- part of the financial class name followed by a hyphen.

You cannot include all financial classes on a single report.

When you select multiple financial classes, the report includes each financial class code in the header, up to two lines. The second line is appended with *+more* if there are more codes than can be listed in two lines.

3. BEGIN DISCHARGE DATE
Enter the beginning discharge date, in the format MMDDYY, of those patients to be included in the report. For example, if you enter 010199, the report includes all patients discharged on or after January 1, 1999. There is no default.

4. END DISCHARGE DATE
Enter the ending discharge date, in the format MMDDYY, of those patients to be included in the report. For example, if you enter 063099, the report includes all patients whose discharge date is on or before June 30, 1999. If you do not enter a date and

you press ENTER, the system puts the current date in this field and the report ends with the last date of patient information in the database (usually the current date).

NOTE: A report for a specific time period (for example, a month, a quarter, or a year) is completed much faster than one that is run against the entire database.

5. PATIENT TYPE
This field indicates which patient types are to be included on the report. When you access this field, the following prompt is displayed:

Enter patient type codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter any combination of patient types. You can enter

- the patient type codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the patient type name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

When you complete these fields, the system displays this prompt:

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

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:

Compiling and Printing

The system displays this message briefly, then returns you to the Core Reports menu.

Impact

Once you accept this screen, the following takes place:

- The Financial Class by Service Report prints at the assigned printer.

Output

The following is a sample of the core report Financial Class by Service.

Figure 6.11 Financial Class by Service Report (PRO4X)

```
Jul 03, 2002 04:22 pm                          Model Hospital A                          Page 1

                                          Financial Class by Service
Selection Criteria
------------------
Service:       ERS,END,MED,OBS,PED,PSY
Patient Type:  All
Disch Dates    02/04/98 to 04/14/00

    Total Pts     B      C      H      K      M      P      S      W
    Total LOS
    Avg LOS
-------------------------------------------------------------------------------------------------------

END    ENDOSCOPY
         4         4     --     --     --     --     --     --     --
         0         0     --     --     --     --     --     --     --
       0.0       0.0     --     --     --     --     --     --     --

ERS    EMERGENCY
         9         2      1     --     --       6    --     --     --
         0         0      0     --     --       0    --     --     --
       0.0       0.0    0.0     --     --     0.0    --     --     --

MED    MEDICAL
       278       114     67     --       7     85    --       4      1
         0         0      0     --       0      0    --       0      0
       0.0       0.0    0.0     --     0.0    0.0    --     0.0    0.0

PED    PEDIATRICS
         2        --      1      1     --     --     --     --     --
         0        --      0      0     --     --     --     --     --
       0.0        --    0.0    0.0     --     --     --     --     --

PSY    PSYCHIATRIC
        23        15      1     --       2      5    --     --     --
         0         0      0     --       0      0    --     --     --
       0.0       0.0    0.0     --     0.0    0.0    --     --     --

Grand Total
       316       135     70      1      9     96    --       4      1
         0         0      0      0      0      0    --       0      0
       0.0       0.0    0.0    0.0    0.0    0.0    --     0.0    0.0


End of Report
```

AGE AND SEX BY SERVICE WITH LOS REPORT (PRO5X)

This report provides information regarding the number of patients discharged by service, which is then further sorted by sex and age groups. The report displays the total number of patients in each service (within the time-frame specified), and the total number of patient days. This is then followed by the cumulative average length of stay (LOS) for the patients in the service. This report does not provide detailed patient information; thus, it is useful mainly for statistical reporting.

This report prints on 8 1/2 x 11 paper. The information on the report is based on data found in the abstract. However, the abstract does not have to be marked complete in order for the information to be included on the report.

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*.

To create this report, select this option from the Core Reports menu. The Age and Sex by Service w/ LOS Processor screen displays:

```
              General Hospital Age and Sex by Service w/ LOS Processor
                                                    Wed Jul 03, 2002 01:48 pm
( 1)Service             :
( 2)Begin Discharge Date:
( 3)End   Discharge Date:
( 4)Patient Type        :
( 5)Age Range(s)        :









Enter service codes separated by `,`, `-` for table lookup, Partial Name`-`, or
=` for All [All]--
```

Field Explanations

1. SERVICE
This field indicates which service codes are to be included on the report. When you access this field, the following prompt is displayed:

Enter service codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter

- the service codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the service name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

When you select multiple services, the report includes each service code in the header, up to two lines. The second line is appended with *+more* if there are more codes than can be listed in two lines.

2. BEGIN DISCHARGE DATE
Enter the beginning discharge date, in the format MMDDYY, of those patients to be included in the report. For example, if you enter 010102, the report includes all patients discharged on or after January 1, 2002. There is no default.

3. END DISCHARGE DATE
Enter the ending discharge date, in the format MMDDYY, of those patients to be included in the report. For example, if you enter 063002, the report includes all patients whose discharge date is on or before June 30, 2002. If you do not enter a date and press ENTER, the system autofills this field with the current date, and the report ends with the last date of patient information in the database (usually the current date).

NOTE: A report for a specific time period (for example, a month, a quarter, or a year) is completed much faster than one that is run against the entire database.

4. PATIENT TYPE
This field indicates which patient types are to be included on the report. When you access this field, the following prompt is displayed:

Enter patient type codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter any combination of patient types. You can enter

- the patient type codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the patient type name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

5. AGE RANGE(S) (SPECIAL FORMAT-R)
Enter up to four age ranges to be included on the report. Separate each age range with a comma. For example, enter 0-12,13-19,20-50,51-150 and press ENTER. If you press ENTER at the prompt without making an entry, one age range of 0 days to 150 years is included on the report.

NOTE: If an age overlaps into two ranges (for example, entering 40-55,54-60), the following warning prompt is displayed:

WARNING! Age ranges overlap (40-55,54-60), Continue? (Y/N)-- |

If you enter **Y** to continue, the report will still print, but be aware that some patients may be counted twice.

When you complete these fields, the system displays this prompt:

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

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:

Compiling and Printing

The system displays this message briefly and then returns you to the Core Reports menu.

Impact

After you accept this screen, the Age and Sex by Service w/ LOS Report prints at the assigned printer.

Output

The following is a sample of the core report Age and Sex by Service w/ LOS.

Figure 6.12 Age and Sex by Service with LOS Report (PRO5X)

Jul 03, 2002 05:04 pm Model Hospital A Page 1

Age and Sex by Service w/ LOS

Selection Criteria

Service: CAR,ERS,MIC,MIC,MED,MED,NUR,OBS,ORT,PED,PSY,SUR
Patient Type: All
Disch Dates 03/25/02 to 07/03/02

		Total Pts Total LOS Avg LOS	Male	Female	0D-12Y	13Y-19Y	20Y-50Y	51Y-150Y
CAR	CARDIOLOGY	3	1	2	--	--	3	--
		9	4	5	--	--	9	--
		3.0	4.0	2.5	--	--	3.0	--
ERS	EMERGENCY	20	6	14	1	--	14	5
		286	7	279	7	--	277	2
		14.3	1.2	19.9	7.0	--	19.8	0.4
MED	MEDICALXX	352	103	249	34	43	194	81
		10242	3031	7211	390	1674	6485	1693
		29.1	29.4	29.0	11.5	38.9	33.4	20.9
NUR	NURSERY	31	12	19	29	--	2	--
		1161	248	913	1161	--	--	--
		37.5	20.7	48.1	40.0	--	0.0	--
OBS	OBSTETRICS	3	--	3	--	--	3	--
		271	--	271	--	--	271	--
		90.3	--	90.3	--	--	90.3	--
ORT	ORTHOPEDICS	1	--	1	--	--	--	1
		26	--	26	--	--	--	26
		26.0	--	26.0	--	--	--	26.0
PED	PEDIATRICS	2	1	1	2	--	--	--
		77	75	2	77	--	--	--
		38.5	75.0	2.0	38.5	--	--	--
PSY	PSYCHIATRIC	29	9	20	2	--	16	11
		1325	991	334	549	--	725	51
		45.7	110.1	16.7	274.5	--	45.3	4.6
SUR	SURGICAL	12	5	7	--	1	7	4
		227	46	181	--	4	167	56
		18.9	9.2	25.9	--	4.0	23.9	14.0
Grand Total		453	137	316	68	44	239	102
		13624	4402	9222	2184	1678	7934	1828
		30.0	32.1	29.1	32.1	38.1	33.2	17.8

End of Report

AGE AND SEX BY FINANCIAL CLASS WITH LOS REPORT (PRO6X)

This report provides information regarding the number of patients discharged by financial class, which is then further sorted by sex and age groups. The report displays the total number of patients in each service (within the time-frame specified) and the total number of patient days. This is then followed by the cumulative average length of stay (LOS) for patients in the service. This report does not provide detailed patient information. Thus, it is useful mainly for statistical type reporting.

The report prints on 8 1/2 x 11 paper. The information on the report is based on data found in the abstract. However, the abstract does not have to be marked complete in order for the information to be included on the report.

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*.

To create this report, select this option from the Core Reports menu. The Age and Sex by Financial Class w/ LOS processor screen displays:

```
          General Hospital Age and Sex by Financial Class w/ LOS Processor
                                                  Wed Jul 03, 2002 02:55 pm
( 1)Financial Classes   : All
( 2)Begin Discharge Date: 12/01/99
( 3)End   Discharge Date: 03/31/00
( 4)Patient Type        : All
( 5)Age Range(s)        :









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

Field Explanations

1. FINANCIAL CLASSES
This field is for entering single, multiple, or all financial classes to be included in the report. When you access this field, the following prompt is displayed:

Enter financial class codes separated by `,`, `-` for table lookup, Partial Name `-`, or `=` for All [All]--

You can enter

- the financial class codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the financial class name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

When you select multiple financial classes, the report includes each financial class code in the header, up to two lines. The second line is appended with *+more* if there are more codes than can be listed in two lines.

2. BEGIN DISCHARGE DATE
Enter the beginning discharge date, in the format MMDDYY, of those patients to be included in the report. For example, if you enter 010199, the report includes all patients discharged on or after January 1, 1999. This is a required field. There is no default.

3. END DISCHARGE DATE
Enter the ending discharge date, in the format MMDDYY, of those patients to be included in the report. For example, if you enter 063099, the report includes all patients whose discharge date is on or before June 30, 1999. If you do not enter a date and you press ENTER, the system autofills the field with the current date, and the report ends with the last date of patient information in the database (usually the current date).

NOTE: A report for a specific time period (for example, a month, a quarter, or a year) is completed much faster than one that is run against the entire database.

4. PATIENT TYPE
This field indicates which patient types are to be included on the report. When you access this field, the following prompt is displayed:

Enter patient type codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter any combination of patient types. You can enter

- the patient type codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the patient type name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

5. AGE RANGE(S) (SPECIAL FORMAT-R)
Enter up to four age ranges to be included on the report. Separate each age range with a comma. For example, enter 0-12,13-19,20-50,51-150 and press ENTER. If you press ENTER at the prompt without making an entry, one age range of 0 days to 150 years is included on the report.

NOTE: If an age overlaps into two ranges (for example, entering 40-55,54-60), the following warning prompt is displayed:

WARNING! Age ranges overlap (40-55,54-60), Continue? (Y/N)-- |

If you enter **Y** to continue, the report will still print, but be aware that some patients may be counted twice.

When you complete these fields, the system displays this prompt:

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

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:

Compiling and Printing

The system displays this message briefly and then returns you to the Core Reports menu.

Impact

After you accept this screen, the Age and Sex by Financial Class with LOS Report prints at the assigned printer.

Output

The following is a sample of the core report Age and Sex by Financial Class with LOS.

Figure 6.13 Age and Sex by Financial Class with LOS Report (PRO6X)

Jul 03, 2002 05:29 pm Model Hospital A Page 1

Age and Sex By Financial Class w/ LOS

Selection Criteria

Financial: B,C,SP,K,M
Patient Type: All
Disch Dates 03/25/02 to 07/03/02

		Total Pts Total LOS Avg LOS	Male	Female	0D-12Y	13Y-19Y	20Y-50Y	51Y-150Y
B	BLUE CROSS	50	19	31	3	4	35	8
		2597	761	1836	312	773	1511	1
		51.9	40.1	59.2	104.0	193.3	43.2	0.1
C	CHAMPUS	7	2	5	3	--	4	--
		901	444	457	444	--	457	--
		128.7	222.0	91.4	148.0	--	114.3	--
K	MEDICAID	27	7	20	2	5	18	2
		351	286	65	281	29	41	--
		13.0	40.9	3.3	140.5	5.8	2.3	0.0
M	MEDICARE	14	3	11	--	1	5	8
		3135	834	2301	--	403	1417	1315
		223.9	278.0	209.2	--	403.0	283.4	164.4
SP	DALE'S SELF PAY	320	92	228	55	31	153	81
		5332	1786	3546	728	473	3664	467
		16.7	19.4	15.6	13.2	15.3	23.9	5.8
Grand Total		418	123	295	63	41	215	99
		12316	4111	8205	1765	1678	7090	1783
		29.5	33.4	27.8	28.0	40.9	33.0	18.0

End of Report

DISCHARGE STATUS/DISPOSITION REPORT (PRO7X)

This report displays patient information based on the discharge status/disposition of the patient. The report also displays a total by group. Primary and secondary sort criteria are also available for the report.

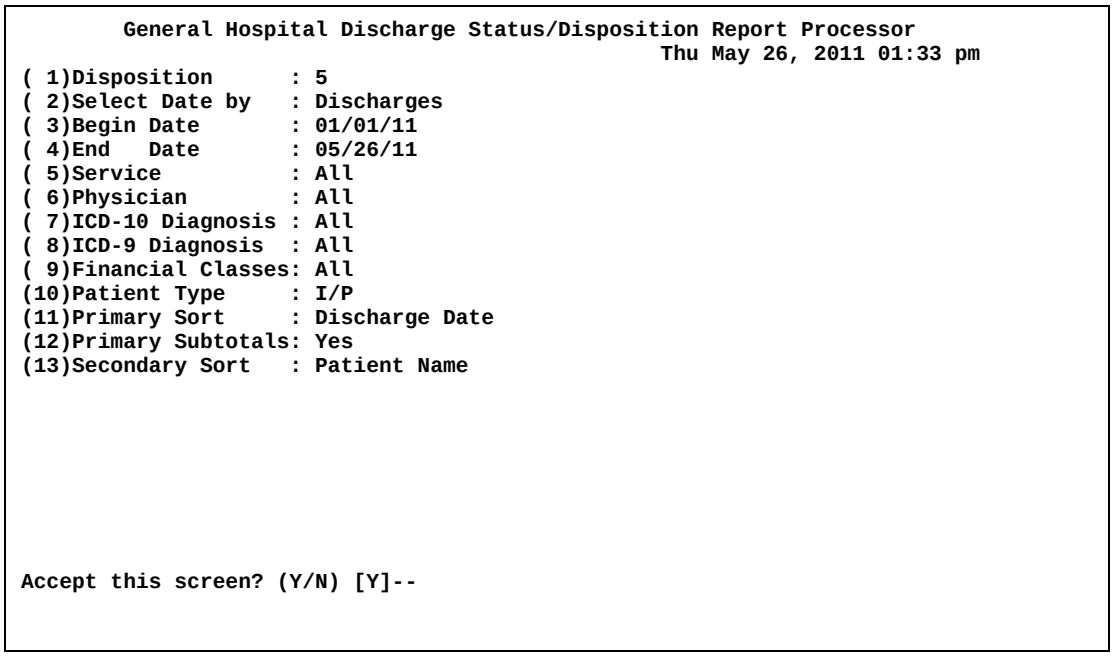
NOTE: Series patient types are included on the report only if a disposition was entered at the time of discharge. The Disposition field is optional for these patient types.

Because this report provides some detailed patient information, it can be used as a chart pull list, as well as for statistical reporting.

This report prints on wide bar (132 column) paper. The information on the report is based on data found in the abstract. However, the abstract does not have to be marked complete in order for the information to be included on the report.

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*.

To create this report, select this option from the Core Reports menu. The Discharge Status/Disposition Processor screen is displayed:



```
        General Hospital Discharge Status/Disposition Report Processor
                                                    Thu May 26, 2011 01:33 pm
( 1)Disposition      : 5
( 2)Select Date by   : Discharges
( 3)Begin Date       : 01/01/11
( 4)End   Date       : 05/26/11
( 5)Service          : All
( 6)Physician        : All
( 7)ICD-10 Diagnosis : All
( 8)ICD-9 Diagnosis  : All
( 9)Financial Classes: All
(10)Patient Type     : I/P
(11)Primary Sort     : Discharge Date
(12)Primary Subtotals: Yes
(13)Secondary Sort   : Patient Name









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

Field Explanations

1. DISPOSITION
When you select this field, the lower portion of the screen displays the Disposition Code table and the following prompt.

Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
end select(NL) next pg(/ or PG DN) Search(TAB)

Make your selections from this table, or press ENTER to include all disposition codes on the report.

2. SELECT DATE BY
This field enables you to select the beginning and ending dates, based on either the discharge date or the admit date. Enter either **A** (admit date) or **D** (discharge date). The default is **D**.

3. BEGIN DATE
Enter the beginning admit or discharge date (based on the response in item 2), in the format MMDDYY, of those patients to be included in the report. For example, if you enter 010199, the report includes all patients admitted or discharged on or after January 1, 1999. There is no default.

4. END DATE
Enter the ending admit or discharge date (based on the response in the Select Date By field) of those patients to be included in the report. For example, if you enter 063099, the report includes all patients whose admit or discharge date is on or before June 30, 1999. If you do not enter a date and you press ENTER, the system autofills the field with the current date, and the report ends with the last date of patient information in the database (usually the current date).

NOTE: A report for a specific time period (for example, a month, a quarter, or a year) is completed much faster than one that is run against the entire database.

5. SERVICE
This field indicates which service codes are to be included on the report. When you access this field, the following prompt is displayed:

Enter service codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter

- the service codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the service name followed by a hyphen, or

- an equal sign (=) or press ENTER for the default of all.

6. PHYSICIANS
This field indicates which physicians are to be included on the report. When you access this field, the following prompt is displayed:

Enter physician codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter

- the physician codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the physican's name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

7. ICD-10 DIAGNOSIS
8. ICD-9 DIAGNOSIS
When you select this field, the system displays the following prompt:

Print report for ICD-9(N), ICD-10(T), or both(B) Coding System? [N]--

In the ICD-10 Diagnosis Field:

- If you enter **N**, the following message autofills the ICD-10 field.

  No Report For ICD-10 Coding System.

  Then, the system prompts you for ICD-9 diagnosis selection. You can enter a single ICD-9 diagnosis code, multiple codes, or range(s) of codes. If you press ENTER without entering a code, the system autofills this field with All, and the report includes all diagnosis codes. Then you are prompted to include secondary codes for ICD-9. The report generates for ICD-9 codes only.

- If you enter **T**, the system prompts you for code selection. You can enter a single diagnosis code, multiple codes, or range(s) of codes. If you press ENTER without entering a code, the system autofills this field with All, and the report includes all diagnosis codes. Then you are prompted to include secondary codes for ICD-10. The report generates for ICD-10 codes only. The following message autofills the ICD-9 field:

  No Report For ICD-9 Coding System.

- If you enter **B** for Both, two reports are generated: one for ICD-10 and one for ICD-9. You can enter a single diagnosis code, multiple codes, or range(s) of codes.

If you press ENTER without entering a code, the system autofills this field with All, and the report includes all diagnosis codes. You are then prompted to include secondary codes for ICD-10 - Yes or No. A second prompt will appear for ICD-9 code selection. You can enter a single diagnosis code, multiple codes, or range(s) of codes. If you press ENTER without entering a code, the system autofills this field with All, and the report includes all diagnosis codes. You are then prompted to include secondary codes for ICD-9.

9. FINANCIAL CLASSES

This field is for entering single, multiple, or all financial classes to be included in the report. When you access this field, the following prompt is displayed:

Enter financial class codes separated by `,`, `-` for table lookup, Partial Name `-`, or `=` for All [All]--

You can enter

- the financial class codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the financial class name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

10. PATIENT TYPE

This field indicates which patient types are to be included on the report. When you access this field, the following prompt is displayed:

Enter patient type codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter any combination of patient types. You can enter

- the patient type codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the patient type name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

11. PRIMARY SORT

This field allows you to select a primary sort (within discharge status/disposition) for the report. Select the primary sort from the options that display when you access the field.

Your options are discharge date, financial class, patient account number, patient name, patient type, physician, principal diagnosis, service, terminal digit, or unit number.

NOTE: If you do not enter a primary sort, the system uses a default of physician.

12. PRIMARY SUBTOTALS (1-A-R)
This field allows you to indicate if subtotals for the primary sort should be included on the report. Enter **Y** or press ENTER for the default of Yes, and the subtotals are included. Enter **N**, and subtotals are not included.

NOTE: The report always includes totals for each discharge status/disposition selected for the report. The sample report that follows does not include subtotals.

13. SECONDARY SORT
This field allows you to select a secondary sort (within discharge status/disposition and primary sort) for the report. Select the secondary sort from the options that display when you access the field. This field is optional; if it is left blank, the report sorts by discharge status/disposition and primary sort.

NOTE: If the primary sort is unit patient account number, patient name, terminal digit, or unit number, the Secondary Sort field cannot be accessed.

When you complete these fields, the system displays this prompt:

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

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 briefly displays the following message and then returns you to the Core Reports menu:

Compiling and Printing

Impact

Upon acceptance of this screen, the Discharge Status/Disposition Report prints at the assigned printer.

Output

The following is a sample of the core report Discharge Status/Disposition Report, with a primary sort of physician and a secondary sort of financial class.

Figure 6.14 Discharge Status/Disposition Report for ICD-10 Codes (PRO7X)

```
Mon Jan 31, 2011 03:57 pm                          Model Hospital A                                                    Page 1
                                                Discharge Status/Disposition Report
                                                   Primary Sort: Discharge Date
                                                   Secondary Sort: Patient Name
Selection Criteria
-----------------
Disposition:         5,H,30,20,7,12,AOT,4,D,8,66,21,62,43,02
Financial:           All
Service:             All
Physician:           All
ICD10 Diagnosis:     All
                     Include Secondary Diagnosis
Patient Type:        All
Disch Dates          01/01/10 to 01/31/11
-------------------------------------------------------------------------------------------------------------------------------
Disposition/Description
Physician/Description          SVC P/T Account#       Unit#          Patient Name       Age/Sex LOS Adm Date Dis Date Prin-Dx  FC
-------------------------------------------------------------------------------------------------------------------------------

*HOME OR SELF CARE

    10 COLEMAN,MICHAEL K       CAR I/P 1000600004     000-00-6254     MERRITT,ADMIT DX   38Y/F   0   01/06/10 01/06/10          S
    10 COLEMAN,MICHAEL K       CAR I/P 1000600001     000-00-6251     MERRITT,NO DX      43Y/M   0   01/06/10 01/06/10          S
    10 COLEMAN,MICHAEL K       CAR I/P 1000600003     000-00-6253     MERRITT,NO MRDX    10Y/F   0   01/06/10 01/06/10          S

   Total for Discharge Date 01/06/10: 3

   575 BASS,NONUMBERS          CAR I/P 1002000001     000-00-6259     MERRITT,ADMITDX IP 43Y/F   0   01/20/10 01/20/10          O

   Total for Discharge Date 01/20/10: 1

    10 COLEMAN,MICHAEL K       NUR NEW 1002100002     000-00-6262     MERRITT,BABY 1 GIR 0D/F    1   01/21/10 01/22/10          B
    10 COLEMAN,MICHAEL K       NUR NEW 1002100003     000-00-6263     MERRITT,BABY 2 BOY 0D/M    1   01/21/10 01/22/10          B
    10 COLEMAN,MICHAEL K       OBS OB  1002100001     000-00-6261     MERRITT,MOM        20Y/F   1   01/21/10 01/22/10          B

   Total for Discharge Date 01/22/10: 3

     1 ADAMS,JAY K             NUR NEW 1002200002     000-00-6265     MERRITT,BABY 1 GIR 0D/F    3   01/22/10 01/25/10          S
     1 ADAMS,JAY K             ENT OB  1002200001     000-00-6264     MERRITT,NEW MOM    43Y/F   3   01/22/10 01/25/10          S

   Total for Discharge Date 01/25/10: 2

  2234 AKER,TOM                SUR I/P 1003900001     000-00-6273     MERRITT,FL IP      77Y/M   0   02/08/10 02/08/10          S

   Total for Discharge Date 02/08/10: 1

    10 COLEMAN,MICHAEL K       CAR I/P 1003900003     000-00-6275     MERRITT,FOREIGN    30Y/M   1   02/08/10 02/09/10          O
    10 COLEMAN,MICHAEL K       CAR I/P 1003900002     000-00-6274     MERRITT,HOMELESS   43Y/F   1   02/08/10 02/09/10          S
   575 BASS,NONUMBERS          CAR I/P 1003900004     000-00-6276     MERRITT,UNKNOWN    55Y/M   1   02/08/10 02/09/10          S

   Total for Discharge Date 02/09/10: 3

  1500 DEBVDOC,WITHAV          MED I/P 1025700004     000-00-6583     BRADLEY,OTHERPAYOR 23Y/F   426 01/01/09 03/03/10          M

   Total for Discharge Date 03/03/10: 1
```

Figure 6.15 Discharge Status/Disposition Report for ICD-9 Codes (PRO7X)

```
Mon Jan 31, 2011 03:57 pm                          Model Hospital A                                                    Page 1
                                              Discharge Status/Disposition Report
                                                 Primary Sort: Discharge Date
                                                 Secondary Sort: Patient Name
Selection Criteria
-----------------
Disposition:         5,H,30,20,7,12,AOT,4,D,8,66,21,62,43,02
Financial:           All
Service:             All
Physician:           All
ICD9 Diagnosis:      All
                     Include Secondary Diagnosis
Patient Type:        All
Disch Dates          01/01/10 to 01/31/11
-------------------------------------------------------------------------------------------------------------------------------
Disposition/Description
Physician/Description          SVC P/T Account#       Unit#          Patient Name       Age/Sex LOS Adm Date Dis Date Prin-Dx  FC
-------------------------------------------------------------------------------------------------------------------------------

*HOME OR SELF CARE

    10 COLEMAN,MICHAEL K       CAR I/P 1000600004     000-00-6254     MERRITT,ADMIT DX   38Y/F   0   01/06/10 01/06/10          S
    10 COLEMAN,MICHAEL K       CAR I/P 1000600001     000-00-6251     MERRITT,NO DX      43Y/M   0   01/06/10 01/06/10          S
    10 COLEMAN,MICHAEL K       CAR I/P 1000600003     000-00-6253     MERRITT,NO MRDX    10Y/F   0   01/06/10 01/06/10          S

   Total for Discharge Date 01/06/10: 3

   575 BASS,NONUMBERS          CAR I/P 1002000001     000-00-6259     MERRITT,ADMITDX IP 43Y/F   0   01/20/10 01/20/10 41060    O

   Total for Discharge Date 01/20/10: 1

    10 COLEMAN,MICHAEL K       NUR NEW 1002100002     000-00-6262     MERRITT,BABY 1 GIR 0D/F    1   01/21/10 01/22/10 0010     B
    10 COLEMAN,MICHAEL K       NUR NEW 1002100003     000-00-6263     MERRITT,BABY 2 BOY 0D/M    1   01/21/10 01/22/10          B
    10 COLEMAN,MICHAEL K       OBS OB  1002100001     000-00-6261     MERRITT,MOM        20Y/F   1   01/21/10 01/22/10 V234     B

   Total for Discharge Date 01/22/10: 3

     1 ADAMS,JAY K             NUR NEW 1002200002     000-00-6265     MERRITT,BABY 1 GIR 0D/F    3   01/22/10 01/25/10          S
     1 ADAMS,JAY K             ENT OB  1002200001     000-00-6264     MERRITT,NEW MOM    43Y/F   3   01/22/10 01/25/10          S

   Total for Discharge Date 01/25/10: 2

  2234 AKER,TOM                SUR I/P 1003900001     000-00-6273     MERRITT,FL IP      77Y/M   0   02/08/10 02/08/10 41060    S

   Total for Discharge Date 02/08/10: 1

    10 COLEMAN,MICHAEL K       CAR I/P 1003900003     000-00-6275     MERRITT,FOREIGN    30Y/M   1   02/08/10 02/09/10 0010     O
    10 COLEMAN,MICHAEL K       CAR I/P 1003900002     000-00-6274     MERRITT,HOMELESS   43Y/F   1   02/08/10 02/09/10 0011     S
   575 BASS,NONUMBERS          CAR I/P 1003900004     000-00-6276     MERRITT,UNKNOWN    55Y/M   1   02/08/10 02/09/10 0050     S

   Total for Discharge Date 02/09/10: 3

  1500 DEBVDOC,WITHAV          MED I/P 1025700004     000-00-6583     BRADLEY,OTHERPAYOR 23Y/F   426 01/01/09 03/03/10 4280     M

   Total for Discharge Date 03/03/10: 1
```

MR/HIM PRODUCTIVITY REPORT (PRO17X)

The MR/HIM Productivity report organizes and displays productivity statistics based on a series of filter criteria. Productivity reporting statistics are collected per abstract. The statistics identify the time required for abstractors, coders, and other employees to complete an account. The report is used to analyze the productivity data collected.

NOTE: Abstracts are included only if the coding or abstract has been marked as complete.

The report contains the following information:

- First line - Patient account number, patient type, service, discharge date, LOS, code or abstract complete date (based on whether coder or abstractor information is requested - use last date if report has both), financial class, primary insurance plan code, primary nursing station, ICD indicator (9,10, or both)
- Second and repeating lines - abstractor or coder who accessed the account (one line per employee that is found in Abstractor/Coder table), first and last date of access, and total duration
- Totals by role for account (subtotal of individual time is in the detail lines above)
- Report totals by employee and by role (abstractor, coder, and other)

You can specify the following criteria for the report:

- patient type
- single coder or abstractor, or all coders, all abstractors, or all coders and abstractors
- discharge date range
- discharge disposition
- service
- financial class
- primary insurance plan
- primary nursing station (where patient spent most time during stay)
- ICD indicator - 9, 10, or both

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*.

To create this report, select this option from the Core Reports menu. The MR/HIM Productivity Report Processor screen is displayed:

```
         General Hospital MR/HIM Productivity Report Processor
                                                 Fri Jun 11, 2010 03:10 pm
( 1)Patient Type       :
( 2)Abstractor/Coder   :
( 3)Disch Date Begin   :
( 4)Disch Date End     :
( 5)Disposition        :
( 6)Service            :
( 7)Financial Class    :
( 8)Primary Ins Plan   :
( 9)Primary Nurse Stn  :
(10)ICD Ind (9,10,B)   :
(11)Primary Sort       :
(12)Primary Subtotals  :
(13)Secondary Sort     :









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

NOTE: You must enter the beginning discharge date and the primary sort. All other fields have been defined with default values.

Field Explanations

1. PATIENT TYPE

This field indicates which patient types are to be included on the report. When you access this field, the following prompt is displayed:

Enter patient type codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter any combination of patient types. You can enter

- the patient type codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the patient type name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

2. ABSTRACTOR/CODER
This field indicates the user who updated the abstract.

You can choose

- one user by employee number
- All (A)bstractors
- All (C)oders, or
- (B)oth Abstractors and Coders, as well as user category of Other (default)

Abstractors and coders are linked to employee numbers in the Abstractor/Coder table.

3. DISCH DATE BEGIN
Enter the beginning discharge date, in the format MMDDYY, of those patients to be included in the report. For example, if you enter 010111, the report includes all patients discharged on or after January 1, 2011. There is no default.

4. DISCH DATE END
Enter the ending discharge date of those patients to be included in the report. For example, if you enter 063011, the report includes all patients whose discharge date is on or before June 30, 2011. If you do not enter a date and you press ENTER, the system autofills the field with the current date, and the report ends with the last date of patient information in the database (usually the current date).

NOTE: A report for a specific time period (for example, a month, a quarter, or a year) is completed much faster than one that is run against the entire database.

5. DISPOSITION
When you select this field, the lower portion of the screen displays the Disposition Code table and the following prompt.

Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
end select(NL) next pg(/ or PG DN) Search(TAB)

Make your selections from this table, or press ENTER to include all disposition codes on the report.

6. SERVICE
This field indicates which service codes are to be included on the report. When you access this field, the following prompt is displayed:

Enter service codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter

- the service codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the service name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

7. FINANCIAL CLASS
This field is for entering single, multiple, or all financial classes to be included in the report. When you access this field, the following prompt is displayed:

Enter financial class codes separated by `,`, `-` for table lookup, Partial Name `-`, or `=` for All [All]--

You can enter

- the financial class codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the financial class name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

8. PRIMARY INS PLAN
This field allows you to select a primary insurance plan. Select a value from the insurance plan table that is displayed when you access this field or select All (default).

9. PRIMARY NURSE STN
This field allows you to select a primary nurse station. Select a value from the nurse station codes table that is displayed when you access this field or select All (default).

10. ICD IND (9, 10, B)
This field indicates the ICD code set used. You can enter

- ICD9
- ICD10, or
- Both (default)

11. PRIMARY SORT
This field allows you to select a primary sort (within discharge status/disposition) for the report. Select the primary sort from the options that display when you access the field.

Your options are Abstractor/Coder, Patient Type, ICD Indicator, Financial Class, Primary Insurance Plan, Disposition, or Patient Account Number.

NOTE: If you do not enter a primary sort, the system uses a default of Abstractor/ Coder.

12. PRIMARY SUBTOTALS
This field allows you to indicate if subtotals for the primary sort should be included on the report. Enter **Y** or press ENTER for the default of Yes, and the subtotals are included. Enter **N**, and subtotals are not included.

13. SECONDARY SORT
This field allows you to select a secondary sort (within primary sort) for the report. Select the secondary sort from the options that display when you access the field. This field is optional; if it is left blank, the report sorts by primary sort.

NOTE: If the primary sort is unit patient account number, patient name, terminal digit, or unit number, the Secondary Sort field cannot be accessed.

When you complete these fields, the system displays this prompt:

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

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 briefly displays the following message and then returns you to the Core Reports menu:

Compiling and Printing

Impact

Upon acceptance of this screen, the MR/HIM Productivity Report prints at the assigned printer.

Output

The following is a sample of the core report MR/HIM Productivity Report.

Figure 6.16 MR/HIM Productivity Report (PRO17X)

```
Wed Jun 15, 2011 03:33 pm                          Model Hospital A                                                    Page 1
                                                MR/HIM Productivity Report
                                              Primary Sort: Financial Class
                                              Secondary Sort: Patient Type
Selection Criteria
----------------------

Patient Type:       All
Abstractor/Coder:   Both
Disch Dates:        04/26/11 to 06/15/11
Disposition:        All
Service:            All
Financial:          All
Primary Ins Plan:   All
Primary Nurse Stn:  All
ICD Indicator:      Both
-------------------------------------------------------------------------------------------------------------------------
Acct Number            P/T    Svc    Dis Dt          LOS      Comp Dt       FC  Ins Pln   Nur Stn     ICD
  Abstractor/Coder Emp #/Name                                 First Dt       Last Dt     Total Time
-------------------------------------------------------------------------------------------------------------------------
  1110100003           I/P    MED    05/03/11        22       05/04/11      M     100100   0SG         9

      Total Abstracting time:     0:00
      Total Coding time:          0:00

  1110300002           I/P    MED    05/19/11        36       06/10/11      M     100100   1E          9

    A 6770      BRADY,MELITTA P                                05/18/11       06/10/11     0:07
    C 6770      BRADY,MELITA P                                 05/19/11       05/19/11     0:06

      Total Abstracting time:     0:07
      Total Coding time:          0:06

  1112500001           I/P    MED    05/05/11        0        06/10/11      M     100100   1E          9

    A 6770      BRADY,MELITTA P                                05/05/11       05/05/11     0:07

      Total Abstracting time:     0:07
      Total Coding time:          0:00

  1113300002           I/P    MED    05/13/11        0        05/25/11      M     100100   1E          9

    A 6770      BRADY,MELITTA P                                05/13/11       06/09/11     0:29
    C 6770      BRADY,MELITTA P                                05/20/11       05/25/11     0:28

      Total Abstracting time:     0:29
      Total Coding time:          0:28

  1113300004           I/P    MED    05/13/11        0        05/27/11      M     100100   2N          9

    A 6770      BRADY,MELITTA P                                05/13/11       05/27/11     0:04

      Total Abstracting time:     0:04
      Total Coding time:          0:00
```

M/R SPECIAL STUDY REPORT (MRSSX)

This report displays patient response information, grouped together based on the special study code that was assigned on the abstract. Because this report provides some detailed patient information, it can be used as a chart pull list, as well as for statistical reporting.

This report prints on wide bar (132 column) paper. The information is based on data entered in the Special Studies screen. The abstract does not have to be marked complete in order for the information to be included on the report (as long as the abstract contains information on the special studies screen).

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*.

To create this report, select this option from the Core Reports menu. The system displays the Special Studies Report Processor screen:

```
              General Hospital Special Studies Report Processor
                                                  Tue Feb 20, 1996 01:50 pm
( 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.

This field requires a response. If you try to skip past it without responding, the system displays this error message:

Error: Field Required!

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.

This field requires a response. If you try to skip past it without responding, the system displays this error message:

Error: Field Required!

4. DISCHARGE ONLY
When you access this field, the system displays this prompt:

Discharged patients only? (Y/N)--

You have the following 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 include all patients, not just those who have been discharged.

5. STUDY DETAIL
When you access this field, the system displays this 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.

- Enter **N** for No to not include this detail in 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
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 hyphen (-) to display the MR Special Study - USA table for selection. You can select as many special studies as you need. When you are done selecting, press ENTER. The system redisplays the Special Study Report Processor screen.

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 patients' last names.

- Enter **A** to have the report information sorted by patients' 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)--[Y]

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 Core Reports menu.

Impact

Upon acceptance of this screen, the following takes place:

The MR Special Study Report prints at the assigned printer.

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.

Output

The following is a sample of the core report Special Study Report.

Figure 6.17 MR Special Study Report (MRSSX)

```
Tue Feb 20, 1996 05:31 pm            General Hospital                          Page 1
                                MR Special Study Report

Date Type: Study Date    Begin Date: 02/01/96           End Date: 02/20/96
Discharge Only: No     Study Detail: Yes
Special Studies: ER
Sort: Patient Name
ER - ER Deaths
 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 patient's B/P at time of arrival
 7   Indicate the patient's O2 level at time of arrival
 8   Did record indicate pupils as fixed and dilated upon arrival?
 9   Was alcohol or drug screening performed?
10   Indicate alcohol level if screen was done
11   Indicate drugs found positive if drug screening was done
12   Indicate time the patient was pronounced dead
13   If a resident pronounced the patient, was an attending present?
14   Time patient's remains were picked up for 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
_____________________________________________________________________________________________

MARTIN,ROBERT    9603000004      000000742        01/30/96    01/31/96   SELF PSY   01/20/96
 1   By ambulance
 2   07:00A
 3   Yes
 4   07:12A
 5   08:12A
 6   80/40
 7   90.2
 8   Yes
 9   Yes
10   0
11   Cocaine
12   08:13A
13   Yes
14   19:30P
15   Yes

End of Report
```

MORTALITY REPORT (PRO12X)

This report displays patient information, grouped together based on the death classification code that was assigned on the abstract. The report also displays a total by group. Primary and secondary sort criteria are also available for the report.

Because this report provides some detailed patient information, it can be used as a chart pull list, as well as for statistical reporting.

This report prints on wide bar (132 column) paper. The information on the report is based on data found in the abstract, and the abstract does not have to be marked complete in order for the information to be included on the report. However, the Death Classification screen of the abstract must contain a valid code in order for the patient to be included.

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*.

To create this report, select this option from the Core Reports menu. The Mortality Report Processor screen displays:

```
                General Hospital Mortality Report Processor
                                                  Wed Jul 03, 2002 06:20 pm
( 1)Death Classification: All
( 2)Begin Discharge Date: 07/03/01
( 3)End   Discharge Date: 07/03/02
( 4)Patient Type        : All
( 5)Physician           : All
( 6)Primary Sort        : Patient Type
( 7)Primary Subtotals   : Yes
( 8)Secondary Sort      : Physician









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

Field Explanations

1. DEATH CLASSIFICATION
When you select this field, the lower portion of the screen displays the Death Classification Code table and the following prompt:

Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
end select(NL) next pg(/ or PG DN) Search(TAB)

Select as many classification codes as desired for inclusion on the report. If you select no codes and you press ENTER, the system autofills the field with All, and the report includes all death classification codes.

2. BEGIN DISCHARGE DATE
Enter the beginning discharge date, in the format MMDDYY, of those patients to be included in the report. For example, if you enter 010199, the report includes all patients discharged on or after January 1, 1999. There is no default.

3. END DISCHARGE DATE
Enter the ending discharge date, in the format MMDDYY, of those patients to be included in the report. For example, if you enter 063099, the report includes all patients whose discharge date is on or before June 30, 1999. If you do not enter a date and you press ENTER, the system autofills the field with the current date, and the report ends with the last date of patient information in the database (usually the current date).

4. PATIENT TYPE
This field indicates which patient types are to be included on the report. When you access this field, the following prompt is displayed:

Enter patient type codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter any combination of patient types. You can enter

- the patient type codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the patient type name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

5. PHYSICIAN
This field indicates which physicians are to be included on the report. When you access this field, the following prompt is displayed:

Enter physician codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter

- the physician codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,

- part of the physican's name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

6. PRIMARY SORT
This field allows you to select a primary sort (within death classification code) for the report. Select the primary sort from the options that display when you access the field.

Your options are age, discharge date, financial class, patient account number, patient name, patient type, physician, terminal digit, or unit number.

NOTE: If you do not enter a primary sort, the system uses a default of physician.

7. PRIMARY SUBTOTALS (1-A-R)
This field allows you to indicate if subtotals for the primary sort should be included on the report. Enter **Y** or press ENTER for the default of Yes, and the subtotals are included. Enter **N**, and subtotals are not included.

NOTE: The report always includes totals for each death classification included on the report. The sample report that follows includes subtotals.

8. SECONDARY SORT
This field allows you to select a secondary sort (within death classification code and primary sort) for the report. Select the secondary sort from the options that display when you access the field. This field is optional; if it is left blank, the report sorts by death classification code and primary sort.

NOTE: If the primary sort is patient account number, patient name, terminal digit, or unit number, the Secondary Sort field cannot be accessed.

When you complete these fields, the system displays this prompt:

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

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 briefly displays the *Compiling and Printing* message and then returns you to the Core Reports.

Impact

After you accept this screen, the Mortality Report prints at the assigned printer.

Output

Following is a sample of the Mortality Report, with a primary sort of patient type and a secondary sort of physician.

Figure 6.18 Mortality Report (PRO12X)

```
Wed Aug 17, 2011 03:23 pm                          Model Hospital A                                                    Page 1
                                                    Mortality Report
                                                Primary Sort: Patient Type
                                                 Secondary Sort: Physician
Selection Criteria
-----------------
Death Classification: All
Disch Dates           06/01/11 to 08/17/11
Patient Type:         All
Physician:            All
-------------------------------------------------------------------------------------------------------------------------------
Death Classification
Physician                          P/T FC Account#       Unit#          Patient Name          Age/Sex Adm Date Dis Date   DOD
-------------------------------------------------------------------------------------------------------------------------------

>48 HRS

      100 SMITH,JOHN               I/P S  1115400001     000-00-6781    ARRAT,GEORGE           66Y/M  06/03/11 06/15/11 06/14/11
      432 BARR,GARY H              I/P S  1116500004     000-00-6790    CARABELL,GRACE         65Y/F  06/14/11 06/22/11 06/22/11
      432 BARR,GARY H              I/P S  1117200006     000-00-6801    FRAMEST,SAMUEL         71Y/M  06/21/11 07/01/11 06/30/11

   Total for Patient Type I/P Regular Inpatient Admission: 3

   Total for death classification 1: 4


<48 HRS

      432 BARR,GARY H              I/P S  1118600011     000-00-6826    BEST,SUE               82Y/F  07/05/11 07/05/11 07/04/11

   Total for Patient Type I/P Regular Inpatient Admission: 1

   Total for death classification 2: 1


AUTOPSY

      100 SMITH,JOHN               I/P S  1115400001     000-00-6781    ARRAT,GEORGE           66Y/M  06/03/11 06/15/11 06/14/11
      432 BARR,GARY H              I/P S  1118600011     000-00-6826    BEST,SUE               82Y/F  07/05/11 07/05/11 07/04/11

   Total for Patient Type I/P Regular Inpatient Admission: 2

   Total for death classification 3: 5


POST OP

      432 BARR,GARY H              I/P S  1118600011     000-00-6826    BEST,SUE               82Y/F  07/05/11 07/05/11 07/04/11

   Total for Patient Type I/P Regular Inpatient Admission: 1

   Total for death classification 7: 1
```

DISCHARGES BY RACE REPORT (PRO13X)

This report displays patient information, grouped together based on the race code that was assigned on the abstract. The report also displays a total by group. Because this report provides some detailed patient information, it can be used as a chart pull list, as well as for statistical reporting.

This report prints on 8 1/2 x 11 paper, with a page break between each race. The information on the report is based on data found in the abstract, and the abstract does not have to be marked complete in order for the information to be included on the report.

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*.

To create this report, select this option from the Core Reports menu. The Discharges by Race Processor screen displays:

```
                General Hospital Discharges by Race Processor
                                                  Wed Jul 03, 2002 06:48 pm
( 1)Race Classification : All
( 2)Begin Discharge Date: 07/03/01
( 3)End   Discharge Date: 07/03/02
( 4)Patient Type        : All
( 5)Primary Sort        : Patient Type









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

Field Explanations

1. RACE CLASSIFICATION
When you select this field, the lower portion of the screen displays the Race Classification Code table. Select as many classification codes as desired for inclusion on the report. If you select no codes and you press ENTER, the system autofills the field with All, and the report includes all race classification codes.

2. BEGIN DISCHARGE DATE
Enter the beginning discharge date, in the format MMDDYY, of those patients to be included in the report. For example, if you enter 010199, the report includes all patients discharged on or after January 1, 1999. There is no default.

3. END DISCHARGE DATE
Enter the ending discharge date, in the format MMDDYY, of those patients to be included in the report. For example, if you enter 063099, the report includes all patients whose discharge date is on or before June 30, 1999. If you enter no date and you press ENTER, the system autofills this field with the current date, and the report ends with the last date of patient information in the database (usually the current date).

This field indicates which patient types are to be included on the report. When you access this field, the following prompt is displayed:

Enter patient type codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter any combination of patient types. You can enter

- the patient type codes directly, each separated by commas,
- a hyphen (-) to do a table lookup,
- part of the patient type name followed by a hyphen, or
- an equal sign (=) or press ENTER for the default of all.

5. PRIMARY SORT
This field allows you to select a primary sort (within race) for the report. Select the primary sort from the options that display when you access the field.

Your options are discharge date, financial class, patient account number, patient name, patient type, terminal digit, or unit number.

NOTE: If you do not enter a primary sort, the system uses a default of unit number.

When you complete these fields, the system displays this prompt:

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

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 briefly displays this message:

Compiling and Printing

and then returns you to the Core Reports menu.

Impact

Upon acceptance of this screen, the following takes place:

- The Discharges by Race Report prints at the assigned printer.

Output

- The following is a sample of one page of the core report Discharges by Race.

Figure 6.19 Discharges by Race Report (PRO13X)

```
Jul 03, 2002 06:49 pm          Model Hospital A                    Page 9

                          Discharges by Race
                    Primary Sort Option: Patient Type

Selection Criteria
------------------
Race Classification: All
Patient Type:        All
Disch Date:          07/03/01 to 07/03/02
-------------------------------------------------------------------------------
Race Classification:   BLACK
Pat Account    Unit #          PT   Patient Name                 F/C Dsch Date
-------------------------------------------------------------------------------

0000555555     A000002453      10A  HARRIS,REJENA                B   08/06/01
0000123456     A000002321      ADV  PARKER,KEITH                 O   08/06/01
0124300002     A000001804      CON  VANCE,KAREN                      08/31/01
0211200006     A000002492      ER   ALEXANDER,ERIC               O   04/22/02
0124200001     A000002492      ER   ALEXANDER,ERIC               O   08/30/01
0124000001     A000002485      ER   JONES,RODNEY                 S   08/28/01
0045679982     A000002321      ER   PARKER,KEITH                 O   08/07/01
0119300002     A000002397      ER   BATES,JUNIOR                 O   07/12/01
0216100002     A000003101      I/P  HAYNE,TRACEY                 SP  06/20/02
0212600023     A000002976      I/P  DONER,DELORES                SP  06/20/02
0210500001     A000002321      I/P  PARKER,KEITH                 SP  04/16/02
0031200058     A000001762      I/P  TUTOR,MICHAEL                B   04/15/02
0208700002     A000001757      I/P  THOMAS,RO                    SP  03/28/02
0031200017     A000001757      I/P  THOMAS,RO                    AB  03/12/02
0123900006     A000002482      LTC  WILLIAMS,GREGORY             B   08/28/01
0205300007     A000002630      O/P  KASSMEIER,JOYCE              SP  02/22/02
0119700006     A000001743      O/P  MERRITT,OTTO                 K   07/16/01
0119300006     A000002401      O/P  BATES,SENIOR                 O   07/12/01
0210100007     A000002776      OPB  DONER,SAMANTHA               SP  04/11/02
0123000001     A000001981      OPB  DONER,ANDREW D               SP  08/18/01
0216100006     A000003105      OPO  BEARD,OLIVE                  SP  06/10/02
0106000004     A000001869      OPO  REED,MARY                    M   04/15/02
0113100003     A000001886      OPO  TATE,MARVIN                  M   11/13/01
0212000019     A000001770      OPT  TATE,PAT                     SP  05/02/02
0210500020     A000002332      SD2  WATKINS,JAMES                SP  04/15/02
0209100004     A000002332      SW1  WATKINS,JAMES                SP  04/01/02


Total for Race Classification BLACK: 26
```

COMBINED HCPCS REPORT (PRO16X)

This report allows you to view patient information based on Medical Record HCPCS codes, Patient Accounting Charge HCPCS codes, or both types of codes. When both types of codes are selected for the report, an indicator is attached to each code to show its origin. Primary and secondary sort criteria are available, and the report displays the total for each sort group.

NOTE: If Patient Accounting information resides on a separate system from Medical Records information, then the report is generated on the Patient Accounting system rather than on the Medical Records system.

Only one Combined HCPCS report can be generated at the same time within a facility. If you attempt to run the report and one is already in progress, the following error message is displayed:

Please try again later. Two versions of the Combined HCPCS report cannot be run at the same time for a facility.

The report cannot be run during midnight processing for Patient Accounting, or while an incremental backup is taking place. If you attempt to run the report during these times, the following error message displays:

Please try again later. Unable to access data at this time.

This report prints on 8 1/2 x 11 paper. The information on the report is based on data found in the abstract and/or the Patient Accounting system.

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*.

To create this report, select Combined HCPCS from the Core Reports menu. The Combined HCPCS Processor screen is displayed:

```
                  General Hospital Combined HCPCS Processor
                                                 Tue Jul 21, 2009 12:00 am
( 1)HCPCS Type          :
( 2)HCPCS               :
( 3)ICD-10 Chg Diag     :
( 4)ICD-9 Chg Diag      :
( 5)Revenue Codes       :
( 6)Modifiers           :
( 7)Financial Classes   :
( 8)Begin Discharge Date:
( 9)End   Discharge Date:
(10)Service             :
(11)Patient Type        :
(12)Physician           :
(13)Print Detail        :
(14)Primary Sort        :
(15)Primary Subtotals   :
(16)Secondary Sort      :



Enter 'M' for MR HCPCS, 'P' for PA Charge HCPCS, or 'B' for Both--  |
```

If you select Criteria for both ICD-10 and ICD-9 codes, two reports are generated; one for ICD-9 codes and one for ICD-10 codes as shown in the following example:

```
            General Hospital View Spooled Reports Processor
                                                 Tue Aug 04, 2009 09:26 pm

Report : PRO16A  Combined HCPCS (A)
Page:01


 Copy  Spooled      Last Printed   Pages     Comment
( 1) 08/04/09 2152  Not Printed        1      Combined HCPCS - ICD10
( 2) 08/04/09 2152  Not Printed        1      Combined HCPCS - ICD9
```

Field Explanations

1. HCPCS TYPE

This field allows you to enter the HCPCS type(s) to be included in the report. When you access this field, the following prompt is displayed:

Enter 'M' for MR HCPCS, 'P' for PA Charge HCPCS, or 'B' for Both--

You can enter:

- **M** to include only Medical Records HCPCS codes
- **P** to include only Patient Accounting Charge HCPCS codes
- **B** to include both types of HCPCS codes

2. HCPCS
This field allows you to enter the HCPCS code(s) to be included in the report. When you access this field, the following prompt is displayed:

Enter HCPCS, HCPCS range(s) separated by `,`, or T# for Top 10-35 HCPCS, or `=` for All--

You can enter:

- a single HCPCS code
- multiple HCPCS codes, separated by commas
- a range (or ranges) of codes (for example, 31300-31420)
- **T** followed by a number from 10-35 to list the top HCPCS codes (for example, if you enter **T25**, the report includes the top 25 HCPCS codes)
- an equal sign (=) or press ENTER for the default of all

When you select multiple HCPCS codes, the report includes each HCPCS code in the header, up to two lines. The second line is appended with *+more* if there are more codes than can be listed in two lines.

Accounts that do not contain any HCPCS procedure codes and that meet the criteria range are included in the *No Procedure Code* section at the beginning of the report.

3. ICD-10 CHG DIAG
4. ICD-9 CHG DIAG
These fields allow you to enter the charge diagnosis or diagnoses to be included in the report.

- ICD-10 CHG DIAG - allows you to access and select ICD-10 codes from a table look-up
- ICD-9 CHG DIAG - allows you to access and select ICD-9 codes from a table look-up

NOTE: These fields are available only if Charge HCPCS codes are selected for the report.

When you access these fields, the following prompt is displayed:

Enter Diagnoses codes separated by `,`,Diagnoses ranges separated by ',', or `=` for All [All]--

You can enter:

- a single diagnosis code
- multiple diagnosis codes, separated by commas
- a hyphen (-) to do a table lookup
- a range (or ranges) of codes
- **T** followed by a number from 10-35 to list the top diagnosis codes (for example, if you enter **T25**, the report includes the top 25 diagnosis codes)
- an equal sign (=) or press ENTER for the default of all

NOTE: When entering a range of diagnosis codes, the first number must be less than the second number. For example, If you enter a range of 67694-650, the system displays the error message *Invalid Entry!*

5. REVENUE CODES

This field allows you to enter the revenue code(s) to be included in the report. When you access this field, the following prompt is displayed:

Enter Rev(s), `-` for table, Rev range(s) separated by `,`, or `=` for All—

You can enter:

- a single revenue code
- multiple revenue codes, separated by commas
- a hyphen (-) to do a table lookup
- a range (or ranges) of codes
- an equal sign (=) or press ENTER for the default of all

6. MODIFIERS

This field allows you to enter the HCPCS modifier(s) to be included in the report. When you access this field, the following prompt is displayed:

Enter Modifiers codes separated by `,`, `-` for table lookup, Partial Name`-` , or `=` for All--

You can enter:

- a single modifier code
- multiple modifier codes, separated by commas
- a hyphen (-) to do a table lookup
- part of the modifier description followed by a hyphen
- an equal sign (=) or press ENTER for the default of all

NOTE: The default of all includes HCPCS codes with no modifiers.

7. FINANCIAL CLASSES
This field allows you to enter the financial class code(s) to be included in the report. When you access this field, the following prompt is displayed:

Enter financial class codes separated by `,`, `-` for table lookup, Partial Name `-`, or `=` for All [All]--

You can enter:

- a single financial class code
- multiple financial class codes, separated by commas
- a hyphen (-) to do a table lookup
- part of the financial class name followed by a hyphen
- an equal sign (=) or press ENTER for the default of all

When you select multiple financial class codes, the report includes each financial class code in the header, up to two lines. The second line is appended with *+more* if there are more codes than can be listed in two lines.

8. BEGIN DISCHARGE DATE
Enter the beginning discharge date, in the format MMDDYY, of those patients to be included in the report. For example, if you enter 010103, the report includes all patients discharged on or after January 1, 2003. There is no default value for this field.

9. END DISCHARGE DATE
Enter the ending discharge date, in the format MMDDYY, of those patients to be included in the report. For example, if you enter 063003, the report includes all patients

whose discharge date is on or before June 30, 2003. If you do not enter a date in this field, the system uses the current date, and the report ends with the last date of patient information in the database (usually the current date).

NOTE: A report that is run for a specific time period (for example, a month, a quarter, or a year) will be completed much faster than one that is run against the entire database.

10. SERVICE

This field allows you to enter the service code(s) to be included in the report. When you access this field, the following prompt is displayed:

Enter service codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter:

- a single service code
- multiple service codes, separated by commas
- a hyphen (-) to do a table lookup
- part of the service name followed by a hyphen
- an equal sign (=) or press ENTER for the default of all

When you select multiple service codes, the report includes each service code in the header, up to two lines. The second line is appended with *+more* if there are more codes than can be listed in two lines.

11. PATIENT TYPE

This field allows you to enter the patient type(s) to be included in the report. When you access this field, the following prompt is displayed:

Enter patient type codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter:

- a single patient type
- multiple patient types, separated by commas
- a hyphen (-) to do a table lookup
- part of the patient type name followed by a hyphen

- an equal sign (=) or press ENTER for the default of all

12. PHYSICIAN
This field allows you to enter the physician(s) to be included in the report. When you access this field, the following prompt is displayed:

Enter physician codes separated by `,`, `-` for table lookup, Partial Name`-`, or `=` for All [All]--

You can enter:

- a single physician code
- multiple physician codes, separated by commas
- a hyphen (-) to do a table lookup
- part of the physican's name followed by a hyphen
- an equal sign (=) or press ENTER for the default of all

13. PRINT DETAIL
This field allows you to include patient detail in the report. Press **Y** for Yes to include detail, which consists of the following patient-related information: account number, unit number, patient name, age and sex, admission date, and discharge date. Press **N** or ENTER for No to include only summary information.

14. PRIMARY SORT
This field allows you to select a primary sort (within HCPCS code) for the report. Select the primary sort from the options that display when you access the field.

NOTE: If you do not enter a primary sort, the system uses a default of physician.

15. PRIMARY SUBTOTALS (1-A-R)
This field allows you to include subtotals for the primary sort in the report. To include subtotals, enter **Y** or press ENTER for the default of Yes. If you enter **N**, subtotals are not included.

NOTE: The report always includes totals for each HCPCS procedure selected for the report.

16. SECONDARY SORT
This field allows you to select a secondary sort (within HCPCS procedure code and primary sort) for the report. Select the secondary sort from the options that display when you access the field. This field is optional. if it is left blank, the report sorts by HCPCS procedure code and primary sort.

The secondary sort options vary depending on your primary sort.

NOTE: If the primary sort is patient name, terminal digit, or unit number, the Secondary Sort field cannot be accessed.

After you complete these fields, the following prompt is displayed:

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

Press **N** if you need to return to any of the fields to make changes. Press **Y** or ENTER to accept the screen. Once you accept the screen, the following message is displayed:

Compiling and Printing

The system displays the message briefly, then returns you to the Core Reports menu.

Impact

After you accept this screen, the Combined HCPCS Report prints at the designated printer.

Output

The following are examples of one page of the Combined HCPCS report for both ICD10 and ICD9. The sample reports include both Medical Record HCPCS codes and Patient Accounting Charge HCPCS codes. The primary sort is by Physician, and there is no secondary sort. All selection criteria are shown at the top of the report.

Figure 6.20 Combined HCPCS ICD10 Detail Report (PRO16X)

```
Tue Aug 04, 2009 09:52 pm                          General Hospital                                                    Page 1
                                                 Combined HCPCS ICD10-Detail
                                                 Primary Sort: Physician
                                                  Secondary Sort: None
Selection Criteria
-----------------
HCPCS Type:          Both
HCPCS:               Range All
Modifiers:           All
ICD10 Chg Dx:        All
Rev Codes:           All
Financial:           All
Service:             All
Patient Type:        All
Physician:           All
Disch Dates          01/01/09 to 08/04/09
-------------------------------------------------------------------------------------------------------------------------------
HCPCS/Description
MR/PA Physician/Description       SVC P/T Acct#            Unit#          FC Disch Date  Dx Cd  Modifiers
-------------------------------------------------------------------------------------------------------------------------------

                                                    End of Report
```

Figure 6.21 Combined HCPCS ICD9 Detail Report (PRO16X)

```
Tue Aug 04, 2009 09:52 pm                          General Hospital                                                    Page 1
                                                 Combined HCPCS ICD9-Detail
                                                 Primary Sort: Physician
                                                  Secondary Sort: None

Selection Criteria
-----------------
HCPCS Type:          Both
HCPCS:               Range All
Modifiers:           All
ICD9 Chg Dx:         All
Rev Codes:           All
Financial:           All
Service:             All
Patient Type:        All
Physician:           All
Disch Dates          01/01/09 to 08/04/09
-------------------------------------------------------------------------------------------------------------------------------
HCPCS/Description
MR/PA Physician/Description       SVC P/T Acct#            Unit#          FC Disch Date  Dx Cd  Modifiers
-------------------------------------------------------------------------------------------------------------------------------

                                                    End of Report
```

POST PAYMENT EVALUATION OPTIONS REPORT (FAR900, FAR901)

NOTE: This report is generated in the STAR Patient Accounting system, but can be accessed from the STAR Records Management Core Reports menu.

This report allows you to create custom reports and worklists in STAR to assist in evaluating how your facility is being reimbursed. The analysis is performed on accounts with insurance payments. Data elements may be selected from Patient Processing, Health Information Management and Patient Accounting information. Insurance payments may be posted using scripting, manual insurance batches or Electronic Remittance Advice (ERA).

Custom reports may be created to use with SQL reporting, as well as for exporting the selected data to Excel or another software package.

To create this report, select Post Payment Evaluation Options from the Core Reports menu. The Post Payment Evaluation Options screen is displayed:

```
      General Hospital Post Payment Evaluation Options Processor
                                                Thu Sep 15, 2011 10:15 pm
Post Payment Evaluation Options Input Options

            Option No.  Option
            ---------------------------------------
                1       Maintain Post Payment Evaluation Table
                2       Maintain Post Payment Evaluation Jobs
                3       Remove Post Payment Evaluation SQL Data

                4       View Post Payment Evaluation Table
                5       View Post Payment Evaluation Jobs
                6       View Post Payment Evaluation Jobs with SQL Data

                7       View Post Payment Evaluation Dictionary
                8       Report Post Payment Evaluation Dictionary




Enter option number--
```

Use Option 1 to create reports. The following reports are available:

- FAR901x – Post Payment Evaluation report

  This report is the smaller version created for printing directly out of STAR. The report allows for 132 characters.

- FAR900x – Post Payment Evaluation Download report

  This report can be downloaded from STAR into Excel. What spools to the report is the header for each data element and the data reported.

Use Option 2 to check reports scheduled. Reports can be run

- Daily
- Weekly
- Monthly
- One Time Runs

The Post Payment Evaluation Options are documented in detail in the *STAR Patient Accounting Account Transactions Volume*, Chapter 3: Other Account Management Functions. For additional information, refer to *STAR Patient Accounting Account Transactions Volume*, Chapter 3.

Appendix A - TABLES

TABLES

Many of the tables defined in the STAR Patient Care Maintenance function are used within the Medical Record Abstracting Module. Rather than review the specifics of each individual table, we provide a list of all the tables used within the Medical Record Abstracting Module that are referenced in this volume of documentation.

For specific table information, please refer to the corresponding entry in the *STAR Patient Care Reference Guide, Tables Volume*.

1. Abstractor/Coder
2. Admission Type
3. Admission Source
4. Anesthesia Codes
5. APGAR Codes for Newborn
6. Arrival Modes
7. Birth Status
8. Birth Types
9. Blood Groups
10. Case Category Code
11. Death Classifications
12. Diagnosis Type
13. Discharge Status/Disposition
14. DRG Payors
15. DRG Unaccepted Reasons
16. Financial Classes
17. HCPCS Payors
18. HCPCS Procedure Pointer
19. Hospital Services

20. ICD Diagnosis Pointer
21. ICD Procedure Pointer
22. Incident Codes
23. Marital Status
24. MR Special Study
25. Newborn Indicators
26. Physician/Resource Specialties
27. Physicians
28. Quality Issue
29. Race Codes
30. Severity of Illness Codes
31. Specialty Units
32. Tissue Codes
33. Triage Codes
34. Type of Unit
35. Visit Types

Index

S

T

U

V

■ Reader Comment Form ■

We value your suggestions for improving our documentation. Please use this form to evaluate the *Medical Record Abstracting Module* of the *STAR Patient Care Reference Guide* for Release 18.0.

Topic	Poor	Fair	Good	Excellent
Organization of information	q	q	q	q
Accuracy of information	q	q	q	q
Completeness of information	q	q	q	q
Clarity of information	q	q	q	q
Amount of overview information	q	q	q	q
Explanation of processes	q	q	q	q

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)

■

McKesson
STAR 2000 Documentation Team

Fold here

Place
Stamp
Here

STAR 2000 Documentation Team
McKesson
Mail Stop ATHQ-3302
5995 Windward Parkway
Alpharetta, GA 30005

Fold here