STAR 2000™

MCKESSON
Empowering Healthcare

**STAR FINANCIALS PATIENT ACCOUNTING
REFERENCE GUIDE
Worksheets Volume**

Preface

The *STAR Financials Patient Accounting Reference Guide* is a multivolume document written for all users of the system. The *Worksheets Volume* contains worksheets you use to complete the tables, master files, and parameters of the base STAR Patient Accounting System.

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Chapter 1 - TABLE MATRIX

INTRODUCTION

The following tables must be completed before the installation of STAR Patient Accounting can be completed. The STAR Patient Care tables referenced on the matrix include additional data or are used in one of the financial tables.

Matrix Explanations

For each table, the matrix includes the following information:

#
This column displays the matrix number used to identify the table on the worksheets.

DESCRIPTION
This column contains the descriptive name of the table. The column may also display one of the following:

(PC)
This table is a STAR Patient Care system or Medical Records table that is included in the matrix for reference purposes. The worksheets necessary for these tables are provided with the STAR Patient Care system or Medical Records system.

(NA)
This table is not available.

DEPENDENT ON #
This column displays the matrix number of the table(s) that must be completed before this table can be completed.

LVL
This column displays the level number assigned to the table. All tables in the same level can be completed at the same time.

REFERENCE
This column displays the matrix number of any table that references this table.

SPLIT?
This column displays whether this table is split by facility. Optional displays are:

Yes
The column displays Yes if this table is always split by facility (if more than one facility exists).

No
The column displays No if this table is never split by facility.

Optional
The column displays Optional if this table can be split by facility at the discretion of the user.

Fac Spec

The column displays Fac Spec is this table is not split by facility but contains facility-specific information making the table entries valid or invalid for a facility.

#	Description	Dependent On #	Lvl	Reference	Split?
1	Accommodations (PC)			64	No
2					
3	Agency Follow-Up Schedules	29, 46, 48, 107	3	20	No
4	Aging By Types	McKesson Defined	0		No
5	Alternate Summary Code 1, 2, 3		1	45	Optional
5a	ASC Payment Group Payor Arrangement	91	3		Yes
5b	ATB Sort Options	McKesson Defined			No
6	Report Aging Code	44	8		Yes
7	Bill Types	McKesson Defined	0		No
7b	Alternate Level of Care		2		No
7a	Bill Type Codes		1	79a	No
8	Billers	60	2	10	No
9	Claim Attachments	88, 95	2	45, 64	No
10	Billing Groups	8	3	44, 64	No
11	Billing Parameters	12, 109	3	44, 64	No
12	Billing Requirements	26, 70	2	11	No
13	Business Offices		3	33	No
	Charge Control Parameters (See 1500 Charge Control Parameters, UB Charge Control Parameters, or UB Charge Control Parameters.)				
14	Claim Disposition Types	McKesson Defined	0		No
15	Claim Generation Parameter	109	2	64	No
16	Claim Load and Edit Parameters	17, 29a, 70,	1	64	No

#	Description	Dependent On #	Lvl	Reference	Split?
16a	Claim Load and Edit Parameters - (CN Only)		1		
17	Claim Types	McKesson Defined	0	16, 64	No
18	Claim Work Status Types	McKesson Defined	0		No
19	CCA/RUA/CPA Parameters	70, 79	3		Yes
20	Collection Agency	3, 22, 51, 109	4	21	No
21	Collection Agency Group	20	5	50	No
22	Collection Group	23	3	20, 44,. 64	No
22a	Contract Follow-Up Schedules		2		
22b	Contract Financial Information		3		
23	Collectors	60	2	22	No
23a	Coverage Options	McKesson Defined			No
24	Credit Ratings (NA)		1	119	No
25	CRT Names (PC)	McKesson Defined			Fac Spec
26	Data Control Codes		1	12	None
27	Data Mailer Messages (NA)	51, 70	1	66	No
28	Detail Revenue Center (PC)			45	Optional
29	Detail Statement Messages	51, 70	1	50, 66	No
29a	Contract Statement Messages		1		
29b	Diagnostic Revenue Codes	118	1	16	Yes
29c	DRG Payment Window Parameters	44,68,79,109,45	1		Yes
30	Electronic Claim Media Types	McKesson Defined	0	64	No

#	Description	Dependent On #	Lvl	Reference	Split?
30a	ERA Facility/Provider Mapping - (US Only)		1	30b, 30g	No
30b	ERA Claim Adjustment Groups		1	30g, 30c	No
30d	ERA Claim Status Codes		1	30g	No
30c	ERA CAS Reason Codes	30b	2	30g	No
30e	ERA Claim Filing Indicator		1	30g	No
30f	ERA Remarks		1	30g	No
30g	ERA Payment Analysis Report	30b, 30c, 30d, 30e, 30f, 58	3	79a	No
31	Employers			32	Optional
32	Facility Information Demographics/Defaults - (US Only)	31, 44, 61, 69, 85	8		Yes
32a	Facility Information Demographics/Defaults - (CN Only)		8		
33	Facility Information PA/ AR Control	13, 51, 109	2		Yes
34	Facility Information: Patient Bill Format	51, McKesson Maintained	1		Yes
34a	Facility Information: Contract Bill Format		1		
35	Facility Information: Sort Sequences	51	1	96, 97	Yes

#	Description	Dependent On #	Lvl	Reference	Split?
37	Facility Information: Biller /Collector Worklist Control		1		Yes
37a	Facility Information: Active Patient Worklist Control	23, 44	8		Yes
38	Facility Information: Retention, Data Retention Parameters	44, 79	8		Yes
39	Facility Information: Balance Designation, Balance Designation Parameters	44, 79, 109	8		Yes
40	Refund Parameters	90, 109	2		Yes
41	Facility Information Insurance Time Out	44, 79, 109	8		Yes
42	1500 Charge Control Parameters - (US Only)	86, 81a	2	64	No
42a	Non Professional Fee 1500 Charge Control Parameters - (US Only)	86, 81a	2	64	No
43	1500 Department / Supplier Override - (US Only)	85, 95	2		Yes
44	Financial Classes	10, 11, 22, 50, 79, 109	7	6, 32, 35, 38, 39, 41, 64	Fac Spec
45	Financial Item Master	5, 9, 28, 88, 93, 95, 112, 117	2		Optional
46	Follow-Up Letters	47	2	50, 66	No
47	Follow-Up Letter Messages	51, 70	1	46	No
48	Follow-Up Type (Guarantor)	McKesson Defined	0	3, 50	No
49	Follow-Up Type (Insurance)	McKesson Defined	0	66	No

#	Description	Dependent On #	Lvl	Reference	Split?
50	Follow-Up Schedules (AR)	21, 29, 46, 48, 107, 109	6	43	No
50a	Follow-Up Schedules (PA)	21, 29, 46, 48, 107, 109	6	43	No
51	Format Types	McKesson Defined	0	27, 29, 34, 35, 36, 67	No
52	Guarantor Sort Option	McKesson Defined	0		No
53	GL Mapping	44, 55, 61, 79, 93 109	9		Yes
54	GL Mapping Table Definition		1	56	Yes
55	GL Mapping Table Key Definition	56, 57	3	53	Yes
56	GL Mapping Parameter	54, *	2	55	Yes
57	GL Mapping Table Key Types	McKesson Defined	0	55	No
58	HCPCS (PC)	AMA Supplied		59	No
58a	HCPCS Panel Codes		1		No
59	HCPCS Summarization Master - (US Only)	58	1	30g	No
60	Hospital Employees		1	8, 23	Fac Spec
61	Hospital Service (PC)			53, 64	Fac Spec
62	ICD-9-CM (PC)	McKesson Supplied		64	No
63	Insurance Carrier	69	1	68	No
64	Insurance Coverage	1, 9, 10, 11, 15, 16, 17, 22, 42, 44, 61, 62, 66, 68, 75a, 79, 88, 89, 91, 92, 99, 108, 109, 113, 117	8		Fac Spec
65	Insurance Follow-Up Letters	67	2	66	No

#	Description	Dependent On #	Lvl	Reference	Split?
66	Insurance Follow-Up Schedules	27, 29, 46, 49, 65, 107	3	64	No
65	Insurance Messages	51, 70	1	65	No
68	Insurance Plan	63	2	64	No
69	Insurance Types	McKesson Defined	0	63	No
70	Internal Elements	McKesson Defined	0	12, 16, 19, 27, 29, 47, 67, 77, 107	No
70a	Medical Records HCPCS Rev Code Range		1	114, 42	No
71	Memo Collection Letter Messages	51, 70	1	73	No
72	Memo Detail Statement Messages	51, 70	1	50	No
73	Memo Follow-Up Letters	56, 109 *	2		No
74	Miscellaneous Cash Codes	109 *	2		Yes
75	Network Product Class	McKesson Defined	0		No
75a	Non Duplicating HCPCS Range		1		No
75b	Non-Professional Charge Control Parameters	86, 95, 118	2	64	No
76	Optional Batch Jobs		0		No
76a	Pathways Contract Management Interface - Reimbursement Master		1		Yes
76b	Pathways Contract Management Interface - Pathways Parameter Processor		1		
77	Patient Bill Message	51, 70	1	11	No
78	Patient Indicators	McKesson Defined	0		No

#	Description	Dependent On #	Lvl	Reference	Split?
79	Patient Type (PC)	85	2	19, 37, 38, 40, 53, 64	Yes
79a	ERA Payment File Definition	7a, 63, 69, 109, 3g	4	91b	No
80	Payor Arrangement	91	3	81, 82, 83	No
81	Payor Table Definition Accommodation Exceptions	1, 80	2		No
81a	Payer HCPCS Cross Reference - (US Only)	58	1	114	No
82	Payor Table Definition Proration Sum Exceptions	80, 88	2		No
83	Payor Table Definition Stop Loss Tables	80	2		No
84	Payor Table Definition Fee Sched Reimbursement		2		No
85	Physicians (PC)			43	No
86	Place of Service - (US Only)		1	42	No
86a	Principal Procedure Revenue Codes		1		No
87	Procedure Coding Method		1		No
88	Proration Summary Code		1	45, 64	No
89	Provider Master - (US Only)		1	64, 79	Optional
89a	Provider Master - (CN Only)		1		
90	Refund Check Messages	51, 70	1	40	No
91	Payor Table Definition	92	2	64, 80	No
91a	ERA Provider Adjustment Reason Codes		1	91b	No

#	Description	Dependent On #	Lvl	Reference	Split?
91b	Provider Level Adjustment Mapping	79a, 91a, 74	3		Yes
92	Reimbursement Payor Code		1	64, 91	No
93	Revenue Center (PC)			45, 53	Optional
94	Selection Sort Option	McKesson Defined	0		No
95	SIM Department (PC)		1	43, 45	Optional
96	Sort Elements	McKesson Defined	0	36	No
97	Sort Keys	McKesson Defined	0	36	No
98	Sort Options	McKesson Defined	0		No
99	Source of Payment		1	64	No
100	Statistics Codes	McKesson Defined	0		No
101	Statistics Groups	102	0	103, 104	No
102	Statistics Keys	McKesson Defined	0	101	Yes
103	Statistics Group Keys	101	1		Yes
104	Statistics Retention	101	1		Yes
105	Status Codes	McKesson Defined	0		No
106	Status Keys	McKesson Defined	0		No
107	Telephone Messages	70, 51	1	50, 50a, 51, 66	No
107a	Contract Telephone Messages		1		
108	Maintain Log ID - (US Only)		1		
109	Transaction Codes	111	1	11, 15, 20, 33, 39, 40, 41, 44, 50, 53, 64, 74	No
110	Transaction Summaries	McKesson Defined	0		No
111	Transaction Types	McKesson Defined	0	109	No
112	Type of Service		1	45	Optional

#	Description	Dependent On #	Lvl	Reference	Split?
112a	Type of Service Cross Reference		1		No
113	UB82 Charge Control Parameters	118	2	64	No
114	UB Charge Control Parameters - (US Only)	81a, 118	2	64	No
115	UB Condition Codes/ Special Statistics Codes		1		No
116	UB Occurrence Codes - (US Only)		1		No
117	UB Occurrence Span Codes - (US Only)		1		No
118	UB Revenue Codes/ Insurance Summary Codes		1	64, 113, 114	No
119	UB Value Codes - (US Only)		1		No
120	Vendor Names (NA)				Yes
121	UB Therapy Revenue Code Table	118	2		No
122	Pre-Collection Batch Job	20	0		Yes
123	Pre-Collection Information	20	5		Yes

*   You must set up GL entity, fiscal year definition, department, subaccount type, subaccounts, and chart of accounts before you can complete these tables.

Chapter 2 - LEVEL 0

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INTRODUCTION

Level 0 contains information maintained by McKesson used to complete subsequent worksheet levels. The information completed in this level includes:

- Aging By Types
- ATB Sort Options
- Bill Types
- Claim Disposition Types
- Claim Types
- Claim Work Status Types
- Coverage Options
- Electronic Claim Media Types
- Follow-Up Type (Billing)
- Follow-Up Type (Claims)
- Format Types
- GL Mapping Table Key Types
- Guarantor Sort Option
- Insurance Type
- Internal Elements
- Network Product Class
- Optional Batch Jobs
- Patient Indicators
- Selection Sort Option
- Sort Elements
- Sort Keys
- Sort Options
- Statistics Codes
- Statistic Groups
- Statistics Keys
- Transaction Summaries
- Transaction Types

AGING BY TYPES

Level   0

Matrix#   4

The following Aging By Types are maintained in the system by McKesson and cannot be changed:

Code	Description
1	Admission Date
2	Bill Date
3	Claim Date
4	Discharge Date
5	Last Account Payment
6	Last Insurance Payment
7	Last Patient Payment
8	Last Insurance F/U Date
9	Last Patient F/U Date

ATB SORT OPTIONS

Level   0

Matrix#   5a

The following ATB Sort Options are maintained in the system by McKesson and cannot be changed:

Code	Description
A	Account Name
N	Account Number
D	Financial Class and Dollars
F	Financial Class and Name
S	Statistical Group

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BILL TYPES

Level   0

Matrix#   7

The following Bill Types are maintained in the system by McKesson and cannot be changed:

Code	Description
A	Adjustment
C	Cycle
F	Final
L	Late
R	Reprint
S	Series

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CLAIM DISPOSITION TYPES

Level   0

Matrix#   14

The following Claim Disposition Types are maintained in the system by McKesson and cannot be changed:

<u>Code</u>	<u>Description</u>
A	Adjusted to Zero
C	Clear Disposition
D	Denied
F	Final Payment
N	No Disposition
P	Partial Payment
R	Replaced
T	Transfer

CLAIM TYPES

Level   0

Matrix#   17

The following Claim Types are maintained in the system by McKesson and cannot be changed:

<u>Code</u>	<u>Description</u>
B	1500
L	2360
J	CA25-1
A	MA 310
D	MA 319 MS
C	MA 319 PI
I	MCLI
O	MCLO
E	MI 1645
F	MI 1649
G	MI 1500
U	UB82
X	UB
Z	Non Pro Fee 1500
R	Medi-Cal UB
N	NJ MC19
H	MOH - Ontario - Ministry of Health
K	UNV - Canadian Universal
M	MA 319 Dental Form
T	TI19
W	WCB - Ontario Worker's Compensation Board
P	BC MSP
V	BC Out of Province
Q	BC Worker's Compensation Elec.
Y	CPBC
K	UNV

CLAIM WORK STATUS TYPES

Level   0

Matrix#   18

The following Claim Work Status Types are maintained in the system by McKesson and cannot be changed:

<u>Code</u>	<u>Description</u>
A	Awaiting Payment
D	Deleted
E	Edit
F	Failed Edits
H	Hold
M	Manually Released
R	System Released
p	Suppressed

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COVERAGE OPTIONS

Level   0

Matrix#   23a

The following Coverage Options are maintained in the system by McKesson and cannot be changed:

Code	**Description**
1	Basic Coverage
2	Room Coverage
3	Ancillary Coverage
4	Major Medical Coverage
5	Daily/Blood Deductibles
6	Flat Rate Coverage
7	Summary Code Exceptions
11	Plan Comments
12	Attachments
13	Facility Options

ELECTRONIC CLAIM MEDIA TYPES

Level   0

Matrix#   30

The following Electronic Claim Media Types are maintained in the system by McKesson and cannot be changed:

<u>Code</u>	<u>Description</u>
A	Electronic Media A
B	Electronic Media B
C	Electronic Media C
D	Electronic Media D
E	Electronic Media E
T	Electronic Media T

FOLLOW UP TYPE (GUARANTOR)

Level   0

Matrix#   48

The following Follow Up Type Billing values are maintained in the system by McKesson and cannot be changed:

Code	Description
L	Collection Letter
D	Detail Statement
T	Telephone
W	Wait Step

FOLLOW UP TYPE (INSURANCE)

Level   0

Matrix#   49

These Follow Up Type Claims values are maintained in the system by McKesson and cannot be changed:

Code   **Description**

L   Collection Letter

T   Telephone

R   Tracer Claim

FORMAT TYPES

Level   0

Matrix#   51

The following Format Types are maintained in the system by McKesson and cannot be changed:

Code	Description
B	1500 Detail
Y	Agency Statement
N	Agency Transfer Notification
A	Archive Statement
R	Cash Posting Receipt
V	Contract Bill Detail
W	Contract Bill Header
M	Memo Statement
D	Patient Bill Detail
H	Patient Bill Header
P	Prorated Bill
C	Series Bill
S	Summary Bill
U	UB82 Detail
T	State Bill

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GL MAPPING TABLE KEY TYPES

Level   0

Matrix#   57

These GL Mapping Table Key Types are maintained in the system by McKesson and cannot be changed. Vendor transactions keys (followed by **) are not implemented at this time.

Code	Description
TRANA	Adjustment Account
TRANE	Agency Cash
TRANV	Agency Fees
AR	AR Control Account
BDAL	Bad Debt Allowance
BD	Bad Debt Asset Account
BDWO	Bad Debt Contra Asset Account
BDRC	Bad Debt Recovery
DFTRANA	Default Adjustments
DFTRANE	Default Agency Cash
DFTRANV	Default Agency Fees
DFAR	Default AR Control Account
DFBDAL	Default BD Allowance
DFBD	Default BD Asset Account
DFBDWO	Default BD Contra Asset
DFBDRC	Default BD Recovery
DFDPRV	Default Department Revenue
DFTRANI	Default Insurance Payment
DFTRAND	Default Insurance Refund
DFTRANF	Default Miscellaneous Cash
DFTRANN	Default Nonpatient Cash **
DFTRANG	Default Other Adjustments **
DFTRANJ	Default Other Refunds
DFPA	Default PA Control

Code	**Description**
DFTRANP	Default Patient Payments
DFDPRF	Default Professional Fees
DFTRANR	Default Refunds
DFTRANU	Default Unapplied Cash
DFVA	Default Vendor PA Control **
DFVB	Default Vendor AR Control **
DFVR	Default Vendor Revenue **
DFREG	Default OP Registrations
DFOPV	Default Outpatient Visits
DFPTD	Default Patient Days
DPRF	Department Professional Fees
DPRV	Department Revenue
TRANI	Insurance Payment
TRAND	Insurance Refunds
TRANF	Miscellaneous Cash
TRANN	Nonpatient Cash **
REG*	OP Registrations
TRANG	Other Adjustments **
TRANJ	Other Refunds
OPV*	Outpatient Visits
PA	PA Control Account
PTD*	Patient Days
TRANP	Patient Payments
RFCASH	Refund Cash Account
TRANR	Refunds
TRANU	Unapplied Cash
UACASH	Unapplied Cash Control
UACHRG	Unapplied Charges Control
VB	Vendor AR Control **
VA	Vendor PA Control **
VR	Vendor Revenue **

*   Used for GL statistics only
**   Not implemented at this time

GUARANTOR SORT OPTION

Level   0

Matrix#   52

The Guarantor Sort Option types are used with the Account Selection Report Request and are valid sort options when the guarantor Account Selection Report is requested. These sort options are maintained in the system by McKesson and cannot be changed:

Code	Description
11	1- Guarantor Name
12	2- Patient Collector Code
13	3- Descending Bal Acct (G
14	4- Descending Bal Pat. (G
15	5- Descending Bal Ins. (G

INSURANCE TYPES

Level 0

Matrix# 69

These Insurance Type codes are maintained in the STAR Patient Care System and should be set as follows:

Code	Description
B	Blue Cross
E	Canadian Commercial Insurance
G	Canadian Military Insurance
D	Canadian Provincial Insurance
F	Canadian Workers Compensation
S	CHAMPUS
C	Commercial
N	HMO
Y	Medicaid Out-of-State (Not for P)
X	Medicaid/Welfare
M	Medicare Part A
P	Medicare Part B
A	Out of Province

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INTERNAL ELEMENTS

Level 0

Matrix# 70

These internal data elements can be inserted into collection letter, data mailer, detail statement, insurance, patient bill, refund check, telephone and insurance follow-up messages. They are maintained in the system by McKesson and cannot be changed. Internal elements are also used to identify data used in editing bills and claims.

Billing Requirements Data Base Elements

2nd Address
ACC/OCC Date
Accident Date/Time
Account Number
Admission Date
Admission Hour
Admission Source Code
Admission Type Code
Admitting Diagnosis Code
Admitting Diagnosis Description
Approval Date
Bill Admitting Doctor
Bill Attending Doctor
Bill From Date
Bill Ins Address Line 2
Bill Ins Address Line 2 [Primary]
Bill Ins Certification [All]
Bill Ins Certification [Primary]
Bill Thru Date
Bill Ins Address Line 1
Bill Ins Address Line 1 [Primary]
Bill Ins Employer Address
Bill Ins Employer City
Bill Ins Employer ID
Bill Ins Employer Info Code
Bill Ins Employer Name
Bill Ins Employer State
Bill Ins Employer Zip
Bill Ins Employment Status
Bill Ins Verification [All]
Bill Ins Verification [Primary]
Bill Ins Pre-notification Flag
Bill Ins Cert/SSN/HIC ID Number

Bill Ins Primary CERT/HIC/SS#
Bill Ins City
Bill Ins Phone
Bill Ins Insured's Sex
Bill Ins Insured's Name
Bill Ins CHAMPUS Branch
Bill Ins CHAMPUS Status
Bill Ins CHAMPUS Rank and Grade
Bill Ins Group Name
Bill Ins Group Name [Primary]
Bill Ins Group Number
Bill Ins Group Number [Primary]
Bill Ins Pat. Relation to Insured
Bill Ins ZIP code
Bill Ins State
Bill Referring Doctor
Birthday - Month
Birthday - Year
Birthday - Day
Blood Deductible
Condition Code 1
Condition Code 2
Condition Code 3
Condition Code 4
Condition Code 5
Condition Code 6
Condition Code 7
DRG Discharge Status
Final DRG
Guarantor Name
Guarantor City
Guarantor Address 1
Guarantor Social Security Number
Guarantor State
Guarantor Zip Code
HCPCS Code 1
Insurance Verified Flag [All]
Ins Approval # [Primary]
Insurance Certified Flag [All]
Insurance Certification [Primary]
Medical Record Number
Occurrence Code 1
Occurrence Code 2
Occurrence Code 3
Occurrence Code 4
Occurrence Code 5
Occurrence Code 6
Occurrence Code 7

Occurrence Code 8
Occurrence Span From Date 1
Occurrence Span From Date 2
Occurrence Span Code 1
Occurrence Span Code 2
Occurrence Span Through Date 1
Occurrence Span Through Date 2
Occurrence Date 1
Occurrence Date 2
Occurrence Date 3
Occurrence Date 4
Occurrence Date 5
Occurrence Date 6
Occurrence Date 7
Occurrence Date 8
Patient City
Patient Sex
Patient Birthdate
Patient Social Security Number
Patient Name
Patient Phone Number
Patient Marital Status
Patient State
Patient Zip Code
Patient Address 1
Payor Identification
Principal or Working Diag Code
Principal Procedure Date
Principal Procedure Code
Principal Diagnosis Code
PSRO Approval Flag
Race
Treatment Authorization Code

Detail Statement Messages Data Base Elements

Account Restart Amount
Account Amount for Promise to Pay
Actual Date of Promise to Pay
Amount of Payments - Account
Amount of Payments - Patient
Claim Submission Date
Collector Name
Collector Phone Number
Collector's Extension
Guarantor Restart Amount
Insurance Collector Name
Promise to Pay Amount

Promise to Pay Date
Provider Phone Number
UB Provider Claim Name

Follow-up Letter Messages Data Base Elements

ACC/OCC Date
Account Restart Amount
Actual Amount from Promise to Pay
Actual Date of Promise to Pay
Amount of Payments - Account
Amount of Payments - Patient
Claim Submission Date
Collector Name
Collector's Extension
Guarantor Restart Amount
Insurance Carrier/Plan Name
Patient Name
Promise to Pay Amount
Promise to Pay Date
Provider Phone Number
UB Provider Claim Number Collector Phone Number

Insurance Messages Data Base Elements

ACC/OCC Date
Claim Submission Date
Current Carrier Balance
Insurance Collector Phone Number
Insurance Collector Extension
Insurance Collector Name
Insurance Last F/U Date
Insurance Last Payment Date
Patient Name
Provider Phone Number
UB Provider Claim Number

Patient Bill Messages Data Base Elements

Admitting Diagnosis Code
Admitting Diagnosis Description
Amount of Payments - Account
Amount of Payments - Patient
Biller Name - Primary
Biller Phone Extension
Biller Phone Number
Last Service Date

Last Payment Date - Account
Last Payment Date - Patient
Provider Phone Number
UB Provider Claim Number

Refund Check Messages Data Base Elements

2nd Address
Account Number
Cert/SSN/HIC ID Number
Contract Number
Insurance Carrier/Plan Name
Insurance Group Number

Telephone Messages Data Base Elements

ACC/OCC Date
Account Restart Amount
Current Carrier Balance
Guarantor Restart Amount
Insurance Last Payment Date
Provider Phone Number
UB Provider Claim Number

NETWORK PRODUCT CLASS

Level   0

Matrix#   75

The following Network Product Class types are maintained in the system by McKesson and cannot be changed:

Code	Description
F	Financials
L	Laboratory
C	STAR Patient Care
P	Pharmacy
X	Radiology

OPTIONAL BATCH JOBS

Level   0

Matrix#   76

The following Optional Batch Jobs values are maintained in the system by McKesson and cannot be changed:

Code	Description
20	CCA Interface
27	Active Patient Workfile
18	Agency Cash and Adjustment Report
31	AP Daily Distribution Register
11	AP PO Distr. Invoice Report
32	AP Recurring Invoice Request
10	AP Refund Invoice
3	AR to Bad Debt Transfer
12	Archive Selection
37	Bad Debt Charge Deletion
4	Bad Debt Pre-List Report
8	Bad Debt Pre-List Selection
13	Bad Debt to Archive Pre-List Report
2	Bad Debt to Archive Pre-List Selection
30	Billed Accounts Report by Financial Class
54	Biller Statistics
80	Biller Statistics Summary Report
36	British Columbia Invoice Report
44	Charge Summary Interface
47	Claim Audit Report
24	Claims Prints Suppressed
112	Claim Index and Workfile Repair
51	Claim Reload
35	Claims Generated but Not Submitted Report
23	Claims on Hold Report

Code	Description
6	Claims Submitted but Unpaid Report
21	Coll Agency Analysis - Detail
22	Coll Agency Analysis - Summary
5	Coll Agency Analysis Report
79	Collection Agency Stat Summary
53	Collection Agency Statistics
7	Collector Reassignment - Guarantor
38	Collector Reassignment - Insurance
55	Collector Statistics
81	Collector Statistics Summary Rpt
42	Contract Accounts Report
46	Contract Department Logs
71	Contract Revenue by Rev Dept Statistics
97	Contract Revenue by Rev Dept Statistics Summary
73	Contract Revenue Statistics
76	Contract Revenue Statistics Summary
104	Credit Balance Report by Carrier/Plan
103	Credit Balance Report by Financial Class
106	Cross Facility Bad Debt Prelist Report
107	Cross Facility Claims Generated - Not Submitted
108	Cross Facility Claims on Hold Report
109	Cross Facility Submitted but Unpaid Report
105	Cross Facility Unverified Insurance Report
15	Department Logs Report
33	Discharge Statistic Report
77	Discharge Statistic Summary Rpt
82	Doctor Census Admitting Stat Summary
56	Doctor Census Admitting Statistics
83	Doctor Census Attending Stat Summary
57	Doctor Census Attending Statistics
84	Doctor Revenue Admitting Stat Summary
58	Doctor Revenue Admitting Statistics
86	Doctor Revenue Attending Stat Summary
60	Doctor Revenue Attending Statistics

<u>Code</u>	<u>Description</u>
85	Doctor Revenue Ordering Stat Summary
59	Doctor Revenue Ordering Statistics
61	Employer Census Statistics
87	Employer Census Statistics Summary
62	Employer Revenue Statistics
88	Employer Revenue Statistics Summary
40	Financial Class Census Stat Summary
74	Financial Class Census Statistics
41	Financial Class Revenue Stat Summary
75	Financial Class Revenue Statistics
16	Financial Review Report
102	Insurance Small Balance Write-off Exceptions
63	Insurance Statistics
89	Insurance Statistics Summary
45	Journal Entry Interface
64	Late Charge Statistics
65	Medical Service Census Statistics
91	Medical Service Census Statistics Summary
66	Medical Service Revenue Statistics
92	Medical Service Revenue Statistics Summary
67	Nurse Station Statistics
93	Nurse Station Statistics Summary
50	PA Fee Sch Reimb Report-Patient Specific
49	PA Fee Schedule Exceptions Report by Department
68	Patient Type Census Statistics
94	Patient Type Census Statistics Summary
69	Patient Type Revenue
95	Patient Type Revenue Summary
19	Pending Claims Report
100	Pending/Candidate Work File Report
34	Rebuild Descending Balance Worklists
43	Receivable Analysis Report
1	Revenue by Financial Group - Summary
9	Revenue Center by Financial Group

Code	**Description**
78	Revenue Center Stat Summary
52	Revenue Center Statistics
70	Transaction Statistics
96	Transaction Statistics Summary
101	Unbilled Accounts with Zero Charge Report
99	Unbilled Accounts Report
29	Unbilled Accounts Report by Financial Class
17	Unbilled Contract Accounts
25	Unverified Insurance Report
72	Zip Code Statistics
98	Zip Code Statistics Summary

AGENCY BATCH JOB PROCESSOR

Level   0

Matrix#   122

This function enables you to schedule an agency batch job run. After you select this option, the system prompts you to enter an agency code or leading characters and a hyphen (-) to display a list of agencies. You can specify the batch job by entering the specific agency code, or by doing a look-up.

Code   (Display Only)

Displays the agency code for this job.

Description   (Display Only)

Displays the description of the agency selected.

Frequency Type   (Circle One)   I   D   W

Determines the frequency type with which the job should be run. Entry options are I for Interval, D for specified day of the month, and W for a specified day within a certain week of the month.

Starting/Next Date   (6N)   ☐☐ / ☐☐ / ☐☐

Contains the starting date on which the Pre-Collection batch job is scheduled to run. This date is automatically incremented after the job is run based on the frequency defined for the job. Enter the starting date to establish a Pre-Collection batch job. To change the next run date, enter the new date on which the job should be run.

NOTE: In order to cancel an existing job, access this field and press ENTER when you are prompted for the new starting/next run date. You will then receive the following prompt:

Do you wish to continue this job? (Y/N)

Enter **Y** to discontinue the job. Cancel appears as the Starting/Next Date.
Once the screen is accepted, the Pre-Collection batch job is cancelled.

Daily Interval/Day of Month/Day-Week of Month

Entry options for this field are determined based on the frequency type selected. If you
select Interval, you are prompted to enter a daily interval from 1-365. An entry of 1 means
that the Pre-Collection batch job will run every day. If you select Day of Month, you are
prompted to enter the day of the month from 1-28 or L for the last day of the month. An
entry of 15 means that the Pre-Collection batch job will run on the 15th of every month. If
you selected Day-Week of Month, you are first prompted to enter the day of the week
(1=Sun, 2=Mon, for example), and then for the week of the month from 1-4 or L for the last
week of the month. For example, an entry of 2 for the day of the week and L for the week of
the month means that the Pre-Collection batch job will run on the last Monday of the month.

Last Run Date   (Display Only)

Contains the date of the last PCJ job run.

Description   (Display Only)

Displays the description of the Pre-Collection agency selected.

PATIENT INDICATORS

Level   0

Matrix#   78

The following patient indicators are maintained in the system by McKesson and cannot be changed.

<u>Code</u>	<u>Description</u>
E	Emergency
I	Inpatient
O	Outpatient

SELECTION SORT OPTION

Level   0

Matrix#   94

The following Selection Sort Option types are used in creating the Account Selection report. They are maintained in the system by McKesson and cannot be changed.

Code	Description
1	Biller Code
2	Insurance Collector Code
3	Patient Name
4	Patient Number
5	Descending Balance Account
6	Descending Balance Patient
7	Descending Balance Ins.
8	Age Category
9	Insurance Carrier/Plan
10	Financial Class
11	Guarantor Name
12	Patient Collector Code
13	Descending Bal Acct (Guar)
14	Descending Bal Pat (Guar)
15	Descending Bal Ins (Guar)

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SORT ELEMENTS

Level   0

Matrix#   96

The following Sort Elements are used in creating special forms and report. They are maintained in the system by McKesson and cannot be changed.

Code	Description
ATT	Attending Physician
BC	Biller Code
BC1	BC1 Biller Code Claim Level
CR	Carrier Code
CR_PL	Carrier/Plan Code
CA	Collection Agency
CC	Collector Code
SC	Collection Schedule
VC	VC Contract Code
FVNM	FVNM Contract Name
DAB	Descending Account Balance
DD	Discharge Date
FC	Financial Class
GCN	Guarantor Corporate Number
FGNM	Guarantor Name
GN	Guarantor Number
MRN	Medical Records Number
MS	Medical Service
ZC	Guarantor Zip Code
IZ	Insurance Carrier Zip Code
EN	Patient Account Number
PI	Patient Indicator
FPNM	Patient Name
PT	Patient Type
RI	Registration Initials

SORT KEYS

Level 0

Matrix# 97

These Sort Keys are used on forms having sort options. They are maintained in the system by McKesson and cannot be changed.

Code	Description
B	1500 Claims
BA	1500 Claims - Archive
CL	2360 Claim
LA	2360 Claim - Archive
A	Archive Statements
BC	Bad Debt Collection Letters
BZ	Bad Debt Detail Statements
YA	Canada Patient Bill Claims - Archive
CY	Canada Patient Bill Claims
N	Collection Agency Notification
Y	Collection Agency Statements
C	Collection Letters
V	Contract Bills
VS	Contract Statements
E	Data Entry Claims
M	Datamailers
Z	Detail Statements
FBC	Failed Bill Requirements by Control Code
F	Financial Review Report
I	Insurance Follow-Up Letters
CA	MA 310 I/P Claim
AA	MA 310 I/P Claim - Archive
DA	MA 319 Medical Services - Archive
CD	MA 319 Medical Services Claim
DCA	MA 319 Physician Invoice - Archive

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Code	**Description**
CC	MA 319 Physician Invoice Claim
CI	Medi-Cal I/P Claim
IA	Medi-Cal I/P Claim - Archive
CO	Medi-Cal O/P Claim
OA	Medi-Cal O/P Claim - Archive
CJ	Medi-Cal 25-1 Claim
JA	Medi-Cal 25-1 Claim Archive
CR	Medi-Cal UB Claim
RA	Medi-Cal UB Claim Archive
CG	Michigan 1500 Claim
GA	Michigan 1500 Claim - Archive
CE	Michigan I/P Claim
EA	Michigan I/P Claim - Archive
CF	Michigan O/P Claim
FA	Michigan O/P Claim - Archive
CN	New Jersey MC19 Claim
NA	New Jersey MC19 Claim Archive
CT	New York Title XIX Claim
TA	New York Title XIX Claim - Archive
CZ	Non Pro Fee 1500
AZ	Non Pro 1500 Claim Archive
H	Patient Bills
U	UB82 Claims
UA	UB82 Claims - Archive
X	UB Claims
XA	UB Claims - Archive
UAZ	Unbilled Accounts with Zero Charges
CK	Universal Claims
KA	Universal Claims - Archive
CW	WCB Claim
WA	WCB Claim Archive

SORT OPTIONS

Level   0

Matrix#   98

These Sort Options are used in generating the Account Selection report. They are maintained in the system by McKesson and cannot be changed.

Code	Description
1	Biller Code
2	Insurance Collector Code
3	Patient Name
4	Patient Number
5	Descending Balance Account
6	Descending Balance Patient
7	Descending Balance Ins.
8	Age Category
9	Insurance Carrier/Plan
10	Financial Class
11	Guarantor Name
12	Patient Collector Code
13	Descending Bal Acct (Guar)
14	Descending Bal Pat (Guar)
15	Descending Bal Ins (Guar)
16	Financial Patient Class

STATISTICS CODES

Level   0

Matrix#   100

The following Statistics Codes are used in maintaining GL statistics. They are maintained in the system by McKesson and cannot be changed.

Code	**Description**
CHG	Charge Amount
CHQ	Charge Quantity
DD	Discharge Days
FTE	Full Time Equivalents
HRS	Salary Hours
LCA	Late Charge Amount
LCQ	Late Charge Quantity
ADM	Number of Admissions
DIS	Number of Discharges
EXP	Number of Expirations
ITR	Number of Internal Transfers
OPV	Number of O/P Departmental VI
ODS	Number of One Day Stays
PTD	Number of Patient Days
REG	Number of Registrations
TRI	Number of Transfers In
TRO	Number of Transfers Out
OIB	Outpatients in Beds
RVL	Relative Value
UOS	Units of Service

STATISTICS GROUPS

Level   0

Matrix#   101

These Statistic Groups are used in maintaining patient accounting statistics. They are maintained in the system by McKesson and cannot be changed.

<u>Code</u>	<u>Description</u>
AGY	Collection Agency Statistics
BIL*	Biller Statistics
COL*	Collector Statistics
CON	Contract Statistics (Contract Sort)
COR	Contract by Revenue Department Statistics
DCA	Doctor Census Admitting Statistics
DIS	Discharge Statistics
DCT	Doctor Census Attending Statistics
DRA	Doctor Revenue Admitting Statistics
DRO	Doctor Revenue Ordering Statistics
DRT	Doctor Revenue Attending Statistics
EMP	Employer Census Statistics
EMR	Employer Revenue Statistics
FCC	Financial Class Census Statistics
FCR	Financial Class Revenue Statistics
IST	Insurance Statistics
LCP	Late Charge Statistics
MED	Medical Service Census Statistics
MER	Medical Service Revenue Statistics
NUR	Nurse Station Statistics
PAT	Patient Type Census Statistics
PTR	Patient Type Revenue Statistics
REV	Revenue Center Statistics
TRC*	Transaction Statistics

Code   **Description**

ZIP   Zip Code Statistics

* Can be used to track daily statistics

STATISTICS KEYS

Level   0

Matrix# 102

The following Statistics Keys are maintained in the system by McKesson and cannot be changed:

Code	Description
DRA	Admitting Physician
DRT	Attending Physician
BC	Biller Code
CR	Carrier Code
CR_PL	Carrier/Plan Code
CB	COB
CA	Collection Agency Code
CC	Collector Code
VC	Contract Code
EE	Employer Code
FC	Financial Class
MS	Medical Service
NS	Nurse Station
DRO	Ordering Physician
PI	Patient Indicator
PT	Patient Type
PL	Plan Code
PS	Proration Summary Code
RD	Revenue Department
SD	SIM Department
SI	SIM Item
TC	Transaction Code
TT	Transaction Type
UB	UB82 Revenue Code
VC	Contract Code
ZC	Zip Code

TRANSACTION SUMMARIES

Level 0

Matrix# 110

The following Transaction Summaries are used to group similar transactions. They are maintained in the system by McKesson and cannot be changed.

<u>Code</u>	<u>Description</u>
A	Adjustments
B	Billing/Claims
C	Cash
M	Memo
N	Notes
R	Refunds
T	Status Transfers

TRANSACTION TYPES

Level   0

Matrix#   111

These Transaction Types are maintained in the system by McKesson and cannot be changed:

<u>Code</u>	<u>Use</u>	<u>Description</u>
T	P	Account Notes
A	P	Adjustment*
E	P	Agency Cash Agency Collected*
B	P	Balance Transfer
Z	P	Claims Processing
V	N	Collection Agency Fees*
I	P	Insurance Payment*
D	P	Insurance Refund*
F	N	Miscellaneous Cash*
O	V	Miscellaneous Notes
N	V	Nonpatient Cash*
G	V	Other Adjustments*
J	N	Other Refunds*
Y	P	Patient Bills
P	P	Payment
R	P	Refund*
S	P	Status Transfer
M	P	System Memos
U	U	Unapplied Cash*

Transaction Type Code Uses

N - Not patient-specific

P - Patient-specific

U - Unapplied cash-specific

V - Vendor-specific (not currently implemented)

Chapter 3 - LEVEL 1

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INTRODUCTION

Level 1 includes the following worksheets to complete the following tables. You must complete these worksheets before beginning Level 2.

- Alternate Summary Code

- ERA Bill Type Codes

- Claim Load and Edit Parameters (US ONLY)

- Claim Load and Edit Parameters (CN ONLY)

- Canadian Claim Types (CN ONLY)

- Credit Rating

- Data Control Codes

- Data Mailer Messages

- Detail Statement Messages

- Contract Statement Messages

- Diagnostic Revenue Code (US ONLY)

- ERA Facility/Provider Mapping (US ONLY)

- ERA Claim Adjustment Groups

- ERA Claim Status Codes

- ERA Claim Filing Indicator

- ERA Remarks Codes

- Facility Information (Patient Bill Format)

- Facility Information (Contract Bill Format)

- Facility Information (Sort Sequences)

- Facility Information (Biller/Collector Worklist Control)

- Follow-up Letter Messages

- GL Mapping Table Definition

- HCPCS Summarization Master (US ONLY)

- Hospital Employees

- Insurance Carrier

- Insurance Messages

- Memo Collection Letter Messages

- Memo Detail Statement Messages

- Patient Bill Message

- Pathways Contract Management Interface - Reimbursement Master

- Payer HCPCS Cross Reference (US ONLY)

- Place of Service (US ONLY)

- Procedure Coding Method

- Proration Summary Code

- Provider Level Adjustment Reason Code (US ONLY)

- Provider Master (CN ONLY)

- Provider Master (US ONLY)

- Refund Check Messages

- Reimbursement Payor Code

- Source of Payment

- Statistics Groups Keys

- Statistics Retention

- Contract Telephone Messages

- Telephone Messages

- Maintain Log ID (US ONLY)

- Transaction Codes

- Type of Service

- UB Condition Codes/Special Statistics Codes

- UB Occurrence Codes (US ONLY)

- UB Occurrence Span Codes (US ONLY)

- UB Revenue Codes/Insurance Summary Codes

- UB Value Codes (US ONLY)

ALTERNATE SUMMARY CODE

Level 1	Matrix# 5	Facility:

The Alternate Summary Code tables (1, 2, and 3) enable you to set up a summary category for groups of like charges. The codes entered can be used for bill and claim form summary and are tied to an individual item in the STAR Patient Care Financial Item Master. This table can be split by facility.

In Canada, the Alternate Summary Code table is used to set up summary categories for the WCB claim form. Alternate Summary Codes 2 and 3 are used as follows:

Alternate Summary Code 2

> Any entry here is used to summarize charges by Diff Code. These are used by the WCB   Inpatient and WCB Community Clinic claim forms.

Alternate Summary Code 3

> Any entry here is used to summarize charges for inclusion into the various types of WCB claim forms (L - Lab, O - Outpatient, C - Community Clinic, T - Therapy, R - Radiology, or I - Inpatient).

The codes entered here can be used for final and cycle bills. As a summary category, these codes are linked with individual items in the STAR Patient Care Financial Item Master. There are three Alternate Summary Code tables available and each one is set up in the same manner. These tables can be split by facility.

Code ☐☐☐☐ (4N)

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| I

Code ☐☐☐☐ (4N)

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Code ☐☐☐☐ (4N)

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Code ☐☐☐☐ (4N)

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

ERA BILL TYPE CODES

Level 1	Matrix# 7a	Facility:

The ERA Bill Type Codes table provides a listing of the UB bill types for which you want to establish processing exceptions for the Part A 835 Health Care Claim Payment/ Advice standard. The payment file definition allows you to enter bill type exceptions which enable you to create a separate cash batch by bill type. The table is not split by facility. The code identifies the UB bill type.

Code   (2N)

The bill type code.

Description

(24AN)

The description of the UB bill type code.

Short Description   (10AN)

The abbreviated description of the UB bill type code that is used in the batch description of the resulting insurance cash/batch from an uploaded ANSI 835 payment file.

Code   (2N)

Description

(24AN)

Short Description   (10AN)

CLAIM LOAD AND EDIT PARAMETERS - (US ONLY)

Code   ☐☐   (3A)

Level 1	Matrix# 16	Facility:

These parameters define the load criteria of the UB, 1500 and state claim forms. They are entered in the Insurance Plan Coverage master and are used during claim loading and editing.

Claim Format   (Circle one)   UB   1500   Non Pro Fee 1500   State _____

Claim Format   This field contains the claim format, depending on which version of the claim is selected for the Claim Load Edit Parameter.   ☐☐☐   (3AN)

Description (30AN)

Begin Date   Date on which claim parameter becomes active in system   ☐☐☐

End Date   Last date on which claim parameter is active in system   ☐☐☐

Media (circle one)   P=paper only, E=electronic only, B=paper & electronic   P   E   B

Electronic Types (circle one)   Types of claims that will be spooled to electronic spoolfiles; A=adjustment, C=cycle, F=final, L=late, R=reprint claims, T = Tracer   A   C   F   L   R   T

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Start Detail (3N)   Line number on the claim form where detail charges should begin printing. (19 on UB, 21 on the 1500). If the form is copied from McKesson masters, this field is supplied.

Stop Detail (3N)   Line number on the claim form where detail charges should stop printing (41 on UB, 43 on 1500). If the form is copied from McKesson masters, this field is supplied.

Load $0.00 Claim   The laim types that can be loaded even when there are no charges to load on the claim: Adjustment Claims, Cycle Claims, Final Claims, Late Claims, Reprint Claims, Cycle Adjustment Claims, and Tracer Claims

Top Line Blank?   Print a blank top margin for UB, 1500 or Non Professional Fee 1500 claim types. Circle Yes or No.

Y	N	

Generation Pending (1A)   Regenerate Claim Programs and Screen?   Y   N
Circle Y for Yes or N for No.

Diagnoses for 1500 Locator 21

Indicate the order that both Medical Records and Charge level diagnoses should be loaded into Locator 21 of the 1500 claim form.

1st Choice

2nd Choice

3rd Choice

4th Choice

5th Choice

6th Choice

7th Choice

DPW Med Info

Extract additional (D)iagnoses, (P)rocedures, (B)oth DX and Proc, HCPCS (H), (A)ll, or (N)one for DPW accounts [N]--   D   P   B   H   A   N

Use ADM Prin/.Sec Dx for Combine Bill/DPW Med Info

Use Admission Prin/Sec Dx for Med Info if no Med Recs Prin/Sec Dx for From Account (Y/N)--   Y   N

Circle Y for Yes or N for No.

UB Loc 54 Prior Pymt Calc

indicates whether UB Locator 54 reflects insurance payments and adjustments, as well as any of the following: Coinsurance from Cash Posting, Deductible from Cash Posting, Co-Pay from Cash Posting, Pat Resp from Cash Posting.   Y   N

Circle Y for Yes or N for No.

ICD10 Effective Date   This field specifies the beginning admission date
                                     or discharge date of ICD-10 diagnosis and
                                     procedure code requirements for payers assigned
                                     this Claim Load Edit Parameter.

Combi   Indicate the type(s) of additional medical information to be
ne Bill   extracted to complete a combined bill claim for a Charge To
Med   account: *(D)iagnoses, (P)rocedures, (B)oth, or (N)one.*
Info

D	P	B

NY Claim Type   Indicate, for New York claims, the   **A   P   S   O   N   G**
(1A)   reimbursement rate used for the
                          claim: New York (A)LC, NY (P)AS/Clinic
                          Rate, NY PA(S)/No Clinic Rate, NY
                          (O)ther, NY Ap (G), or (N)one [N]--
                          .

CA UB?   Should the UB claim should be processed for   Y   N
                          California Medicaid requirements.format.
                          Circle Y for Yes or N for No.

CA Modifier Table   Should the California Modifier Table be used   Y   N
                          for claims loading in the California Medicaid
                          format. Circle Y for Yes or N for No.

CLAIM LOAD AND EDIT PARAMETERS - (CN ONLY)

Level 1	Matrix# 16a	Facility:

These parameters define the load criteria of the UB, 1500 and state claim forms. They are entered in the Insurance Plan Coverage master and are used during claim loading and editing.

Claim Types   (Circle one)   MOH   UNV   WCB   Non Pro Fee 1500

Claim Parameter   Defines basic format and how trans. to carrier   ☐☐☐ (3AN)

Claim Parameter Description (30AN)

Begin Date   Date on which claim parameter becomes active in system   ☐☐☐☐☐☐

End Date   Last date on which claim parameter is active in system   ☐☐☐☐☐☐

Claim Media (circle one)   P=paper only, E=electronic only, D=Diskette,   P   E   D   B
B=paper & electronic

   NOTE: MOH must be set for Diskette

Electronic Types (circle one)   Types of claims that will be spooled to electronic   A   C   F   L   R
spoolfiles; A=adjustment, C=cycle, F=final,
L=late, R=reprint claims

NOTE: Not applicable for MOH Claims

Start Detail (3N)   Line number on the claim form where detail charges should begin printing. (79 on MOH, 53 on UNV, 12 on WCB). If the form is copied from McKesson masters, this field is supplied.

Stop Detail (3N)   Line number on the claim form where detail charges should stop printing (79 on MOH, 58 on UNV, 19 on WCB). If the form is copied from McKesson masters, this field is supplied.

Generation Pending (1A)   Regenerate Claim Programs and Screen?   Circle   Y   N Y for Yes or N for No.

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CLAIM FORM EDIT PARAMETERS (US ONLY)

Level 1	Matrix# 16	Facility:

1500 and UB Forms

Use the following worksheets to set up the 1500, Non Professional Fee 1500, and UB forms as used by your hospital. If your base STAR Financials system is available, you can print these master forms through the Claim Load and Edit parameters.

Each set of worksheets includes two sections. The first section documents the McKesson Master Parameter Setup, which conforms to Medicare regulations. The second set of worksheets are blank. Use the second set of worksheets to define the requirements specific to your facility, such as whether a specific form locator should be printed, renamed, edited against specified valid codes, print a default value, etc.

The system contains McKesson masters for each claim type, for example, claim type X-UB, claim type B-1500 (Revised 1992) and claim type Z - Non-Professional Fee 1500 Claim Forms.

Claim Form Edit Parameters

1500 Print for 1992

Claim Type B - 1500

Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
0	1	Insurance Company	N	N	4	38	45	X	N/A	N/A	Insurance Carrier/ Plan Name
0	2	Insurance Address Line 1	N	N	5	38	45	X	N/A	N/A	Insurance Address Line 1
0	3	Insurance Address Line 2	N	N	6	38	45	X	N/A	N/A	Insurance Address Line 2
0	4	Insurance City	N	N	7	38	20	X	N/A	N/A	Insurance City
0	5	Insurance State	N	N	7	59	2	X	N/A	N/A	Insurance State
0	6	Insurance Zip Code	N	N	7	63	10	X	N/A	N/A	Insurance Zip Code
1	1	Medicare Box	N	Y	10	1	1	A	X	X	N/A
1	2	Medicaid Box	N	Y	10	8	1	X	X	N/A	N/A
1	3	Champus Box	N	Y	10	15	1	X	X	N/A	N/A
1	4	Champva Box	N	Y	10	24	1	X	X	N/A	N/A
1	5	Group Box	N	Y	10	31	1	X	X	N/A	N/A
1	6	FECA Box	N	Y	10	39	1	X	X	N/A	N/A
1	7	Other Box	N	Y	10	45	1	X	X	N/A	N/A
1	8	Insured's Policy #	Y	Y	10	50	29	X	N/A	N/A	Cert/SSN/HIC ID Number
2	1	Patient Name	Y	Y	12	1	29	X	N/A	N/A	Patient Name

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Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
3	1	Patient's Birthdate	Y	Y	12	31	9	D	N/A	N/A	Patient Birthdate
3	2	Patient's Sex	Y	Y	12	42	6	X	F, M	N/A	Patient Sex
4	1	Insured's Name	N	Y	12	50	29	X	N/A	N/A	Insured's Name
5	1	Patient's Address 1	N	Y	14	1	29	X	N/A	N/A	Patient Address 1
5	2	Patient's City	Y	Y	16	1	24	X	N/A	N/A	Patient City
5	3	Patient's State	Y	Y	16	26	2	X	N/A	N/A	Patient State
5	4	Patient's ZIP	Y	Y	18	1	10	X	N/A	N/A	Patient ZIP Code
5	5	Patient's Phone	N	Y	18	14	14	X	N/A	N/A	Patient Phone Number
6	1	Patient Rel to Insured	Y	Y	14	33	16	X	C, O, P, S	N/A	1500 Patient Relation to Insured
7	1	Insured's Address Line	N	Y	14	50	29	X	N/A	N/A	Insured's Address 1
7	2	Insured's City	N	Y	16	50	23	X	N/A	N/A	Insured's City
7	3	Insured's State	N	Y	16	74	2	X	N/A	N/A	Insured's State
7	4	Insured's ZIP Code	N	Y	18	50	10	X	N/A	N/A	Insured's ZIP Code
7	5	Insured's Phone	N	Y	18	63	14	X	N/A	N/A	Insured's Phone Number
8	1	Marital Status	N	Y	16	35	13	X	D, M, O, P, S, U, W, X	N/A	Patient Marital Status
8	2	Employment	N	Y	18	35	1	X	X	N/A	1500 Employed Box MSP Info
8	3	Full Time Student	N	Y	18	41	1	X	X	N/A	Full Time Student Box

Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
8	4	Part Time Student	N	Y	18	47	1	X	X	N/A	Part Time Student Box
9	1	Other Insured's Name	N	Y	20	1	28	X	N/A	N/A	N/A
9	2	Other Insured Policy/ Group#	N	Y	22	1	28	X	N/A	N/A	N/A
9	3	Other Insured Birthdate	N	Y	24	1	8	D	N/A	N/A	Current Date
9	4	Other Insured's Sex	N	Y	24	18	7	X	F, M	N/A	Male Female Box
9	5	Other Ins Employer/ School	N	Y	26	1	28	X	N/A	N/A	N/A
9	6	Other Insurance Plan Name	N	Y	28	1	28	X	N/A	N/A	N/A
10	1	Employment Related	N	Y	22	35	7	X	N, Y	N/A	1500 Employment Rel Accident
10	2	Auto Accident Related	N	Y	24	35	7	Y	N, Y	N/A	1500 Auto Related Accident
10	3	Accident Place State	N	Y	24	46	2	X	N/A	N/A	N/A
10	4	Other Accident	N	Y	26	35	7	Y	N, Y	N/A	1500 Other Accident Related
10	5	Reserved - Local Use	N	Y	28	31	18	X	N/A	N/A	N/A
11	1	Insured's Group Number	N	Y	20	50	29	X	N/A	N/A	Insurance Group Number
11	2	Insured's Birthdate	N	Y	22	54	8	D	N/A	N/A	Insured's Birthdate
11	3	Insured's Sex	N	Y	22	68	8	X	F, M	N/A	Insured's Sex
11	4	Insured Employer/ School	N	Y	24	50	29	X	N/A	N/A	Insured's Employer Name

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Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
11	5	Insurance Plan Name	N	Y	26	50	29	X	N/A	N/A	Insurance Carrier/ Plan Name
11	6	Another Health Plan	N	Y	28	52	6	Y	N, Y	N/A	1500 Other Insurance Box
12	1	Patient Signature	N	Y	32	6	27	X	N/A	Signature on file	N/A
12	2	Signature Date	N	Y	32	36	8	D	N/A	N/A	Current Date
13	1	Auth Payment Signature	N	Y	32	56	20	X	N/A	Signature on file	N/A
14	1	Date of Onset of Symptoms	N	Y	34	2	8	D	N/A	N/A	1500 Onset of Systems
15	1	Prev Condition Date	N	Y	34	37	8	D	N/A	N/A	Current Date
16	1	Dt Pat Unable Work Fr	N	Y	34	54	8	D	N/A	N/A	Current Date
16	2	Dt Pat Unable Work Th	N	Y	34	68	8	D	N/A	N/A	Current Date
17	1	Refer Physician Name	N	Y	36	1	26	X	N/A	N/A	Doctor Name
17	2	Refer Physician ID #	N	Y	36	28	21	X	N/A	N/A	Doctor Other ID Number 1
18	1	Admission Date	N	Y	36	54	8	D	N/A	N/A	Admission Date
18	2	Discharge Date	N	Y	36	68	8	D	N/A	N/A	Discharge Date
19	1	Reserved for Local Use	N	Y	38	1	48	X	N/A	N/A	N/A
20	1	Outside Lab Work	N	Y	38	52	6	Y	N, Y	N/A	Yes No Flag
20	2	Outside Lab Charges	N	Y	38	62	7	M	N/A	N/A	N/A
21	1	Diagnosis Code - 1	Y	Y	40	3	6	X	N/A	N/A	1500 Diagnosis Box 21 - Field 1

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Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
21	2	Diagnosis Desc - 1	N	N	40	10	18	X	N/A	N/A	N/A
21	3	Diagnosis Code - 2	N	Y	42	3	6	X	N/A	N/A	1500 Diagnosis Box 21 - Field 2
21	4	Diagnosis Desc - 2	N	N	42	10	18	X	N/A	N/A	N/A
21	5	Diagnosis Code - 3	N	Y	40	30	6	X	N/A	N/A	1500 Diagnosis Box 21 - Field 3
21	6	Diagnosis Desc - 3	N	N	40	37	11	X	N/A	N/A	N/A
21	7	Diagnosis Code - 4	N	Y	42	30	6	X	N/A	N/A	1500 Diagnosis Box 21 - Field 4
21	8	Diagnosis Desc - 4	N	N	42	37	11	X	N/A	N/A	N/A
22	1	Medicaid Resubmission Code	N	Y	40	50	11	X	N/A	N/A	N/A
22	2	Original Reference Number	N	Y	40	62	17	X	N/A	N/A	N/A
23	1	Prior Authorization #	N	Y	42	50	29	X	N/A	N/A	N/A
25	1	Physician's Tax Id Number	N	Y	58	1	15	X	N/A	N/A	Doctor's Social Security Number
25	2	SSN - EIN Box	N	Y	58	17	4	X	E, S	S	1500 SSN & EIN Boxes
26	1	Patient Account Number	Y	Y	58	23	12	X	N/A	N/A	Account Number
27	1	Accept Assignment	Y	Y	58	38	6	Y	N, Y	Y	Yes No Flag
28	1	Total Charges	N	Y	58	52	9	M	N/A	N/A	Money
29	1	Amount Paid	N	Y	58	62	8	M	N/A	0	Money
30	1	Balance Due	N	Y	58	71	9	M	N/A	N/A	Money
31	1	Physician Name	Y	Y	63	5	11	X	N/A	N/A	Doctor Name

Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
31	2	Signature Date	Y	Y	63	19	8	D	N/A	N/A	Current Date
32	1	Provider Name	N	Y	60	23	25	X	N/A	N/A	1500 Provider Claim Name
32	2	Provider Address	N	Y	61	23	25	X	N/A	N/A	1500 Provider Street
32	3	Provider City	N	Y	62	23	11	X	N/A	N/A	Provider City
32	4	Provider State	N	Y	62	35	2	X	N/A	N/A	Provider State
32	5	Provider ZIP Code	N	Y	62	38	10	N	N/A	N/A	Provider ZIP Code
32	6	Mammography Certification	N	Y	63	29	21	X	N/A	N/A	N/A
33	1	Supplier Name	Y	Y	60	50	29	X	N/A	N/A	Doctor Name
33	2	Supplier Address	N	Y	61	50	29	X	N/A	N/A	Doctor Address Line 1
33	3	Supplier City	Y	Y	62	50	15	X	N/A	N/A	Doctor City
33	4	Supplier State	Y	Y	62	66	2	X	N/A	N/A	Doctor State
33	5	Supplier ZIP Code	Y	Y	62	69	10	N	N/A	N/A	Doctor ZIP Code
33	6	Supplier Phone	N	N	63	50	14	N	N/A	N/A	N/A
33	7	Supplier Pin #	N	Y	63	52	10	X	N/A	N/A	Doctor Other ID Number 1
33	8	Supplier GRP# ID #	Y	Y	63	67	12	X	N/A	N/A	Doctor's State License Number
34	1	Remarks	N	Y	65	1	30	X	N/A	N/A	N/A

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Claim Form Edit Parameters

1500 Print for 1992

Claim Type B - 1500

Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
0	1	Insurance Company									
0	2	Insurance Address Line 1									
0	3	Insurance Address Line 2									
0	4	Insurance City									
0	5	Insurance State									
0	6	Insurance Zip Code									
1	1	Medicare Box									
1	2	Medicaid Box									
1	3	Champus Box									
1	4	Champva Box									
1	5	Group Box									
1	6	FECA Box									
1	7	Other Box									
1	8	Insured's Policy #									
2	1	Patient Name									
3	1	Patient's Birthdate									

Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
3	2	Patient's Sex									
4	1	Insured's Name									
5	1	Patient's Address 1									
5	2	Patient's City									
5	3	Patient's State									
5	4	Patient's ZIP									
5	5	Patient's Phone									
6	1	Patient Rel to Insured									
7	1	Insured's Address Line									
7	2	Insured's City									
7	3	Insured's State									
7	4	Insured's ZIP Code									
7	5	Insured's Phone									
8	1	Marital Status									
8	2	Employment									
8	3	Full Time Student									
8	4	Part Time Student									
9	1	Other Insured's Name									
9	2	Other Insured Policy/ Group#									

Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
9	3	Other Insured Birthdate									
9	4	Other Insured's Sex									
9	5	Oth Ins Employer/ School									
9	6	Other Insurance Plan Name									
10	1	Employment Related									
10	2	Auto Accident Related									
10	3	Accident Place State									
10	4	Other Accident									
10	5	Reserved - Local Use									
11	1	Insured's Group Number									
11	2	Insured's Birthdate									
11	3	Insured's Sex									
11	4	Insured Employ/ School									
11	5	Insurance Plan Name									
11	6	Another Health Plan									
12	1	Patient Signature									
12	2	Signature Date									
13	1	Auth Payment Signature									

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Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
14	1	Date of Onset of Symptoms									
15	1	Prev Condition Date									
16	1	Dt Pat Unable Work Fr									
16	2	Dt Pat Unable Work Th									
17	1	Refer Physician Name									
17	2	Refer Physician ID #									
18	1	Admission Date									
18	2	Discharge Date									
19	1	Reserved for Local Use									
20	1	Outside Lab Work									
20	2	Outside Lab Charges									
21	1	Diagnosis Code - 1									
21	2	Diagnosis Desc - 1									
21	3	Diagnosis Code - 2									
21	4	Diagnosis Desc - 2									
21	5	Diagnosis Code - 3									
21	6	Diagnosis Desc - 3									
21	7	Diagnosis Code - 4									
21	8	Diagnosis Desc - 4									

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Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
22	1	Medicaid Resubmission Code									
22	2	Original Reference Number									
23	1	Prior Authorization #									
25	1	Physician's Tax ID Number									
25	2	SSN - EIN Box									
26	1	Patient Account Number									
27	1	Accept Assignment									
28	1	Total Charges									
29	1	Amount Paid									
30	1	Balance Due									
31	1	Physician Name									
31	2	Signature Date									
32	1	Provider Name									
32	2	Provider Address									
32	3	Provider City									
32	4	Provider State									
32	5	Provider ZIP Code									
32	6	Mammography Certification									

Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
33	1	Supplier Name									
33	2	Supplier Address									
33	3	Supplier City									
33	4	Supplier State									
33	5	Supplier ZIP Code									
33	6	Supplier Phone									
33	7	Supplier Pin									
33	8	Supplier GRP# ID #									
34	1	Remarks									

Claim Form Edit Parameter

Non-Professional Fee

Claim Type 1500

Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
0	1	Insurance Company	N	N	4	38	45	X	N/A	N/A	Insurance Carrier/ Plan Name
0	2	Insurance Address Line 1	N	N	5	38	45	X	N/A	N/A	Insurance Address Line 1
0	3	Insurance Address Line 2	N	N	6	38	45	X	N/A	N/A	Insurance Address Line 2
0	4	Insurance City	N	N	7	38	20	X	N/A	N/A	Insurance City
0	5	Insurance State	N	N	7	59	2	X	N/A	N/A	Insurance State

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Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
0	6	Insurance Zip Code	N	N	7	63	10	X	N/A	N/A	Insurance Zip Code
1	1	Medicare Box	N	Y	10	1	1	A	X	N/A	N/A
1	2	Medicaid Box	N	Y	10	8	1	X	X	X	N/A
1	3	Champus Box	N	Y	10	15	1	X	X	N/A	N/A
1	4	Champva Box	N	Y	10	24	1	X	X	N/A	N/A
1	5	Group Box	N	Y	10	31	1	X	X	N/A	N/A
1	6	FECA Box	N	Y	10	39	1	X	X	N/A	N/A
1	7	Other Box	N	Y	10	45	1	X	X	N/A	N/A
1	8	Insured's Policy #	Y	Y	10	50	29	X	N/A	N/A	Cert/SSN/HIC ID Number
2	1	Patient Name	Y	Y	12	1	29	X	N/A	N/A	Patient Name
3	1	Patient's Birthdate	Y	Y	12	31	9	D	N/A	N/A	Patient Birthdate
3	2	Patient's Sex	Y	Y	12	42	6	X	F, M	N/A	Patient Sex
4	1	Insured's Name	N	Y	12	50	29	X	N/A	N/A	Insured's Name
5	1	Patient's Address 1	N	Y	14	1	29	X	N/A	N/A	Patient Address 1
5	2	Patient's City	Y	Y	16	1	24	X	N/A	N/A	Patient City
5	3	Patient's State	Y	Y	16	26	2	X	N/A	N/A	Patient State
5	4	Patient's ZIP	Y	Y	18	1	10	X	N/A	N/A	Patient ZIP Code
5	5	Patient's Phone	N	Y	18	14	14	X	N/A	N/A	Patient Phone Number
6	1	Patient Rel to Insured	Y	Y	14	33	16	X	C, O, P, S	N/A	1500 Patient Relation to Insured
7	1	Insured's Address Line	N	Y	14	50	29	X	N/A	N/A	Insured's Address 1
7	2	Insured's City	N	Y	16	50	23	X	N/A	N/A	Insured's City

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Chapter 3 - LEVEL 1

Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
7	3	Insured's State	N	Y	16	74	2	X	N/A	N/A	Insured's State
7	4	Insured's ZIP Code	N	Y	18	50	10	X	N/A	N/A	Insured's ZIP Code
7	5	Insured's Phone	N	Y	18	63	14	X	N/A	N/A	Insured's Phone Number
8	1	Marital Status	N	Y	16	35	13	X	D, M, O, P, S, U, W, X	N/A	Patient Marital Status
8	2	Employment	N	Y	18	35	1	X	X	N/A	1500 Employed Box MSP
8	3	Full Time Student	N	Y	18	41	1	X	X	N/A	Full Time Student Box
8	4	Part Time Student	N	Y	18	47	1	X	X	N/A	Part Time Student Box
9	1	Other Insured's Name	N	Y	20	1	28	X	N/A	N/A	N/A
9	2	Other Insured Policy/Group#	N	Y	22	1	28	X	N/A	N/A	N/A
9	3	Other Insured Birthdate	N	Y	24	1	8	D	N/A	N/A	Current Date
9	4	Other Insured's Sex	N	Y	24	18	7	X	F, M	N/A	Male Female Box
9	5	Oth Ins Employer/ School	N	Y	26	1	28	X	N/A	N/A	N/A
9	6	Other Insurance Plan Name	N	Y	28	1	28	X	N/A	N/A	N/A
10	1	Employment Related	N	Y	22	35	7	X	N, Y	N/A	1500 Employment Rel Accident
10	2	Auto Accident Related	N	Y	24	35	7	Y	N, Y	N/A	1500 Auto Related Accident
10	3	Accident Place State	N	Y	24	46	2	X	N/A	N/A	N/A
10	4	Other Accident	N	Y	26	35	7	Y	N, Y	N/A	1500 Other Accident Related

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Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
10	5	Reserved - Local Use	N	Y	28	31	18	X	N/A	N/A	N/A
11	1	Insured's Group Number	N	Y	20	50	29	X	N/A	N/A	Insurance Group Number
11	2	Insured's Birthdate	N	Y	22	54	8	D	N/A	N/A	Insured's Birthdate
11	3	Insured's Sex	N	Y	22	68	8	X	F, M	N/A	Insured's Sex
11	4	Insured Employer/ School	N	Y	24	50	29	X	N/A	N/A	Insured's Employer Name
11	5	Insurance Plan Name	N	Y	26	50	29	X	N/A	N/A	Insurance Carrier/ Plan Name
11	6	Another Health Plan	N	Y	28	52	6	Y	N, Y	N/A	1500 Other Insurance Box
12	1	Patient Signature	N	Y	32	6	27	X	N/A	Signature on file	N/A
12	2	Signature Date	N	Y	32	36	8	D	N/A	N/A	Current Date
13	1	Auth Payment Signature	N	Y	32	56	20	X	N/A	Signature on file	N/A
14	1	Date of Onset of Symptoms	N	Y	34	2	8	D	N/A	N/A	1500 Onset of Symptoms
15	1	Prev Condition Date	N	Y	34	37	8	D	N/A	N/A	Current Date
16	1	Dt Pat Unable Work Fr	N	Y	34	54	8	D	N/A	N/A	Current Date
16	2	Dt Pat Unable Work Th	N	Y	34	68	8	D	N/A	N/A	Current Date
17	1	Refer Physician Name	N	Y	36	1	26	X	N/A	N/A	Doctor Name
17	2	Refer Physician ID #	N	Y	36	28	21	X	N/A	N/A	Doctor's State License Number
18	1	Admission Date	N	Y	36	54	8	D	N/A	N/A	Admission Date
18	2	Discharge Date	N	Y	36	68	8	D	N/A	N/A	Discharge Date

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Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
19	1	Reserved for Local Use	N	Y	38	1	48	X	N/A	N/A	N/A
20	1	Outside Lab Work	N	Y	38	52	6	Y	N, Y	N/A	Yes No Flag
20	2	Outside Lab Charges	N	Y	38	62	7	M	N/A	N/A	N/A
21	1	Diagnosis Code - 1	Y	Y	40	3	6	X	N/A	N/A	Principal or Working Diag Code
21	2	Diagnosis Desc - 1	N	N	40	10	18	X	N/A	N/A	Principal or Working Diag Desc
21	3	Diagnosis Code - 2	N	Y	42	3	6	X	N/A	N/A	Secondary Diagnosis Code
21	4	Diagnosis Desc - 2	N	N	42	10	18	X	N/A	N/A	Other Diagnosis Description 1
21	5	Diagnosis Code - 3	N	Y	40	30	6	X	N/A	N/A	Other Diagnosis Code 2
21	6	Diagnosis Desc - 3	N	N	40	37	11	X	N/A	N/A	Other Diagnosis Description 2
21	7	Diagnosis Code - 4	N	Y	42	30	6	X	N/A	N/A	Other Diagnosis Code 3
21	8	Diagnosis Desc - 4	N	N	42	37	11	X	N/A	N/A	Other Diagnosis Description 3
22	1	Medicaid Resubmission Code	N	Y	40	50	11	X	N/A	N/A	N/A
22	2	Original Reference Number	N	Y	40	62	17	X	N/A	N/A	N/A
23	1	Prior Authorization #	N	Y	42	50	29	X	N/A	N/A	N/A
25	1	Physician's Tax Id Number	N	Y	58	1	15	X	N/A	N/A	Provider Federal Tax ID
25	2	SSN - EIN Box	N	Y	58	17	4	X	E, S	E	1500 SSN & EIN Boxes
26	1	Patient Account Number	Y	Y	58	23	12	X	N/A	N/A	Account Number

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Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
27	1	Accept Assignment	Y	Y	58	38	6	Y	N, Y	Y	Yes No Flag
28	1	Total Charges	N	Y	58	52	9	M	N/A	N/A	Money
29	1	Amount Paid	N	Y	58	62	8	M	N/A	0	Money
30	1	Balance Due	N	Y	58	71	9	M	N/A	N/A	Money
31	1	Physician Name	Y	Y	63	5	11	X	N/A	N/A	Doctor Name
31	2	Signature Date	Y	Y	63	19	8	D	N/A	N/A	Current Date
32	1	Provider Name	N	Y	60	23	25	X	N/A	N/A	1500 Provider Claim Name
32	2	Provider Address	N	Y	61	23	25	X	N/A	N/A	1500 Provider Street
32	3	Provider City	N	Y	62	23	11	X	N/A	N/A	Provider City
32	4	Provider State	N	Y	62	35	2	X	N/A	N/A	Provider State
32	5	Provider ZIP Code	N	Y	62	38	10	N	N/A	N/A	Provider ZIP Code
32	6	Mammography Certification	N	Y	63	29	21	X	N/A	NA/	N/A
33	1	Supplier Name	Y	Y	60	50	29	X	N/A	N/A	Provider Medicaid Claim Name
33	2	Supplier Address	N	Y	61	50	29	X	N/A	N/A	Provider Medicaid Street
33	3	Supplier City	Y	Y	62	50	15	X	N/A	N/A	Provider City
33	4	Supplier State	Y	Y	62	66	2	X	N/A	N/A	Provider State
33	5	Supplier ZIP Code	Y	Y	62	69	10	N	N/A	N/A	Provider ZIP Code
33	6	Supplier Phone	N	N	63	50	14	N	N/A	N/A	N/A
33	7	Supplier Pin #	N	Y	63	52	10	X	N/A	N/A	Provider Medicare Provider Number
33	8	Supplier GRP# ID #	Y	Y	63	67	12	X	N/A	N/A	N/A

Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
34	1	Remarks	N	Y	65	1	30	X	N/A	N/A	N/A

Claim Form Edit Parameters

Non-Professional Fee

Claim Type 1500

Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
0	1	Insurance Company									
0	2	Insurance Address Line 1									
0	3	Insurance Address Line 2									
0	4	Insurance City									
0	5	Insurance State									
0	6	Insurance Zip Code									
1	1	Medicare Box									
1	1	Medicare Box									
1	2	Medicaid Box									
1	3	Champus Box									
1	4	Champva Box									
1	5	Group Box									
1	6	FECA Box									
1	7	Other Box									
1	8	Insured's Policy #									

Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
2	1	Patient Name									
3	1	Patient's Birthdate									
3	2	Patient's Sex									
4	1	Insured's Name									
5	1	Patient's Address 1									
5	2	Patient's City									
5	3	Patient's State									
5	4	Patient's ZIP									
5	5	Patient's Phone									
6	1	Patient Rel to Insured									
7	1	Insured's Address Line									
7	2	Insured's City									
7	3	Insured's State									
7	4	Insured's ZIP Code									
7	5	Insured's Phone									
8	1	Marital Status									
8	2	Employment									
8	3	Full Time Student									
8	4	Part Time Student									
9	1	Other Insured's Name									
9	2	Other Insured Policy/ Group#									

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Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
9	3	Other Insured Birthdate									
9	4	Other Insured's Sex									
9	5	Oth Ins Employer/School									
9	6	Other Insurance Plan Name									
10	1	Employment Related									
10	2	Auto Accident Related									
10	3	Accident Place State									
10	4	Other Accident									
10	5	Reserved - Local Use									
11	1	Insured's Group Number									
11	2	Insured's Birthdate									
11	3	Insured's Sex									
11	4	Insured Employ/School									
11	5	Insurance Plan Name									
11	6	Another Health Plan									
12	1	Patient Signature									
12	2	Signature Date									
13	1	Auth Payment Signature									
14	1	Date of Onset of Symptoms									
15	1	Prev Condition Date									
16	1	Dt Pat Unable Work Fr									

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Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
16	2	Dt Pat Unable Work Th									
17	1	Refer Physician Name									
17	2	Refer Physician ID #									
18	1	Admission Date									
18	2	Discharge Date									
19	1	Reserved for Local Use									
20	1	Outside Lab Work									
20	2	Outside Lab Charges									
21	1	Diagnosis Code - 1									
21	2	Diagnosis Desc - 1									
21	3	Diagnosis Code - 2									
21	4	Diagnosis Desc - 2									
21	5	Diagnosis Code - 3									
21	6	Diagnosis Desc - 3									
21	7	Diagnosis Code - 4									
21	8	Diagnosis Desc - 4									
22	1	Medicaid Resubmission									
22	2	Original Reference No									
23	1	Prior Authorization #									
25	1	Physician's Tax ID Number									
25	2	SSN - EIN Box									

Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
26	1	Patient Account Number									
27	1	Accept Assignment									
28	1	Total Charges									
29	1	Amount Paid									
30	1	Balance Due									
31	1	Physician Name									
31	2	Signature Date									
32	1	Provider Name									
32	2	Provider Address									
32	3	Provider City									
32	4	Provider State									
32	5	Provider ZIP Code									
32	6	Mammography Certification									
33	1	Supplier Name									
33	2	Supplier Address									
33	3	Supplier City									
33	4	Supplier State									
33	5	Supplier ZIP Code									
33	6	Supplier Phone									
33	7	Supplier Pin									
33	8	Supplier Grp# ID #									

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Box	Field	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entry	Default Value	Internal Element
34	1	Remarks									

Claim Form Edit Parameters

UB Form

Field Type: **X**-Alphanumeric, **Y**-Yes, **N**-No, **D**-Date, **M**-Money, **N**-Numbers Only, **A**-Letters Only

Box	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entries	Default Value	Internal Element
1A	Provider Name	Yes	Yes	2	4	24	X			UB PROVIDER CLAIM NAME
1B	Provider Street Address	Yes	Yes	3	3	25	X			UB PROVIDER STREET
1C	Provider City	Yes	Yes	4	3	11	X			PROVIDER CITY
1D	Provider State	Yes	Yes	4	15	2	X			PROVIDER STATE
1E	Provider ZIP Code	Yes	Yes	4	18	10	X			PROVIDER ZIP CODE
1F	Provider Telephone Number	Yes	Yes	5	3	25	X			PROVIDER PHONE NUMBER
2A	UB Box 2 - Upper Line	No	Yes	2	30	29	X			
2B	UB Box 2 - Lower Line	No	Yes	3	29	30	X			
3	Patient Control Number	Yes	Yes	3	60	20	X			ACCOUNT NUMBER
4A	Type of Bill - First Digit	Yes	Yes	3	81	1	N		1	
4B	Type of Bill - Second Digit	Yes	Yes	3	82	1	N		user must set	UB BILL TYPE FOR O/P - 2ND DIGIT
4C	Type of Bill - Third Digit	Yes	Yes	3	83	1	N			UB BILL TYPE - 3RD DIGIT
5A	Federal Tax ID # Upper Line	No	Yes	4	35	4	X			
5B	Federal Tax ID # Lower Line	Yes	Yes	5	29	10	X			PROVIDER FEDERAL TAX ID

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Box	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entries	Default Value	Internal Element
6A	Statement Covers From Date	Yes	Yes	5	40	8	D			BILL FROM DATE
6B	Statement Covers Through Date	Yes	Yes	5	47	8	D			BILL THRU DATE
7	Covered Days	Yes	Yes	5	54	3	N			COVERED DAYS FOR BILL
8	Non-Covered Days	No	Yes	5	58	4	N			BILL TOTAL NON-COVERED DAYS
9	Coinsurance Days	No	Yes	5	63	3	N			UB COINSURANCE DAYS
10	Lifetime Reserve Days	No	Yes	5	67	3	N			UB LIFETIME RESERVE DAYS
11A	UB Box 11 - Upper Line	No	Yes	4	72	12	X			
11B	UB Box 11 - Lower Line	No	Yes	5	71	13	X			
12	Patient Name	Yes	Yes	7	3	30	X			PATIENT NAME
13A	Patient Address	Yes	Yes	7	34	25	X			PATIENT ADDRESS 1
13B	Patient City	Yes	Yes	7	60	10	X			PATIENT CITY
13C	Patient State	Yes	Yes	7	71	2	X			PATIENT STATE
13D	Patient Zip Code	Yes	Yes	7	74	10	X			PATIENT ZIP CODE
14	Patient Birthdate	Yes	Yes	9	3	10	D			PATIENT BIRTHDATE
15	Patient Sex	Yes	Yes	9	12	1	X	F,M,U		PATIENT SEX
16	Patient Marital Status	Yes	Yes	9	15	1	X			PATIENT MARITAL STATUS
17	Admission Date	Yes	Yes	9	17	8	D			ADMISSION DATE
18	Admission Hour	Yes	Yes	9	24	2	T			ADMISSION HOUR
19	Admission Type	Yes	Yes	9	28	1	N			ADMISSION TYPE CODE
20	Admit Source	Yes	Yes	9	31	1	N			ADMISSION SOURCE CODE
21	Discharge Hour	Yes	Yes	9	33	2	T			DISCHARGE HOUR

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Box	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entries	Default Value	Internal Element
22	Discharge Status	Yes	Yes	9	36	2	X		30	UB DISCHARGE STATUS
23	Medical Record Number	Yes	Yes	9	39	17	X			MEDICAL RECORD NUMBER
24	Condition Code 1	No	Yes	9	57	2	X			CONDITION CODE 1
25	Condition Code 2	No	Yes	9	60	2	X			CONDITION CODE 2
26	Condition Code 3	No	Yes	9	63	2	X			CONDITION CODE 3
27	Condition Code 4	No	Yes	9	66	2	X			CONDITION CODE 4
28	Condition Code 5	No	Yes	9	69	2	X			CONDITION CODE 5
29	Condition Code 6	No	Yes	9	72	2	X			CONDITION CODE 6
30	Condition Code 7	No	Yes	9	75	2	X			CONDITION CODE 7
31A	UB Box 31 - Upper line	No	Yes	8	79	5	X			
31B	UB Box 31 - Lower Line	No	Yes	9	78	6	X			
32A	Occurrence Code 32a	No	Yes	11	3	2	X			OCCURRENCE CODE 1
32B	Occurrence Date 32a	No	Yes	11	6	8	D			OCCURRENCE DATE 1
32C	Occurrence Code 32b	No	Yes	12	3	2	X			OCCURRENCE CODE 5
32D	Occurrence Date 32b	No	Yes	12	6	8	D			OCCURRENCE DATE 5
33A	Occurrence Code 33a	No	Yes	11	13	2	X			OCCURRENCE CODE 2
33B	Occurrence Date 33a	No	Yes	11	16	8	D			OCCURRENCE DATE 2
33C	Occurrence Code 33b	No	Yes	12	13	2	X			OCCURRENCE CODE 6
33D	Occurrence Date 33b	No	Yes	12	16	8	D			OCCURRENCE DATE 6
34A	Occurrence Code 34a	No	Yes	11	23	2	X			OCCURRENCE CODE 3
34B	Occurrence Date 34a	No	Yes	11	26	8	D			OCCURRENCE DATE 3
34C	Occurrence Code 34b	No	Yes	12	23	2	X			OCCURRENCE CODE 7

Box	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entries	Default Value	Internal Element
34D	Occurrence Date 34b	No	Yes	12	26	8	D			OCCURRENCE DATE 7
35A	Occurrence Code 35a	No	Yes	11	33	2	X			OCCURRENCE CODE 4
35B	Occurrence Date 35a	No	Yes	11	36	8	D			OCCURRENCE DATE 4
35C	Occurrence Code 35b	No	Yes	12	33	2	X			OCCURRENCE CODE 8
35D	Occurrence Date 35b	No	Yes	12	36	8	D			OCCURRENCE DATE 8
36A	Occurrence Span Code 36a	No	Yes	11	43	2	X			OCCURRENCE SPAN CODE 1
36B	Occurrence From Date 36a	No	Yes	11	46	8	D			OCCURRENCE SPAN FROM DATE 1
36C	Occurrence Through Date 36a	No	Yes	11	53	8	D			OCCURRENCE SPAN THRU DATE 1
36D	Occurrence Span Code 36b	No	Yes	12	43	2	X			OCCURRENCE SPAN CODE 2
36E	Occurrence Span From Date 36b	No	Yes	12	46	8	D			OCCURRENCE SPAN FROM DATE 2
36F	Occurrence Span Thru Date 36b	No	Yes	12	53	8	D			OCCURRENCE SPAN THRU DATE 2
37A	Internal Control Number 37a	No	Yes	10	61	23	X			
37B	Internal Control Number 37b	No	Yes	11	61	23	X			
37C	Internal Control Number 37c	No	Yes	12	61	23	X			
38A	Guarantor Name	Yes	Yes	13	4	40	X			GUARANTOR NAME
38B	Guarantor Address Line 1	Yes	Yes	14	3	40	X			GUARANTOR ADDRESS 1
38C	Guarantor Address Line 2	No	Yes	15	3	40	X			GUARANTOR ADDRESS 2
38D	Guarantor City	Yes	Yes	16	3	27	X			GUARANTOR CITY
38E	Guarantor State	Yes	Yes	16	31	2	X			GUARANTOR STATE
38F	Guarantor ZIP Code	Yes	Yes	16	34	10	X			GUARANTOR ZIP CODE
38G	Guarantor Phone Number	No	Yes	17	3	40	X			GUARANTOR PHONE

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Box	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entries	Default Value	Internal Element
39A	Value Code 39a	No	Yes	14	46	2	X			VALUE CODE 1
39B	Value Code Amount 39a	No	Yes	14	49	10	M			VALUE CODE 1 AMOUNT
39C	Value Code 39b	No	Yes	15	46	2	X			VALUE CODE 4
39D	Value Code Amount 39b	No	Yes	15	49	10	M			VALUE CODE 4 AMOUNT
39E	Value Code 39c	No	Yes	16	46	2	X			VALUE CODE 7
39F	Value Code Amount 39c	No	Yes	16	49	10	M			VALUE CODE 7 AMOUNT
39G	Value Code 39d	No	Yes	17	46	2	X			VALUE CODE 10
39H	Value Code Amount 39d	No	Yes	17	49	10	M			VALUE CODE 10 AMOUNT
40A	Value Code 40a	No	Yes	14	59	2	X			VALUE CODE 2
40B	Value Code Amount 40a	No	Yes	14	62	10	M			VALUE CODE 2 AMOUNT
40C	Value Code 40b	No	Yes	15	59	2	X			VALUE CODE 5
40D	Value Code Amount 40b	No	Yes	15	62	10	M			VALUE CODE 5 AMOUNT
40E	Value Code 40c	No	Yes	16	59	2	X			VALUE CODE 8
40F	Value Code Amount 40c	No	Yes	16	62	10	M			VALUE CODE 8 AMOUNT
40G	Value Code 40d	No	Yes	17	59	2	X			VALUE CODE 11
40H	Value Code Amount 40d	No	Yes	17	62	10	M			VALUE CODE 11 AMOUNT
41A	Value Code 41a	No	Yes	14	72	2	X			VALUE CODE 3
41B	Value Code Amount 41a	No	Yes	14	75	10	M			VALUE CODE 3 AMOUNT
41C	Value Code 41b	No	Yes	15	72	2	X			VALUE CODE 6
41D	Value Code Amount 41b	No	Yes	15	75	10	M			VALUE CODE 6 AMOUNT
41E	Value Code 41c	No	Yes	16	72	2	X			VALUE CODE 9
41F	Value Code Amount 41c	No	Yes	16	75	10	M			VALUE CODE 9 AMOUNT

Box	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entries	Default Value	Internal Element
41G	Value Code 41d	No	Yes	17	72	2	X			VALUE CODE 12
41H	Value Code Amount 41d	No	Yes	17	75	10	M			VALUE CODE 12 AMOUNT
50A	Payer Name 50a	No	Yes	43	3	25	X			INSURANCE CARRIER/PLAN NAME
50B	Payer Name 50b	No	Yes	44	3	25	X			INSURANCE CARRIER/PLAN NAME
50C	Payer Name 50c	No	Yes	45	3	25	X			INSURANCE CARRIER/PLAN NAME
51A	Payer Provider Number 51a	No	Yes	43	29	13	X			PROVIDER NUMBER-INSURANCE LEVEL
51B	Payer Provider Number 51b	No	Yes	44	29	13	X			PROVIDER NUMBER-INSURANCE LEVEL
51C	Payer Provider Number 51c	No	Yes	45	29	13	X			PROVIDER NUMBER-INSURANCE LEVEL
52A	Payer Release Information 52a	No	Yes	43	43	1	Y			UB RELEASE INFORMATION IND.
52B	Payer Release Information 52b	No	Yes	44	43	1	Y			UB RELEASE INFORMATION IND.
52C	Payer Release Information 52c	No	Yes	45	43	1	Y			UB RELEASE INFORMATION IND.
53A	Payer Benefits Assigned 53a	No	Yes	43	46	1	Y			UB ASSIGNMENT OF BENEFITS IND.
53B	Payer Benefits Assigned 53b	No	Yes	44	46	1	Y			UB ASSIGNMENT OF BENEFITS IND.
53C	Payer Benefits Assigned 53c	No	Yes	45	46	1	Y			UB ASSIGNMENT OF BENEFITS IND.
54A	Payer Prior Payments 54a	No	Yes	43	48	11	M			MONEY
54B	Payer Prior Payments 54b	No	Yes	44	48	11	M			MONEY
54C	Payer Prior Payment 54c	No	Yes	45	48	11	M			MONEY
54D	Patient Prior Payments	No	Yes	46	48	11	M			AMOUNT OF PYMTS-PATIENT

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Box	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entries	Default Value	Internal Element
55A	Payer Estimated Amount Due 55a	No	Yes	43	59	11	M			ESTIMATED AMOUNT DUE
55B	Payer Estimated Amount Due 55b	No	Yes	44	59	11	M			ESTIMATED AMOUNT DUE
55C	Payer Estimated Amount Due 55c	No	Yes	45	59	11	M			ESTIMATED AMOUNT DUE
55D	Payer Estimated Amount Due	No	Yes	46	59	11	M			PATIENT BALANCE
56A	UB Box 56 - Line 1	No	Yes	42	71	13	X			
56B	UB Box 56 - Line 2	No	Yes	43	70	14	X			
56C	UB Box 56 - Line 3	No	Yes	44	70	14	X			
56D	UB Box 56 - Line 4	No	Yes	45	70	14	X			
56E	UB Box 56 - Line 5	No	Yes	46	70	14	X			
57	UB Box 57	No	Yes	46	4	27	X			
58A	Insured's Name 58a	No	Yes	48	3	25	X			INSURED'S NAME
58B	Insured's Name 58b	No	Yes	49	3	25	X			INSURED'S NAME
58C	Insured's Name 58c	No	Yes	50	3	25	X			INSURED'S NAME
59A	Pat. Relation to Insured 59a	No	Yes	48	29	2	X			PATIENT RELATION TO INSURED
59B	Pat. Relation to Insured 59b	No	Yes	49	29	2	X			PATIENT RELATION TO INSURED
59C	Pat. Relation to Insured 59c	No	Yes	50	29	2	X			PATIENT RELATION TO INSURED
60A	CERT/SSN/HIC ID No. 60a	No	Yes	48	32	19	X			CERT/SSN/HIC ID NUMBER
60B	CERT/SSN/HIC ID No. 60b	No	Yes	49	32	19	X			CERT/SSN/HIC ID NUMBER
60C	CERT/SSN/HIC ID No. 60c	No	Yes	50	32	19	X			CERT/SSN/HIC ID NUMBER
61A	Group Name 61a	No	Yes	48	52	14	X			INSURANCE GROUP NAME
61B	Group Name 61b	No	Yes	49	52	14	X			INSURANCE GROUP NAME

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Box	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entries	Default Value	Internal Element
61C	Group Name 61c	No	Yes	50	52	14	X			INSURANCE GROUP NAME
62A	Insurance Group No. 62a	No	Yes	48	67	17	X			INSURANCE GROUP NUMBER
62B	Insurance Group No. 62b	No	Yes	49	67	17	X			INSURANCE GROUP NUMBER
62C	Insurance Group No. 62c	No	Yes	50	67	17	X			INSURANCE GROUP NUMBER
63A	Treatment Authorization 63a	No	Yes	52	3	18	X			INSURANCE APPROVAL #
63B	Treatment Authorization 63b	No	Yes	53	3	18	X			INSURANCE APPROVAL #
63C	Treatment Authorization 63c	No	Yes	54	3	18	X			INSURANCE APPROVAL #
64A	Employment Status Code 64a	No	Yes	52	22	1	N			INSURED'S EMPLOYMENT STATUS
64B	Employment Status Code 64b	No	Yes	53	22	1	N			INSURED 'S EMPLOYMENT STATUS
64C	Employment Status Code 64c	No	Yes	54	22	1	N			INSURED 'S EMPLOYMENT STATUS
65A	Employer Name 65a	No	Yes	52	24	24	X			INSURED'S EMPLOYER NAME
65B	Employer Name 65b	No	Yes	53	24	24	X			INSURED'S EMPLOYER NAME
65C	Employer Name 65c	No	Yes	54	24	24	X			INSURED'S EMPLOYER NAME
66A	Employer Location 66a	No	Yes	52	49	35	X			INSURED'S EMPLOYER LOCATION
66B	Employer Location 66b	No	Yes	53	49	35	X			INSURED'S EMPLOYER LOCATION
66C	Employer Location 66c	No	Yes	54	49	35	X			INSURED'S EMPLOYER LOCATION
67	Principal Diagnosis Code	Yes	Yes	56	3	6	X			PRINCIPAL DIAGNOSIS CODE
68	Other Diagnosis Code 1	No	Yes	56	10	6	X			SECONDARY DIAGNOSIS CODE
69	Other Diagnosis Code 2	No	Yes	56	17	6	X			OTHER DIAGNOSIS CODE 2
70	Other Diagnosis Code 3	No	Yes	56	24	6	X			OTHER DIAGNOSIS CODE 3
71	Other Diagnosis Code 4	No	Yes	56	31	6	X			OTHER DIAGNOSIS CODE 4
72	Other Diagnosis Code 5	No	Yes	56	38	6	X			OTHER DIAGNOSIS CODE 5

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Box	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entries	Default Value	Internal Element
73	Other Diagnosis Code 6	No	Yes	56	45	6	X			OTHER DIAGNOSIS CODE 6
74	Other Diagnostic Code 7	No	Yes	56	52	6	X			OTHER DIAGNOSIS CODE 7
75	Other Diagnostic Code 8	No	Yes	56	59	6	X			OTHER DIAGNOSTIC CODE 8
76	Admit Diagnostic Code	No	Yes	56	67	6	X			ADMITTING DIAGNOSIS CODE
77	E-Code	No	Yes	56	74	6	X			ECODE DIAGNOSIS CODE
78A	UB Box 78 - Upper Line	No	Yes	55	82	2	X			
78B	UB Box 78 - Lower Line	No	Yes	56	81	3	X			
79	Procedure Coding Method	Yes	Yes	58	3	1	X		9	PROCEDURE CODING METHOD
80A	Principal Procedure Code	No	Yes	58	6	7	X			PRINCIPAL PROCEDURE CODE
80B	Principal Procedure Date	No	Yes	58	14	8	D			PRINCIPAL PROCEDURE DATE
81A	Other Procedure Code A	No	Yes	58	21	7	X			OTHER PROCEDURE CODE 1
81B	Other Procedure Date A	No	Yes	58	29	8	D			OTHER PROCEDURE 1 DATE
81C	Other Procedure Code B	No	Yes	58	36	7	X			OTHER PROCEDURE CODE 2
81D	Other Procedure Date B	No	Yes	58	44	8	D			OTHER PROCEDURE 2 DATE
81E	Other Procedure Code C	No	Yes	60	6	7	X			OTHER PROCEDURE CODE 3
81F	Other Procedure Date C	No	Yes	60	14	8	D			OTHER PROCEDURE 3 DATE
81G	Other Procedure Code D	No	Yes	60	21	7	X			OTHER PROCEDURE CODE 4
81H	Other Procedure Date D	No	Yes	60	29	8	D			OTHER PROCEDURE 4 DATE
81I	Other Procedure Code E	No	Yes	60	36	7	X			OTHER PROCEDURE CODE 5
81J	Other Procedure Date E	No	Yes	60	44	8	D			OTHER PROCEDURE 5 DATE
82A	Attend Physician ID - Upper	No	Yes	57	61	23	X			
82B	Attend Physician ID - Lower	No	Yes	58	52	32	X			UPIN # UPIN

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Box	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entries	Default Value	Internal Element
83A	Other Physician ID A - Upper	No	Yes	59	59	25	X			
83B	Other Physician ID A - Lower	No	Yes	60	52	32	X			UPIN # UPIN
83C	Other Physician ID B - Upper	No	Yes	61	59	25	X			
83D	Other Physician ID B - Lower	No	Yes	62	52	32	X			
84A	Remarks - Line 1	No	Yes	61	8	43	X			
84B	Remarks - Line 2	No	Yes	62	3	48	X			
84C	Remarks - Line 3	No	Yes	63	3	48	X			
84D	Remarks - Line 4	No	Yes	64	3	48	X			
85	Provider Representative	No	Yes	64	53	22	X			BILLER NAME - INSURANCE
86	Date Bill Submitted	No	Yes	64	76	8	D			CLAIM SUBMISSION DATE

Claim Form Edit Parameters

UB Form

Field Type: **X**-Alphanumeric, **Y**-Yes, **N**-No, **D**-Date, **M**-Money, **N**-Numbers Only, **A**-Letters Only

Box	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entries	Default Value	Internal Element
1A	Provider Name									
1B	Provider Street Address									
1C	Provider City									
1D	Provider State									
1E	Provider ZIP Code									
1F	Provider Telephone Number									

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Box	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entries	Default Value	Internal Element
2A	UB Box 2 - Upper Line									
2B	UB Box 2 - Lower Line									
3	Patient Control Number									
4A	Type of Bill - First Digit									
4B	Type of Bill - Second Digit									
4C	Type of Bill - Third Digit									
5A	Federal Tax ID # Upper Line									
5B	Federal Tax ID # Lower Line									
6A	Statement Covers From Date									
6B	Statement Covers Through Date									
7	Covered Days									
8	Non-Covered Days									
9	Coinsurance Days									
10	Lifetime Reserve Days									
11A	UB Box 11 - Upper Line									
11B	UB Box 11 - Lower Line									
12	Patient Name									
13A	Patient Address									
13B	Patient City									
13C	Patient State									
13D	Patient Zip Code									
14	Patient Birthdate									

Box	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entries	Default Value	Internal Element
15	Patient Sex									
16	Patient Marital Status									
17	Admission Date									
18	Admission Hour									
19	Admission Type									
20	Admit Source									
21	Discharge Hour									
22	Discharge Status									
23	Medical Record Number									
24	Condition Code 1									
25	Condition Code 2									
26	Condition Code 3									
27	Condition Code 4									
28	Condition Code 5									
29	Condition Code 6									
30	Condition Code 7									
31A	UB Box 31 - Upper line									
31B	UB Box 31 - Lower Line									
32A	Occurrence Code 32a									
32B	Occurrence Date 32a									
32C	Occurrence Code 32b									
32D	Occurrence Date 32b									

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Box	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entries	Default Value	Internal Element
33A	Occurrence Code 33a									
33B	Occurrence Date 33a									
33C	Occurrence Code 33b									
33D	Occurrence Date 33b									
34A	Occurrence Code 34a									
34B	Occurrence Date 34a									
34C	Occurrence Code 34b									
34D	Occurrence Date 34b									
35A	Occurrence Code 35a									
35B	Occurrence Date 35a									
35C	Occurrence Code 35b									
35D	Occurrence Date 35b									
36A	Occurrence Span Code 36a									
36B	Occurrence From Date 36a									
36C	Occurrence Through Date 36a									
36D	Occurrence Span Code 36b									
36E	Occurrence Span From Date 36b									
36F	Occurrence Span Thru Date 36b									
37A	Internal Control Number 37a									
37B	Internal Control Number 37b									
37C	Internal Control Number 37c									
38A	Guarantor Name									

Box	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entries	Default Value	Internal Element
38B	Guarantor Address Line 1									
38C	Guarantor Address Line 2									
38D	Guarantor City									
38E	Guarantor State									
38F	Guarantor ZIP Code									
38G	Guarantor Phone Number									
39A	Value Code 39a									
39B	Value Code Amount 39a									
39C	Value Code 39b									
39D	Value Code Amount 39b									
39E	Value Code 39c									
39F	Value Code Amount 39c									
39G	Value Code 39d									
39H	Value Code Amount 39d									
40A	Value Code 40a									
40B	Value Code Amount 40a									
40C	Value Code 40b									
40D	Value Code Amount 40b									
40E	Value Code 40c									
40F	Value Code Amount 40c									
40G	Value Code 40d									
40H	Value Code Amount 40d									

Box	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entries	Default Value	Internal Element
41A	Value Code 41a									
41B	Value Code Amount 41a									
41C	Value Code 41b									
41D	Value Code Amount 41b									
41E	Value Code 41c									
41F	Value Code Amount 41c									
41G	Value Code 41d									
41H	Value Code Amount 41d									
50A	Payer Name 50a									
50B	Payer Name 50b									
50C	Payer Name 50c									
51A	Payer Provider Number 51a									
51B	Payer Provider Number 51b									
51C	Payer Provider Number 51c									
52A	Payer Release Information 52a									
52B	Payer Release Information 52b									
52C	Payer Release Information 52c									
53A	Payer Benefits Assigned 53a									
53B	Payer Benefits Assigned 53b									
53C	Payer Benefits Assigned 53c									
54A	Payer Prior Payments 54a									
54B	Payer Prior Payments 54b									

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Box	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entries	Default Value	Internal Element
54C	Payer Prior Payment 54c									
54D	Patient Prior Payments									
55A	Payer Estimated Amount Due 55a									
55B	Payer Estimated Amount Due 55b									
55C	Payer Estimated Amount Due 55c									
55D	Payer Estimated Amount Due									
56A	UB Box 56 - Line 1									
56B	UB Box 56 - Line 2									
56C	UB Box 56 - Line 3									
56D	UB Box 56 - Line 4									
56E	UB Box 56 - Line 5									
57	UB Box 57									
58A	Insured's Name 58a									
58B	Insured's Name 58b									
58C	Insured's Name 58c									
59A	Pat. Relation to Insured 59a									
59B	Pat. Relation to Insured 59b									
59C	Pat. Relation to Insured 59c									
60A	CERT/SSN/HIC ID No. 60a									
60B	CERT/SSN/HIC ID No. 60b									
60C	CERT/SSN/HIC ID No. 60c									
61A	Group Name 61a									

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Box	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entries	Default Value	Internal Element
61B	Group Name 61b									
61C	Group Name 61c									
62A	Insurance Group No. 62a									
62B	Insurance Group No. 62b									
62C	Insurance Group No. 62c									
63A	Treatment Authorization 63a									
63B	Treatment Authorization 63b									
63C	Treatment Authorization 63c									
64A	Employment Status Code 64a									
64B	Employment Status Code 64b									
64C	Employment Status Code 64c									
65A	Employer Name 65a									
65B	Employer Name 65b									
65C	Employer Name 65c									
66A	Employer Location 66a									
66B	Employer Location 66b									
66C	Employer Location 66c									
67	Principal Diagnosis Code									
68	Other Diagnosis Code 1									
69	Other Diagnosis Code 2									
70	Other Diagnosis Code 3									
71	Other Diagnosis Code 4									

Box	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entries	Default Value	Internal Element
72	Other Diagnosis Code 5									
73	Other Diagnosis Code 6									
74	Other Diagnostic Code 7									
75	Other Diagnostic Code 8									
76	Admit Diagnostic Code									
77	E-Code									
78A	UB Box 78 - Upper Line									
78B	UB Box 78 - Lower Line									
79	Procedure Coding Method									
80A	Principal Procedure Code									
80B	Principal Procedure Date									
81A	Other Procedure Code A									
81B	Other Procedure Date A									
81C	Other Procedure Code B									
81D	Other Procedure Date B									
81E	Other Procedure Code C									
81F	Other Procedure Date C									
81G	Other Procedure Code D									
81H	Other Procedure Date D									
81I	Other Procedure Code E									
81J	Other Procedure Date E									
82A	Attend Physician ID - Upper									

Box	Base System	Req	Print	Form Row	Form Col	Form Length	Field Type	Valid Entries	Default Value	Internal Element
82B	Attend Physician ID - Lower									
83A	Other Physician ID A - Upper									
83B	Other Physician ID A - Lower									
83C	Other Physician ID B - Upper									
83D	Other Physician ID B - Lower									
84A	Remarks - Line 1									
84B	Remarks - Line 2									
84C	Remarks - Line 3									
84D	Remarks - Line 4									
85	Provider Representative									
86	Date Bill Submitted									

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CLAIM FORM EDIT PARAMETERS - (CN ONLY)

Level 1	Matrix# 16a	Facility:

The STAR Financials Patient Accounting system supports the following Canadian claim types:

- H-MOH - Ontario Ministry of Health, referred to as OHIP claims

- W-WCB - Ontario Worker's Compensation Board

- K-UNV - Universal claim, used to submit to commercial carriers.

Refer to the *Canadian Claims Processing Volume* in the *STAR Financials Patient Accounting Reference Guide* for information on the Canadian claim types.

CREDIT RATINGS

Level 1	Matrix# 24	Facility:

This table is used to assign hospital-defined credit ratings to vendors. It is not yet implemented in the system.

Code ☐ (1A)

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Code ☐ (1A)

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Code ☐ (1A)

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Code ☐ (1A)

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

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DATA CONTROL CODES

Level 1	Matrix# 26	Facility:

Data Control codes are used in bill editing to identify the hospital department responsible for supplying required information. For example, final diagnosis may be required to produce a final bill with Medical Records identified as the department responsible for supplying this information. A report listing the missing information and the responsible department is available. The codes entered here are also used in completing the Billing Requirements parameter. Data Control codes are attached to actual billing requirements in the Billing Requirement parameter.

Code |_|_|_| (3A)

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Print on Failed Billing Requirements report?   Y   N

Print on Failed Billing Requirements by Control Code report?   Y   N

Include Zero Charge Accounts on Failed Billing Requirements by Control Code report?   Y   N

Sort Sequence on Failed Bill Requirements by Control Code report

Choose three sort items:

Attending Physician	
Biller Code Bill	
Carrier/Plan Code	
Descending Account Balance	
Discharge Date	
Financial Class	
Medical Records Number	
Medical Service	

Sort Sequence on Failed Bill Requirements by Control Code report

Patient Type

Registration Initials

Code ☐☐☐ (3A)

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Print on Failed Billing Requirements report?   Y   N

Code: ☐☐☐ (3A)

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Print on Failed Billing Requirements report?   Y   N

DATA MAILER MESSAGES

Level 1	Matrix# 27	Facility:

This table contains messages that can be printed on data mailers. This table is not split by facility. Refer to the list of available internal elements in LEVEL 0 to determine which elements can be inserted in data mailer messages. This table is not currently implemented.

Code [ ][ ][ ][ ] 4N

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Maximum Width [ ][ ] 2N

Default message line width in columns. Range is 10-50. This is not yet implemented.

Maximum Lines [ ] 1N

Default number of lines in message. Range is 1-4. This is not yet implemented.

Text **(Enter up to four lines of 50 characters each)**

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DENIAL TRACKING NORMALIZED REASON CODE TABLE

Code   (4AN)   [ ][ ][ ][ ]

PCON Normalized   (10AN)   [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]
Code

Description   [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

(30AN)   [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

DENIAL TRACKING ROOT CAUSE CODE TABLE

Code   (4AN)   [ ][ ][ ][ ]

Description   [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

(30AN)   [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

DETAIL STATEMENT MESSAGES

Level 1	Matrix# 29	Facility:

This table contains messages printed on the Detail Statement used in guarantor, Pre-Collection and Bad Debt Follow-up. Refer to the list of available internal elements in Level 0 to determine which elements can be inserted in detail statement messages.

Code |_|_|_|_| 4N

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Maximum Width |_|_| 2N

Default message line width in columns. Range is 10-75.

Maximum Lines |_|_| 2N

Default number of lines in message. Range is 1-10.

Text   (Enter up to 10 lines of 75 characters each)

CONTRACT STATEMENT MESSAGES

Level 1	Matrix# 29a	Facility:

This table contains messages printed on the Contract Collection. Refer to the list of available internal elements in LEVEL 0 to determine which elements can be inserted in contract statement messages.

Code ☐☐☐☐ 4N

Description _____

(**30AN**) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Maximum Width ☐☐ 2N

Default message line width in columns. Range is 10-75.

Maximum Lines ☐☐ 2N

Default number of lines in message. Range is 1-10.

Text   (Enter up to 10 lines of 75 characters each)

DIAGNOSTIC REVENUE CODE - (US ONLY)

Level 1	Matrix# 29b	Facility:

The Diagnostic Revenue Code Table defines which UB revenue codes qualify for a type of bill second digit of 4 (diagnostic) in locator 4 of the UB claim form. If the account has only revenue codes listed in this table on the UB, has an outpatient patient indicator, and uses the internal element of *UB Bill Type for O/P - 2nd Digit* for the second digit of the type of bill in the UB Claim Load and Edit Parameter, the system will print a type of bill second digit of 4 on the claim.

UB Revenue Codes   (3N)

Revenue Code Description   (30AN)

Requires HCPCS for DPW Processing?   Y   N

UB Revenue Codes   (3N)

Revenue Code Description   (30AN)

UB Revenue Codes   (3N)

Revenue Code Description   (30AN)

Requires HCPCS for DPW Processing?   Y   N

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DRG PAYMENT WINDOW PARAMETERS

Level 1	Matrix#29c	Facility:

This table contains the criteria for selecting accounts for charge transfers.

DPW Code   (3AN)

DPW Description   (30AN)

Edit Date (Display Only)   (21AN)

Financial Classes   (2AN Code)

You may enter multiple financial classes.

Patient Types   (3AN Code)

You may enter multiple patient types.

Edit By (Display Only)   (30A)

Insurance Carrier/Plan (6N Code)

You may enter multiple insurance
carriers/plans.

O/P Abstract   Y   N

Start Trans Code/Desc   (4N Code)

Exclude FIM Dept   (3AN Code)

You may enter multiple FIM
departments to exclude.

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Exclude FIM Codes   (8AN Code)

You may enter multiple FIM codes to be excluded.

All Chgs   Enter # of days ☐☐   Circle one to indicate Transfer   T   R
                                         or Report Charges

Eval Diag Chgs   Enter # of days ☐☐   Circle one to indicate Transfer   T   R
                                            or Report Charges

Eval Non-Diag Chgs   Circle one to indicate Transfer or Report Charges   T   R

Rpt Detail Charges   Y   N

Rpt Cumulative   Y   N

Rpt Facilities   (1A)

You may enter multiple codes.

End Trans Code/Desc   (4N Code)

Chg Trans Code/Desc   (4N Code)

Effective Date (Display Only)   (18AN)

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ERA FACILITY/PROVIDER MAPPING - (US ONLY)

Level 1	Matrix# 30a	Facility:

This table provides the cross-references needed to identify the facility for each provider for which payments are sent. This table is used to determine the facility for the cash batch to be created based on the provider number that is returned from the intermediary using the ANSI 835 Health Care Claim Payment/Advice standard. This table is not used for electronic payment files received from a vendor. This table is not split by facility.

Provider No

(15AN)

The provider number must be in the same format that is returned by the electronic software. The provider number must match the number returned by the electronic payment software so that the facility can be determined.

Facility   (1A)

The facility must be a valid STAR facility that is associated with the provider number.

Description

(24AN)

The description of the provider number. McKesson recommends that you include the facility code in the description.

Provider No

(15AN)

Facility   (1A)

Description

(24AN)

Provider No

(15AN)

Facility　　　(1A)

Description

(24AN)

Provider No

(15AN)

Facility　　　(1A)

Description

(24AN)

ERA PROVIDER LEVEL ADJUSTMENT REASON CODES

Level 1	Matrix# 91a	Facility:

This table provides a listing of the two-character reason codes adopted for the National Health Care Claim Payment/Advice (835A and 835B). The existing entries may be modified by the user. This table is not split by facility.

Code   (2AN)

The 835 provider level adjustment reason code.

Description

(24AN)

The description associated with the provider level adjustment reason code.

Code   (2AN)

Description

(24AN)

Code   (2AN)

Description

(24AN)

FACILITY INFORMATION

Level 1	Matrix# 34	Facility:

Patient Bill Format

This table contains the bill formats used for detail, summary and insurance proration bills. The Patient Bill formats are maintained by McKesson and *must* be split by facility. In order to complete this table, the Bill Charge Groups, Patient Bill Header, Patient Bill Detail, Summary Bill and Prorated Bill formats must all be completed.

The Patient Bill Format should be completed by your McKesson installation team after forms design.

Detail Bills?   Y   N

(Print detail bills in separate spoolfile?)

Summary Bills?   Y   N

(Print summary bills in separate spoolfile?)

Prorated Bills?   Y   N

(Print prorated bills in separate spoolfile?)

Summarize By (Circle one of the following)

Alternate SIM Group I	Proration Summary Code	UB Code
Alternate SIM Group II	Department	
Alternate SIM Group III	Revenue Center	

Number of Digits   [ ]   1N, range is 1-6

(Enter the number of digits on which to summarize.)

SIM or FIM Description   [ ][ ][ ]   3A

Amount Due Balance (Circle one)   Patient   Account   Calculate

Should the balance due reflect the Patient Balance, Account Balance, or calculate as the total charges less the sum of the estimated insurance balances?

Print Bills with Zero   Y   N
Charges?

Series Amount Due Balance   (Circle response)   Patient   Account

Should balance due on series bills reflect the Patient balance or the Account balance?

Spool Demand Series Bill?   (Circle Y or N)   Y   N

Should demand series bill be spooled to print in batch or print on demand?

State Bill?   (Circle Y or N)   Y   N

Enter new two-character state code.

Exclude Offsetting Charges/Credits from bills?   Y   N

PRINT DETAIL BILLS ON FBR904?   (Circle Y or N)   Y   N

Should detail bills should spool to their own spoolfile, separately from the FBR900x Patient Bills spoolfile.

PRINT SUMMARY BILLS ON FBR905?   (Circle Y or N)   Y   N

Should summary bills should spool to their own spoolfile, separately from the FBR900x Patient Bills spoolfile?

PRINT PRORATED BILLS ON FBR906?   (Circle Y or N)   Y   N

Should prorated bills spool to their own spoolfile, separately from the FBR900x Patient Bills spoolfile?

CYCLE ADJ BILL IND   (Circle Y or N)   Y   N

Is cycle adjustment bill processing is allowed for accounts associated with this billing parameter.

Chg Bill Window   ▯▯▯ 3N

Indicate an overall facility level number of days between **1** and **999** that you can enter a charge on an AR account, after the Date of Service has passed, before the AR account is automatically placed on Bill Hold with a type of O (Old Charge).

Cycle Adjustment Parameters

If the Cycle Adj Bill Ind field is set to Yes (allow cycle adjustment billing), the following parameters should be set.

CYCA MAX DAYS SINCE SERVICE   (4C) | | | U (Unlimited |

This field indicates the maximum number of days from charge service date that a charge can be included on a cycle adjustment bill. You can also enter U (Unlimited).

CYCA ZERO BAL   (Circle Y or N)   Y   N

Should the system automatically generate a cycle adjustment bill if the account balance is zero?

MANUAL CYCA CHG/   (Circle Y or N)   Y   N
CR/DYS OVERRIDE
FOR SUBSEQUENT
BILLS

Should the system override the minimum number and amount for unbilled charges/credits defined in the Min Unbilled Charges, Min Unbilled Charge Amt, Min Unbilled Credits, Min Unbilled Credit Amt, and CycA Max Days Since Service fields when producing subsequent cycle adjustment bills?

Auto Cycle Adj   (Circle Y or N)   Y   N

Should the system produce an automatic cycle adjustment bill based on the entries made in either the Minimum Unbilled Charges and Minimum Unbilled Charge Amount fields and the Minimum Unbilled Credits and Minimum Unbilled Credit Amount fields?

MIN UNBILLED CHARGES   (2N)

Enter the minimum number of unbilled charges required to generate an automatic and manual cycle adjustment bill.

MIN UNBILLED CHARGE AMT   (4N)

Enter the minimum unbilled charge amount necessary to generate an automatic and manual cycle adjustment bill.

MIN UNBILLED CREDITS (2N) ☐☐

Enter the minimum number of unbilled credits required to generate an automatic and manual cycle adjustment bill.

CYCA SUPPRESS (Circle Y or N) Y N
SUBSEQUENT BILLS/
DO NOT LOAD CLMS

Indicate, for subsequent cycle adjustments bills, whether bills should be suppressed and claims should not be loaded if there are no new/qualifying charges for subsequent cycle adjustment bills.

Chg Bill Window (3N) ☐☐☐

Enter the number of days that you can enter a charge on an AR account, after the Date of Service has passed, before the AR account is automatically placed on Bill Hold with a type of O. (Old Charge).

Bill formats are maintained within the system. Once the header, body, and summary are entered in fields 1, 4, 7, 10, 16, 19, and 22, the Start On and Stop On fields automatically display Start On/Stop On line numbers according to the formats which are maintained in the system. You may alter or update these numbers.

Detail Bill Header ☐☐☐☐ 4AN

Start On ☐☐ 2N

(Enter the number of the line on which to start detail bill header.)

Stop On ▢▢ 2N

(Enter the number of the line on which to stop detail bill header.)

Detail Bill Body ▢▢▢▢ 4AN

Start On ▢▢ 2N

(Enter the number of the line on which to start detail bill body.)

Stop On ▢▢ 2N

(Enter the number of the line on which to stop detail bill body.)

Summary Bill Header ▢▢▢▢ 4AN

Start On ▢▢ 2N

(Enter the number of the line on which to start summary bill header.)

Stop On ▢▢ 2N

(Enter the number of the line on which to stop summary bill header.)

Summary Bill Body ▢▢▢▢ 4AN

Start On ☐☐ 2N

(Enter the number of the line on which to start summary bill body.)

Stop On ☐☐ 2N

(Enter the number of the line on which to stop summary bill body.)

Prorated Bill Header ☐☐☐☐ 4AN

Start On ☐☐ 2N

(Enter the number of the line on which to start prorated bill header.)

Stop On ☐☐ 2N

(Enter the number of the line on which to stop prorated bill header.)

Prorated Bill Body ☐☐☐☐ 4AN

Start On ☐☐ 2N

(Enter the number of the line on which to start prorated bill body.)

Stop On ☐☐ 2N

(Enter the number of the line on which to stop prorated bill body.)

Series Bill Header ☐☐☐☐ 4AN

Start On ☐☐ 2N

(Enter the number of the line on which to start series bill header.)

Stop On ☐☐ 2N

(Enter the number of the line on which to stop series bill header.)

Series Bill Body ☐☐☐☐ 4AN

Start On ☐☐ 2N

(Enter the number of the line on which to start series bill body.)

Stop On ☐☐ 2N

(Enter the number of the line on which to stop series bill body.)

State Bill Header ☐☐☐☐ 4AN

Start On ☐☐ 2N

(Enter the number of the line on which to start state bill header.)

Stop On   ☐☐   2N

(Enter the number of the line on which to stop state bill header.)

State Bill Body   ☐☐☐☐   4AN

Start On   ☐☐   2N

(Enter the number of the line on which to start state bill body.)

Stop On   ☐☐   2N

(Enter the number of the line on which to stop state bill body.)

Contract Bill Format

This table contains the bill formats used for detail, summary and insurance proration bills. The Contract Bill formats are maintained by McKesson and *must* be split by facility. In order to complete this table, the Bill Charge Groups, Patient Bill Header, Patient Bill Detail, Summary Bill and Prorated Bill formats must all be completed.

Start On and Stop On line numbers automatically display once the header and body is chosen. Start On and Stop On line numbers are formatted by the format maintained in the system. You may alter or update these numbers.

The Contract Bill Format should be completed by your McKesson installation team after forms design.

Detail Bills?   Y   N

(Print detail bills separately?)

Summary Bills?   Y   N

(Print summary bills separately?)

Prorated Bills?   Y   N

(Print prorated bills separately?)

          Summarize By   This field is not used for contract bills.

          Number of Digits   This field is not used for contract bills.

SIM or FIM Description   (Circle One)   S   F

      Should the detail bill print the charge description from the Service Item Master (S) or Financial Item Master (F).

Bill Transaction Code: Y   (4N)   ☐ ☐ ☐ ☐

Balance Forward?   (Circle Y or N)   Y   N

Balance forward bills?

Detail Bill Header   ☐ ☐ ☐ ☐   4AN

Start On   ☐ ☐   2N

(Enter the number of the line on which to start detail bill header)

Stop On   ☐ ☐   2N

(Enter the number of the line on which to stop detail bill header)

Detail Bill Body ☐☐☐☐ 4AN

Start On ☐☐ 2N

(Enter the number of the line on which to start detail bill body)

Stop On ☐☐ 2N

(Enter the number of the line on which to stop detail bill body)

Sort Sequences

Level 1	Matrix# 35	Facility:

The system provides a series of sort options for printing forms. Each sort option has a number of sort fields assigned to it. Depending on the number assigned, no more than six sort fields can be selected for any one sort option. On these worksheets, you will assign sort fields and their sequence to the sort options established in the system.

SYSTEM SORT OPTIONS

- 1500 Claims

- 1500 Claims - Archive

- Archive Statements

- BD Collection Letters

- BD Detail Statements

- Collection Letters

- Contract Bills

- Datamailers (not yet implemented)

- Detail Statements

- Financial Review Report

- Insurance Follow-Up Letters

- Patient Bills

- UB82 Claims

- UB82 Claims - Archive

- UB Claims

- UB Claims - Archive

- Non Pro Fee 1500 - Archive

- Non Pro Fee 1500 Claim

- Universal Claims

- Universal Claims - Archive

- WCB Claim

- WCB Claim - Archive

1500 CLAIMS

Only assign as many as needed; up to six:

Sort Field	Sequence
Biller Code Bill	
Biller Code Claim	
Carrier Code	
Carrier/Plan Code	
Financial Class	
Guarantor Name	
Patient Account Number	
Patient Indicator	
Patient Name	
Patient Type	

1500 CLAIMS - ARCHIVE

Only assign as many as needed; up to six:

Sort Field	Sequence
Biller Code Bill	
Biller Code Claim	
Carrier Code	
Carrier/Plan Code	
Financial Class	
Guarantor Name	
Patient Account Number	
Patient Indicator	
Patient Name	

ARCHIVE STATEMENTS

Only assign as many as needed; up to six:

Sort Field	Sequence
Carrier Code	
Carrier/Plan Code	
Financial Class	
Guarantor Name	
Patient Account Number	
Patient Indicator	
Patient Name	
Patient Type	

BD COLLECTION LETTERS

Only assign as many as needed; up to four:

Sort Field	Sequence
Collection Schedule	

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Collector Code

Guarantor Name

Guarantor Zip Code

BD DETAIL STATEMENTS

Only assign as many as needed; up to four:

Sort Field	Sequence
Collection Schedule	
Collector Code	
Guarantor Name	
Guarantor Zip Code	

COLLECTION LETTERS

This sort sequence controls guarantor and Pre-Collection letters. Only assign as many as needed; up to four:

Sort Field	Sequence
Collector Code	
Financial Class	
Guarantor Name	
Guarantor ZIP	

CONTRACT BILLS

Only assign as many as needed; up to two:

Sort Field	Sequence
Contract Code	
Contract Name	

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DATAMAILERS

Only assign as many as needed; up to six.

Sort Field	Sequence
Collector Code	
Financial Class	
Guarantor Name	
Guarantor ZIP	
Patient Account Number	
Patient Indicator	
Patient Name	
Patient Type	

DETAIL STATEMENTS

This sort sequence controls guarantor and Pre-Collection detail statements. Only assign as many as needed; up to four. Financial Class should only be assigned if Account Level Follow-up is used.

Sort Field	Sequence
Collector Code	
Financial Class	
Guarantor Name	
Guarantor ZIP	

FINANCIAL REVIEW REPORT

Only assign as many as needed; up to three:

Sort Field	Sequence
Patient Account Number	
Patient Indicator	
Patient Name	

INSURANCE FOLLOW-UP LETTERS

Only assign as many as needed; up to six. Financial Class should only be assigned if Account Level Follow-up is used.

Sort Field	Sequence
Collector Code	
Financial Class	
Insurance Carrier ZIP	
Patient Account Number	
Patient Indicator	
Patient Name	
Patient Type	

PATIENT BILLS

Only assign as many as needed; up to six:

Sort Field	Sequence
Biller Code Bill	
Carrier Code	
Carrier/Plan Code	
Discharge Date	
Financial Class	
Guarantor ZIP	
Patient Account Number	
Patient Indicator	
Patient Name	
Patient Type	

NON PRO FEE 1500 - ARCHIVE

Only assign as many as needed; up to six:

Sort Field	Sequence
Biller Code Bill	
Biller Code Claim	
Carrier Code	
Carrier/Plan Code	
Financial Class	
Guarantor Name	
Patient Account Number	
Patient Indicator	
Patient Name	
Patient Type	

NON PRO FEE 1500

Only assign as many as needed; up to six:

Sort Field	Sequence
Biller Code Bill	
Biller Code Claim	
Carrier Code	
Carrier/Plan Code	
Financial Class	
Guarantor Name	
Patient Account Number	
Patient Indicator	
Patient Name	
Patient Type	

UB CLAIMS

Only assign as many as needed; up to six:

Sort Field	Sequence
Biller Code Bill	
Biller Code Claim	
Carrier Code	
Carrier/Plan Code	
Financial Class	
Guarantor Name	
Patient Account Number	
Patient Indicator	
Patient Name	
Patient Type	
UB Type of Bill Form Loc 4	

UB CLAIMS - ARCHIVE

Only assign as many as needed; up to six:

Sort Field	Sequence
Biller Code Bill	
Biller Code Claim	
Carrier Code	
Carrier/Plan Code	
Financial Class	
Guarantor Name	
Patient Account Number	
Patient Indicator	
Patient Name	
Patient Type	
UB Type of Bill Form Loc 4	

Biller/Collector Worklist Control

Level 1	Matrix# 37	Facility:

This table determines if bills, claims and paper follow-up should be included in the biller and collector workfiles.

Bills passing edits?   Y   N

Include bills that passed edits in the worklist?

Bills failing edits?   Y   N

Include bills that failed edits in the worklist?

Bills with zero charges?   Y   N

Include bills with zero charges in the online workfile?

Claims passing edits?   Y   N

Include claims that passed edits in the worklist?

Claims failing edits?   Y   N

Include claims that failed edits in the worklist?

Include Replaced Claims?   Y   N

Should the account lookup for claims display original and Cycle/Final adjusted claims or only Cycle/Final adjustment (replacement) claims.

Insurance worklist subgroup   1-N   (Circle one)

Contract Name   Group Number

Insurance worklist primary sort   (Circle one)

Descending dollar balance (claim amount)

Patient name

Days since claim submission

Days since final bill

Days since last follow-up

Number of days in worklist

Financial class

Insurance worklist secondary sort (Circle one)

Descending dollar balance (claim amount)

Patient name

Days since claim submission

Days since final bill

Days since last follow-up

Number of days in worklist

Guarantor worklist primary sort   (Circle one)

Descending dollar balance (claim amount)

Guarantor name

Days since claim submission

Days since final bill

Days since last follow-up

Number of days in worklist

Guarantor worklist secondary sort   (Circle one)

Descending dollar balance

Guarantor name

Days since claim submission

Days since final bill

Days since last follow-up

Number of days in worklist

Contract worklist primary sort   (Circle one)

Descending dollar balance

Contract code

Bill date

Number of days in worklist

Contract worklist secondary sort   (Circle one)

Descending dollar balance

Contract code

Bill date

Number of days in worklist

Edit Notes   (Circle one)   Y   N

Allow notes the edited by the original user?

Confidential Notes   (Circle one)   Y   N

Activate confidentiality for notes?

FOLLOW-UP LETTER MESSAGES

Level 1	Matrix# 47	Facility:

This table, which is not split by facility, contains messages (paragraphs) that can be combined into collection letters used in guarantor, Pre-Collection, and Bad Debt Follow-up. Refer to the list of available internal elements in LEVEL 0 to determine which elements can be inserted in follow-up letter messages

This table also includes a message code called MCK for MCK Free Form Message. The MCK message code is automatically included in the table, and it is used when building follow-up letters. The MCK message code allows hospitals to create letters that can contain a free form message. This allows collectors to utilitze the edit collection functionality and type in a free form message through the PA, AR, or BD Demand Follow-Up forms on the Receivables Workstation.

This table is not split by facility. After this table is selected, you are prompted to select a facility and enter a follow-up letter message code. To view the MCK message code you must perform a dash lookup to view the table. You cannot enter the code of MCK. The MCK message code has an associated description of MCK Free Form Message. The MCK message code cannot be updated or viewed. When selecting the MCK message code from the list, the following message displays "Message controlled by McKesson, press NL.".

Message Code (4N)

Message Description

(30AN)

Maximum Width

(10-65 columns)

Maximum Length

(1-18 lines)

Message Text   (message limits are 18 line by 65 columns)

GL MAPPING TABLE DEFINITION

Level 1	Matrix# 54	Facility:

This table, which must be split by facility, contains codes identifying the mapping table used to map automatic postings from patient accounting to the General Ledger.

Table Number   (2N)   [ ][ ]

Table Description

(30AN)

HCPCS PANEL CODE TABLE - (US ONLY)

Level 1	Matrix# 58a	Facility:

This table contains the HCPCS Panel Codes and their components that cannot appear more than once on a UB claim form for the same date of service.

Code   (5N)

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Seq   (2N)

Enter a HCPCS procedure code, or enter a hyphen (-) to select a HCPCS procedure code from the Medical Record HCPCS Procedure Code Table.

HCPCS   **(5AN)**

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HCPCS SUMMARIZATION MASTER - (US ONLY)

Level 1	Matrix# 59	Facility:

This table is used to summarize HCPCS procedure codes and associated charges.

Code   (3N) | | | |

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Number of Charges   (3N) | | | |

(Enter the number of charges associated with the selected HCPCS procedure codes to cause summarization. The range is 1 to 999)

Max Count   (2N) | | |

(Enter the maximum count to be used in adjusting the HCPCS code, regardless of the number of charges summarized)

Seq (2N)   HCPCS Code (5N)   **Seq (2N)   HCPCS Code (5N)**

Seq (2N)   HCPCS Code (5N)   **Seq (2N)   HCPCS Code (5N)**

HOSPITAL EMPLOYEES

Level 1	Matrix# 60	Facility:

All employees using STAR Financials must have a system security code assigned in STAR Patient Care.

Employee Name

(22A, format Last, First Initial)

Position

(40AN)

Employee Number   (12N)

ID Code   (9N or * for auto. assignment)

Department

(33AN)

Home Phone   (10N)

Beeper Phone   (10N, optional)

Initials   (3A, the employee's initials)   ☐ ☐ ☐

Security   (2N)   ☐ ☐

Temporary Security   (2N)   ☐ ☐   **Valid Until**   ☐ ☐ ☐

Initial Menu   (6AN)   ☐ ☐ ☐ ☐ ☐ ☐

CRT   (3AN)   ☐ ☐ ☐

Facilities   (1A)   ☐   ☐   ☐   ☐

Entities   (1A)   ☐   ☐   ☐   ☐

Pharmacy Employee Type?   Y   N

INSURANCE CARRIER

Level 1	Matrix# 63	Facility:

This STAR Patient Care table, which is not split by facility, contains demographic information about an insurance carrier such as address and contact names. It is used in admission, registration, and insurance verification.

Insurance Carrier Code   (Up to 6N if used with plan processing)

Insurance Carrier Name

(33AN)

Primary?   Y   N

Can this carrier by a primary carrier? Circle Y or N. The default is Y.

MSP Screen? (Circle Response)   Y   N

Bring up the Medicare Questionnaire screens during insurance processing if COB 1?

Insurance Type

(1A: **B**-Blue Cross, **S**-CHAMPUS, **E-**Canadian Commercial, **G**-Canadian Military,

D-Canadian Provincial, **F**-Canadian Workers Compensation, **C**-Commercial, **N**-HMO,

X-MEDICAID/Welfare, **M**-MEDICARE Part A, **P**-MEDICARE Part B, **A**-Out of Province. If required, McKesson installation personnel can help select the proper insurance type.)

Contact Name/

Mail to Person

(36AN)

Contact's Company Name

(35C)

Address 1

(25AN)

Address 2

(25AN)

City

(18AN)

State   (2A)

ZIP Code   (9N)

Phone   (13N)

Phone Ext.   (5C)

Country   (2C)

Group Number Format (17C)

Pol/Cert/ID Format (20C)

Online Elig?   Y   N

Eligibility code   (5AN)

Admission Office Text   (Up to 4 lines of 60 characters each)

Line 1

Line 2

Line 3

Line 4

INSURANCE MESSAGES

Level 1	Matrix# 67	Facility:

This table, which is not split by facility, contains messages (paragraphs) that can be combined into insurance follow-up letters. The information entered here is also used in the Insurance Follow-up Schedule parameter and the on-line Insurance Follow-up Request function. Refer to the list of available internal elements in LEVEL 0 to determine which elements can be inserted into insurance messages.

NOTE: This table is used for the Edit Insurance Collection Letter functionality available through the Receivables Workstation (RWS). If you have the RWS and want to utilize the Edit Insurance Collection Letter functionalit, attach the MCK message code to any letter to which you want to be able to add free form text. The description of the MCK message code is MCK Free Form Message. If you attach the MCK message code to a letter multiple times then the same free form message will print multiple times. We advise that you only associate one MCK message code to your letter.

Insurance Message Code   (4N)

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Maximum Width

(Message line width in columns.   Range is 10-75.)

Maximum Lines

(Number of message lines. Range is 1-18.)

Message Text   **(message limits are 18 lines by 75 columns)**

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MEDICAL RECORDS HCPCS REV CODE RANGE TABLE

Level 1	Matrix# 70a	Facility:

This table allows the system to search on additional UB revenue codes when pulling medical records HCPCS to the claim. This table is not split by facility.

Table Code   (5N)

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Seq   (2N)

Claim UB Code   (4N)

Med Rec HCPCS Rev Codes

(29AN)

MEMO COLLECTION LETTER MESSAGES

Level 1	Matrix# 71	Facility:

This table contains memo messages used in building letters that are sent to guarantors who have accounts with pending insurance. Memo collection letters can be used in PA, AR, and Pre-Collection follow-up schedules and in PA and AR Demand Follow-up to indicate when a letter should be sent to a guarantor. This table is also used for the edit collection letter functionality available through Receivables Workstation (RWS). If you have RWS and want to utilize the edit collection letter functionality, you need to attach the MCK message code to any letter to which you want to be able to add free form text. The description of the MCK message code is MCK Free Form Message. Note: If you attach the MCK message code to a letter multiple times, then the same free form message will print multiple times. McKesson recommends that you only associate one MCK message code to your letter.

This table is not split by facility.

Message Code   (3N) |___|___|___|

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Maximum Width |___|___|

(Message line width in columns. Range is 10-75.)

Maximum Lines |___|___|

(Number of message lines. Range is 1-15.)

Message Text   (can be up to 15 lines by 75 columns)

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MEMO DETAIL STATEMENT MESSAGES

Level 1	Matrix# 72	Facility:

This table is used to define the messages that are printed on detail statements used in PA, AR, and Pre-Collection Follow-up for guarantors who have accounts with pending insurance. This table is not split by facility.

Message Code   (3N)

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Maximum Width

(Message line width in columns.   Range is 10-75.)

Maximum Lines

(Number of message lines. Range is 1-15.)

Message Text   (can be up to 15 lines by 75 columns)

NON DUPLICATING HCPCS RANGE TABLE - (US ONLY)

Level 1	Matrix# 75a	Facility:

This table contains the HCPCS Procedures codes that the system uses to edit for duplicate HCPCS codes on the same day of service.

Seq   (2N)

Starting HCPCS   (5AN)

Enter the HCPCS procedure code that starts the range of HCPCS codes that cannot be duplicated for the same date of service.

Ending HCPCS   (5AN)

Enter the HCPCS procedure code that ends the range of HCPCS codes that cannot be duplicated for the same date of service.

Seq   (2N)

Starting HCPCS   (5AN)

Enter the HCPCS procedure code that starts the range of HCPCS codes that cannot be duplicated for the same date of service.

Ending HCPCS   (5AN)

Enter the HCPCS procedure code that ends the range of HCPCS codes that cannot be duplicated for the same date of service.

Seq   (2N)

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Starting HCPCS   (5AN)

Enter the HCPCS procedure code that starts the range of HCPCS codes that cannot be duplicated for the same date of service.

Ending HCPCS   (5AN)

Enter the HCPCS procedure code that ends the range of HCPCS codes that cannot be duplicated for the same date of service.

Seq   (2N)

Starting HCPCS   (5AN)

Enter the HCPCS procedure code that starts the range of HCPCS codes that cannot be duplicated for the same date of service.

Ending HCPCS   (5AN)

Enter the HCPCS procedure code that ends the range of HCPCS codes that cannot be duplicated for the same date of service.

PATIENT BILL MESSAGE

Level 1	Matrix# 77	Facility:

This table contains messages that can be printed on the patient bill. Refer to the list of available internal elements in LEVEL 0 to determine which elements can be inserted in patient bill messages.

Patient Bill Message Code   (4N)   ☐☐☐☐

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Maximum Width   ☐☐

(Message line width in columns.   Range is 10-75.)

Maximum Lines   ☐

(Number of message lines. Range is 1-5.)

Message Text   (can be up to 5 lines by 75 columns)

PATHWAYS CONTRACT MANAGEMENT INTERFACE - REIMBURSEMENT MASTER

Level 1	Matrix# 76a	Facility:

This Master file is used to define the processing parameters for each facility that is using Pathways Contract Management for reimbursement calculations.

UB Active?   (Circle Y or N)   Y   N

Is the Pathways Contract Management UB system going to be used to determine the expected reimbursement for patient accounts in this facility?

UB Pass-through Active?   (Circle Y or N)   Y   N

Is the Pass-through Claims to PCON Interface active?

Contr Adj Approval Method   (Circle S or U)   S   U

Should the contractual adjustment batch that is returned from Pathways Contract Management be automatically approved and posted by the System (S) or manually approved by the User (U).

UB Source File Retention Days   (3N)

The number of days the UB source file is held on STAR Patient Accounting prior to purging. (Enter a value of 1 - 999.)

Return File Retention Days   (3N)

The number of days the return file is held on STAR Patient Accounting prior to purging. (Enter a value from 1 - 999.)

Activity File Retention Days   (3N)   ☐☐☐

> The number of days the activity file is held on STAR Patient Accounting prior to purging. (Enter a value from 1 - 999.)

Account Detail Retention Days   (3N)   ☐☐☐

> The number of days the detail for the account is held on STAR Patient Accounting prior to purging. (Enter a value from 1 - 999.)

1500 Active?   (Circle Y or N)   Y   N

Is the Pathways Contract Management CMS 1500 system going to be used to determine the expected reimbursement for patient accounts in this facility?

1500 Source File Retention Days   (3N)   ☐☐☐

> The number of days the 1500 source file is held on STAR Patient Accounting prior to purging. (Enter a value from 1 - 999.)

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PATHWAYS CONTRACT MANAGEMENT - PATHWAYS PARAMETERS PROCESSOR

Level 1	Matrix# 76b	Facility:

UB Directory Path

(22AN)

Upload UB Return File in Downtime   (Circle Y or N)   Y   N

Delay PA Daily Bal Until?

(4NC)

UB Source File Format

(1NO)

UB PCON Release

(1NO)

**Resend
Attempts**

(1NO)

PAYER HCPCS CROSS REFERENCE - (US ONLY)

Level 1	Matrix# 81a	Facility:

The Payer HCPCS Cross Reference table defines which Financial Item Master HCPCS are to use an alternate HCPCS/ICD-9-CM Code on the UB, 1500, or Non Pro Fee 1500 Claim Form for the payer. You can enter numerous payer HCPCS Cross Reference tables for payers that require alternate HCPCS, and then link these tables to the appropriate Charge Control Parameters for the payers.

Payer HCPCS Cross Reference Table Number   (2AN)

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Edit HCPCS Master or ICD-9-CM Master (Circle H or I)   H   I

FIM HCPCS Code   (7AN)

FIM HCPCS Description *   **(30AN)**

Alternate HCPCS/ ICD-9-CM Code   (7AN)

Alternate HCPCS/ ICD-9-CM Description*   **(30AN)**

* Displayed from previously defined table

Payer HCPCS Cross Reference Table Number   (2AN)

FIM HCPCS Code   (7AN)

**FIM HCPCS   (30AN)
Description***

Alternate HCPCS/ICD-9-CM Code   (7AN)

**Alternate HCPCS/ICD-9-CM   (30AN)
Description ***

* Displayed from previously defined table

Payer HCPCS Cross Reference Table Number   (2AN)

FIM HCPCS Code   (7AN)

FIM HCPCS   (30AN)
Description *

Alternate HCPCS/   (7AN)
ICD-9-CM Code

Alternate HCPCS/   (30AN)
ICD-9-CM Description *

* Displayed from previously defined table

Payer HCPCS Cross Reference Table Number   (2AN)

FIM HCPCS Code   (7AN)

FIM HCPCS   (30AN)
Description *

Alternate HCPCS/   (7AN)
ICD-9-CM Code

Alternate HCPCS/   (30AN)
ICD-9-CM Description*

* Displayed from previously defined table

PLACE OF SERVICE - (US ONLY)

Level 1	Matrix# 86	Facility:

This table, which is not split by facility, contains place of service codes used for 1500 claim and Non Pro Fee 1500 Claim form processing.

Code   (2AN) ▢▢

Description _____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Code   (2AN) ▢▢

Description _____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Code   (2AN) ▢▢

Description _____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Code   (2AN) ▢▢

Description _____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

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PRINCIPAL PROCEDURE REVENUE CODE TABLE - (US ONLY)

Level 1	Matrix# 86a	Facility:

This table contains the UB Revenue Codes that require an ICD-9 Procedure Code and Date for Form Locator 80 of the UB claim form.

Code   (3N) ☐☐☐

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Seq   (2N) ☐☐

UB Code   (3N) ☐☐☐

Seq   (2N) ☐☐

UB Code   (3N) ☐☐☐

Seq   (2N) ☐☐

UB Code   (3N) ☐☐☐

Seq   (2N) ☐☐

UB Code   (3N)   ☐☐☐

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PROCEDURE CODING METHOD

Level 1	Matrix# 87	Facility:

This table contains codes identifying the method used to code diagnosis information on the UB claim form. Refer to your UB manual for valid values.

Code (2N)

Description

(33AN)

Code (2N)

Description

(33AN)

Code (1N)

Description

(33AN)

PRORATION SUMMARY CODE

Level 1	Matrix# 88	Facility:

These codes, which are tied to individual charge items, are used to group charges for proration purposes. This table is not split by facility.

Proration Summarization Code   (6N) | | | | | | |

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Proration Summarization Code   (6N) | | | | | | |

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Proration Summarization Code   (6N) | | | | | | |

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Proration Summarization Code   (6N) | | | | | | |

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

PROVIDER MASTER - (US ONLY)

Level 1	Matrix# 89	Facility:

This table, which can be split by facility, contains the form names, addresses and provider numbers used by the hospital in processing claim forms. It also specifies if condition, occurrence, occurrence span, and value codes should be automatically created for patients assigned to a specific provider code for UB claim processing. Providers are assigned based on patient type with exceptions entered in the Insurance Plan Coverage master.

Provider Code   (6N)

Provider Name

(20AN)

Federal Tax ID   (10AN)

UB Claim Name

(25AN)

UB Street Address

(25AN)

1500 Claim Name

(30AN)

1500 Street Address

(30AN)

Medicaid Claim Name

(30AN)

Medicaid Street Address

(30AN)

City
(18AN)

State   (2A)

ZIP Code   (5 or 9AN)

Phone   (10N)
Number

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Alt Prov Name

(25AN)

Alt Prov Address 1

(25AN)

Alt Prov Address 2

(25AN)

Alt Prov City

(25AN)

Alt State (2AN)

Alt Zip (10N)

Alt Prov Phone   (10N)

UB Provider Number   (10AN)

(For Medicare providers, UB form locator 51)

1500 Provider Number   (11AN)

(1500 form locator 31; ID number)

Blue Cross Provider Number

(22AN)

 (UB form locator 51)

Medicaid State 1   (2A)

(UB form locator 51)

Medicaid Provider Number 1

(18AN)

Medicaid State 2   (2A)

(UB form locator 51)

Medicaid Provider Number 2

(18AN)

Medicaid State 3   (2A)

(UB form locator 51)

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Medicaid Provider Number 3

(18AN)

Lab CLIA #   (10A)

This field contains the Lab Clinical Laboratory Improvement Amendment Number. This value can be pulled to a claim by using Internal Element "LAB CLIA."

Provider NPI #   (10A)

This field contains the National Provider ID (NPI).

CONDITION CODES

Condition Code 02 (Circle Y or N)   Y   N
(Condition Employment Related)

Condition Code 09 (Circle Y or N)   Y   N
(Patient Nor Spouse Employed)

Condition Code 10 (Circle Y or N)   Y   N
(Pt/Souse Employed, No EGHP)

Condition Code 26 (Circle Y or N)   Y   N
(VA Eligible, Chooses Medicare)

Condition Code 28 (Circle Y or N)   Y   N
(Pt/Spouse EGHP is Second to Medic)

Condition Code 40 (Circle Y or N)   Y   N

CONDITION CODES

(Same Day Transfer)

Condition Code 60 (Circle Y or N)   Y   N
(Day Outlier)

Condition Code 61 (Circle Y or N)   Y   N
(Cost Outlier)

Condition Code Y5 (Circle Y or N)   Y   N
(New York Cost Outlier)

OCCURRENCE CODES

Occurrence Code 01 (Circle Y or N)   Y   N
(Auto Accident)

Occurrence Code 02 (Circle Y or N)   Y   N
(Auto Accident/No Fault Insurance)

Occurrence Code 03 (Circle Y or N)   Y   N
(Auto Accident/Tort Liability)

Occurrence Code 04 (Circle Y or N)   Y   N
(Accident/Employment Related)

Occurrence Code 05 (Circle Y or N)   Y   N
(Other Accident)

Occurrence Code 06 (Circle Y or N)   Y   N
(Crime Victim)

Occurrence Code 10 (Circle Y or N)   Y   N
(Last Menstrual Period)

OCCURRENCE CODES

Occurrence Code 18 (Circle Y or N)   Y   N
(Date of Retirement - Patient)

Occurrence Code 19 (Circle Y or N)   Y   N
(Date of Retirement - Spouse)

Occurrence Code 31 (Circle Y or N)   Y   N
(Intent to Bill Accommodations)

Occurrence Code 35 (Circle Y or N)   Y   N
(Physical Therapy Start Dt)

Occurrence Code 42 (Circle Y or N)   Y   N
(Date of Discharge)

Occurrence Code 44 (Circle Y or N)   Y   N
(Occupational Therapy Start Dt)

Occurrence Code 45 (Circle Y or N)   Y   N
(Speech Therapy Start Dt)

Occurrence Code 46 (Circle Y or N)   Y   N
(Cardiac Rehab Start Dt)

Occurrence Code A1 (Circle Y or N)   Y   N
(Birthdate of Insured Payer A)

Occurrence Code B1 (Circle Y or N)   Y   N
(Birthdate of Insured Payer B)

Occurrence Code C1 (Circle Y or N)   Y   N
(Birthdate of Insured Payer C)

OCCURRENCE CODES

OCCURRENCE SPAN CODES

Occurrence Span Code 72 (Circle Y or N) (First/Last Visit for Series)	Y	N
Occurrence Span Code 74 (Circle Y or N) (Non-Covered Level of Care/LOA)	Y	N
Occurrence Span Code 75 (Circle Y or N) (SNF Level of Care)	Y	N
Occurrence Span Code M0 (Circle Y or N) (PRO/UR Approved Stay Dates)	Y	N

VALUE CODES

Value Code 01 (Circle Y or N) (Most Common Semi Private Rate)	Y	N
Value Code 02 (Circle Y or N) (Hospital Has No Semi Private Rooms)	Y	N
Value Code 05 (Circle Y or N) (Professional Fees Included in Charges)	Y	N
Value Code 07 (Circle Y or N) (Medicare Cash Deductible)	Y	N
Value Code 08 (Circle Y or N)	Y	N

VALUE CODES

(Medicare Lifetime Reserve Amount In
First Calendar Year)

Value Code 09 (Circle Y or N)   Y   N

(Medicare Co-Insurance Amount In First
Calendar Year)

Value Code 12 (Circle Y or N)   Y   N

(Working Aged Beneficiary - EGHP)

Value Code 14 (Circle Y or N)   Y   N

(Nofault Inc Auto/Other)

Value Code 16 (Circle Y or N)   Y   N

(PHS or Other Federal Agency)

Value Code 24 (Circle Y or N)   Y   N

(New York Medicaid Rate Code)

Value Code 31 (Circle Y or N)   Y   N

(Patient Liability Amount)

Value Code 36 (Circle Y or N)   Y   N

(NY Medicaid ALC Grace Days)

Value Code 37 (Circle Y or N)   Y   N

(Pints of Blood Furnished)

Value Code 38 (Circle Y or N)   Y   N

(Blood Deductible Pints)

Value Code 39 (Circle Y or N)   Y   N

(Pints of Blood Replaced)

VALUE CODES

Value Code 45 (Circle Y or N) (Accident Hour)	Y	N
Value Code 46 (Circle Y or N) (Number of Grace Days)	Y	N
Value Code 50 (Circle Y or N) (Physical Therapy # Visits)	Y	N
Value Code 51 (Circle Y or N) (Occupational Therapy # Visits)	Y	N
Value Code 52 (Circle Y or N) (Speech Therapy # Visits)	Y	N
Value Code 53 (Circle Y or N) (Cardiac Rehab Therapy # Visits)	Y	N
Value Code 54 (Circle Y or N) (Newborn Weight in Grams)	Y	N
Value Code A1 (Circle Y or N) (Deductible Payer A)	Y	N
Value Code A2 (Circle Y or N) (Coinsurance Payer A)	Y	N
Value Code A3 (Circle Y or N) (Estimated Responsibility Payer A)	Y	N
Value Code A8 (Circle Y or N) (Patient Weight in Kilograms)	Y	N
Value Code A9 (Circle Y or N)	Y	N

VALUE CODES

(Patient Height in Centimeters)

Value Code B1 (Circle Y or N)	Y	N
(Deductible Payer B)		
Value Code B2 (Circle Y or N)	Y	N
(Coinsurance Payer B)		
Value Code B3 (Circle Y or N)	Y	N
(Estimated Responsibility Payer B)		
Value Code C1 (Circle Y or N)	Y	N
(Deductible Payer C)		
Value Code C2 (Circle Y or N)	Y	N
(Coinsurance Payer C)		
Value Code C3 (Circle Y or N)	Y	N
(Estimated Responsibility Payer C)		
Value Code D3 (Circle Y or N)	Y	N
(Estimated Responsibility Patient)		
Value Code X1 (Circle Y or N)	Y	N
(Indigent Care Assessment Pay A)		
Value Code X2 (Circle Y or N)	Y	N
(Indigent Care Assessment Pay B)		
Value Code X3 (Circle Y or N)	Y	N
(Indigent Care Assessment Pay C)		

VALUE CODES

Value Code Y1 (Circle Y or N)   Y   N

(GME Assessment Payer A)

Value Code Y2 (Circle Y or N)   Y   N

(GME Assessment Payer B)

Value Code Y3 (Circle Y or N)   Y   N

(GME Assessment Payer C)

PROVIDER MASTER - (CN ONLY)

Level 1	Matrix# 89a	Facility:

This table, which can be split by facility, contains the form names, addresses and provider numbers used by the hospital in processing claim forms. It also specifies if condition, occurrence, occurrence span, and value codes should be automatically created for patients assigned to a specific provider code for UB claim processing. Providers are assigned based on patient type with exceptions entered in the Insurance Plan Coverage master.

Provider Code   (6N)

Description

(20A)

Billing Inst #   (4-AN-R)

REFUND CHECK MESSAGES

Level 1	Matrix# 90	Facility:

This table, which is not split by facility, contains messages that can be printed on
refund checks.

Code   (4N) | | | | |

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Maximum Width

(Message line width in columns.   Range is 10-75.)

Maximum Lines

(Number of message lines. Range is 1-6.)

Message Text   (up to 6 lines of 75 characters each)

REIMBURSEMENT PAYOR CODE

Level 1	Matrix# 91a	Facility:

Level 1	Matrix# 92	Facility:

This table, which is not split by facility, contains codes identifying third party payors for reimbursement. It is used in the Insurance Plan Coverage master and the Reimbursement master.

Reimbursement Payor Code   (2A)

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Reimbursement Payor Code   (2A)

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Reimbursement Payor Code   (2A)

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Reimbursement Payor Code   (2A)

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

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SOURCE OF PAYMENT

Level 1	Matrix# 99	Facility:

This table, which is not split by facility, contains codes identifying the source of payment codes used in electronic claims submission for the UB. Refer to your UB manual for completion of the table.

Source of Payment Code   (1A) ☐

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Source of Payment Code   (1A) ☐

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Source of Payment Code   (1A) ☐

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Source of Payment Code   (1A) ☐

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

STATISTICS GROUPS KEYS

Level 1	Matrix# 103	Facility:	Fiscal Year:

This worksheet is used to determine whether Patient Indicator or Patient Type should be inactive as secondary sorts for the BIL and COL statistics groups.

NOTE: You should work with the McKesson installation personnel in setting up this table.

BIL - Biller Statistics

Should Patient Indicator be active as a secondary sort?   Y   N
(Circle Y or N)

Should Patient Type be active as a secondary sort?   Y   N
(Circle Y or N)

COL - Collector Statistics

Should Patient Indicator be active as a secondary sort?   Y   N
(Circle Y or N)

Should Patient Type be active as a secondary sort?   Y   N
(Circle Y or N)

STATISTICS RETENTION

Level 1	Matrix# 104	Facility:	Fiscal Year:

This worksheet is used to determine the number of fiscal years statistics data should be retained on the system. You can set this value for each statistic group.

AGY-Collection Agency Statistics

Number of Fiscal Years' Data to Retain   (2N)

Number of Fiscal Years' Period Summaries to Retain   (2N)

BIL-Biller Statistics

Number of Fiscal Years' Data to Retain   (2N)

Number of Fiscal Years' Period Summaries to Retain   (2N)

COL-Collector Statistics

Number of Fiscal Years' Data to Retain   (2N)

Number of Fiscal Years' Period Summaries to Retain   (2N)

CON - Contract Statistics (Contract Sort)

Number of Fiscal Years' Data to Retain   (2N)

Number of Fiscal Years' Period Summaries to Retain   (2N)   [|]

COR-Contract by Revenue Department Statistics

Number of Fiscal Years' Data to Retain   (2N)   [|]

Number of Fiscal Years' Period Summaries to Retain   (2N)   [|]

DIS-Discharge Statistics

Number of Fiscal Years' Data to Retain   (2N)   [|]

Number of Fiscal Years' Period Summaries to Retain   (2N)   [|]

DCA-Doctor Census Admitting Statistics

Number of Fiscal Years' Data to Retain   (2N)   [|]

Number of Fiscal Years' Period Summaries to Retain   (2N)   [|]

DCT-Doctor Census Attending Statistics

Number of Fiscal Years' Data to Retain   (2N)   [|]

Number of Fiscal Years' Period Summaries to Retain   (2N)   ☐☐

DRA-Doctor Revenue Admitting Statistics

Number of Fiscal Years' Data to Retain   (2N)   ☐☐

Number of Fiscal Years' Period Summaries to Retain   (2N)   ☐☐

DRO-Doctor Revenue Ordering Statistics

Number of Fiscal Years' Data to Retain   (2N)   ☐☐

Number of Fiscal Years' Period Summaries to Retain   (2N)   ☐☐

DRT-Doctor Revenue Attending Statistics

Number of Fiscal Years' Data to Retain   (2N)   ☐☐

Number of Fiscal Years' Period Summaries to Retain   (2N)   ☐☐

EMP-Employer Census Statistics

Number of Fiscal Years' Data to Retain   (2N)   ☐☐

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Number of Fiscal Years' Period Summaries to Retain   (2N) ☐☐

EMR-Employer Revenue Statistics

Number of Fiscal Years' Data to Retain   (2N) ☐☐

Number of Fiscal Years' Period Summaries to Retain   (2N) ☐☐

FCC-Financial Class Census Statistics

Number of Fiscal Years' Data to Retain   (2N) ☐☐

Number of Fiscal Years' Period Summaries to Retain   (2N) ☐☐

FCR-Financial Class Revenue Statistics

Number of Fiscal Years' Data to Retain   (2N) ☐☐

Number of Fiscal Years' Period Summaries to Retain   (2N) ☐☐

IST-Insurance Statistics

Number of Fiscal Years' Data to Retain   (2N) ☐☐

Number of Fiscal Years' Period Summaries to Retain (2N) ☐☐

LCP-Late Charge Statistics

Number of Fiscal Years' Data to Retain   (2N) ☐☐

Number of Fiscal Years' Period Summaries to Retain (2N) ☐☐

MED-Medical Service Census Statistics

Number of Fiscal Years' Data to Retain   (2N) ☐☐

Number of Fiscal Years' Period Summaries to Retain (2N) ☐☐

MER-Medical Service Revenue Statistics

Number of Fiscal Years' Data to Retain   (2N) ☐☐

Number of Fiscal Years' Period Summaries to Retain (2N) ☐☐

NUR-Nurse Station Statistics

Number of Fiscal Years' Data to Retain   (2N) ☐☐

Number of Fiscal Years' Period Summaries to Retain   (2N) ▢▢

PAT-Patient Type Census Statistics

Number of Fiscal Years' Data to Retain   (2N) ▢▢

Number of Fiscal Years' Period Summaries to Retain   (2N) ▢▢

PTR-Patient Type Revenue Statistics

Number of Fiscal Years' Data to Retain   (2N) ▢▢

Number of Fiscal Years' Period Summaries to Retain   (2N) ▢▢

REV-Revenue Center Statistics

Number of Fiscal Years' Data to Retain   (2N) ▢▢

Number of Fiscal Years' Period Summaries to Retain   (2N) ▢▢

TRC-Transaction Statistics

Number of Fiscal Years' Data to Retain   (2N) ▢▢

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Number of Fiscal Years' Period Summaries to Retain   (2N)   ☐☐

ZIP-ZIP Code Statistics

Number of Fiscal Years' Data to Retain   (2N)   ☐☐

Number of Fiscal Years' Period Summaries to Retain   (2N)   ☐☐

CONTRACT TELEPHONE MESSAGES

Level 1	Matrix# 107a	Facility:

This table, which is not split by facility, contains messages that can be inserted into the contract collector workfile. Refer to the list of available internal elements (Matrix #61) in LEVEL 0 to determine which elements can be inserted in telephone messages.

Message Code   (4N) | | | | |

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Maximum Width | | |

(Message line width in columns.   Range is 10-75.)

Maximum Lines | | |

(Number of message lines. Range is 1-15.)

Message Text   (can be up to 15 lines by 75 columns)

TELEPHONE MESSAGES

Level 1	Matrix#107	Facility:

This table, which is not split by facility, contains messages that can be inserted into the collector workfile. Refer to the list of available internal elements (Matrix #61) in LEVEL 0 to determine which elements can be inserted in telephone messages.

Message Code   (3N)   ☐ ☐ ☐

Description _____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Maximum Width   ☐ ☐

(Message line width in columns.   Range is 10-75.)

Maximum Lines   ☐ ☐

(Number of message lines. Range is 1-18.)

Message Text   (can be up to 15 lines by 75 columns)

MAINTAIN LOG ID - (US ONLY)

Level 1	Matrix# 108	Facility:

This table, which can be split by facility, contains codes identifying the third party logs used by the system. These codes are used by the Insurance Plan Coverage master to identify the log(s) updated by a specific carrier/plan. Log reconciliation is done per log ID.

Log ID Code   (2AN)

Log Description

(30AN)

DRG based payor?   Y   N

DRG?   (Circle response)   R   U   B

What criteria should the system use to select accounts displayed on the Log Report? Circle R to use Reconciled DRGs, U to use Unreconciled DRGs, or B for Both.

DRG Reim Amount?   (Circle response)   R   U   B

What criteria should the system use to select accounts displayed on the Log Report? Circle R to use Reconciled DRG amounts, U to use Unreconciled DRG amounts, or B for Both.

Outlier?   (Circle response)   R   U   B

What criteria should the system use to select accounts displayed on the Log Report? Circle R to use Reconciled DRG amounts, U to use Unreconciled DRG amounts, or B for Both.

Days?   (Circle response)   R   U   B

What criteria should the system use to select accounts displayed on the Log Report? Circle R to use Reconciled DRG days, U to use Unreconciled DRG days, or B for Both.

Reim Amount?   (Circle response)   R   U   B

What criteria should the system use to select accounts displayed on the Log Report for a payor (not DRG based)? Circle R to use Reconciled amounts, U to use Unreconciled amounts, or B for Both.

Liability?   (Circle response)   R   U   B

What criteria should the system use to select accounts displayed on the Log Report comparing carrier balance from total payments and adjustments? Circle R for Reconciled liability, payments, and adjustments; U for Unreconciled liability, payments, and adjustments; or B for Both.

Reconciliation Allowance? (4N)   [|] . [|]

What is the dollar amount an account may be
unreconciled by but still be considered reconciled

Column 54   (Circle response)   C   N   Blank

Does the system print covered or non-covered charges for the claim on the UB in column 54 for each line. Circle **C** for Covered, **N** for Non-covered, or **Blank** for non-UB type claims. This field should be set according to the UB Charge Control Parameter. UB82 claims do not reference this field, only UB claims.

Column 56   (Circle response)   C   N   Blank

Does the system print covered or non-covered charges for the claim on the UB82 in column 56 for each line. Circle **C** for Covered, **N** for Non-covered, or **Blank** for non-UB82 type claims. This field should be set according to the UB82 Charge Control Parameter. UB claims do not reference this field, only UB82 claims.

TRANSACTION CODES

Level 1	Matrix# 109	Facility:

Transaction codes are used for cash posting, adjustment posting, balance transfer, location transfer and memo notations. They are also used in several system parameters and masters.

Transaction Types		
Type Code	**Use**	**Description**
A	P	Adjustment *
E	P	Agency Cash Agency Collected *
B	P	Balance Transfer
Z	P	Claims Processing
T	P	Account Notes
I	P	Insurance Payment *
D	P	Insurance Refund *
F	N	Miscellaneous Cash *
O	V	Miscellaneous Notes (not implemented)
N	V	Nonpatient Cash *
G	V	Other Adjustments *
Y	P	Patient Bills
P	P	Payment *
R	P	Refund *
S	P	Status Transfer
M	P	System Memos
U	U	Unapplied Cash *
V	N	Agency Fees *
J	V	Other Refunds*

*Adding a transaction code of this type requires the GL Mapping table to be set up for this new transaction code.

Code Use	
N	Not patient-specific
P	Patient-specific
U	Unapplied cash-specific
V	Vendor-specific

Transaction Type   (1A)   [ ]

(From list on preceding page)

Transaction Code   (4N)   [ ][ ][ ][ ]

Description_____

          (30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Accum. Stats?   Y   N

Accumulate statistics for this transaction? The default is Y.

Valid Accounts   (Circle response)   A   C   R

Which accounts are valid for the transaction code. Circle A for Any, C for Bad Debt, or R for PA and AR.

Combine?   (Circle Y or N)   Y   N

Combine this transaction code with another transaction code on bills and statements? The default is N.
If you enter Y, you must also complete the next two fields:

Combined to Transaction Type   (1A)

Combined to Transaction Code   (4N)

TYPE OF SERVICE

Level 1	Matrix# 112	Facility:

This table, which is not split by facility, contains codes identifying the types of service used for 1500 and Non Pro Fee 1500 claim processing. These codes are also used in the FIM for each professional fee.

In Canada, this table defines the type of service codes for WCB claim form processing. These codes are used in the STAR Patient Care Financial Item Master (FIM).

Type of Service Code   (2AN)

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Type of Service Code   (2AN)

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Type of Service Code   (2AN)

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Type of Service Code   (2AN)

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

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TYPE OF SERVICE CROSS REFERENCE TABLE

Level 1	Matrix# 112a	Facility:

This table allows you to print an alternate Type of Service (TOS) code on the 1500 claim in Locator 24C.

Code (2AN)

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

FIM TOS (2AN)

Enter the TOS code that is contained on the FIM

Alternate TOS (2AN)

Enter the TOS code to be used instead of the TOS that is in the FIM on the 1500 claim form.

UB CONDITION CODES/SPECIAL STATISTICS CODES

Level 1	Matrix# 115	Facility:

This table identifies the condition codes that are used in UB claim processing. Refer to your state UB manual for valid values.

In Canada, these codes are referred to as insurance summary codes. Although they are attached to individual items in the STAR Patient Care Financial Item Master, they do not control claim processing for Canadian claims. In general, the insurance summary codes entered are the same as the proration summary codes, which do control claim processing in Canada.

UB Condition Code   (2AN)   ☐☐

       Description_____

       (30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

UB Condition Code   (2AN)   ☐☐

       Description_____

       (30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

UB Condition Code   (2AN)   ☐☐

       Description_____

       (30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

UB Condition Code   (2AN)   ☐☐

       Description_____

       (30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

UB OCCURRENCE CODES - (US ONLY)

Level 1	Matrix# 116	Facility:

This table identifies the occurrence codes used in UB claim processing. Refer to your state UB manual for valid values.

UB Occurrence Code   (2AN) |__|__|

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

UB Occurrence Code   (2AN) |__|__|

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

UB Occurrence Code   (2AN) |__|__|

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

UB Occurrence Code   (2AN) |__|__|

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

UB OCCURRENCE SPAN CODES - (US ONLY)

Level 1	Matrix# 117	Facility:

This table identifies the occurrence span codes used in UB claim processing. Refer to your state UB manual for valid values.

UB Occurrence Span Code   (2AN)   ☐☐

Description _____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

UB Occurrence Span Code   (2AN)   ☐☐

Description _____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

UB Occurrence Span Code   (2AN)   ☐☐

Description _____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

UB Occurrence Span Code   (2AN)   ☐☐

Description _____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

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UB REVENUE CODES/INSURANCE SUMMARY CODES

Level 1	Matrix# 118	Facility:

This table identifies the revenue codes that are used in UB claim processing. Refer to your state UB manual for valid values.

In Canada, these codes are referred to as insurance summary codes. Although they are attached to individual items in the STAR Patient Care Financials Item Master, they do not control claim processing for Canadian claims. In general, the insurance summary codes entered are the same as the proration summary codes, which do control claim processing in Canada.

UB Revenue Code   (4N)   ☐☐☐☐

Description _____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

UB Revenue Code   (4N)   ☐☐☐☐

Description _____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

UB Revenue Code   (4N)   ☐☐☐☐

Description _____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

UB Revenue Code   (4N)   ☐☐☐☐

Description _____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

UB VALUE CODES - (US ONLY)

Level 1	Matrix# 119	Facility:

This table identifies the value codes used in UB claim processing. Refer to your state UB manual for valid values.

UB Value Code   (2AN)   ☐☐

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

UB Value Code   (2AN)   ☐☐

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

UB Value Code   (2AN)   ☐☐

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

UB Value Code   (2AN)   ☐☐

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Chapter 4 - LEVEL 2

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INTRODUCTION

This chapter contains worksheets to complete the following tables. You should complete these worksheets before beginning the worksheets in Level 3.

- Alternate Level of Care

- Billers

- Billing Requirements

- Claim Attachments

- Claim Generation Parameter

- Collectors

- Contract Follow-up Schedules

- Facility Information PA/AR Control

- Facility Information Refund Parameters (US Only)

- 1500 Charge Control Parameters

- Non Professional Fee 1500 Charge Control Parameters (US Only)

- 1500 Department/Supplier Override (US Only)

- Financial Item Master

- Follow-up Letters

- GL Mapping Parameter

- Insurance Follow-up Letters

- Insurance Plan

- Memo Follow-up Letters

- Miscellaneous Cash Codes

- Patient Type

- Payment File Definition

- Payor Table Definition

- Payor Table Definition Stop Loss Table

- Payor Table Definition Accommodation Exceptions

- Payor Table Definition Proration Summary Exceptions

- Payor Table Definition Fee Schedule Exceptions

- UB82 Charge Control Parameters (US Only)

- UB Charge Control Parameters (US Only)

- UB Therapy Revenue Code Table

- Split Claims Criteria Table

ALTERNATE LEVEL OF CARE

Level 2	Matrix# 7b	Facility:

This table is used to set the Maximum Reimbursement Amount (up to 99999999.99, or U for Unlimited) for the Total ALC reimbursement (this field is only for ALC reimbursement and does not take into account the DRG reimbursement amount), the Non Primary Reimbursement Percentage (which can be set to 100%), and the Per Diem Amount and Maximum Days for each ALC Type.

Reimbursement Payor Code　　　　(2A)

Table Number　　　(3N):

Maximum Reimbursement Amount　　　(10N or U for Unlimited)

Non Primary Reimb Percentage　　　(3N):

ALC Type　　　(3N):

Per Diem Amount　　　(9N)

Maximum Days   (3N):   ☐☐☐

ALC Type   (3N):   ☐☐☐

Per Diem Amount   (9N)   ☐☐☐☐☐☐☐☐☐

Maximum Days   (3N):   ☐☐☐

ALC Type   (3N):   ☐☐☐

Per Diem Amount   (9N)   ☐☐☐☐☐☐☐☐☐

Maximum Days   (3N):   ☐☐☐

ALC Type   (3N):   ☐☐☐

Per Diem Amount   (9N)   ☐☐☐☐☐☐☐☐☐

Maximum Days   (3N):   ☐☐☐

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ALC Type   (3N):   ☐☐☐

Per Diem Amount   (9N)   ☐☐☐☐☐☐☐☐☐

Maximum Days   **(3N):**   ☐☐☐

BILLERS

Level 2	Matrix# 8	Facility:

This table lists the hospital billers and their supervisors. Billers must be established as hospital employees. It is used when the biller worklist is created and in building the Biller Group table. Billers are automatically assigned to an account at admission. Billing supervisors should be entered before billers. If a biller is inactivated, the user should delete or replace this biller in the biller group.

Biller Code (3N)

Identifier Enter the method by which the biller will be identified in the system. Entry options are the employee system ID number, employee number, or last name.

System ID* (12N)

Employee Number (9N)

Biller Name (15AN)
(Last, First, MI)

Biller Phone Number (10N)

Extension (4N)

Supervisor/Manager Flag (1A - S, M, or N)

Is this a supervisor or manager? Options are S (supervisor), M (manager), or N (neither).

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Supervisor   If you enter N in the Supervisor/Manager Flag field, you must identify
                       the supervisor for this biller.

(25AN or 3N
Biller Code*)

      *   From a previously defined table.

Accessible   If you enter M in the Supervisor/Manager Flag field, identify the
Billers   billers managed by this biller.

(25AN or 3N
Biller Code)

(25AN or 3N
Biller Code)

(25AN or 3N
Biller Code)

(25AN or 3N
Biller Code)

(25AN or 3N
Biller Code)

(25AN or 3N
Biller Code)

(25AN or 3N
Biller Code)

(25AN or 3N
Biller Code)

(25AN or 3N
Biller Code)

Allow Access to CPTAFB   (1A -Y or N)
Workfile Functions?

Can this biller have access to Change Patient Type After Final Billing workfile functions? Options are Y (Yes) or N (No).

BILLING REQUIREMENTS

Level 2	Matrix# 12	Facility:

This parameter enables you to indicate specific fields that must be present on a patient account in order for a final bill to be generated. This parameter also indicates through data control which department is responsible for this information. A billing requirements code is given to each final bill parameter.

Billing Requirements Code   (2N)

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Charge Summary Flag?   Y   N

Should summary charges be reviewed? Default is N.

1500 HCPCS Hold   (Circle Y or N)   Y   N

Should the system hold a bill from production for professional fee charges missing a HCPCS code.

Data Control Code   (3AN)

If you circle Yes for 1500 Diag Hold, enter the data control code representing the department responsible for the 1500 information.

1500 Diag Hold   (Circle Y or N)   Y   N

Should the system hold a bill from production for professional fee charges missing a diagnosis.

Data Control Code   (3AN)

If you circle Yes for 1500 Diag Hold, enter the data control code representing the department responsible for the 1500 information.

1500 Performing Dr Hold   (Circle Y or N)   Y   N

Should the system hold a bill from production for professional fee charges missing a performing physician.

ABN Hold   (Circle Y or N)   Y   N

Should the system hold bills for charges that are not determined to be medically necessary based on user-entered ICD-9-CM diagnoses defined in the STAR Medical Records HCPCS Table?

CYCLE ADJ BILL CHG-   (Circle Y or N)   Y   N
CR AMT/#

Should a bill should be edited for unbilled cycle charges and credits and should the edit be excluded for accounts using the Pre-bill Edit functionality. The edit is only for final bills and for final adjustment bills, if the hospital is performing edits for final adjustment bills.?

If you enter Yes to the   (Circle One)   I (Include)   E (Exclude)
above, indicate whether the
edit should be excluded
for accounts using the
Pre-bill Edit functionality.

Data Control Code   (3AN)   [   ][   ][   ]

If you circle Yes for 1500 Performing Dr Hold, enter the data control code representing the department responsible for the 1500 information.

SEQ	Data Base Element	Required/ Not Allowed		Controlled By
	(8AN)	Circle R or N*		(Data Control Code)
1		R	N	
2		R	N	

SEQ	Data Base Element							Required/ Not Allowed			Controlled By		
	(8AN)							Circle R or N*			(Data Control Code)		
3								R		N			
4								R		N			
5								R		N			
6								R		N			
7								R		N			
8								R		N			
9								R		N			
10								R		N			
11								R		N			
12								R		N			
13								R		N			
14								R		N			
15								R		N			
16								R		N			
17								R		N			
18								R		N			
20								R		N			
21								R		N			
22								R		N			
23								R		N			
24								R		N			
25								R		N			

* Not allowed option means the claim will fail if this information is present on the patient record.

CLAIM ATTACHMENTS

Level 2	Matrix# 9	Facility:

The Claim Attachment Code table contains codes indicating an attachment should accompany claims made on a specific insurance plan. These codes can be entered for an individual charge item in the Financial Item Master. This table is not split by facility.

Attachment Code ☐☐ (2A)

Description _____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Service Item?   Is this attachment related to a service item (circle Yes   Y   N
or No)?

Description _____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Service Item?   Is this attachment related to a service item (circle Yes or No)?   Y   N

Attachment Code ☐☐ (2A)

Description _____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Service Item?   Is this attachment related to a service item (circle Yes   Y   N
or No)?

CLAIM GENERATION PARAMETER

Level 2	Matrix# 15	Facility:

This parameter indicates the transaction codes used when a claim is loaded, produced and submitted. It also defines the number of days a claim failing edits should be held before automatic release.

Claim Generation Parameter Code   (4A)   ☐☐☐☐

Description _____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Suspense Days   (2N or U)   ☐☐

Enter the number of days to hold claim failing edits from printing. Enter **U** for unlimited.

Cycle Claim Transaction Code: Z (type)   (4N code)*   ☐☐☐☐

Final Claim Transaction Code: Z (type)   (4N code)*   ☐☐☐☐

Adjustment Claim Transaction Code: Z (type)   (4N code)*   ☐☐☐☐

Reprint Claim Transaction Code: Z (type)   (4N code)*   ☐☐☐☐

Late Claim Transaction Code: Z (type)   (4N code)*   ☐☐☐☐

Cycle Adjustment Claim Transac Code   (4N code)*   ☐☐☐☐

* From a previously-defined table.

COLLECTORS

Level 2	Matrix# 23	Facility:

This table lists the hospital collectors and their supervisors and managers. It is used when the collector worklist is created and in building the Collector Group table. Guarantor collectors are automatically assigned to an account at bill time. Collector supervisors should be entered before collectors. The Collectors table is used to grant or restrict a collector's rights to approve refunds. The table defines the maximum dollar limit for refund approvals by type of refund. When a refund approval screen is accessed, the maximum dollar amount analysis is made by the system. If the dollar value defined on this table is not met, the person cannot access the screen to approve the refund. The maximum dollar value is not facility-specific.

Collector Code   (3N)

Identifier   Enter the method by which the collector will be identified in the system. Entry options are the employee system ID number, employee number, or last name.

System ID*   (12N)

Employee Number   (9N)

Employee Last Name   (15A)

Collector Name   This field is display only; it is filled in by the system when the System ID field is completed.

Collector Phone Number   (10N)

Extension   (4N)

Supervisor/Manager Flag   (1A - S, M, or N)

Is this a supervisor or manager? Options are S (supervisor), M (manager), or N (neither).

Supervisor   If you entered N in the Supervisor/Manager Flag field, identify the supervisor for this
                        collector in the format Last Name, First.

(25AN or 3N
Collector
Code)

Maximum Accounts   (6N)

Accessible   If you entered M in the Supervisor/Manager Flag field, identify the collectors managed
Collectors   by this collector in the format Last Name, First.

(25AN or 3N
Collector
Code)

(25AN or 3N
Collector
Code)

(25AN or 3N
Collector
Code)

(25AN or 3N
Collector
Code)

(25AN or 3N
Collector
Code)

(25AN or 3N
Collector
Code)

(25AN or 3N
Collector
Code)

(25AN or 3N
Collector
Code)

Refund Collectors   (table lookup)

This field defines the collectors who can request refunds.

Guarantor Refund   (8-N)

This field defines the maximum guarantor refund dollar amount that can be
approved by the collector. Enter a dollar range from 0.00 to 999,999.99.

Carrier Refund   (8-N) | | | | | | | | |

This field defines the maximum carrier refund dollar amount that can be
approved by the collector. Enter a dollar range from 0.00 to 999,999.99.

Unapplied Refund   (8-N) | | | | | | | | |

This field defines the maximum unapplied cash refund dollar value that can be
approved by the collection. Enter a dollar range from 0.00 to 999,999.99.

CONTRACT FOLLOW-UP SCHEDULES

Level 2	Matrix# 22a	Facility:

Schedule #   (3N) | | | |

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Wait Days   (2N) | | |

Enter the minimum number of days to wait after bill creation before beginning the collection process. The default is 1.

Defining Follow-Up Frequency
The system provides three ways for you to define follow-up frequency:

• Day of month (for example, the 1st of the month)

• Day of week within a given week of the month (for example, Tuesday of the second week of the month)

• Interval, or a specified number of days between each follow-up (for example, every 24 days)

Complete the following worksheet fields keeping these guidelines in mind:

• If you select *Day of Month*:

  - Leave the Day of Week and Week of Month entries blank

  - Leave the interval for each sequence blank

• If you select *Day of Week* and *Week of Month*:

  - Leave the Day of Month entry blank

  - Leave the interval for each sequence blank

• If you select *Interval*:

- Leave the Day of Month, Day of Week, and Week of Month entries blank

Day of Month   (2N)   ☐☐

The day statements should be sent. Optional entries are 1-28 or L for Last day of the month.

Day of Week   (1N)   ☐

The day of the week statements should be sent, where Sunday=1, Monday=2, ... Saturday=7.

Week of Month   (1N)   ☐

The week of the month on which follow-up should be sent. Optional entries are 1-4. This field is not required if a value is entered to the Day of Month field.

Max Paper Bal   (8N or U)   ☐☐☐☐☐ . ☐☐

The maximum balance for paper follow-up. If the bill balance is greater than the maximum paper balance, telephone follow-up will be done. The default is U for Unlimited. If the Collector Workstation is not used, the response should be "U".

Min Balance   (8N)   ☐☐☐☐☐☐   ☐☐

The minimum balance needed to continue sending paper follow up.

In the following table, complete the columns as follows:

SEQ
Enter up to a two-digit number referring to a line in the follow-up schedule. The number of lines is unlimited.

PAPER CODE
This field identifies the type of paper follow-up to be sent. This field is required if the Collector Workstation is not used. If this field is left blank, complete the Phone Code field.

PHONE CODE
Enter the four-digit code for the phone message to be displayed in the collector's workfile when the maximum paper balance is exceeded or no paper code is entered. This field is not accessible if the Collector Workstation is not used.

INTERVAL
Enter the number of days, from 1 to 999, to wait before continuing to the next sequence number in the collection schedule. This field can only be completed if the Day of Month, Day of Week, and Week of Month fields are blank.

Seq #	Paper Code (4N)				Phone Code (4N)				Interval (3N)		
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
20											

FACILITY INFORMATION PA/AR CONTROL

Level 2	Matrix# 33	Facility:

The PA/AR Control Master defines the two most common semi-private room rates, the bulk mail requirements, the delay days, patient and guarantor account lookup at admitting and registration, period reclassification, closing parameters, and patient communication formats.

SP Rate 1   (4N - whole dollars)

Enter the most common semi-private room rate.

Effective Date   (6N)   / /

Enter the date the semi-private room rate 1 becomes effective.

SP Rate 2   (4N - whole dollars)

Enter the second most common semi-private room rate.

Effective Date   (6N)   / /

Enter the date the semi-private room rate 2 becomes effective.

WD Rate 1   (4N - whole dollars)

Enter the most common ward rate.

Effective Date   (6N)   / /

Enter the date the ward rate 1 becomes effective.

WD Rate 2   (4N - whole dollars)   ☐☐☐☐

Enter the second most common ward rate.

Effective Date   (6N)   ☐☐ / ☐☐ / ☐☐

Enter the date the ward rate 2 becomes effective.

I/P

Pat?   (Circle Y or N)   Y   N

Perform patient account lookup during admission for inpatients? The default is N.

Guar?   (Circle Y or N)   Y   N

Perform guarantor account lookup during admission for inpatients? The default is N.

Plan?   (Circle Y or N)   Y   N

Do insurance verification during admission for inpatients? The default is N.

Chg?   (Circle Y or N)   Y   N

Allow insurance changes on Patient Care after insurance verification for inpatients? The default is N.

O/P

Pat?   (Circle Y or N)   Y   N

Perform patient account lookup during admission for outpatients? The default is N.

Guar?   (Circle Y or N)   Y   N

Perform guarantor account lookup during admission for outpatients? The default is N.

Plan?   (Circle Y or N)   Y   N

Do insurance verification during admission for outpatients? The default is N.

Chg?   (Circle Y or N)   Y   N

Allow insurance changes on Patient Care after insurance verification for outpatients? The default is N.

Reclass

Closed P?   (Circle Y or N)   Y   N

Allow reclassification to closed periods?

Max Pds   (2N, range is 1-13)

Enter the maximum number of prior periods to allow reclassification.

Auto Close Days

Fiscal Pd   (3N, range is 1-366)

Enter the number of days after period end before marking period as closed.

Fiscal Yr   (3N, range is 1-366)

Enter the number of days after fiscal year end before marking fiscal year as closed.

Reclass Default   (Circle one)   E   T

Enter the earliest reclass date default prompt. E is Earliest; T is Today.

Avg Dly Rev Mths   (1N, range is 0-9)   ☐

Enter the number of months of average daily revenue. This is used in calculating A/R days.

Backdate Days   (2N, range is 0-999)   ☐☐☐

Enter the number of days to allow backdated cash and adjustment posting.

Days/Sort for Unpaid Rpt   (3N, range is 0-999)   ☐☐☐

Enter the number of days before claims print on the Unpaid Claims Report (FCR280).

Refund Pg Break   (Circle one)   Yes   No

Page break the Refund Reports by financial class?

C/A Batch Bal?   (Circle one)   Y   N

Should variances in the Contractual Allowance fields not allow approval of cash batches?

UB LOC 54 PRIOR PYMT CALC   Indicate whether UB Locator 54 reflects   Y   N
insurance payments and adjustments, as well
as any of the following: Coinsurance from
Cash Posting, Deductible from Cash Posting,
Co-Pay from Cash Posting, Pat Resp from
Cash Posting. If this field is blank, the UB Loc
54 Prior Pymt Calc field on the PAAR Control
screen is used.

Circle Y for Yes or N for No.

If you enter Yes, circle the items from payment
transaction to be included in prior payment total:

(1) Adjustments (Auto Cont. and Manual)

(2) Coinsurance from Cash Posting

(3) Deductible from Cash Posting

(4) Co-Pay from Cash Posting

(5) Pat Resp from Cash Posting

UB Loc 55   (Circle one)   C   B

Update UB locator 55 with current estimated amount due (C) or current carrier balance (B) for waiting
claims.

Trans Hist View   (Circle one)   D   B   P

Enter the default view for transaction history. D = date, B = balance, and P =
prompt. If P, then select either default of D or B.

**Take Home Rx UB
Revenue Code**   (4AN)   ☐ ☐ ☐ ☐

Take Home Rx Proration Summary Code   (4AN)   [ ][ ][ ][ ]

Claims List Order   (Circle one)   Oldest   Most Recent

Ins. Letter Format   (2AN)   [ ][ ]

Installation personnel will help you set up format files.

Print Facility   (Circle one)   D   L   I   A

Print account number with facility on (D) Detail Statements, (L) Collection Letters, (I) Insurance Collection Letters, or (A) All.

Business Office   (2A)   [ ][ ]

Enter the code for the business office that bills and collects for this facility.

Bulk Mail

Pieces   (3N)   [ ][ ][ ]

Enter the number of pieces to accumulate for bulk mail.

Delay Days

Detail Statement   (1N)   [ ]

Enter the number of days to wait for reaching the bulk mail requirement before sending a detail statement.

Collection Letter   (1N)   [ ]

Enter the number of days to wait for reaching the bulk mail requirement before sending a collection letter.

Insurance Letter   (1N)   [ ]

Enter the number of days to wait for reaching the bulk mail requirement before sending a carrier follow-up letter.

Guarantor/Account F/U   (Circle one)   Guarantor   Account

Identify whether follow-up should be performed at the guarantor or account level.

Pre-Col Del Action?   (Circle Y or N)   Y   N

Identify whether accounts that are automatically or manually deleted from Pre-Collection should return to guarantor or account follow-up.

Prepaid Amount   (Circle one)   Yes   No

Should prepaid amounts be calculated and displayed on payment plan accounts?

Zero/Balance F/U?   (Circle one)   Yes   No

Include zero balance accounts during guarantor F/U? The default is No.

Archive Method   (Circle one)   Paper   Tape

Identify the preferred archive method. This option is not currently implemented.

Perform Auto PA F/U   (Circle one)   Yes   No

Do you want to put PA accounts in follow up automatically?

PA F/U Exception Schedule   (3N code)   [ ][ ][ ]

Enter the PA follow up schedule which can be assigned to accounts that are not in automatic PA follow up.

Workfile Max Report Days   (3N code)   [ ][ ][ ]

Enter the telephone workfile entries exceeding a specific number of days. The qualifying telephone workfile entries are summarized in two online functions and detailed in the Collector Statistics Telephone Entries Report (FFR275). This field is optional.

Ins FC Update of AR   (Circle one)   Yes   No
F/U

Do you want guarantor follow-up information to be updated for accounts in AR when a financial class change occurs as a result of an insurance change?

                          (Circle one)   Yes   No

Should the guarantor follow-up information should be updated when an account is linked to an external AR pre-collect agency?

Collector   (Circle one)   Account   Patient
Assignment Balance

This field determines whether the system uses the account or the patient balance when assigning the PA, AR, Pre-Collection, and Internal Bad Debt collectors. This field is also used to assign external pre-collect agencies for guarantor collections only, through the Collection Agency Group table.

INS COV FOR AUTO   (Circle one)   Account   Insurance
SERIES RE-REG

This field determines the source of insurance plan coverage information when
an account is registered during midnight processing via auto series re-
registration.

AUTO ADJ REBILL   (Circle one)   Yes   No
CPTAFB?

Do you want an automatic adjustment bill to be generated when a
Change Patient Type After Final Bill transaction occurs for an account?

If you answer Yes, you can define which indicators should trigger an
adjustment bill.
(1) Basic Coverage

(2) Room Coverage

(3) Ancillary Coverage

(4) Major Medical Coverage

(5) Daily/Blood Deductibles

(6) Flat Rate Coverage

(7) Billing/Claims Parameters

(8) Collection Parameters

(9) Reimbursement

(10) Claim Attachments

Edit Adj Bill?   (Circle one)   Yes   No

Indicate whether bill edits should be performed on adjustment bills.

EDIT ADJ BILL FOR   (Circle one)   Yes   No
CPTAFB

Indicate whether bill edits should be performed on the first adjustment
bill after a CPTAFB transaction.

BD TO AR   (Circle one)   Yes   No
TRANSFER IN
CPTAFB

Indicate whether you want to be able to add a request to transfer an
account from bad debt (BD) to accounts receivable (AR) within the
Change Patient Type After Final Bill (CPTAFB) processor.

Ins. Letter Transaction Code: T   (4N code)

PA Detail Statement Format   (4AN)*

PA Detail Statement Transaction Code: T   (4N code)*

PA Collection Letter Format   (4AN)*

PA Collection Letter Transaction Code: T   (4AN)*

AR Detail Statement Format   (4AN)*

AR Detail Statement Transaction Code: T   (4N code)*

AR Collection Letter Format   (4AN)*

AR Collection Letter Transaction Code: T   (4N code)* | | | | |

BD Detail Statement Format   (table lookup)

BD Detail Statement Transaction Code: T   (4N code)* | | | | |

BD Collection Letter Format   (table lookup)

BD Collection Letter Transaction Code: T   (4N code)* | | | | |

Archive Statement Format   (4AN)* | | | | |

Archive Statement Transaction Code: T   (4N code)* | | | | |

Cash Receipt Print Format   (4AN code)* | | | | |

Phone Message for Null F/U Schedule   (4N code)* | | | | |

Claim Label Print Format   (Circle one)   1 Across   2 Across   3 Across

Wait Step Transaction Code: T   (4N code)*   ☐☐☐☐

Entry Into Phone Workfile Transaction Code: M   (4N)*   ☐☐☐☐

Telephone Follow-Up Transaction Code: T   (4N code)*   ☐☐☐☐

* From a previously defined table

Key Data Revision Transaction Code: S   (4N code)*   ☐☐☐☐

Tracer Transaction Code: Z   (4N code)*   ☐☐☐☐

Bad Debt Prelist Transaction Code: M   (4N code)*   ☐☐☐☐

FC Change Without Reclass Transaction Code: M   (4N code)*   ☐☐☐☐

Free Form Notes Transaction Code: T   (4N code)*   ☐☐☐☐

Insurance Change Transaction Code: M   (4N code)*   ☐☐☐☐

User Hold Archive Prelist Transaction Code: M   (4N code)* | | | | |

System Archive Prelist Transaction Code: M   (4N code)* | | | | |

User Archive Prelist Transaction Code: M   (4N code)* | | | | |

User Remove Archive Prelist Transaction Code: M   (4N code)* | | | | |

Archive Write-Off Transaction Code: M   (4AN code)* | | | | |

FC Repricing Memo Transaction Code: M   (4N code)* | | | | |

   * From a previously defined table.

REFUND PARAMETERS

Level 2	Matrix# 40	Facility:

This parameter, which is split by facility, sets the edits performed for refunds and is used during refund processing.

Carrier Refund Parameters

Insurance Balance   (Circle Y or N)   Y   N

Must the insurance balance cover the carrier refund?

Account Balance   (Circle Y or N)   Y   N

Must the account balance cover the carrier refund?

Print Facility on Insurance Refund Check   (Circle Y or N)   Y   N

Acct Bal Cut-Off Amt   (12N)

Min Amount   (12N)

Refund Check Message   (4N - from previously defined table)

Memo Transaction Code: M   (4N - from previously defined table)

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Guarantor Refund Parameters

Patient Balance   (Circle Y or N)   Y   N

Must the patient balance cover the guarantor refund?

Insurance Balance   (Circle Y or N)   Y   N

Must the insurance balance cover the guarantor refund?

Print Facility   (Circle Y or N)   Y   N

Print facility on guarantor refund check?

Min Refund Amount   (12N)   ☐☐☐☐☐☐☐☐☐☐ . ☐☐

Refund Check Message   (4N - from previously defined table)   ☐☐☐☐

Memo Transaction Code: M   (4N - from previously defined table)   ☐☐☐☐

Process Refund Checks?   (Circle Y or N)   Y   N

Should refund checks be processed in Patient Accounting?

Refund Retry Days   (3N)   ☐☐☐

Refund Ck. Format   (4AN)

Format of checkform. McKesson will help set this up.

Unapplied Cash Refund   (4N - from previously defined table)
Check Message

Unapplied Cash Refund   (4N - from previously defined table)
Transaction Code: J

1500 CHARGE CONTROL PARAMETERS - (US ONLY)

Level 2	Matrix# 42	Facility:

This parameter is used to determine how charges are printed on the 1500 claim form.

Code   (3N)   [ ][ ][ ]

Description _____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Separate Claims?   (Circle P, D, or N)   P   D   N

Should a separate claim be loaded for each physician (P), department (D), or do not load separate claims (N).

EC2000   Claim   Account

Should either the account or claim level charges be sent to EC2000 CA.

EPSDT

The Early and Periodic Screening, Diagnosis, and Treatment value that should print for every charge line of the 1500 in Locator 24H.

Detail/Summarize Items?   (Circle response)   D   S

Should the system print detail (D) or should like items be summarized for the same service date, HCPCS Code, Diagnosis, and Physician (S). The default is D.

Diagnosis Print   (Circle response)   D   R

Should the system print the diagnosis code from the charge line or the reference number from form locator 21 in form locator 24E on the form?

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HCPCS Cross Reference   (2AN)

Enter the HCPCS Cross Reference table to be used with this Charge Control Parameter.

Use Med Rec HCPCS   (Circle Y or N)   Y   N

Should Med Rec HCPCS print on the 1500 claim form in locator 24D?

M/R HCPCS UB Rev Code   (5AN, from a previously defined table)

Enter the Medical Records HCPCS UB Rev Code Table number.

Print UOS?   (Circle Y or N)   Y   N

Should units of service print on the 1500 claim form in locator 24G? The default is Y.

Place of Service   (2AN, from a previously defined table)

Enter the place of service that should print on the 1500 Claim Form in locator 24B for charge departments without a place of service in the 1500 Department/Supplier Override table.

Print Phys/Dept ID Upper?   (Circle Y or N)   Y   N

Should the Physician or Department ID print in the upper portion of Box 24K on the 1500 claim form? The default is N. If Yes, select two Physician Identification Numbers from table as listed (first and second choices).

Physician Identification Numbers to use in Locator 24K (Circle two):

UB ID Number

Commercial ID Number

Medicare ID Number

Medicaid ID Number

Blue Cross ID Number

Other ID Number 1

Upin ID Number

Pin ID Number

Fin Interface ID Number

Tax ID Number

Other ID Number 2

National Provider ID (NPI #)

Print Phys/Dept ID Lower?   (Circle Y or N)   Y   N

Should the Physician or Department ID print in the lower portion of Box 24K on the 1500 claim form? The default is N. If Yes, select two Physician Identification Numbers from table as listed (first and second choices).

Physician Identification Number to use in Locator 24K (Circle two):

UB ID Number

Commercial ID Number

Medicare ID Number

Medicaid ID Number

Blue Cross ID Number

Other ID Number 1

Upin ID Number

Pin ID Number

Fin Interface ID Number

Tax ID Number

Other ID Number 2

National Provider ID (NPI #)

Print TOS?   (Circle Y or N)   Y   N

Should type of service from the FIM print on the 1500 claim form in locator 24C? The default is Y.

Type of Service Cross Reference   (2AN, from a previously defined table)

Print EMG?   (Circle Y or N)   Y   N

Should the EMG code from the Insurance Demographics screen print on the 1500 claim form in locator 24I? The default is Y.

Default Diagnosis   (Circle R, A, or P)   R   A   P

Default the diagnosis in locator 24E to the reference number 1 (R), the Principal/Admitting Diagnosis (A), or the Principal/Working Diagnosis (P).

Default Physician   (Circle Y or N)   Y   N

Default to the pro fee physician in the Pricing Information screen of the SIM for charges without a performing physician.

Edit Pro Fee Charges?   (Circle all that apply)   H   D   I

Edit professional fee charges for HCPCS Code (H), Diagnosis Code (D), or Physician ID (I).

24A Date Print   (Circle Format)   MMDDYYYY   MM DD YY

Print Anesthesia Time   (Circle Y or N)   Y   N

PCON PHY/DEPT ID   (Circle U or L)   U   L
                                                            (Upper   (Lower
)   )

Indicate whether the Physician ID should print for the charge line in locator 24K Upper or Lower, and if it is printing, what field in the Physician Master table to use to pull the number.

Non Specific HCPCS   Enter the table for the non-
                                specific HCPS for this
                                1500 Charge Control
                                Parameter

Reference Facility   (Circle Y or N)   Y   N

Should the system further sort claim charge lines by the Reference Facility codes?

RF Rev Codes

Indicate which revenue
codes are sorted further
by Reference Facility
codes, or enter A (All)
to select all UB revenue
codes.

<table>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
</table>

IDE Code   (Circle Y or N)   Y   N

Should the system further sort claim charge lines by the IDE Code (Investigational
Device Exemption code)?

IDE Rev Codes

Indicate which revenue
codes are sorted further
by IDE codes, or enter
A (All) to select all UB
revenue codes.

<table>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
</table>

NDC

Further sort claim charge lines by National Drug Code? (Y/N) [N]--

NDC Rev Codes

Indicate which UB
revenue codes are
sorted further by IDE
codes, or enter A (All)
to select all UB revenue
codes.

NDC Unit Qual/Units

If no Unit Qualifier and/or no NDC Units for NDC, leave (B)lank, leave blank and (E)dit, or (D)efault Unit Qualifier? (B/E/D) [B] --

Revise UB Revenue Code   (Circle Y or N)   Y   N
Pro Fee Exclusions?

If Yes, enter the UB-92 Revenue Codes to exclude.

Revise Pro Fee SIM Items for Exclusion?   (Circle Y or N)   Y   N

If Yes for SIM Item exclusions,

SIM Dept			

SIM Item			

Revise FIM Items to Load \$0.00 Charges on the 1500?   (Circle Y or N)   Y   N

If Yes for \$0.00 FIM Item exclusions,

FIM Dept			

FIM Item							

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NON PROFESSIONAL FEE 1500 CHARGE CONTROL PARAMETERS (US ONLY)

Level 2	Matrix# 42a	Facility:

This parameter is used to determine how charges are printed on the non professional fee 1500 claim form.

Code   (3N)   ▢▢

Description _____

   (30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

   Separate Claim by Department   (Circle Y or N)   Y   N

   Should a separate claim be printed for each department? The default is Y.

Detail/Summarize Items?   (Circle Response)   D   S   P

Should the system print detail (D) or should like items be summarized for the same service date and HCPCS code (S). The default is (D).

Print UOS?   (Circle Y or N)   Y   N

Should units of service print on the claim form in locator 24G? The default is Y.

Place of Service   (2AN)   ▢▢

        Enter the Place of Service that should print on the claim form in locator 24B

Departments to Include   (3A)

Enter the SIM Departments to be included on the claim form.

Print TOS?   (Circle Y or N)   Y   N

Should the type of service from the FIM print on the claim form in locator 24C? The default is Y.

Print EMG?   (Circle Y or N)   Y   N

Should the EMG code from the Insurance Demographics screen print on the non pro fee 1500 claim form in the locator 24I? The default is Y.

Diagnosis to be Printed   (Circle Response)   A   P

Should the system print the (A) Admitting/Working or the (P) Principal/Working Diagnosis Code in locator 24E? The default is A.

HCPCS Cross Reference   (2AN)

Enter the HCPCS Cross Reference table to be used with this Charge Control Parameter.

EPSDT Value   (2AN)

Enter the code that should print in locator 24H for each charge line.

Revise Non-Pro Fee   (Circle Y or N)   Y   N
Charge Exceptions?

Revise UB Revenue Code   (Circle Y or N)   Y   N
Non-Pro Fee Exclusions?

If Yes, enter the UB-92 Revenue Codes to exclude.

Revise Non-Pro Fee SIM Items for Exclusion?   (Circle Y or N)   Y   N

If Yes for SIM Item exclusions,

SIM Dept			

SIM Item			

Revise FIM Items to Load $0.00 Charges   (Circle Y or N)   Y   N
on the 1500?

If Yes for $0.00 FIM Item exclusions,

FIM Dept			

FIM Item							

UB Revenue Codes to Include and Default HCPCS Code

Enter the UB Revenue Codes within the Departments to Include that should be included on the claim form, and the default HCPCS Code to use for charges with the revenue code that do no have a FIM HCPCS Code.

SEQ	UB Code (3N)	Description (26AN)	Include (Y or N)	HCPCS (7AN)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				

SEQ	UB Code (3N)	Description (26AN)	Include (Y or N)	HCPCS (7AN)
24				
25				
26				
27				
28				
29				
30				
31				
32				
33				
34				
35				
36				
37				
38				
39				
40				
41				
42				
43				
44				
45				
46				
47				
48				
49				
50				
51				

SEQ	UB Code (3N)	Description (26AN)	Include (Y or N)	HCPCS (7AN)
52				
53				
54				
55				
56				
57				
58				
59				
60				
61				
62				
63				
64				
65				
66				
67				
68				
69				
70				
71				
72				
73				
74				
75				
76				
77				
78				
79				

SEQ	UB Code (3N)	Description (26AN)	Include (Y or N)	HCPCS (7AN)
80				
81				
82				
83				
84				
85				
86				
87				
88				
89				
90				
91				
92				
93				
94				
95				

1500 DEPARTMENT/SUPPLIER OVERRIDE - (US ONLY)

Level 2	Matrix# 43	Facility:

This parameter is used to override the assigned performing physician for a specific department as printed on the 1500 claim form. Complete this table according to the following guidelines:

DEPARTMENT NAME
Enter the STAR Patient Care department location code.

OVERRIDE
Enter one of the following:

   A for Admitting

   T for Attending

   R for Referring

   P for Performing

   C for Charging

   O for Other Physician

PHYSICIAN NAME
Enter the STAR Patient Care Physician table code if O for Other Physician is entered for the department.

MINUTES
Circle Y if this value is reported as a number of minutes; N if this is a dollar amount.

Seq.	Department Name (4AN)				Override (1A)			Physician Name or Code (5N)					Place of Service (2AN)		Minutes (Circle Y or N)	
1															Y	N
2															Y	N
3															Y	N
4															Y	N
5															Y	N
6															Y	N
7															Y	N
8															Y	N
9															Y	N

FINANCIAL ITEM MASTER

Level 2	Matrix# 45	Facility:

NOTE:The Financial Item Master parameter is defined through Patient Care tables.

Department *   (3A)

Code   (8N)

Effective Date   (6N)

Description (33AN)

Revenue Code *   (4N)

Detail Revenue Center *   (4N)

Proration Summary Code *   (6N)

Alt. Bill Summary Cd 1 *   (4N)

Alt. Bill Summary Cd 2 *   (4N)   ☐ ☐ ☐ ☐

Alt. Bill Summary Cd 3 *   (4N)   ☐ ☐ ☐ ☐

Type of Service *   (2AN)   ☐ ☐

Billing Attachment Code *   (2A)   ☐ ☐

Alternate Code   (10AN)   ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Inventory Location *   (2AN)   ☐ ☐

Inventory Number *   (6AN)   ☐ ☐ ☐ ☐ ☐ ☐

Statistic Flag   (Circle response)   S   B   Both

Circle S to enter statistics only, B to print on bill only, or Both. The default is Both.

Relative Value   (5N)   ☐ ☐ ☐ . ☐ ☐

HCPCS Procedure Code   (7AN)   ☐ ☐ ☐ ☐ ☐ ☐ ☐

SOB (Canada)   (5AN)

UB Revenue Code *   (3N)

Insurance Summary Code (Canada)   (3N)

Clinic # (Canada)   (4N)

* From a previously defined table

FOLLOW-UP LETTERS

Level 2	Matrix# 46	Facility:

This table, which is not split by facility, ties follow-up letter messages together and creates a follow-up letter number, which is placed in the PA, AR, Internal Pre-collect or BD Follow-up Schedule. You are not limited to five paragraphs if additional ones are needed. These letters are also displayed through demand PA, AR and BD follow-up.

This table is used for the Edit Collection Letter functionality available through the Receivables Workstation (RWS). If you have the RWS and want to utilize the Edit Collection Letter functionality, then attach the MCK message code to any letter to which you want to be able to add free form text. The description of the MCK message code is MCK Free Form Message. Note, if you attach the MCK message code to a letter multiple times then the same free form message will print multiple times. We advise that you only associate one MCK message code to your letter.

.

Follow-Up Letter Code   (3N)   ☐☐☐

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

File Type   (Circle one) | A | R |

Circle A (Automatic) to spool collection letters to the existing collection letters spool files. Circle R (Review) to spool collection letters to the Review Collection Letter spool files.

Sequence   1   Msg *   (4N)   ☐☐☐☐☐

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Blank Lines   (2N - range is 0 - 99)   ☐☐

Disallow Break?   (Circle Y or N)   Y   N

Sequence   2   Msg *   (4N)

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Blank Lines   (2N - range is 0 - 99)

Disallow Break?   (Circle Y or N)   Y   N

Sequence   3   Msg *   (4N)

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Blank Lines   (2N - range is 0 - 99)

Disallow Break?   (Circle Y or N)   Y   N

Sequence   4   Msg *   (4N)

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Blank Lines   (2N - range is 0 - 99)

Disallow Break?   (Circle Y or N)   Y   N

Sequence   5   Msg *   (4N) | | | | | |

Description: *
(30AN)

Blank Lines   (2N - range is 0 - 99) | | |

Disallow Break?   (Circle Y or N)   Y   N

* From a previously defined table. Descriptions are identified with the message.

GL MAPPING PARAMETER

Level 2	Matrix# 56	Facility:

This parameter, which can be split by facility, indicates the conversion table number and the suspense account used to post funds with invalid or missing table key definitions to the general ledger.

Current Table #/Description   (2N)   ☐☐

G/L Entity   (2A)   ☐☐

G/L Suspense Account

G/L Department   (10N)   ☐☐☐☐☐☐☐☐☐☐

Sub Account   (10N)   ☐☐☐☐☐☐☐☐☐☐

INSURANCE FOLLOW-UP LETTERS

Level 2	Matrix# 65	Facility:

This table ties insurance follow-up messages together and creates a follow-up letter, which is placed in the insurance follow-up schedule.

Insurance Collection Letter Code   (3N) |___|___|___|

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

File Type   (Circle one) | A | R |

Circle A (Automatic) to spool collection letters to the existing collection letters spool files. Circle R (Review) to spool collection letters to the Review Collection Letter spool files.

Sequence   1   Msg *   (4N) |___|___|___|___|___|

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Blank Lines   (2N - range is 0 - 99) |___|___|

Disallow Page Break?   (Circle Y or N)   Y   N

Sequence   2   Msg *   (4N) |___|___|___|___|___|

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Blank Lines   (2N - range is 0 - 99)

Disallow Page Break?   (Circle Y or N)   Y   N

Sequence   3   Msg *   (4N)

        Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Blank Lines   (2N - range is 0 - 99)

Disallow Page Break?   (Circle Y or N)   Y   N

Sequence   4   Msg *   (4N)

        Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Blank Lines   (2N - range is 0 - 99)

Disallow Page Break?   (Circle Y or N)   Y   N

Sequence   5   Msg *   (4N)

        Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Blank Lines   (2N - range is 0 - 99) |__|__|

Disallow Page Break?   (Circle Y or N)   Y   N

* From a previously defined table. Descriptions are identified with the message.

INSURANCE PLAN

Level 2	Matrix# 68	Facility:

The Insurance Plan Table, which is not split by facility, contains plan information such as the type of insurance and whether verification and precertification of the plan is necessary. It is used in admission, registration and patient insurance verification.

NOTE: STAR Financials Financial Class information is defined in Level 1. The Financial Class and Default Financial Class are display only.

Insurance Plan Code   (up to 4N or up to 6N)

If this is a plan code, the code can be up to four digits long. If this is a combined carrier and plan code, the code can be up to six digits long.

Plan Name

(33AN,

Optional)

Primary?   (Circle Y or N)   Y   N

Can this insurance plan be primary? The default is Y.

Conversion Code   (4AN)

Enter the appropriate conversion code.

Insurance Type   (Circle One)   B   E   G   D   F   S   C   N   I   Y   X   M   P   A

Circle **B** for Blue Cross, **E** for Canadian Commercial, **G** for Canadian Military, **D** for Canadian Provincial, **F** for Canadian Workers Compensation, **S** for CHAMPUS, **C** for Commercial, **N** for HMO, **I** for IFAS Insurance Type, **Y** for Medicaid Out-of-State - Not for P, **X** for Medicaid/Welfare, **M** for Medicare Part A or **P** for Medicare Part B, or **A** for Out of Province. Consult with McKesson installation personnel for more information.

Mail To   (Circle response)   E   C   G   P

Circle E for Employer, C for Carrier, G for Group, or P for Plan.

Contact's Name/Mail to Person   (36C)

Contact's Company Name   (35C)

Address Line 1   (25AN)

Address Line 2   (25AN)

City

(18AN)

State *   (2A)

Prov. (Canada) (2A) ☐☐

ZIP Code * (9N) ☐☐☐☐☐☐☐☐☐ or (5N) ☐☐☐☐☐

Post Code (Canada) * (6AN) ☐☐☐☐☐☐

> **NOTE:** Only the ZIP Code/Post Code need be entered here; the system will automatically complete the remaining fields if you enter the ZIP Code/Post Code.

Country (2AN) ☐☐

Phone Number (13N) ☐☐☐ - ☐☐☐ - ☐☐☐☐

Phone Ext. (5C) ☐☐☐☐☐

Allow Update Pat. Master (Circle Y or N) Y N

Allow updating patient's MPI Master Insurance Table? The default is Yes.

CMS Compliant (Circle Y or N) Y N

Process for CMS Compliance?

* From a previously defined table.

Admission Office Text   **(Up to four lines of 60 characters each)**

(1)

(2)

(3)

(4)

Group Name

(30AN, optional)

Group Number Format

(17C, optional)

Group Number

(17C, optional)

Effective From   (8N)   ☐☐ / ☐☐ / ☐☐

This date must be before the admissions date, or be the same as the
admission date, in order for the insurance to be available to assign to the
account.

Effective Thru   (8N)   ☐☐ / ☐☐ / ☐☐

If the effective thru date is before the admission date of the account, the
insurance will not be available to assign to the account.

Pol/Cert/ID Format

(20C, optional)

1500 Plan Code   (6N)   ☐☐☐☐☐☐

Verification?   (Circle Y or N)   Y   N

Is verification required? The default is Y.

Pre-notification?   (Circle Y or N)   Y   N

Is pre-notification required? The default is Y.

Verify Phone   (13C)

Ext. (5C)

Verify Fax (13C)

Approval Phone (13C)

Ext. (5C)

Approval Fax (13C)

Review Agency (30AN)

Contact Name

(20AN)

Reference Number (10C)

Review Phone (13C)

Ext. (5C)

Review Fax (13C)

Print Attestation?   (Circle Y or N)   Y   N

Should an attestation print when this plan is associated with a patient?

Online Eligibility?   (Circle Y or N)   Y   N

Should eligibility requests generate automatically for this plan?

Eligibility Code (5AN)   [ ][ ][ ][ ][ ]

Eligibility Provider Number (12C)   [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Notice of Admission?   (Circle Y or N)   Y   N

Should a notice of admission be sent to the carrier? This option is not yet implemented.

Alternate Plan Name 1

(33C, Optional)

Alternate Plan Name 2

(33C, Optional)

Alternate Plan Name 3

(33C, Optional)

Alternate Plan Name 4

(33C, Optional)

Alternate Plan Name 5

(33C, Optional)

Alternate Plan Name 6

(33C, Optional)

MEMO FOLLOW UP LETTERS

Level 2	Matrix# 73	Facility:

This table is used to combine memo collection letter messages into memo collection letters. These letters are then used in the Follow-up Schedules table to indicate that a letter should be sent to a guarantor.

This table is used for the Edit Collection Letter functionality available through the RWS. If you have the RWS and want to utilize the Edit Collection Letter functionality available through the RWS, then attach the MCK message code to any letter to which you want to be able to add free form text. The description of the MCK message code is MCK Free Form Message. Note, if you attach the MCK message code to a letter multiple times then the same free form message will print multiple times. We advise that you only associate one MCK message code to your letter

Code   (3N)   □□□□

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Sequence   1   Msg *   (4N)   □□□□□

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

File Type   (Circle one) | A | R |

Circle A (Automatic) to spool collection letters to the existing collection letters spool files. Circle R (Review) to spool collection letters to the Review Collection Letter spool files.

Blank Lines   (2N - range is 0 - 99)   □□

Disallow Page Break?   (Circle Y or N)   Y   N

Sequence   2   Msg *   (4N) | | | | | |

        Description_____

        (30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Blank Lines   (2N - range is 0 - 99) | | |

Disallow Page Break?   (Circle Y or N)   Y   N

Sequence   3   Msg *   (4N) | | | | | |

        Description_____

        (30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Blank Lines   (2N - range is 0 - 99) | | |

Disallow Page Break?   (Circle Y or N)   Y   N

Sequence   4   Msg *   (4N) | | | | | |

        Description_____

        (30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Blank Lines   (2N - range is 0 - 99) | | |

Disallow Page Break?   (Circle Y or N)   Y   N

Sequence   5   Msg *   (4N) | | | | | |

                   Description_____

                   (30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Blank Lines   (2N - range is 0 - 99) | | |

Disallow Page Break?   (Circle Y or N)   Y   N

       * From a previously defined table.

MISCELLANEOUS CASH CODES

Level 2	Matrix# 74	Facility:

This table contains codes that handle the accounting for non-patient related revenue such as cafeteria receipts and parking fees.

Miscellaneous Cash Code   (3AN)   ☐☐☐

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Transaction Type/Code: F *   (4N)   ☐☐☐☐

Used to make the debit posting.

Department Code *   (10N)   ☐☐☐☐☐☐☐☐☐☐

The department used to make the credit posting. The length of this field is determined by the Dept # Size and Subaccount Size fields on the Fiscal Year Definitions screen in the STAR Financials General Ledger System.

Subaccount Code *   (10N)   ☐☐☐☐☐☐☐☐☐☐

The subaccount used to make the credit posting. The length of this field is determined by the Dept # Size and Subaccount Size fields on the Fiscal Year Definitions screen in the STAR Financials General Ledger System.

* From a previously defined table

PATIENT TYPE

Level 2	Matrix# 79	Facility:

This STAR Patient Care table, which is always split by facility, assigns a provider number to patients that is used for third party billing. The rest of this table is completed during table build for STAR Patient Care.

Patient Type Code   (3AN) |___|___|___|

Description_____

(30AN) |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Provider   (6N) |___|___|___|___|___|___|

Number of Bills to Generate   (1N) |___|

Patient Type Code   (3AN) |___|___|___|

Description_____

(30AN) |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Provider   (6N) |___|___|___|___|___|___|

Number of Bills to Generate   (1N) |___|

PAYOR TABLE DEFINITION

Level 2	Matrix# 91	Facility:

This table contains the reimbursement types and methods for a payor. This table also contains the valid effective from and to (through) dates.

Reimbursement Payor Code   (2A)

Payor Reimbursement Type   (Circle response)   O   D   M   P   G   A   C   I   S

Circle O for Overall Plan, D for ICD-9-CM Diagnosis Code, M for Medical Service, P for ICD-9-CM Procedure Code, G for DRG, A for ASC Payment Group, C for Major Diagnostic Category, I for Pathway Contract Management, or S for Specified DRG Codes.

Effective Date Type   (Circle response)   A   D

Is the effective date based on Admission (A) or Discharge (D)?

Table No.	Effective From Date	Effective Thru Date	Post Reimb. Charges* (Y or N)	Post Cont'l. by Dept. (Y or N)
			Y N	Y N
			Y N	Y N
			Y N	Y N
			Y N	Y N
			Y N	Y N
			Y N	Y N
			Y N	Y N
			Y N	Y N

Should the system post an adjustment when reimbursement is greater than the covered charges?

PAYOR TABLE DEFINITION STOP LOSS TABLES

Level 2	Matrix# 83	Facility:

This table, which is not split by facility, contains the stop loss payment arrangements agreed to between the hospital and the payor.

Reimbursement Payor Code   (2A)*   ☐☐

Payor Reimbursement Type   (Circle response)   O   D   M   P   G   A   C   I   S

Circle O for Overall Plan, D for ICD-9-CM Diagnosis Code, M for Medical Service, P for ICD-9-CM Procedure Code, G for DRG, A for ASC Payment Group, C for Major Diagnostic Category, I for Pathways Contract Management, or S for Specified DRG Codes.

Table Number   (3N):   ☐☐☐

Diagnosis, Procedure, or Medical Service   (6AN)*   ☐☐☐☐☐☐

The maximum length for Medical Service is 3AN.

Max Reimbursement Amount   (10N)   ☐☐☐☐☐☐☐☐.☐☐

Calculation Method   (Circle response)   F   D   C

Circle F for Flat Rate, D for Days, or C for Charges.

Flat Rate Amount   (10N)   ☐☐☐☐☐☐☐☐.☐☐

Stop Loss Days   (3N)   ☐☐☐

Stop Loss Charges   (10N)   ☐☐☐☐☐☐☐☐ . ☐☐

Stop Loss Threshold %   (5C)   ☐☐☐☐☐

Enter the percentage by which the account must exceed the normal reimbursement before the additional reimbursement amount defined in the Add'l Reimbursement % field goes into effect. Complete this field only if Stop Loss Days and Stop Loss Charges are Unlimited.

* From a previously defined table.

Add'l Reimbursement %   (5C)   ☐☐☐☐☐

Enter the percentage added to the normal reimbursement if the amount identified in the Stop Loss Threshold % field is exceeded. Complete this field only if Stop Loss Days and Stop Loss Charges are Unlimited.

Day/Charge Ranges

Enter the following information to the table below:

THRU/DAY OR THRU CHARGE $
If entering a Per Diem amount, the maximum length is 4N.

%/AMT
Enter P for a Percentage or A for an Amount. This field is valid only for charge-based reimbursement.

REIMB AMT, REIMB AMT PER DAY, OR %
Enter the flat reimbursement amount, the reimbursement amount per day, or the percentage. If a percentage, the maximum is 100%, with two decimal places supported.

Thru/Day or Thru Charge $ (7N)							% / Amt (1A)	Reimb Amt, Reimb Amt Per Day, or % (9N)								

PAYOR TABLE DEFINITION ACCOMMODATION EXCEPTIONS

Level 2	Matrix# 81	Facility:

This table, which is not split by facility, contains the Accommodation code exceptions for a specific payment arrangement.

Reimbursement Payor Code   (2A)*   ☐☐

Payor Reimbursement Type   (Circle response)   O   D   M   P   G   A   C   I   S

Circle O for Overall Plan, D for ICD-9-CM Diagnosis Code, M for Medical Service, P for ICD-9-CM Procedure Code, G for DRG, A for ASC Payment Group, C for Major Diagnostic Category, I for Pathways Contract Management, or S for Specified DRG Codes.

Table Number   (2N)*   ☐☐☐

Diagnosis, Procedure, or Medical Service   (6AN)*   ☐☐☐☐☐☐

The maximum length for Medical Service is 3AN.

Accommodation Code   (1A)*   ☐

Calculation Method   (Circle response)   F   D   C

Circle F for Flat Rate, D for Days, or C for Charges.

Flat Rate Amount   (10N)   ☐☐☐☐☐☐☐☐ . ☐☐

  * From a previously defined table.

Day/Charge Ranges

Enter the following information to the table below:

THRU/DAY OR THRU CHARGE $
If entering a Per Diem amount, the maximum length is 4N.

%/AMT
Enter P for a Percentage or A for an Amount. This field is valid only for charge-based reimbursement.

REIMB AMT, REIMB AMT PER DAY, OR %
Enter the flat reimbursement amount, the reimbursement amount per day, or the percentage. If a percentage, the maximum is 100%, with two decimal places supported.

Thru/Day or Thru Charge $ (7N)							% / Amt (1A)	Reimb Amt, Reimb Amt Per Day, or % (9N)								

PAYOR TABLE DEFINITION PRORATION SUMMARY EXCEPTIONS

Level 2	Matrix# 82	Facility:

This table, which is not split by facility, contains the Proration Summary code exceptions for a specific payment arrangement.

Reimbursement Payor Code   (2A)*   [ ][ ]

Payor Reimbursement Type   (Circle response)   O   D   M   P   G   A   C   I   S

Circle O for Overall Plan, D for ICD-9-CM Diagnosis Code, M for Medical Service, P for ICD-9-CM Procedure Code, G for DRG, A for ASC Payment Group, C for Major Diagnostic Category, I for Pathways Contract Management, or S for Specified DRG Codes.

Table Number   (2N)*   [ ][ ][ ]

Diagnosis, Procedure, or Medical Service   (6AN)*   [ ][ ][ ][ ][ ][ ]

The maximum length for Medical Service is 3AN.

Proration Summary Code   (6N)*   [ ][ ][ ][ ][ ][ ]

Calculation Method   (Circle response)   F   C

Circle F to use the Flat Rate calculation method or C to use Charges.

Flat Rate Amount   (10N)   [ ][ ][ ][ ][ ][ ][ ][ ] . [ ][ ]

Enter the amount of the flat rate. Complete this field if you use the Flat Rate calculation method.

Charge Ranges   (9N) | | | | | | | . | | |

(Circle response)   P   A

If the calculation method is charges, enter the percentage of charges or dollar amount. Circle P if this is a percentage or A if this is an amount.

    * From a previously defined table.

PAYOR TABLE DEFINITION FEE SCHEDULE EXCEPTIONS

Level 2	Matrix# 84	Facility:

This table contains the reimbursement types and methods for a payor and the valid effective from and to (through) dates.

Reimbursement Payor Code   (2A)*   ☐☐

Payor Reimbursement Type   (Circle response)   O   D   M   P   G   A   C   I   S

Circle O for Overall Plan, D for ICD-9-CM Diagnosis Code, M for Medical Service, P for ICD-9-CM Procedure Code, G for DRG, A for ASC Payment Group, C for Major Diagnostic Category, I for Pathways Contract Management, or S for Specified DRG Codes.

Table Number   (2N)*   ☐☐☐

Department   (10N)*   ☐☐☐☐☐☐☐☐☐☐

Non-Included SIM Item Coverage   (Circle response)   N   A   P   C

Circle N for Normal, A for No Addition, P for same as Proration Summary Exception, or C for Calculation.

Calculation Type   (Circle response)   A   P

Circle A for Amount or P for Percent.

Amount or %   (9N or 3N)   ☐☐☐☐☐☐☐ . ☐☐
                                          ☐☐☐

Contractual Adj. Tran. Code   (4N)   [ ][ ][ ][ ]

ProSummary Code   (3AN)*   [ ][ ][ ]

* From a previously defined table.

Enter the following information to the table below:

SIM ITEM CODE
Enter the code for the Service Item Master item.

%/AMT
Enter P for a Percentage or A for an Amount. This field is valid only for charge-based reimbursement.

REIMBURSEMENT AMOUNT
Enter the reimbursement amount or percentage. If a percentage, the maximum is 100%, with two decimal places supported.

SIM Item Code (5N)					% / Amt. (1A)	Reimbursement Amount								

SIM Item Code (5N)					% / Amt. (1A)	Reimbursement Amount								

UB CHARGE CONTROL PARAMETERS - (US ONLY)

Level 2	Matrix# 114	Facility:

This parameter is used to determine how charges are printed on the UB claim form. The following fields represent the default values if a UB Revenue Code is added to the system but this parameter is not updated.

Refer to the *STAR Financials Patient Accounting Tables, Masters, and Parameters* volume for information on the fields of this table.

Code   (3N)   ☐☐☐

Description_____

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Summarize By   (Circle response)   S   R   U

Summarize by revenue code within service date (S), service date within revenue code (R), or by UB revenue code (U)? The default is U.

EC2000   (Circle A or C)   A   C

Send (A)ccount or (C)laim level charges to EC2000 CA?

Edit Room Chgs?   (Circle Y or N)   Y   N

Should charges be edited against covered and non-covered days? The default is N

If Yes, UB Revenue Codes to Exclude from room edit:

.

HCPCS Cross Reference (Table lookup)   (2N)   ☐☐

> Which HCPCS cross reference table should be used in conjunction with this charge control parameter?

Prin Proc Rev Code (Table lookup)   (2AN)   ☐☐

> Which Principal Procedure Cross Reference table should be used in conjunction with this charge control parameter?

M/R HCPCS UB Rev Code (Table lookup)   (5N)   ☐☐☐☐☐

> Which Medical Records HCPCS UB Rev Code table should be used in conjunction with this charge control parameter?

Print Non-Covered Charges   (Circle Y or N)   Y   N

> Should non-covered charges print in locator 48? If Yes, circle non-covered charges to print:

- Proration Non Covered

- ABN Yes Signed

- ABN Not Signed

- ABN Freq Yes Signed

- ABN Freq Not Signed

- ABN Self Pay Yes Signed

- ABN Self Pay Not Signed

- ABN Self Pay Freq Yes Signed

- ABN Self Pay Freq Not Signed

- Duplicate HCPCS

- Component/Comprehensive HCPCS Conflict

- Mutually Exclusive HCPCS Conflict

Non Cvd Separate Line   (Circle Y or N)   Y   N

> If the Print Non-Covered Chgs field is set to print non-covered charges, should the non-covered portion of the charge print on its own charge line?

Combine Pro Fees   (Circle Y or N)   Y   N

> If the Summarize By field is set to Revenue Code within Service Date or Service Date within Revenue Code, should the professional fees roll up into the associated ancillary charge line? The default is N.

001/0001 Total Rev Code   (4N)

> Print Revenue Code 001 or 0001 for total line?

Total First   (Circle Y or N)   Y   N

> Should the 001 or 0001 Revenue Code for total charges print as the first revenue code on the claim (Y) or should the 001 or 0001 Revenue Code print as the last revenue code on the claim (N)? The default is N.

NY Claim   (Circle Y or N)   Y   N

Use Rx Quantity   (Circle Y or N)   Y   N

Use the Pharmacy Quantity on the claim?

I/P Rehab   (Circle Y or N)   Y   N

Should the system check if Rehab Revenue Code 0024, 024, or 24 was loaded to the claim?

Edit Chg Srv Dates?   (Circle Y or N)   Y   N

Should the system fail claims with service dates within a specified time frame?

_____ Enter starting charge edit service date

_____ Enter ending charge edit service date

Zero Fill UB Rev Cd?   (Circle Y or N)   Y   N

Should the system zero fill the UB Revenue Code on the UB claim in Claim Print/ Spool?

Reference Facility

Should the system further sort claim charge lines by the Reference Facility codes?

RF Rev Codes

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RF Rev Codes

Indicate which UB
revenue codes are
sorted further by
Reference Facility
codes, or enter A (All)
to select all UB revenue
codes.

<table>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
</table>

Exclude ABN Self Pay   (Circle Y or N)   Y   N

IDE Code   (Circle Y or N)   Y   N

Should the system further sort claim charge lines by the by IDE Code (Investigational
Device Exemption code)?

IDE Rev Codes

Indicate which UB
revenue codes are
sorted further by IDE
codes, or enter A (All)
to select all UB revenue
codes.

IDE Code   (Circle Y or N)   Y   N

IDE Rev Codes   (Circle Y or N)   Y   N

IDE Code   (Circle Y or N)   Y   N

IDE Rev Codes   (Circle Y or N)   Y   N

**Edit Unused MR
HCPCS**   (Circle Y or N)   Y   N

**Edit MR HCPCS Rev
Cd?**   (Circle Y or N)   Y   N

Unused Med Rec HCPCS Prim Or Prim/ Split?	Edit P (Primary) or S (Both Primary and Split) claims for Unused Medical Records HCPCS?	P S

Earliest Serv Date UB Rev Codes

Specify the revenue codes that should summarize to the earliest service date for charges with the same Revenue Code, HCPCS code or Room Rate, but different Service Dates.

Earliest Service Date UB Rev Codes	Enter the revenue codes that should summarize using the earliest service date.
Req Rev Codes (UB04 format only)	Enter the revenue code(s) that are required on the claim.
Addtl Chg Srv Date Edits?	Edit charges outside the billing dates.

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Default UB Revenue Code Setups

NDC Code   (Circle Y or N)   Y   N

Rev Codes   (Circle Y or N)   Y   N

HCPCS   (Circle Y or N)   Y   N

Override Rev Desc   (Circle Y or N)   Y   N

Unit Qual/Units   (Circle Y or N)   Y   N

Print Charges?   (Circle Y or N)   Y   N

HCPCS Procedures	(Circle response)	FIM/ Charge	Both/ Detail	Charge/ Default Medical Records	Medical Records	None	Override	Both/ Summary

HCPCS Required   (Circle Y or N)   Y   N

HCPCS Rollup	(Circle Response)	FIM Department/ Code	Revenue Code

.

HCPCS Summary   (Circle Y or N)   Y   N

If the HCPCS Procedures field is set to FIM/Charge, should the HCPCS Summarization Master be used? The default is N.

Ancillary Units   (Circle response)   S   Q   V   H   D

Print Ancillary Units of Service (S), Quantity (Q), Visits (V), Hours (H), or Days (D). Visits always equal 1.

R&B Units   (Circle response)   S   Q   V   H   D

Print Room and Board Units of Service (S), Quantity (Q), Visits (V), Hours (H), or Days (D). Visits always equal 1.

Total   (Circle Y or N)   Y   N

Should units be included in the total line? The default is N.

Date Loc 45   (Circle Y or N)   Y   N

Should the service date print for the revenue code in form locator 45? The options are Y for Yes to edit the HCPCS for the same date of service and load the service date, U for Use to load the service but not edit, or N do not load the service date.

HCPCS/Room   (Circle response)   R   H   B

Should room and bed charges print the (R) Room Rate, (H) HCPCS Code or a (B) Blank in Locator 44? The default is R.

Itemize Charges   (Circle Y or N)   Y   N

Should specific FIM items are itemized and printed in detail.? If you enter **Y** (Yes), indicate the FIM Department(s) and the FIM Items within the department(s) that should print in detail.

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Loc 45 Creation Date   (Circle Y or N)   Y   N

Load Admit Date for Charges?   (Circle Y or N)   Y   N

Split Claims   (Circle Y or N)   Y   N

> Should the system split UB claims? If so, list the split claim names (from the Split Claims Criteria table) in the order which split claims are to be processed by the system.

Options by Revenue Code

> Enter the following information on the table on Page .

> **SEQ**
> A number identifying the UB code and description entry on the screen.

> **UB CODE/DESCRIPTION**
> This code is displayed from the UB Revenue Code table (matrix #85).

> **PRINT CHGS**
> Should this UB revenue code be printed on the UB claim form? The options are Y for Yes or N for No with a default response of Y.

> **HCPCS PROCEDURES**
> What HCPCS codes should be used for this revenue code: (C) FIM/Charge, (D) Both/ Detail, (F) Charge/Default Medical Records, (M) Medical Records, (N) None, (O) Override, (S) Both/Summary.

HCPCS REQUIRED
Are HCPCS codes required for this revenue code? Enter Y (Yes) or N (No).

HCPCS Rollup
Rollup charges with no HCPCS code for the revenue code by FIM Department Code (F) or by Revenue Code (R).

HCPCS Summary
If the HCPCS Procedures field is set to C for FIM/Charge, should the HCPCS Summarization Master be used? Enter Y (Yes) or N (No).

ANCIL UNITS
Should units print for the revenue code? Valid options are Summary (S) which is the occurrence of the charge or credit, Quantity (Q) which is the true quantity on the charge or credit, Visit (V) which always prints a 1, Hours (H) which converts the quantity into hours, or Days (D).

R&B UNITS
Should units print for the revenue code? Valid options are Summary (S) which is the occurrence of the charge or credit, Quantity (Q) which is the true quantity on the charge or credit, Visit (V) which always prints a 1, Hours (H) which converts the quantity into hours, or Days (D).

TOTAL
Should units be included in the total line? (Y or N). The options are Y for Yes or N for No. The default is N.

DATE LOC 45
Should the service date print for the revenue code in form locator 45? The options are Y for Yes to edit the HCPCS for the same date of service and load the service date, U for Use to load the service but not edit, or N for No not to load the service date.

HCPCS/ROOM
Should room and bed charges print the Room Rate, HCPCS Code, or a Blank in locator 44? The options are R for Room Rate, H for HCPCS Code or B for Blank. The default is R.

Figure 4.1 Options by Revenue Code

Seq	UB Code				Print Chgs	HCPCS Procs	HCPCS Req'd	HCPCS Rollup	HCPCS Sum	Ancil Units	R&B Units	Total	Date
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													

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Do you wish to add SIM items for exclusion?   (Circle Y or N)   Y   N

> The system displays this prompt when you exit the screen. If you enter Y, the system displays a screen from which you can select SIM Departments and SIM Items (within departments) to be excluded. The default is N.

Do you wish to modify UB code for FIM Items?   (Circle Y or N)   Y

> The system displays this prompt when you exit the SIM item screen. If you answer Y, the system displays a screen from which you can select FIM departments and FIM items (within   FIM department) to be assigned an alternate UB revenue code for use on the claim form.   The default is N.

SIM Item Exclusions

SIM Dept   (3AN)

Department Description

(19A)*

SIM Code   (4N)*

Item Description

(30AN)

Seq   (2N)

SIM Dept   (3AN)

Department Description

(19A)*

SIM Code   (4N)*

Item Description

(30AN)

Seq   (2N)

SIM Dept   (3AN)

SIM Code   (4N)*   □□□□

Item Description   □□□□□□□□□□□□□□
(30AN)   □□□□□□□□□□□□□□
                         □□□□

           * From a previously defined table.

FIM Item Modifications

Seq   (2N)   □□

FIM Dept   (3AN)   □□□

FIM Code   (8N)*   □□□□□□□□ or All (enter Old UB code to search on.)

Item Description*   □□□□□□□□□□□□□□
(30AN)   □□□□□□□□□□□□□□
                         □□□□

Old UB Code   (4N)*   □□□□

New UB Code   (4N)   □□□□

Seq   (2N)   ☐☐

FIM Dept   (3AN)   ☐☐☐

FIM Code   (8N)*   ☐☐☐☐☐☐☐☐   or All (enter old UB to search on.)

Item Description*   ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
(30AN)   ☐☐☐☐☐☐☐☐☐☐☐
                         ☐☐☐☐☐

Old UB Code*   (4N)   ☐☐☐☐

New UB Code   (4N)   ☐☐☐☐

    *   From a previously defined table.

Zero Dollar Charges to Load to Claim

Do you wish to revise FIM Items to   (Circle   Y   N
load zero dollar charges to the   Y or N)
UB?

          The system displays this prompt when you exit the screen. If you enter Y, the system
          displays a screen from which you can select FIM Departments and FIM items (within
          FIM Department) to load to the claim, even if the charge amount is $0.00.

Seq   2N

FIM Dept   (3AN)

FIM Code   (8N)

Item Description   (30AN)

Seq   2N

FIM Dept   (3AN)

FIM Code   (8N)

Item Description   (30AN)

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Seq   2N   ☐☐

FIM Dept   (3AN)   ☐☐☐

FIM Code   (8N)   ☐☐☐☐☐☐☐☐

Item Description   (30AN)   ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

UB THERAPY REVENUE CODE TABLE

Level 2	Matrix# 121	Facility:

This table is used to determine which UB Revenue Codes the system should search on to determine if the account has had a physical therapy, occupational therapy, speech therapy, or cardiac rehab therapy visit.

Physical Therapy UB Revenue Codes   (4N)

Occupational Therapy UB Revenue Codes   (4N)

Speech Therapy UB Revenue Codes   (4N)

Cardiac Rehab Therapy UB Revenue Codes (4N)   (4N)

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ADD MANUAL VALUE CODE AMOUNT?   (Circle Y or N)   Y   N

UB SPLIT CLAIMS CRITERIA TABLE

Level 2	Matrix# 122	Facility:

This table allows you to split UB claims at the charge level, based on the following:

- UB Revenue Code

- Charge Level HCPCS

- FIM Item

- Service Date of Charge

- Patient Type at the Charge Level

Split Name   (14A)

Enter the name for the split claim criteria.

Description   (25A)

Enter a description for the split claim critiera.

UB Revenue Codes   (4N)

Enter the UB revenue code(s) that are to be on a separate claim

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FIM HCPCS   (5AN)

Enter the FIM HCPCS code(s) that should be split to a separate claim.

FIM Department Items

Enter the FIM Department Item(s) that should be split to a separate claim.

FIM Department

FIM Item

FIM Department

FIM Item

FIM Department

FIM Item

FIM Department

FIM Item

Service Date Split   (Circle Y or N)   Y   N

This field indicates whether the system should load a split UB claim for each unique date of service on the charges.

Charge Level Pt Split

This field contains patient types that are recorded on the charges that will split to the same UB.

ALTERNATE CLAIM LOAD EDIT PARAMETER

This field contains the UB Claim Load Edit parameter to use for this split claim.

ALTERNATE CHARGE CONTROL PARAMETER

This field contains the UB Charge Control parameter to use for this split claim.

ALTERNATE PROVIDER MASTER

This field contains the alternate Provider Master to use for this split claim.

PSYCHIATRIC DRG GROUPER PARAMETERS

Financial Classes for Psych DRG Grouper

Indicate the financial classes for which the information should be accumulated because the Psych DRG Grouper is being used.

Revenue Codes for Electroconvulsive Therapy Units

Indicate the revenue code(s) used to accumulate the electroconvulsive therapy units.

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Chapter 5 - LEVEL 3

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INTRODUCTION

This chapter contains worksheets to complete the following tables. You should complete these worksheets before beginning the worksheets in Level 4.

- 3M OPPS Facility Parameters

- Agency Follow-up Schedules

- ASC Payment Group - Payor Arrangement

- Billing Groups

- Billing Parameters

- Business Offices

- CCA/RUA/CPA Parameters

- Collection Group

- Insurance Follow-up Schedules

- ERA Provider Level Adjustment Mapping

- Payor Arrangement

- Horizon Performance Manager Facility Parameters

3M OPPS FACILITY PARAMETERS

Level 3	Matrix#124	Facility:

This table contains information needed to maintain the facility parameters for the 3M OPPS interface including the daytime and Midnight Processing options, and edits used by the 3M OPPS interface for editing claims.

Process in MNP   (Circle Y or N)   Y   N

Process files in 3M during Midnight Processing?

Number of Claims/   (3AN)
MNP Batch

Maximum number of claims per Midnight Processing batch.

MNP Wait Time for   (2N)
Return

Minutes to await return of file from 3M during MNP (1/60).

Download/Upload During   (Circle Y or N)   Y   N
Downtime MNP

Download/upload files in downtime MNP?

Delay Claim Edits Until   (4NR)

Try to apply results before claim edits in MNP until what time?

Delay PA Daily Bal Until   (4NR) | | | | |

Try to post contractual adjustments before PA Daily Balancing until what time?

AGENCY FOLLOW-UP SCHEDULES

Level 3	Matrix#3	Facility:

This table contains information regarding the type of follow-up used on guarantor accounts by internal and external collection agencies.

Schedule #   (3N)

Description

(30AN)

Internal?   (Circle Y or N)   Y   N

Enter Y or N to indicate whether this Follow-Up Schedule is an Internal Follow-Up Schedule (Y) or External Agency Follow-Up Schedule (N).

Wait Days   (2N)

Enter the minimum number of days from final billing to wait before beginning follow-up. The default is 0.

Defining Follow-Up Frequency

The system provides three ways for you to define follow-up frequency:

- Day of month (for example, the 1st of the month)

- Day of week within a given week of the month (for example, Tuesday of the second week of the month)

- Interval, or a specified number of days between each follow-up (for example, every 24 days)

Complete the following worksheet fields keeping these guidelines in mind:

- If you select *Day of Month*:

- Leave the Day of Week and Week of Month entries blank

- Leave the interval for each sequence blank

- If you select *Day of Week* and *Week of Month*:

  - Leave the Day of Month entry blank

  - Leave the interval for each sequence blank

- If you select *Interval*:

  - Leave the Day of Month, Day of Week, and Week of Month entries blank

Day of Month   (2N)

The day follow-up should be sent. Optional entries are 1-28 or L for Last day of the month.

Day of Week   (1N)

The day of the week follow-up should be sent, where Sunday=1, Monday=2, ... Saturday=7.

Week of Month   (1N)

The week of the month on which follow-up should be sent. Optional entries are 1-4. This field is not required if a value is entered to the Day of Month field.

Due Days   (2N)

The number of days used in calculating the due date. The entry range is 0 to 99 days; the default is 0.

Grace Days   (2N)

The number of days after the due date before the account is delinquent. The entry range is 0 to 99 days; the default is 0.

Restart %   (2N)

The percent of the balance due that must be paid by the guarantor in order to resequence follow-up to another event. Follow-up continues on to the next event (sequence number) until this amount is paid. The entry range is 0 to 99.99%

Restart Amount   (8N)

The minimum amount that must be paid by the guarantor in order to resequence follow-up to another event. Follow-up continues on to the next event (sequence number) until this amount is paid. The entry range is 0 to $99,999.99 (you must enter the decimal point).

Max Paper Bal   (9N or U)

The maximum balance for paper follow-up. If the account balance is greater than the maximum paper balance, then the guarantor is selected for telephone follow-up only. The default is U for Unlimited.

Min Balance   (9N)

The minimum balance needed to continue follow-up. This field sets the upper limit for small balance write-off.

Max Delete Bal   (9N)

The maximum balance for automatically selecting accounts for archive. The default is 0.

Auto Delete?   (Circle Y or N)   Y   N

Automatically select account for archive after the last follow-up? The default is Y.

Xfer External   (1N)   ☐

Indicates if an internal bad debt agency should transfer to an external bad debt collection agency. This field is only accessed if the Internal field is set to Yes.   If Xfer External field is completed with a Yes, then access the Ext Agency field, the Min External Bal field, and the Max External Bal field.

Ext Agency Grp   (Table Lookup)   ☐

Indicates the external collection agency group that accounts transfer to if the Xfer External field is set to Yes.

Ext Agency?   (Circle Y or N)   Y   N

Contains the external agency that accounts will transfer to if the Xfer External field is completed with a Yes. This field is only accessed if the Xfer External field is set to Yes.

Min External Bal   (9N)   ☐☐☐☐☐☐☐☐☐

Indicates the minimum account balance for transfer to an external agency.

Max External Bal   (9N)   ☐☐☐☐☐☐☐☐☐

Indicates the maximum account balance for transfer to an external agency.

Delinquent F/U Type   (Circle one)   D   L   T

Indicates the type of follow-up that is generated when a payment plan account becomes delinquent. Entry options are D (detail statements), L (letter), or T (telephone).

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Delinquent F/U Message
Contains the message that appears on the follow-up type entered in the Delinquent F/U Type field.

Partial Payment F/U Type   (Circle one)   D   L   T

Indicates the type of follow-up that is generated when a payment plan account receives a payment that is not equal to full payment. Entry options are D (detail statements), L (letter), or T (telephone).

Partial Payment F/U Message
Contains the message that appears on the follow-up type entered in the Partial Pay F / U Type field.

In the following table, complete the columns as follows:

SEQ
Enter up to a two-digit number referring to a line in the follow-up schedule. The number of lines is unlimited.

DESCRIPTION
Contains the description of the follow-up schedule entered on the first screen of the transaction.

SCHEDULE #
Enter up to a two-digit number referring to a line in the follow-up schedule. The number of lines is unlimited.

F/U Type   (Circle one)   L   D   T   W

Contains the type of follow-up that is performed for this sequence number. Entry options are L (collection letter), D (detail statement), T (telephone), or W(wait). Select W (wait) if no follow-up is to be done during this sequence. This field can only be completed with a W if the Agency Follow-up schedule has been set to No for the Internal field.

F/U MSG
Contains the code identifying the paper message used when generating a collection letter or detail statement. This field can only be completed if the Agency Follow-up schedule has been set to Yes for the Internal field.

PHONE MSG CODE
Identifies the code representing the telephone message inserted into the collector's workfile. Telephone follow-up will be generated if the Follow Type field is equal to a T or if the maximum paper balance for this account is reached. These messages are entered and maintained in the Telephone Messages table. This field can only be completed if the Agency Follow-up schedule has been set to Yes for the Internal field.

RESTART SEQ

This field is not required for external agencies. This field contains the follow-up sequence number that is used if the Restart % or Restart Amount is met. The restart sequence number must be less than or equal to the current sequence number.

INTERVAL

Contains the number of days between follow-up events. The entry range is 1 to 999 days. This field is completed only if the Day of Month, Day of Week, and Week of Month fields are not completed in the first screen of this transaction. The system schedules the first follow-up from the AR to Bad Debt transfer date. All subsequent follow-up activity is scheduled from the date of the most recent follow-up. The number of days between follow up can vary by sequence number.

ASC PAYMENT GROUP - PAYOR ARRANGEMENT

Level 3	Matrix# 5a	Facility:

The ASC Payment Group - Payor Arrangement Table contains the reimbursement rates used in the ASC Payment Group Reimbursement calculation.

Reimbursement Type   (1A) | A | ASC Payment Group

Reimbursement Payor Code   (2A)

Table Number   (2N)

Maximum Reimb Amount   (10N)

The maximum calculated reimbursement amount. (Up to 99,999,999.99.)

Non-Primary Reimb Percentage   (5N)

Enter the percentage at which non-primary ASC Payment Groups will be reimbursed.

Group 00 Reimb Amount   (10N)

The dollar amount assigned to ASC Group 00 for reimbursement calculation.

Group 01 Reimb Amount   (10N)

The dollar amount assigned to ASC Group 01 for reimbursement calculation.

Group 02 Reimb Amount   (10N)

The dollar amount assigned to ASC Group 02 for reimbursement calculation.

Group 03 Reimb Amount   (10N)

The dollar amount assigned to ASC Group 03 for reimbursement calculation.

Group 04 Reimb Amount   (10N)

The dollar amount assigned to ASC Group 04 for reimbursement calculation.

Group 05 Reimb Amount   (10N)

The dollar amount assigned to ASC Group 05 for reimbursement calculation.

Group 06 Reimb Amount   (10N)

The dollar amount assigned to ASC Group 06 for reimbursement calculation.

Group 07 Reimb Amount   (10N)

The dollar amount assigned to ASC Group 07 for reimbursement calculation.

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Group 08 Reimb Amount   (10N) | | | | | | | | | . | | |

The dollar amount assigned to ASC Group 08 for reimbursement calculation.

Group 09 Reimb Amount   (10N) | | | | | | | | | . | | |

The dollar amount assigned to ASC Group 09 for reimbursement calculation.

BILLING GROUPS

Level 3	Matrix# 10	Facility:

The Billing Groups table contains user-defined codes that group like billers together. These codes are used in the Insurance Plan Coverage master, the Financial Class table and in facility-specific information. This table contains the group's default biller, a list of all billers in the group, the letters of the alphabet and the patient indicators (specifying the patients for whom they are responsible for billing).

Billing Group Code   (2N)

Description

(30AN)

Default Biller   (2N)

Patient Indicator (Circle One)*			Last Name (up to 3A)			Biller (2N)	
E	I	O					
E	I	O					
E	I	O					
E	I	O					
E	I	O					
E	I	O					
E	I	O					
E	I	O					
E	I	O					
E	I	O					

* Circle E for Emergency Room, I for Inpatient, or O for Outpatient.

NOTE: The Last Name field should contain entries such as HZZ, where the biller would be responsible for the last name range A through H.

BILLING PARAMETERS

Level 3	Matrix# 11	Facility:

The Billing Parameter, which is not split by facility, selects accounts for cycle, final, and late billing, and adjustment rebills. Cycle and final billing parameters are assigned at admission or registration with reassignment if the primary carrier is changed. They are associated with each insurance plan and financial class (for self-pay patients) and can be changed on an individual account basis. The billing parameter also includes the transaction codes used to log a billing event in the account's transaction history.

Billing Parameter Code   (3AN)

Description

(30AN)

Bill Parm Type   (Circle response)   F   C

Circle F if this parameter is for Final bills; circle C if this parameter is for Cycle bills.

Detail Bill?   (Circle Y or N)   Y   N

Produce a detail bill? The default is Y.

Summary Bill?   (Circle Y or N)   Y   N

Produce a summary bill? The default is N.

Prorated Bill?   (Circle Y or N)   Y   N

Produce a prorated bill? The default is N.

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Series Bill?   (Circle Y or N)   Y   N

Produce a series bill? The default is N. This option is available *only* for cycle bill types.

Combine Prof. Fees?   (Circle Y or N)   Y   N

Should hospital and professional fees be combined on the bill? The default is N.

Bill Transaction Code: Type Y   (4N)   [ ][ ][ ][ ]

Enter the transaction code that updates the account's transaction history when a bill is produced.

Patient Bill Message   (4N)   [ ][ ][ ][ ]

Enter the code, from the Patient Bill Messages table, to print on the last page of the patient detail bill and summary bill.

Series Bill Transaction Code: Type Y   (4N)   [ ][ ][ ][ ]

Enter the transaction code that updates the account's transaction history when a series bill is produced. This field is required only if you enter Y to Series Bill above.

Series Bill Message   (4N)   [ ][ ][ ][ ]

Enter the code, from the Patient Bill Messages table, to print on the last page of all series bills. This field is required only if you enter Y to Series Bill above.

Type of Charge   (Circle One)   P   B

Enter whether patient charges only or both patient charges and insurance charges appear on the Canadian patient bill. Circle P for patient charges to be on the Canadian patient bill, or B for both patient and insurance charges to be on the bill.

Print Adj Detail   (Circle One)   Y   N

Enter whether or not you want the adjustment bill to print or not print on the Canadian patient bill. Circle Y if you want detail adjustment information for the specified billing parameter to print on the Canadian patient bill. Enter N if you do not want detail adjustment information for the specified billing parameter to print on the Canadian patient bill. The default is N.

Final Bill

Bill Suspense Days   (2N)

Enter the days after discharge before final bill. The Suspense Days defined on the STAR Patient Care Patient Type Table should be less than this entry.

ICD-10 EFFECTIVE DATE   (8N)

Enter the beginning admission date or discharge date of ICD-10 diagnosis and procedure code requirements for payers assigned this Final Bill Parameter.The Billing Parameter is assigned based on the COB 1 insurance plan, and if there are no insurances on the account, on the Financial Class of the account.

Edit Suspense Days   (2N)

The number of days after discharge to perform billing requirements edits.

Maximum Hold Days   (2N or U)

The maximum number of days to hold a bill after failing edits. Enter the number of days or U for unlimited.

Zero Charge Report Days   (3N)

The number of days after discharge to wait before reporting accounts with zero charges on the Unbilled Accounts with Zero Charges report.

Zero Charge Bill Days   (3N)   ☐☐☐

The number of days after the suspense days have been met that an unbilled account with zero charges is held before forced billing occurs.

Auto Late Bill?   (Circle Y or N)   Y   N

Should the system automatically produce a late bill? The default is N.

Minimum Late Charges   (2N)   ☐☐

The minimum number of late charges required to generate late bill. A late bill contains only late charges.

Minimum Late Charge Amount   (4N whole dollar amount)   ☐☐☐☐

The minimum late charge amount required to generate a late bill.

Zero Balance   (Circle Y or N)   Y   N

Automatically generate the late bill if the account balance is zero?

Minimum Late Credits   (2N)   ☐☐

The minimum number of late credits required to generate late bill.

Minimum Late Credit Amount   (5C leading - Sign)   ☐☐☐☐☐

The minimum number of late credit amount required to generate late bill.

Auto Adj Rebill?   (Circle Y or N)   Y   N

Should the system automatically produce an adjustment bill? The default is N. An adjustment bill prints all charges from the final bill plus any late charges.

Minimum Late Charges   (2N)

The minimum number of late charges required to generate a late bill.

Minimum Late Charge Amount   (4N - whole dollar amount)

The minimum late charge amount required to generate an adjustment bill.

Zero Balance   (Circle Y or N)   Y   N

Automatically generate the adjustment bill if the account balance is zero?

Minimum Late Credits   (2N)

The minimum number of late credits required to generate a late bill.

Minimum Late Credit Amount   (5C leading - sign)

The minimum number of late credit amount required to generate a late bill.

Auto Adj Rebill DRG/Dx/Proc   (Circle One)   A   R   N

Should the system automatically produce an adjustment bill when the DRG code, any Diagnosis, or Procedure code is revised? Circle A for automatic adjustment bill and report, R for report only, or N if neither is desired. The default is N.

Cycle Bills

Cycle Bill Selection Method   (Circle One)   A   F   E   U   S

Circle A for Admission, F for Fixed Day, E for End of Month, U for Unbilled, or S for Service Date. Your entry to this field determines which of the remaining fields you must complete.

Days After Admission/Last Bill   (2N)   [ ][ ]

Enter the number of days after admission or last bill before billing. This field is valid only if you selected Cycle Bill Selection Method A (Admission).

Cycle Bill Suspense Days   (2N)   [ ][ ]

Enter the number of suspense days after bill selection to wait before producing a cycle bill. The range is 0-40.

Cycle Bill Suspense Charge Selection   (Circle A or S)   A   S

Circle A to include all unbilled charges or S to include charges meeting the Service Date criteria. For End of Month and Service Date cycle bill types, circle S.

Fixed Day of Month   (2N)   [ ][ ]

Enter the day of the month for billing. This option is valid only if you selected Cycle Bill Selection Method F (Fixed Day).

Unbilled Balance Amount   (5N)   [ ][ ][ ][ ][ ]

Enter the maximum unbilled dollar amount needed before the system generates a cycle bill. This field is required if you selected Cycle Bill Selection Method U (Unbilled Amount).

Audit Bill?   (Circle Y or N)   Y   N

Produce an audit bill? The default is N. This field is valid only if you selected Cycle Bill Selection Method E (End of Month), A (Admission), or F (Fixed Day).

Audit Bill Suspense Days   (2N)   ☐☐

Enter the number of days to wait after bill eligibility before producing an audit bill. The default is 0. This field is valid only if you selected Cycle Bill Selection Method E (End of Month), A(Admission), or F (Fixed Day). The days entered here should be less than the days for cycle bill suspense in order to give you time to review the audit bill.

Auto Cycle Bill?   (Circle Y or N)   Y   N

Should the system produce an automatic cycle bill for any active accounts assigned to this billing parameter if the same patient is admitted/registered with a new account number? The default is N.

Cycle Adj Bill Ind   (Circle one)   Y(Yes)   N(No)   B (Blank)

This field determines whether cycle adjustment bill processing is allowed for accounts associated with this billing parameter.

Chg Bill Window   (3N)   ☐☐☐

This field indicates the number of days that a user can enter a charge on an AR account, after the Date of Service has passed, before the AR account is placed automatically on bill hold with a type of O (Old Charge)*.*

Cycle Adjustment Parameters

If the Cycle Adj Bill Ind field is set to Yes (allow cycle adjustment billing), the following parameters should be set.

CYCA MAX DAYS SINCE SERVICE   (4C)

			U (Unlimited

This field indicates the maximum number of days from charge service date that a charge can be included on a cycle adjustment bill. You can also enter U (Unlimited).

CYCA ZERO BAL   (Circle Y or N)   Y   N

Should the system automatically generate a cycle adjustment bill if the account balance is zero?

MANUAL CYCA CHG/   (Circle Y or N)   Y   N
CR/DYS OVERRIDE
FOR SUBSEQUENT
BILLS

Should the system override the minimum number and amount for unbilled charges/credits defined in the Min Unbilled Charges, Min Unbilled Charge Amt, Min Unbilled Credits, Min Unbilled Credit Amt, and CycA Max Days Since Service fields when producing subsequent cycle adjustment bills?

Auto Cycle Adj   (Circle Y or N)   Y   N

Should the system produce an automatic cycle adjustment bill based on the entries made in either the Minimum Unbilled Charges and Minimum Unbilled Charge Amount fields and the Minimum Unbilled Credits and Minimum Unbilled Credit Amount fields?

MIN UNBILLED CHARGES   (2N)

Enter the minimum number of unbilled charges required to generate an automatic and manual cycle adjustment bill.

MIN UNBILLED CHARGE AMT   (4N)

Enter the minimum unbilled charge amount necessary to generate an automatic and manual cycle adjustment bill.

MIN UNBILLED CREDITS   (2N)   ☐☐

Enter the minimum number of unbilled credits required to generate an automatic and manual cycle adjustment bill.

 MIN UNBILLED CREDIT AMT   (5N)   ☐☐☐

Enter the minimum unbilled credit amount necessary to generate an automatic and manual cycle adjustment bill.

CYCA SUPPRESS   (Circle Y or N)   Y   N
SUBSEQUENT BILLS/
DO NOT LOAD CLMS

Indicate, for subsequent cycle adjustments bills, whether bills should be suppressed and claims should not be loaded if there are no new/qualifying charges for subsequent cycle adjustment bills.

BUSINESS OFFICES

Level 3	Matrix# 13	Facility:

This table contains codes identifying a logical business office. The business office is assigned to the facility it bills and collects for in Facility Maintenance-PAAR Control.

NOTE: This table is only valid if you do not use the Receivables Workstation.

Business Office Code   (2A)

Description

(33AN)

Telephone F/U Last Payment Days   (3N)

Minimum number of days since last guarantor payment to trigger telephone follow-up.

Telephone F/U Transaction Code: T   (3N)

Transaction code displaying on the account's transaction history after business office follow-up has occurred.

Promise to Pay Transaction Code: T   (4N)

Transaction code displaying on the account's transaction history after promise to pay follow-up has occurred.

Follow-Up Schedule

Use the following fields to define the selection criteria for business office follow-up:
Minimum follow-up scheduled steps to be performed.

Seq. (2N)	Balance (9N dollar amount)												Patient or Account Balance (Circle One)		
								.				P		A
								.				P		A
								.				P		A
								.				P		A
								.				P		A

Default Telephone Collector   (2N)   ☐☐

Enter the code of the collector who serves as the default collector.

Use the fields in the following table to define alphabetic categories for business office follow-up, based on the patient's last name. For example, if you enter HZZ to the first Last Name field, the collector in the Telephone Collector field is responsible for all accounts whose last names begin with AAA to all accounts whose last names begin with HZZ (for example, from A through H). The collector on the next line would be responsible for all patients whose last names begin with I.

Last Name (3A)			Telephone Collector (2N)			Last Name (3A)			Telephone Collector (2N)	

Defining Financial Class Exceptions

Use the following fields to define financial class exceptions for this business office.

Financial Class   (2AN)   ☐☐

Enter the financial class for which you are establishing exceptions.

Default Telephone Collector   (2N)   [ ][ ]

Enter the code of the collector who serves as the default collector.

Use the fields in the following table to define alphabetic categories for the financial class exceptions for business office follow-up, based on the patient's last name. For example, if you enter HZZ to the first Last Name field, the collector in the Telephone Collector field is responsible for all accounts whose last names begin with AAA to all accounts whose last names begin with HZZ (for example, from A through H). The collector on the next line would be responsible for all patients whose last names begin with I.

Last Name (3A)			Telephone Collector (2N)			Last Name (3A)			Telephone Collector (2N)	

CCA/RUA/CPA PARAMETERS

Level 3	Matrix# 19	Facility:

General/CCA Parameters

The CCA/RUA/CPA Parameters table, which is split by facility, is completed for the CCA interface and indicates the patients who should be included in the interface. The hospital should define these parameters based on the information contained in TRENDSTAR.

Hospital Code   (3AN)   ☐ ☐ ☐ ☐

Enter the code used for the interface.

 # Accounts   (5N or A)   ☐ ☐ ☐ ☐ ☐

Enter the maximum number of discharged accounts to be included in an interface file or enter A for All. The default is All.

 # Non-discharged/Accounts   (4N or A)   ☐ ☐ ☐ ☐

Enter the maximum number of non-discharged accounts to be included in an interface file or enter A for All. The default is All.

> **Products**   CCA
>
> RUA
>
> CPA / Rules Based Reimbursement
>
> CPA / Claims Management

CCA must be circled as a product. RUA and the CPA Products are optional. Choose only one CPA product.

> **Transfer Method**   (Circle one)   T   N   A

Circle T to transfer interface file to TRENDSTAR by Tape, N to transfer interface file using TCP/IP NFS or A to transfer interface file using the TRENDSTAR TCP/IP interface. The default is T.

File Retention   (2N)   ☐ ☐

Enter the number of days to retain an interface file in STAR. The default is 7.

SDS Patient Types   (3AN) | | | |

(3AN)

(3AN)

(3AN)

(3AN)

(3AN)

(3AN)

(3AN)

Enter the patient types to be sent to TRENDSTAR as Same Day Surgery patient type.

Start Date   (6N)

Enter the discharge date to begin sending accounts to TRENDSTAR. Any accounts discharged before this date will be excluded. Enter E for Earliest if all accounts should be sent. The default is E.

Transfer Newborn Accounts with No Charges   (Circle Y or N)   Y   N

Circle Y if you want newborn accounts which have no charges to be transferred to TRENDSTAR. Circle N if you do not want newborn accounts which have no charges to be transferred to TRENDSTAR. The default is Y.

Transfer Other Accounts with No Charges   (Circle A, S or N)   A   S   N

Circle A if you want all accounts other than newborn who do not have charges to be transferred to TRENDSTAR. Circle S if you want to specify by patient type certain accounts with no charges to be transferred to TRENDSTAR. Circle N if you do not want any accounts with no charges to be sent to TRENDSTAR. The default is N.

If S is selected, enter the patient types which you want to transfer to TRENDSTAR even if the account has no charges. The system displays a table for this selection.

(3AN)

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Excluded Patient Types   (3AN) | | | |

(3AN) | | | |
(3AN) | | | |
(3AN) | | | |
(3AN) | | | |
(3AN) | | | |
(3AN) | | | |
(3AN) | | | |

Enter the patient types to exclude from the interface. The system displays a table for this selection.

Include SDS Patient Types   (Circle Y or N)   Y   N

Should the Same Day Surgery patient types be included in the interface? The default is Y.

FC/Ins Code   (Circle F or I)   F   I

FC/Ins Code   (Circle M or P)   M   P

Send the Financial Class (F) or the Primary Insurance Code (I) over the interface. The default is F. If F is chosen, choose M to send MPI Primary Financial Class or P for Patient Accounting Financial Class.

Transfer DRG   (Circle Y or N)   Y   N

Circle Y if you want the STAR DRG to be sent to TRENDSTAR. Enter N if you do not
want the STAR DRG to be sent to TRENDSTAR and you want TRENDSTAR to
calculate the DRG. The default is Y.

MR Number   (Circle Y or N)   Y   N

Circle Y if you want the facility indicator to appear on the patient's medical record
number when it is sent to TRENDSTAR. Circle N if you do not want the facility indicator
to appear on the patient's medical record number when it is sent to TRENDSTAR. The
default is Y.

Uncombine mother Newborn charges?   (Circle Y or N)   Y   N

Circle Y if you are combining mother and newborn charges and if you want the
newborn's charges to appear on the newborn's account. Circle N if you do not want
the uncombine the mother and newborn accounts. The default is N.

Uncombine other account's charges   (Circle A, S or   A   S   N
                                          N)

Circle A if you want charges for all non-newborn accounts that are combined to be
place on the original accounts they were charged to. Circle S if you want to specify by
patient types certain non-newborn accounts to uncombine. Circle N if you do not want
any to be uncombined. The default is N.

 If S is selected enter the patient types for which you want the changes uncombined.

(3AN)

(3AN)

(3AN)

(3AN)

(3AN)

(3AN)

(3AN)

(3AN)

Uncombine DPW account's charges   (Circle A, S or N)   A   S   N

Circle A if you want charges for all DPW accounts that are combined to be place on the original accounts they were charged to. Circle S if you want to specify by patient types certain DPW accounts to uncombine. Circle N if you do not want any to be uncombined. The default is N.

If S is selected enter the patient types for which you want the changes uncombined.

(3AN)

(3AN)

(3AN)

(3AN)

(3AN)

(3AN)

(3AN)

(3AN)

Procedure Phy #1 (Circle one)	Surgeon	Anesthetist	Team Member 1	Team Member 2
	Team Member 3	Team Member 4	Team Member 5	Team Member 6
	Team Member 7	Team Member 8	Team Member 9	Team Member 10

Circle the physician you want to transfer to TRENDSTAR as physician 1 in the Procedure Detail record.

Procedure Phy #2   Surgeon   Anesthetist   Team Member 1   Team Member 2
(Circle one)

                        Team Member 3   Team Member 4   Team Member 5   Team Member 6

                        Team Member 7   Team Member 8   Team Member 9   Team Member 10

Circle the physician you want to transfer to TRENDSTAR as physician 2 in the Procedure Detail record.

Physician A-D

Up to four additional doctor records can be sent over the interface. Circle the physician(s) from the following list whose records should be sent over the interface.

1st Consulting Physician   Procedure 1 Surgeon

2nd Consulting Physician   Procedure 2 Surgeon

3rd Consulting Physician   Procedure 3 Surgeon

4th Consulting Physician   Procedure 4 Surgeon

5th Consulting Physician   Procedure 5 Surgeon

6th Consulting Physician   Procedure 6 Surgeon

7th Consulting Physician   Procedure 7 Surgeon

8th Consulting Physician   Procedure 8 Surgeon

9th Consulting Physician   Procedure 9 Surgeon

10th Consulting Physician   Procedure 10 Surgeon

Attending Physician   Procedure 11 Surgeon

Admitting Physician   Procedure 12 Surgeon

Discharge Physician   Procedure 13 Surgeon

Primary Care Physician   Procedure 14 Surgeon

Referring Physician   Procedure 15 Surgeon

Procedure 1 Anesthetist   Procedure 1 Phys 1

Procedure 2 Anesthetist   Procedure 2 Phys 1

Procedure 3 Anesthetist   Procedure 3 Phys 1

Procedure 4 Anesthetist	Procedure 4 Phys 1
Procedure 5 Anesthetist	Procedure 5 Phys 1
Procedure 6 Anesthetist	Procedure 6 Phys 1
Procedure 7 Anesthetist	Procedure 7 Phys 1
Procedure 8 Anesthetist	Procedure 8 Phys 1
Procedure 9 Anesthetist	Procedure 9 Phys 1
Procedure 10 Anesthetist	Procedure 10 Phys 1
Procedure 11 Anesthetist	Procedure 11 Phys 1
Procedure 12 Anesthetist	Procedure 12 Phys 1
Procedure 13 Anesthetist	Procedure 13 Phys 1
Procedure 14 Anesthetist	Procedure 14 Phys 1
ER Physician	Shared Care Physician
Procedure 1 Phys 2	Procedure 1 Phys 3
Procedure 2 Phys 2	Procedure 2 Phys 3
Procedure 3 Phys 2	Procedure 3 Phys 3
Procedure 4 Phys 2	Procedure 4 Phys 3
Procedure 5 Phys 2	Procedure 5 Phys 3
Procedure 6 Phys 2	Procedure 6 Phys 3
Procedure 7 Phys 2	Procedure 7 Phys 3
Procedure 8 Phys 2	Procedure 8 Phys 3
Procedure 9 Phys 2	Procedure 9 Phys 3
Procedure 10 Phys 2	Procedure 10 Phys 3
Procedure 11 Phys 2	Procedure 11 Phys 3
Procedure 12 Phys 2	Procedure 12 Phys 3
Procedure 13 Phys 2	Procedure 13 Phys 3
Procedure 14 Phys 2	Procedure 14 Phys 3
Procedure 15 Phys 2	Procedure 15 Phys 3
Procedure 1 Phys 4	Procedure 1 Phys 5
Procedure 2 Phys 4	Procedure 2 Phys 5
Procedure 3 Phys 4	Procedure 3 Phys 5
Procedure 4 Phys 4	Procedure 4 Phys 5

Procedure 5 Phys 4   Procedure 5 Phys 5

Procedure 6 Phys 4   Procedure 6 Phys 5

Procedure 7 Phys 4   Procedure 7 Phys 5

Procedure 8 Phys 4   Procedure 8 Phys 5

Procedure 9 Phys 4   Procedure 9 Phys 5

Procedure 10 Phys 4   Procedure 10 Phys 5

Procedure 11 Phys 4   Procedure 11 Phys 5

Procedure 12 Phys 4   Procedure 12 Phys 5

Procedure 13 Phys 4   Procedure 13 Phys 5

Procedure 14 Phys 4   Procedure 14 Phys 5

Procedure 15 Phys 4   Procedure 15 Phys 5

Additional Audit Reports   (Circle one or more)

Cases and Charges by Month/Fiscal Period

Cases and Charges by Insurance Plan/
Financial Class

Totals by Record Type

Circle the additional audit reports you would like to see when the CCA/RUA/CPA
Optional Batch Job is run.

Refunds with Payments   (Circle Y or N)   Y   N

Circle Y if you want refunds to be included with summarized payments in
TRENDSTAR. Circle N if you do not want refunds to be included with summarized
payments in TRENDSTAR. The default is Y.

Series Processing   (Circle Y or N)   Y   N

Circle Y if you want to store outpatient cycle bills as separate accounts on
TRENDSTAR. Circle N if you want outpatient cycle bills to be merged into one account
on TRENDSTAR. The default is N.

APC Data	(Circle P, R, B, or N)	P	R	B	N

Circle the APC record types that should be sent to TRENDSTAR. The options are P (Patient level), R (Procedural level), B (Both procedural and patient level), or N (No APC data will be created). The default is N.

RUA Parameters

These parameters control how the data is sent for RUA product. Complete these only if you have RUA specified as a product on the General/CCA Parameters.

Autopsy Code   (9N)

Enter the appropriate death codes classification. The system displays a table of options.
Enter up to nine autopsy codes.

Physician E-S

Up to fifteen additional doctor records can be sent over the interface. Circle the physician(s) from the following list whose records should be sent over the interface.

1st Consulting Physician	Procedure 1 Surgeon
2nd Consulting Physician	Procedure 2 Surgeon
3rd Consulting Physician	Procedure 3 Surgeon
4th Consulting Physician	Procedure 4 Surgeon
5th Consulting Physician	Procedure 5 Surgeon
6th Consulting Physician	Procedure 6 Surgeon
7th Consulting Physician	Procedure 7 Surgeon
8th Consulting Physician	Procedure 8 Surgeon
9th Consulting Physician	Procedure 9 Surgeon
10th Consulting Physician	Procedure 10 Surgeon
Attending Physician	Procedure 11 Surgeon
Admitting Physician	Procedure 12 Surgeon
Discharge Physician	Procedure 13 Surgeon
Family Physician	Procedure 14 Surgeon

Referring Physician	Procedure 15 Surgeon
Procedure 1 Anesthetist	Procedure 1 Phys 1
Procedure 2 Anesthetist	Procedure 2 Phys 1
Procedure 3 Anesthetist	Procedure 3 Phys 1
Procedure 4 Anesthetist	Procedure 4 Phys 1
Procedure 5 Anesthetist	Procedure 5 Phys 1
Procedure 6 Anesthetist	Procedure 6 Phys 1
Procedure 7 Anesthetist	Procedure 7 Phys 1
Procedure 8 Anesthetist	Procedure 8 Phys 1
Procedure 9 Anesthetist	Procedure 9 Phys 1
Procedure 10 Anesthetist	Procedure 10 Phys 1
Procedure 11 Anesthetist	Procedure 11 Phys 1
Procedure 12 Anesthetist	Procedure 12 Phys 1
Procedure 13 Anesthetist	Procedure 13 Phys 1
Procedure 14 Anesthetist	Procedure 14 Phys 1
ER Physician	Shared Care Physician
Procedure 1 Phys 2	Procedure 1 Phys 3
Procedure 2 Phys 2	Procedure 2 Phys 3
Procedure 3 Phys 2	Procedure 3 Phys 3
Procedure 4 Phys 2	Procedure 4 Phys 3
Procedure 5 Phys 2	Procedure 5 Phys 3
Procedure 6 Phys 2	Procedure 6 Phys 3
Procedure 7 Phys 2	Procedure 7 Phys 3
Procedure 8 Phys 2	Procedure 8 Phys 3
Procedure 9 Phys 2	Procedure 9 Phys 3
Procedure 10 Phys 2	Procedure 10 Phys 3
Procedure 11 Phys 2	Procedure 11 Phys 3
Procedure 12 Phys 2	Procedure 12 Phys 3
Procedure 13 Phys 2	Procedure 13 Phys 3
Procedure 14 Phys 2	Procedure 14 Phys 3

Procedure 15 Phys 2   Procedure 15 Phys 3

Procedure 1 Phys 4   Procedure 1 Phys 5

Procedure 2 Phys 4   Procedure 2 Phys 5

Procedure 3 Phys 4   Procedure 3 Phys 5

Procedure 4 Phys 4   Procedure 4 Phys 5

Procedure 5 Phys 4   Procedure 5 Phys 5

Procedure 6 Phys 4   Procedure 6 Phys 5

Procedure 7 Phys 4   Procedure 7 Phys 5

Procedure 8 Phys 4   Procedure 8 Phys 5

Procedure 9 Phys 4   Procedure 9 Phys 5

Procedure 10 Phys 4   Procedure 10 Phys 5

Procedure 11 Phys 4   Procedure 11 Phys 5

Procedure 12 Phys 4   Procedure 12 Phys 5

Procedure 13 Phys 4   Procedure 13 Phys 5

Procedure 14 Phys 4   Procedure 14 Phys 5

Procedure 15 Phys 4   Procedure 15 Phys 5

Expanded Charge Records   (Circle Y or N)   Y   N

Circle Y if you want to send the expanded procedure charge record (record type 99) to TRENDSTAR. Circle N if you do not want to send the expanded procedure charge record (record type 99) to TRENDSTAR. The default is N.

If answered Y above then you have a choice of one of more of the following data elements to send in the expanded procedure charge record.

(Circle one or more)   Order Date   Order Time   Point of Service

One or all of the above may be chosen.

Transfer Acuity   (Circle Y or N)   Y   N

Should acuity from the Patient Acuity and Nurse Staffing module of STAR Patient Care be transferred to TRENDSTAR?

Pharmacy Metric Quantity   (Circle Y or N)   Y   N

Circle Y if you want to send the metric quantity for pharmacy items in the charge record to TRENDSTAR. Circle N if you do not want to send the metric quantity for pharmacy items in the charge record to TRENDSTAR. The default is N.

Expanded HCPCS Records   (Circle Y or N)   Y   N

Circle Yes or No to indicate whether the Expanded Medical and Billing CPT4/HCPCS and Rev Code Information records (10.15 and 10.16) are to be sent to TRENDSTAR instead of the Medical and Billing CPT-4 Data records (10.05 and 10.06). The default is No.

CPA Parameters

These parameters should only be completed if CPA/Rules Based Reimbursement or CPA/Claims Management were chosen as products in the General/CCA Parameters. These parameters control how CPA data is sent to TRENDSTAR.

Authorization #1 - #9

Up to four authorization numbers are available if the Yes/Claims Management option is available. Circle the authorization number(s) from the following list whose records should be sent over the interface.

Approval Name COB 1

Approval Name COB 2

Approval Name COB 3

Approval Name COB 4

Approval Name COB 5

Approval Name COB 6

Approval Name COB 7

Approval Name COB 8

Approval Name COB 9

Approval Number COB 1

Approval Number COB 2

Approval Number COB 3

Approval Number COB 4

Approval Number COB 5

Approval Number COB 6

Approval Number COB 7

Approval Number COB 8

Approval Number COB 9

Insurance Verified Name COB 1

Insurance Verified Name COB 2

Insurance Verified Name COB 3

Insurance Verified Name COB 4

Insurance Verified Name COB 5

Insurance Verified Name COB 6

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Insurance Verified Name COB 7

Insurance Verified Name COB 8

Insurance Verified Name COB 9

Second Opinion COB 1

Second Opinion COB 2

Second Opinion COB 3

Second Opinion COB 4

Second Opinion COB 5

Second Opinion COB 6

Second Opinion COB 7

Second Opinion COB 8

Second Opinion COB 9

Insurance Notified Date COB 1

Insurance Notified Date COB 2

Insurance Notified Date COB 3

Insurance Notified Date COB 4

Insurance Notified Date COB 5

Insurance Notified Date COB 6

Insurance Notified Date COB 7

Insurance Notified Date COB 8

Insurance Notified Date COB 9

Approval Date COB 1

Approval Date COB 2

Approval Date COB 3

Approval Date COB 4

Approval Date COB 5

Approval Date COB 6

Approval Date COB 7

Approval Date COB 8

Approval Date COB 9

Insurance Verified Date COB 1

Insurance Verified Date COB 2

Insurance Verified Date COB 3

Insurance Verified Date COB 4

Insurance Verified Date COB 5

Insurance Verified Date COB 6

Insurance Verified Date COB 7

Insurance Verified Date COB 8

Insurance Verified Date COB 9

Insurance Verified Name COB 2

Insurance Verified Name COB 3

Insurance Verified Name COB 4

Insurance Verified Name COB 5

Insurance Verified Name COB 6

Insurance Verified Name COB 7

Insurance Verified Name COB 8

Insurance Verified Name COB 9

Second Opinion COB 1

Second Opinion COB 2

Second Opinion COB 3

Second Opinion COB 4

Second Opinion COB 5

Second Opinion COB 6

Second Opinion COB 7

Second Opinion COB 8

Second Opinion COB 9

Insurance Notified Date COB 1

Insurance Notified Date COB 2

Insurance Notified Date COB 3

Insurance Notified Date COB 4

Insurance Notified Date COB 5

Insurance Notified Date COB 6

Insurance Notified Date COB 7

Insurance Notified Date COB 8

Insurance Notified Date COB 9

Approval Date COB 1

Approval Date COB 2

Approval Date COB 3

Approval Date COB 4

Approval Date COB 5

Approval Date COB 6

Approval Date COB 7

Approval Date COB 8

Approval Date COB 9

Insurance Verified Date COB 1

Insurance Verified Date COB 2

Insurance Verified Date COB 3

Insurance Verified Date COB 4

Insurance Verified Date COB 5

Insurance Verified Date COB 6

Insurance Verified Date COB 7

Insurance Verified Date COB 8

Insurance Verified Date COB 9

Contract ID Format   (Circle Y or N)   Y   N

Circle Y if you want the leading zeros of the insurance carrier/plan code to be suppressed when
sending it to TRENDSTAR as the contract ID. Circle N if you do not want the leading zeros of the
insurance carrier/plan code to be suppressed. The default is N.

Include 8.01 Record   (Circle Y or N)   Y   N

Circle Y if you want to send the expected reimbursement from STAR to TRENDSTAR. Circle N if you want TRENDSTAR to calculate expected reimbursement. The default is N.

Refunds with Payment Detail   (Circle Y or N)   Y   N

This should only be completed if CPA/Claims Management was chosen as a product in the General/CCA Parameters. Circle Y if you want to include refunds with the detail payment records. Circle N if you do not want to include refunds with the detail payment records. The default is Y.

Deductible/Coinsurance Source   (Circle P or R)   P   R

Circle P if you want the deductible and coinsurance amounts to be taken from payment information. Circle R if you want deductible and coinsurance amounts to be taken from proration information.

User-Defined Fields
Up to 500 user-defined fields can be sent over the interface. The user-defined fields are alpha-numeric fields. These user-defined fields must match the information in TRENDSTAR.   Refer to Appendix A: TRENDSTAR Data Definitions in the *General Information Volume* of the *STAR Patient Accounting Reference Guide* for more information about user-defined fields, setup routines, and print routines. If applicable, setup routines and print routines can be defined with the user-defined fields.

User-Defined Elements	Setup Routines	Print Routines

User-Defined Elements	Setup Routines	Print Routines

User-Defined Elements	Setup Routines	Print Routines

User-Defined Elements	Setup Routines	Print Routines

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User-Defined Elements	Setup Routines	Print Routines

AR/BD Add Parameters

These parameters control how AR/BD Add accounts will be sent to TRENDSTAR.

AR/BD Add Accounts   (Circle Y or N)   Y   N

Circle Y if you want AR/BD Add accounts to be sent to TRENDSTAR in the interface.
Circle N if you do not want AR/BD Add accounts to be sent to TRENDSTAR in the
interface. The default is N.

The following parameters only need to be completed if you responded Yes to above
parameter.

Summarized Payments (6.04)   (Circle Y or N)   Y   N

Circle Y if you want summarized payments amounts to be sent to TRENDSTAR in the 6.04
record. The default is N.

Replace or Add to summarized payment amounts in TRENDSTAR   (Circle R or A)   R   A

This is completed only if you circle Y for the Summarized Payment parameter. Circle
R if you want the summarized payment amounts in STAR to replace summarized
payments in TRENDSTAR. Circle A if you want summarized payment amounts in
STAR to add to summarized payments in TRENDSTAR.

Detail Payments (8.10)   (Circle Y or N)   Y   N

This should be completed only if CPA/Claims Management is listed as a product on the
General/CCA Parameters. Circle Y if you want the detail payment records to be sent
to TRENDSTAR. Circle N if you do not want the detail payment records to be sent to
TRENDSTAR. The default is N.

Replace or Add to summarized payment amounts in TRENDSTAR   (Circle R or A)   R   A

This is completed only if circled Y for the Detail Payment parameter. Circle R if you
want the detail payments in STAR to replace the detail payments in TRENDSTAR.
Circle A if you want the detail payments in STAR to add to the detail payments in
TRENDSTAR.

Detail Adjustments (8.11)   (Circle Y or N)   Y   N

This is completed only if you have CPA/Claims Management listed as a product on the
General/CCA Parameter screen. Circle Y if you want detail adjustments to be sent to
TRENDSTAR. Circle N if you do not want detail adjustments to be sent to
TRENDSTAR.

Replace or Add to detail adjustments in TRENDSTAR   (Circle R or A)   R   A

This is completed only if circled Y for the Detail Adjustment parameter. Circle R if you want the detail adjustments in STAR to replace the detail adjustments in TRENDSTAR. Circle A if you want the detail adjustments in STAR to add to the detail adjustments in TRENDSTAR.

Account Balance Data (8.09)   (Circle Y or N)   Y   N

This is completed only if you have CPA/Claims Management listed as a product on the General/CCA Parameter Screen. Circle Y if you want account balance data (record type 8.09) to be sent to TRENDSTAR. Circle N if you do not want account balance data to be sent to TRENDSTAR.

Transaction Code to Exclude   (5AN)   [ ][ ][ ][ ][ ]

This is only completed if you have CPA/Claims Management listed as a product on the General/CCA parameter screen and if you are including detail adjustments. List the adjustment transaction codes which you do not want to be sent to TRENDSTAR.

Patient Contract Data (8.03)   (Circle A, S, or N)   A   S   N

Circle A if you want all the data elements in the patient contract data record (record type 8.03) sent to TRENDSTAR. Circle S if you want some of the patient contract data record to be sent to TRENDSTAR. Circle N if you do not want any of the patient contract data record to be sent to TRENDSTAR.

If you circle S then circle the following data elements which you want sent in the patient contract data record.

Final Bill Date

COB 1 First Payment Date

COB 2 Last Payment Date

Account Location Code

Medical Service Code

Employer Name

Payment/Adjustment/Refund UDFs   (Circle A, S or N)   A   S   N

Circle A if you want all the payment/adjustment/refund UDFs which you specified on the User Defined Field Parameter screen to be sent to TRENDSTAR. Circle S if you want some of these UDFs to be sent to TRENDSTAR. Circle N if do not want any of these UDFs to be sent to TRENDSTAR.

If you circled S then list the payment/adjustment/refund UDFs which you want to send TRENDSTAR. These UDFs must be chosen in the User Defined Field parameters.

User Defined Field Parameters
1
2
3
4
5
6
7
8
9
10

Converted Accounts Parameter

These parameters control how converted accounts will be sent to TRENDSTAR.

Converted Accounts   (Circle Y or N)   Y   N

Circle Y if you want converted accounts to be sent to TRENDSTAR in the interface. Circle N if you do not want converted accounts to be sent to TRENDSTAR in the interface. The default is N.

Do you want to send a complete record?   (Circle Y or N)   Y   N

Complete this parameter only if responded Y to be above parameter.

The following parameters only need to be completed if you responded Yes to converted account parameter.

Summarized Payments   (6.04)   (Circle Y or N)   Y   N

Circle Y if you want summarized payment amounts to be sent to TRENDSTAR in the 6.04 record. The default is N.

Replace or Add to summarized payment amounts in   (Circle R or A)   R   A
TRENDSTAR

This is completed only if you circled Y for the Summarized Payment parameter. Circle R if you want the summarized payment amounts in STAR to replace summarized payments in TRENDSTAR. Circle A if you want summarized payments amounts in STAR to add to summarized payments in TRENDSTAR.

Detail Payments   (8.10)   (Circle Y or N)   Y   N

This should be completed only if CPA/Claims Management is listed as a product on the General/CCA Parameters. Circle Y if you want the detail payment records to be sent to TRENDSTAR. Circle N if you do not want the detail payment records to be sent to TRENDSTAR. The default is N.

Replace or Add to detail payment in TRENDSTAR   (Circle R or A)   R   A

This is completed only if circled Y for the Detail Payment parameter. Circle R if you want the detail payments in STAR to replace the detail payments in TRENDSTAR. Circle A if you want the detail payments in TRENDSTAR. Circle A if you want the detail payments in STAR to add to the detail payments in TRENDSTAR.

Detail Adjustments   (8.11)   (Circle Y or N)   Y   N

This is completed only if you have CPA/Claims Management listed as a product on the General/CCA Parameter screen. Circle Y if you want detail adjustments to be sent to TRENDSTAR. Circle N if you do not want detail adjustments to be sent to TRENDSTAR.

Replace or Add to detail adjustments in TRENDSTAR   (Circle R or A)   R   A

This is completed only if you circled Y for the Detail Adjustment parameter. Circle R if you want the detail adjustments in STAR to replace the detail adjustments in

TRENDSTAR. Circle A if you want the detail adjustments in STAR to add to the detail adjustments in TRENDSTAR.

Account Balance Data (8.09)   (Circle Y or N)   Y   N

This is completed only if you have CPA/Claims Management listed as a product on the General/CCA Parameter Screen. Circle Y if you want account balance data (record type 8.09) to be sent to TRENDSTAR. Circle N if you do not want account balance data to be sent to TRENDSTAR.

General Patient Information (0 and 1)   (Circle one)   A   S

Circle A if you want all the data elements in the general patient information records (record types 0 and 1) to be sent to TRENDSTAR. Circle S if you want some of the data elements to be sent to TRENDSTAR.

If you circle S then circle the following data elements which you want sent to TRENDSTAR.

     Patient Name

     Age

     Sex

     Zip Code

     Primary Carrier Plan / Financial Class

     Discharge Status

     Attending Physician

     DRG

     MDC

     LOS

Patient Contract Data (8.03)   (Circle one)   A   S   N

Circle A if you want all the data elements in the patient contract data record (record type 8.03) sent to TRENDSTAR. Circle S if you want some of the patient contract data

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record to be sent to TRENDSTAR. Circle N if you do not want any of the patient contract data record to be sent to TRENDSTAR.

If you circled S then circle the following data elements which you want sent in the patient contract data record.

Final Bill Date

COB 1 First Payment Date

COB 2 Last Payment Date

Account Location Code

Medical Service Code

Employer Name

Non Payment UDFs   (Circle one)   Y   N

Circle Y if you want UDFs that are not payment-, adjustment-, or refund-related to be sent to TRENDSTAR. Circle N if you do not want the UDFs that are not payment-, adjustment-, or refund-related to be sent to TRENDSTAR.

Payment/Adjustment/Refund UDFs   (Circle one)   A   S   N

Circle A if you want all the payment/adjustment/refund UDFs which you specified on the User Defined Field Parameter screen to be sent to TRENDSTAR. Circle S if you want some of these UDFs to be sent to TRENDSTAR. Circle N if you do not want any of these UDFs to be sent to TRENDSTAR.

If you circle S then list the payment/adjustment/refund UDFs which you want to send to TRENDSTAR. These UDFs must be chosen in the User Defined Field parameters.

User Defined Field Parameters
1
2
3
4
5
6

7
8
9
10

Inhouse Accounts at Conversion

These parameter control how inhouse accounts at conversion will be sent to TRENDSTAR.

Should inhouse accounts at conversion be processed separately?   (Circle one)   Y   N

Circle Y if you want accounts which are inhouse at the time of conversion to be processed as a separate file using the following parameters. Circle N if you do not inhouse accounts to be processed separately.

The following parameters only need to be completed if you responded Yes to above parameter.

Enter STAR Patient Accounting Live Date   (8AN)   ☐☐☐☐☐☐☐☐

Summarized Payments (6.04)   (Circle Y or N)   Y   N

Circle Y if you want summarized payment amounts to be sent to TRENDSTAR in the 6.04 record. The default is N.

Replace or Add to summarized payment amounts in TRENDSTAR   (Circle one)   R   A

This is completed only if you circled Y for the Summarized Payment parameter. Circle R if you want the summarized payment amounts in STAR to replace summarized payments in TRENDSTAR. Circle A if you want summarized payments amounts in STAR to add to summarized payment in TRENDSTAR.

Detail Payments (8.10)   (Circle Y or N)   Y   N

This should be completed only if CPA/Claims Management is listed as a product on the General/CCA Parameters. Circle Y if you want the detail payment records to be sent to TRENDSTAR. Circle N if you do not want the detail payment records to be sent to TRENDSTAR. The default is N.

Replace or Add to detail payment amounts in   (Circle one)   R   A
TRENDSTAR

This is completed only if circled Y for the Detail Payment parameter. Circle R if you want the detail payments in STAR to replace the detail payments in TRENDSTAR. Circle A if you want the detail payments in STAR to add to the detail payments in TRENDSTAR.

Detail Adjustments (8.11)   (Circle Y or N)   Y   N

This is completed only if you have CPA/Claims Management listed as a product on the General/CCA Parameter screen. Circle Y if you want detail adjustments to be sent to TRENDSTAR. Circle N if you do not want detail adjustments to be sent to TRENDSTAR.

Replace or Add to detail adjustment amounts in   (Circle one)   Y   N
TRENDSTAR

This is completed only if circled Y for the Detail Adjustment parameter. Circle R if you want the detail adjustments in STAR to replace the detail adjustments in TRENDSTAR.

Circle A if you want the detail adjustments in STAR to add to the detail adjustments in TRENDSTAR.

Charge Detail   (Circle One)   R   A

Circle R if you want STAR charges to replace the charges currently on TRENDSTAR. Circle A if you want STAR charges to add to charges currently on TRENDSTAR.

Transaction Code to Exclude   (5AN) | | | | | |

This is only completed if you have CPA/Claims Management listed as a product on the General/CCA parameter screen and if you are including detail adjustments. List the adjustment transaction codes which you do not want to be sent to TRENDSTAR.

SIM Department to Exclude   (3AN) | | | |

Enter the SIM Department which contains charges which you do not want to send to TRENDSTAR.

Patient Contract Data (8.03)   (Circle One)   A   S   N

Circle A if you want all the data elements in the patient contract data record (record type 8.03) sent to TRENDSTAR. Circle S if you want some of the patient contract data record to be sent to TRENDSTAR. Circle N if you do not want any of the patient contract data record to be sent to TRENDSTAR.

If you circled S then circle the following data elements which you want sent in the patient contract data record.

Final Bill Date

COB 1 First Payment Date

COB 2 Last Payment Date

Account Location Code

Medical Service Code

Employer Name

Non Payment UDFs   (Circle one)   Y   N

Circle Y if you want UDFs that are not payment-, adjustment-, or refund-related to be sent to TRENDSTAR. Circle N if you do not want the UDFs that are not payment-, adjustment-, or refund-related to be sent to TRENDSTAR.

Payment/Adjustment/Refund UDFs   (Circle one)   A   S   N

Circle A if you want all the payment/adjustment/refund UDFs which you specified on the User Defined Field Parameter screen to be sent to TRENDSTAR. Circle S if you want some of these UDFs to be sent to TRENDSTAR. Circle N if you do not want any of these UDFs to be sent to TRENDSTAR.

If you circle S then list the payment/adjustment/refund UDFs which you want to send to TRENDSTAR. These UDFs must be chosen in the User Defined Field parameters.

User Defined Field Parameters
1
2

3	
4	
5	
6	
7	
8	
9	
10	

Trigger Events

These parameters determine how accounts will be triggered to TRENDSTAR.

INPATIENTS

Should inhouse accounts be processed in the interface?   (Circle one)   Y   N

Circle Y if you want inhouse accounts to be processed in the interface. Circle N if you do not want inhouse accounts to be processed.

Transfer accounts based upon Discharge or Final Bill?   (Circle one)   D   F

Circle D if you want accounts to go to TRENDSTAR after they are discharged. Circle F if you want accounts to go to TRENDSTAR after Final Bill. Complete this field only if you have responded N to the previous question.

What discharge date should be used for inhouse accounts   (Circle one)   C   Z

Only complete this parameter if answered Y to above parameter. Circle C if you want to use the file creation date as the discharge date. Circle Z if you want the discharge date to be zero.

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Trigger Events/Transfer Charges

Circle the trigger events you want to use for inpatients. Circle Y if you want charges transferred when the account is triggered. Circle N if you do not want charges transferred when the account is triggered.

Abstract Flagged as Complete	Y	N
Patient Admission	Y	N
Adjustment Bill	Y	N
Patient Discharge/Disposition	Y	N
Archive	Y	N
Patient Historization	Y	N
Balance Transfer	Y	N
Patient Registration	Y	N
Changes to Ins / FC	Y	N
Payment / Adjustment	Y	N
Charge Revision	Y	N
DPW Addition/Change/Deletion	Y	N
RESQOR Case Information	Y	N
Charge / Credit	Y	N
Refund	Y	N
Combine Bill	Y	N
Transfer Visits	Y	N
Cycle Bill	Y	N
Transfer to Bad Debt	Y	N
Final Bill	Y	N
Late Bill	Y	N
Merge Patient	Y	N
Update Abstract Newborn / Death	Y	N
Update Abstract General Information	Y	N
Update Additional Demographic Information	Y	N
Update Addl Episode Information	Y	N
Update UB Data	Y	N
Update Consultation Information	Y	N
Update User Defined MPI Fields	Y	N
Update DRG Information	Y	N

Update User Defined Visit Field	Y	N
Update Demographic Information	Y	N
Update Utilization Review Information	Y	N
Update ICD-9-CM Diagnostic Information	Y	N
Update ICD-9-CM Procedure Information	Y	N
Update Insurance Information	Y	N
Update Medical Information	Y	N
Update Medical Records HCPS	Y	N
Update Misc Visit Information	Y	N
Update Patient Employer	Y	N
Update Special Studies Information	Y	N

OUTPATIENTS

Should non-discharged outpatients be transferred in the interface?   (Circle one)   Y   N

Circle Y if you want non-discharged outpatients to TRENDSTAR. Circle N if you do not want non-discharged outpatients to be sent to TRENDSTAR.

Transfer accounts based upon Discharge or Final Bill?   (Circle one)   D   F

Circle D if you want accounts to go to TRENDSTAR after they are discharged. Circle F if you want accounts to go to TRENDSTAR after Final Bill. Complete this field only if you have responded N to the previous question.

What discharge date should be used for non-discharged outpatients?   (Circle one)   L   C   Z

Complete this only if sending non-discharged outpatients to TRENDSTAR. Circle L if you want the discharge date to be the last service date of the patient. Circle C if you want the file creation date to be the discharge date and circle Z if you want the discharge date to be zero.

Trigger Events/Transfer Charges

Circle the trigger events you want to use for outpatients. Circle Y if you want charges transferred when the account is triggered. Circle N if you do not want charges transferred when the account is triggered.

Abstract Flagged as Complete	Y	N
Patient Admission	Y	N
Adjustment Bill	Y	N
Patient Discharge/Disposition	Y	N
Archive	Y	N
Patient Historization	Y	N
Balance Transfer	Y	N
Patient Registration	Y	N
Payment / Adjustment	Y	N
Charge Revision	Y	N
RESQOR Case Information	Y	N
Charge / Credit	Y	N
Refund	Y	N
DPW Addition/Change/Deletion	Y	N
Combine Bill	Y	N
Transfer Visits	Y	N
Cycle Bill	Y	N
Transfer to Bad Debt	Y	N
Final Bill	Y	N
Late Bill	Y	N
Merge Patient	Y	N
Update Abstract Newborn / Death	Y	N
Update Abstract General Information	Y	N
Update Additional Demographic Information	Y	N
Update Addl Episode Information	Y	N
Update UB Data	Y	N
Update Consultation Information	Y	N
Update User Defined MPI Fields	Y	N
Update DRG Information	Y	N
Update User Defined Visit Field	Y	N

Update Demographic Information	Y	N
Update Utilization Review Information	Y	N
Update ICD-9-CM Diagnostic Information	Y	N
Update ICD-9-CM Procedure Information	Y	N
Update Insurance Information	Y	N
Update Medical Information	Y	N
Update Medical Records HCPS	Y	N
Update Misc Visit Information	Y	N
Update Patient Employer	Y	N
Update Special Studies Information	Y	N

PATIENT TYPE EXCEPTIONS

Identify the patient type for the patient type exception   (3AN)

Abstract Flagged as Complete	Y	N
Patient Admission	Y	N
Adjustment Bill	Y	N
Patient Discharge/Disposition	Y	N
Archive	Y	N
Patient Historization	Y	N
Balance Transfer	Y	N
Patient Registration	Y	N
Changes to Ins / FC	Y	N
Payment / Adjustment	Y	N
Charge Revision	Y	N
RESQOR Case Information	Y	N
Charge / Credit	Y	N
Refund	Y	N
Combine Bill	Y	N
Transfer Visits	Y	N
Cycle Bill	Y	N
Transfer to Bad Debt	Y	N
Final Bill	Y	N
Late Bill	Y	N
Merge Patient	Y	N
Update Abstract Newborn / Death	Y	N
Update Abstract General Information	Y	N
Update Additional Demographic Information	Y	N
Update Addl Episode Information	Y	N
Update UB Data	Y	N
Update Consultation Information	Y	N
Update User Defined MPI Fields	Y	N
Update DRG Information	Y	N
Update User Defined Visit Field	Y	N

Update Demographic Information	Y	N
Update Utilization Review Information	Y	N
Update ICD-9-CM Diagnostic Information	Y	N
Update ICD-9-CM Procedure Information	Y	N
Update Insurance Information	Y	N
Update Medical Information	Y	N
Update Medical Records HCPS	Y	N
Update Misc Visit Information	Y	N
Update Patient Employer	Y	N
Update Special Studies Information	Y	N

This will need to be completed for as many patient type exceptions that you will have.

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COLLECTION GROUP

Level 3	Matrix# 22	Facility:

The Collection group table contains user-defined codes that group like collectors together. These codes are used in the Insurance Plan Coverage master and the Business Office table.

Collection Group Code   (2N)   [ ][ ]

Description

(33AN)

Default Collector   (2N)   [ ][ ]

Patient Indicator* (Circle One)			Last Name (3A)			Collector (2N)			Patient Indicator* (Circle One)			Last Name (3A)			Collector (2N)		
E	I	O							E	I	O						
E	I	O							E	I	O						
E	I	O							E	I	O						
E	I	O							E	I	O						
E	I	O							E	I	O						
E	I	O							E	I	O						
E	I	O							E	I	O						
E	I	O							E	I	O						
E	I	O							E	I	O						
E	I	O							E	I	O						

* Circle E for Emergency Room, I for Inpatient, or O for Outpatient.

COLLECTION AGENCY GROUP

Level 3	Matrix# 22A	Facility:

The Collection Agency Group table is used to identify collection agencies to be assigned to patient accounts for use in guarantor and insurance collections. The information stored in this table is used in assigning accounts/carriers to an AR agency.

Collection Group Code   (3N)

Enter the code identifying this collection agency group.

Description

(30AN)

Agency Group Type   (1-A)

Enter one of four types related to the group: CCI, Agency, Insurance, or Bad Debt. Internal and external bad debt agencies are grouped together for this table.

Default Collection Agency   **(4-A)**

Enter the default collection agency code and
name for this group. This agency is responsible
for all accounts not assigned to another agency
in the group in the Last Name/Collection
Agency field on this table.

Pat Ind   (Table
                                          Lookup)

This field defines the patient indicator, such as emergency, inpatient,
or outpatient.

Name   (Table
                                          Lookup)

This field defines a name parameter for assignment to the collection
agency. The Name entry refers to the first three characters of the last
guarantor name for which this agency is responsible. For example, if the
first entry is GZZ, the agency involved collects from all eligible guarantors
whose last name begins with a letter from A to G. If RZZ is entered for the
next range, the assigned agency collects from all accounts whose
guarantor's last name begins with a letter from H to R

Dollar Amt   (1-AN)

This field defines the dollar amount for which
the agency is responsible. You can enter **U**
(Unlimited) for the agency to be assigned to
any dollar amount account or enter a number
between 1.00 and 999,999.99.

FC   (Table
                                          Lookup)

THis field defines financial class exceptions within the Dollar Amt range.

PT   (Table Lookup)

This field defines patient type exceptions within the dollar amount range.

Collection Agency   **(6-C)**

This field defines the collection agency responsible for the range of guarantors defined in the Name field

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INSURANCE FOLLOW-UP SCHEDULES

This table defines the type and frequency of follow-up that is performed on an insurance carrier after a claim is submitted.

Schedule #   (3N)

Description

(30AN)

Appl?   (Circle Y or N) | Y | N |

Is this an insurance appeal follow-up schedule?

Int/Ext   (Circle I (Internal) | I | E |
or E (External)

This field defines whether this schedule type is used for internal collections or for external collections. This field does not apply to denial and appeal schedules, and is accessible only if the Appl? (Appeal) field is defined as No.

Multiple Accts?   (Circle Y or N)   Y   N

Include multiple accounts on one follow-up letter? Multiple accounts print on the same follow-up letter if the accounts are selected for the same follow-up message and are covered by the same carrier plan. The default is N.

Wait Days   (2N)

Enter the minimum number of days to wait after claim submission before sending a follow-up. The default is 0.

Defining Follow-Up Frequency

The system provides three ways for you to define follow-up frequency:

- Day of month (for example, the 1st of the month)

- Day of week within a given week of the month (for example, Tuesday of the second week of the month)

- Interval, or a specified number of days between each follow-up (for example, every 24 days)

Complete the following worksheet fields keeping these guidelines in mind:

- If you select *Day of Month*:

  - Leave the Day of Week and Week of Month entries blank

  - Leave the interval for each sequence blank

- If you select *Day of Week* and *Week of Month*:

  - Leave the Day of Month entry blank

  - Leave the interval for each sequence blank

- If you select *Interval*:

  - Leave the Day of Month, Day of Week, and Week of Month entries blank

Day of Month   (2N)   ☐☐

The day statements should be sent. Optional entries are 1-28 or L for Last day of the month.

Day of Week   (1N)   ☐

The day of the week statements should be sent, where Sunday=1, Monday=2, ... Saturday=7.

Week of Month   (1N)   ☐

The week of the month on which follow-up should be sent. Optional entries are 1-4. This field is not required if a value is entered to the Day of Month field.

Max Paper Bal   (8N or U)   [ ][ ][ ][ ][ ][ ] . [ ][ ]

The maximum balance for paper follow-up. If the carrier balance is greater than the maximum paper balance, telephone follow-up will be done. The default is U for Unlimited.

Min Balance   (8N)   [ ][ ][ ][ ][ ][ ] . [ ][ ]

The minimum balance needed to continue follow-up.

Timeout Days   (3N or U)   [ ][ ][ ]

Enter the number of days after the end of the schedule to time out or U for Unlimited.

Resequence?   (Circle Y or N)   Y   N

Determines if partial insurance payments should resequence insurance follow-up back to step one. A value of Y for Yes indicates that follow-up should resequence back to step one. A value of N for No indicates that follow-up should not resequence back to step one.

Post Agency Sch   (Table Lookup)

This field defines the insurance follow-up schedule which is defined when a claim is removed from an external agency and defaults to being placed into STAR collections. This parameter can only be accessed for a schedule type defined as External. This schedule type can only be defined as an internal type schedule.

ISBWO   (Circle Y or N)   Y   N

Determines if an insurance should be reviewed for an insurance small balance write-off (ISBWO). Circle Y if an insurance using this follow-up schedule should be considered for an ISBWO. Circle N if an insurance using this follow-up schedule should not be considered for an ISBWO.

ISBWO Amt   (4NC)

Enter the minimum insurance balance required for an insurance to be considered for an ISBWO.

ISBWO Claims   (Circle Y or N)   Y   N

Indicates whether accounts with an insurance using this follow-up schedule should be considered for an ISBWO if there are claims for the insurance that have not been submitted and do not have a final disposition. Circle Y if the accounts with an insurance using this follow-up schedule should be considered for an ISBWO regardless of if the claim has not been submitted or does not have a final disposition. Circle N if accounts with an insurance using this follow-up schedule should not be considered for an ISBWO if there are claims for the insurance that have not been submitted and do not have a final disposition.

ISBWO Days from Submit Date   (3N)

If the ISBWO Claims field is set to No, enter the number of days after the claim submit date that the system should wait before performing an Insurance Small Balance Write-off.

ISBWO Trans Code/Desc: Type A   (4N)

Enter the transaction code that identifies the insurance small balance write-off.

F/U Type   (Circle response)   D   M   L   T

This field identifies the type of follow-up to be sent to the guarantor at insurance time-out. Circle D for Details Statement, M for Data Mailer, L for Letter, or T for Telephone.

Code   (4N)

Enter the code number representing the specific message to be sent, depending on the type of time-out follow-up selected in the F/U Type field above.

Amount Due Balance?   (Circle P or A)   P   A

Indicates whether the patient or account is used as the balance due amount for guarantor follow-up at time-out. Circle P for patient balance or A for account balance.

Produce F/U for CCI Accounts?   (Circle Y or N)   Y   N

This field determines if the time out guarantor follow-up, specified in the above follow-up type field, should be produced for CCI Collection accounts that time-out. A value of Y for Yes indicates that time-out follow-up should be produced. A value of N for No indicates that time-out follow-up shouldn't be produced for accounts at CCI.

Produce F/U for Agency Accounts   (Circle Y or N)   Y   N
(int/ext)?

This field determines if the time out guarantor follow-up, specified in the above follow-up type field, should be produced for agency accounts that timeout. A value of Y for Yes indicates that timeout follow-up should be produced for Internal or external agency accounts. A value of N for No indicates that timeout follow-up shouldn't be produced for internal or external agency accounts.

In the following table, complete the columns as follows:

SEQ
Enter up to a two-digit number referring to a line in the follow-up schedule. The number of lines is unlimited.

PAPER CODE
This field identifies the type of paper follow-up to be sent. Enter the four-digit Insurance Letter code or T for a tracer claim. It this field is left blank, complete the Phone Code field.

PHONE CODE
Enter the four-digit code for the phone message to be displayed in the collector's workfile when the maximum paper balance is exceeded.

INTERVAL
Enter the number of days, from 1 to 999, to wait before continuing to the next sequence number in the collection schedule. Complete this field only if the Days of Month, Day of Week, and Week of Month fields are blank.

Seq #	Paper Code (4N)	Phone Code (4N)	Interval (3N)	Agency Group (4N)

1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20												

INSURANCE FOLLOW UP SCHEDULE DOLLAR DEFINITION

This table defines the maximum dollar amount for an insurance follow-up schedule.

Code   (3AN)

This field contains the code identifying the insurance
follow-up schedule dollar definition.

Description

(30AN)

This field contains the code description.

Default Ins F/U Schedule   (3AN)

This field contains the default schedule code.

Dollar   (9N)

This field contains the dollar amount that is used to assign the schedule. Enter the maximum amount
for schedule assignment. The default is U (Unlimited). The entry range is 0 to $9,999,999.99 (you
must enter the decimal point).

Schedule   (Table
                                    Lookup)

This field contains the code and the description of the insurance follow up
schedule. Enter the code or a hyphen to display a list of insurance
follow-up schedules. The field is required if the Dollar amount is entered.

CONTRACT FINANCIAL INFORMATION

Level 3	Matrix# 22b	Facility:

This table contains information pertinent to financial type processing for the contract.

F/U Collector (2N)

This information is pulled from the Collectors table and identifies who is responsible for the collection process for the contract.

F/U Sched # (3N)

This information defines the collection schedule define in the Contract Follow-Up Schedule table.

Multiple? (Circle Y or N)   Y   N

This field defines whether each bill will be collected on individually (N) or if all bills will be collected in a combined fashion (Y).

Statement Format Code (Select from the list)   .

This field defines the format of the paper follow-up document.

Statement Transaction Code T (type) (4N code*)

This field defines the format of the paper follow-up document.

Workfile Memo Transaction Code M (type) (4N code*)

Telephone Transaction Code T (type) (4N code*)

Auto Adjust Transaction Code G (type)   (4N code*)   [ ][ ][ ][ ]

This field also determines where the system calculated contractual adjustment will be posted in the General Ledger.

W/O Percent   (6N)   [ ][ ][ ] . [ ][ ]

Valid values are -100.00 to 100.00 where negative values represent a markup and positive values represent mark downs.

Suppress 0 Bills?   (Circle Y or N)   Y   N

Should zero value bills be generated?

After accepting the initial screen the system will prompt the user to set up Department level and/or Charge level exceptions as to the amount of the contractual write-off. The following applies to the Department level exceptions.

Write Off Percentage   (6N)   [ ][ ][ ] . [ ][ ]

The valid values are -100.00 to 100.00. This values applies to the specified SIM department selected.

The following applies to the Charge level Exceptions.

Dollar Amount   (10N)   [ ][ ][ ][ ][ ][ ][ ] . [ ][ ]

This field defines the dollar amount to be charged to the contract for the specified charge.

ERA PROVIDER LEVEL ADJUSTMENT MAPPING

Level 3	Matrix# 91b	Facility:

This table is used to direct non-patient adjustments to the appropriate General Ledger accounts based on the reason codes sent by the intermediary. This table is split by facility.

Payment File Definition Code (3AN)

The payment file definition code.

Non Patient Payments (2AN)

The miscellaneous cash code that is used to post the amount for any non-patient related payment sent by the intermediary.

Default (2AN)

The miscellaneous cash code that is used to post the amount for any adjustment reason code that is not defined in the subsequent table.

Mapping

Map each adjustment reason code to the appropriate miscellaneous cash code.

Adjustment Reason Code			Miscellaneous Cash Code		
(2AN)			(2AN)		
(2AN)			(2AN)		
(2AN)			(2AN)		
(2AN)			(2AN)		

Adjustment Reason Code		
(2AN)		

Miscellaneous Cash Code		
2(AN)		

PAYOR ARRANGEMENT

Level 3	Matrix# 80	Facility:

This table, which is not split by facility, contains the payment arrangements agreed to between the hospital and the payor. The payor arrangements are based on the four reimbursement types.

Reimbursement Type   (1A)   (Circle One)

A -   ASC Payment Group

C -   Major Diagnostic Category

D -   ICD-9 Diagnostic Code

G -   DRG

I -   Pathways Contract Mgmt

M -   Medical Service

O -   Overall Plan

P -   ICD-9 Procedure Code

S -   Specified DRG Codes

Reimbursement Payor Code   (2A)

Table Number   (2N)

Diagnosis, Procedure, Medical Service, Specified   (6AN)
DRG, Major Diagnostic Category or Other

If diagnosis or procedure, maximum length is 6AN. If Medical Service, maximum length is 3AN. If Specified DRG, maximum length is 3N. If Major Diagnostic Category, maximum length is 2N. If Overall Plan, ASG Payment Group, DRG, or Pathways leave blank.

Max. Reimbursement Amount   (10N)

Calculation Method   (1A)   ☐

Flat Rate Amount   (10N)   ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ . ☐ ☐

Day/Charge Ranges		
Thru/Day or Thru Charge $ (7N; up to 4N if Per Diem)	Percentage or Amount* (Circle One)	Reimb Amt, Reimb Amt Per Day, or % (9N dollar amount or percentage up to 100.00 with 2 decimal places)
	P A	
	P A	
	P A	
	P A	
	P A	
	P A	
	P A	
	P A	
	P A	
	P A	
	P A	
	P A	
	P A	
	P A	

* Valid only for charge-based reimbursement.

HORIZON PERFORMANCE MANAGER PARAMETERS

Level 3	Matrix# 91b	Facility:

The Parameter screens contain parameters needed for processing the Horizon Performance Manager Interface files.

Enterprise Parameters

Enterprise Code   32-A-R

The enterprise code that is used in the Horizon Performance Manager Enterprise Header to group the data for an enterprise.

Facility Parameters - Screen 1

The facility parameter screen contains parameters needed for processing the Interface files. There are three facility parameter screens.

Active?

(Circle Y or N)	Y	N

Circle Y if you want the Interface to be active at this facility. The default is N. If you enter Y, acccounts begin to be written to the Horizon Performance Manager Interface index. If you enter N, the system prompts you for the beginning admit date of accounts to run the payment/adjustment/refund backload.

 # Accounts   (5-N-R)

The number of discharged accounts that can be in the interface before the file is transferred to Horizon Performance Manager.

Transfer Method   (1-A-R)

The method used to determine how the Horizon Performance Manager
files are transferred from STAR to Horizon Performance Manager. Enter
A for ASCII or N for NFS.

File Retention   (2-N-R)

The number of days that a transferred file remains available to be
transferred again. The default is 7.

Start Date   (6N)

Enter the starting admit date to begin processing accounts or enter **E** for earliest.

Transfer Newborn Accts With No Charges   (Circle Y or N) | Y | N |

Enter Y for Yes to indicate that newborn accounts are transferred even if these accounts
have no charges. The default is Yes. If you enter N for No, newborn accounts with no
charges are not transferred to Horizon Performance Manager.

Transfer Other Accts With No Charges	(Circle A (All), S(Some) or (N) None)	A	S	N

Enter **A** for All to transfer all accounts (that are not
newborns) with no charges to Horizon Performance
Manager. Enter N for None to not transfer non-newborn
accounts that have no charges to Horizon Performance
Manager. Enter **S** for Some to select non-newborn
accounts with no charges by patient type to transfer to
Horizon Performance Manager. When *S* is selected, the
patient type table is displayed and you can select the
patient type for the accounts with no charges to transfer to
Horizon Performance Manager. Enter the patient types in
the table below.

Patient Type	
Patient Type	
Patient Type	
Patient Type	
Patient Type	
Patient Type	
Patient Type	
Patient Type	

Source System Code   (Circle choice)
This field determines the code used as the Source System Code in Horizon Performance Manager.

(1) Unit Number
(2) Unit Number without facility
(3) Corporate Number
(4) Social Security Number
(5) Account Number
(6) Account Number without facility

Exluded Patient Types   (Table Lookup)

Contains the patient types that are excluded in the Horizon Performance Manager interface. Contract Accounts, Internal Preadmit Accounts, and any Preadmission where the patient is not assigned an account number are not included in the interface. Enter the patient types to exclude in the table below.

Excluded Patient Types

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Update Optional Encounter Keys   (Circle Y or N) | Y | N

If you respond **Y** for Yes, a 1 will be placed in field 36 of the Encounter Header Record. A 1 indicates that Horizon Performance Manager will update the Optional Encounter Keys (fields 30-35 of the Encounter Record) with the values in this record. If you respond **N** for No, a 0 will be placed in field 36 of the Encounter Record. A 0 indicates that Horizon Performance Manager will ignore the data and will not update the data base

Transfer DRG   (Circle Y or N) | Y | N

Enter **Y** for Yes to indicate that the DRG and MDC from STAR are transferred with the account information to Horizon Performance Manager. The default is Yes. Enter **N** for No to indicate that the STAR and MDC from STAR are not transferred with the account information to Horizon Performance Manager, and DRG grouping occurs on Horizon Performance Manager.

This parameter only controls the DRG sent in the Encounter Record.

MR Number   (Circle Y or N) | Y | N

Enter **Y** for Yes to indicate that the facility indicator is included on the medical record number. If you enter yes, the facility indicator precedes the Medical Record Number in the Encounter Header record. The default is Yes. Enter **N** for No to indicate that the facility indicator is not included on the medical record number.

Horizon Performance Manager Entity Code   (32A R)   [   ]

Enter the user-defined entity code for this facility. The default for this field is the STAR facility code.

Default Payor Code   (5-A-R)   [   ]

Enter the Payor Code to be used for accounts that have no insurance plan assigned to them. This code will also be used as the Payor Code to identify patient payments in the Encounter Payor Actual Payment Record and as the Payor Code in the Encounter Payor Record to identify the patient as the payor. This Payor Code will be included in the Common File.

Default Plan Code   (5-A-R) | | | | | | | | | | |

This field is used to determine the Health Plan Code and Contract Code to be used for accounts that have no insurance plan assigned to them. This code will also be used as the Health Plan/Contract Code to identify the patient as the payor in the Encounter Payor Record. This code will be included in the Health Plan Record and the Contract Code Record mapped to the Default Payor Code

Uncombine Other Account's Charges	(Circle A (All), S(Some) or (N) None)	A	S	N

Circle **A** to uncombine charges, UB Revenue Codes, and billing HCPCS codes for non-newborn accounts. This information is sent with the account they were originally charged to. Circle **N** to send data as they appear on STAR. Circle **S** for Some. If you enter S, enter the patient types in the table below for non-newborn accounts that you want to uncombine.

Patient Types

Facility Parameters Processor - Screen 2

Uncombine DPW account's charges	(Circle A, S or N)	A	S	N

Circle **A** for All for the system to uncombine all accounts in the Horizon Performance Manager interface file for which charges were transferred using the DPW function. Circle **S** for Some to uncombine charges for certain patient types only. Circle **N** for None to send the charges for accounts that have been transferred using the DPW function to Horizon Performance Manager the way the charges appear in the STAR system. If S is circled, enter patient types to uncombine in the table below.

Patient Types

Refunds with Payments	(Circle S, D, N, or B)	S	D	N	B

This field allows you to send refunds in the payment fields as a negative payment. If you circle **S** for summarized payments, then refunds will be added to the Actual Payment field in the Encounter Payor record as negative payments. If you circle **D** for Detail payments, then refunds will be included in the Encounter Payor Actual Payment record as a negative payment. If you circle **N** for Neither refunds will not be included as payments. If you circle **B** for both, then refunds will be included in both the Encounter Payor and the Encounter Payor Actual Payment records as negative payments. The default is Both.

Payor Authorization #1	(Table Lookup-O)

Contains the authorization number to send to Horizon Performance Manager in the Authorization Code field of the Encounter Payor record. Choose one code from the table. Enter your choice in the table below.

Authorization Code
Insurance Verified Name
Insurance Verified Date
Insurance Verified By
Second Opinion
Insurance Notified Date
Approval Name
Approval Number
Approval Date
Approved LOS
No. Approved Visits
Approved Visits Until

Payor Authorization #2   (Table Lookup-O)

Contains the authorization number to send to Horizon Performance Manager in the Authorization 2 Code field of the Encounter Payor record. Choose one code from the table. Enter your choice in the table below.

Authorization Code
Insurance Verified Name
Insurance Verified Date
Insurance Verified By
Second Opinion
Insurance Notified Date
Approval Name
Approval Number
Approval Date
Approved LOS
No. Approved Visits
Approved Visits Until

Payor Authorization #3   (Table Lookup-O)

Contains the authorization number to send to Horizon Performance Manager in the
Authorization 3 Code field of the Encounter Payor record. Choose one code from the
table. Enter your choice in the table below.

Authorization Code
Insurance Verified Name
Insurance Verified Date
Insurance Verified By
Second Opinion
Insurance Notified Date
Approval Name
Approval Number
Approval Date
Approved LOS
No. Approved Visits
Approved Visits Until

Payor Authorization #4   (Table Lookup-O)

Contains the authorization number to send to Horizon Performance Manager in the
Authorization 4 Code field of the Encounter Payor record. Choose one code from the
table. Enter your choice in the table below.

Authorization Code
Insurance Verified Name
Insurance Verified Date
Insurance Verified By
Second Opinion
Insurance Notified Date
Approval Name

Authorization Code
Approval Number
Approval Date
Approved LOS
No. Approved Visits
Approved Visits Until

R&B Minutes	Circle Y or N	Y	N	

Enter Y for Yes or N for No to indicate whether to send the Room and Bed Minutes for Timed bed charges in the Unit field of the Encounter Service Item record. The default is No.

Autopsy Code	(Table Lookup-O)			

Choose the death classification code that indicates that an autopsy has been performed.

Contract/Plan ID Format	Circle Y or N	Y	N	

Enter **Y** to exclude leading zeros if the insurance carrier code is less than three digits. Enter **N** for No to include leading zeros if the insurance code is less than three digits.

Exp Payment COB1	Circle R, P, or N	R	P	N

If you circle **R** for reimbursement, if there is an expected payment amount for COB1 which was calculated using Pathways Contract Management or STAR Reimbursement module, that value will be sent as the Expected Payment for COB1. If you circle **P** for proration, then Estimated Liability from the Balance Summary screen will be the value sent as the Expected Payment for COB1. If **N** is chosen for Neither, then the Expected Payment for COB1 will be null.

Exp Payment COB 2-9

Circle Y or N	Y	N	

If you choose **Y** for Yes then the Estimated Liability for COB2 -9 from the Balance Summary screen will be sent as the Expected Payment for COB2-9. If **N** for No is chosen then the Expected Payment for COB will be null.

Special Series Processing

Circle Y or N	Y	N	

This field controls how the outpatient series accounts are processed. If you circle **N** for No, the outpatient series accounts are processed the same as other accounts. Whenever the nondischarged series accounts are triggered, all charges are transferred. Therefore, these accounts need to be merged on Horizon Performance Manager so that charges are not overstated. The default is No. If you select **Y** for Yes, the admit date is the bill from date of the account. Series accounts will not go to Horizon Performance Manager until the account has had its first cycle bill. When the account gets retriggered, the most current bill from date will be used as the admit date.

Additional Audit Reports

(Table Lookup-O)

Choose the additional audit reports you want generated when the Horizon Performance Manager optional batch job is run.

Audit Reports
Cases and Charges by Month/Fiscal Period
Cases and Charges by Health Plan
Totals by Record Type
Cases and Charge by Patient Type

Height Unit | (Table Lookup-O) |

Circle the type of unit to use when sending height information in the Checkin Height field of the Encounter record:

Feet

Inches

Centimeters

Weight Unit | (Table Lookup-O) |

Circle the type of unit to use when sending weight information for the Checkin Weight and Discharge Weight fields of the the Encounter record:

pounds

ounces

kilograms

grams

Department | (Table Lookup-O) |

Circle which data to send as the Department Code in the Encounter Service Item header record.

Department

Alternate Bill Summary Code 1

Alternate Bill Summary Code 2

Alternate Bill Summary Code 3

Department with facility code prefix

Department with facility code suffix

GL Department Number

HCPCS/UB Rev Code	Circle F (FIM) or C (Calculate)	F	C

Circle F for FIM to pull the HCPCS code and the UB Revenue Code from the Patient Accounting charge record. Circle C for Horizon Performance Manager to calculate the codes. The default is F.

12 Digit Acct No.	Circle Y or N	Y	N

Circle N for No (the default) to leave the current format of the Patient Account Number unchanged. Circle Y for Yes to change the format of the account number to 12 digits with leading zeros.

Facility Parameters Screen - 3

AR/BD Add Accounts	Circle Y or N	Y	N

If you circle **N** for No, no AR or Bad Debt Add accounts will be transferred in the interface. The default is No.

If you circle **Y** for Yes, when AR and BD Add accounts become eligible for transfer to Horizon Performance Manager, these accounts will go to the AR/BD Add accounts index.

Summarized Payments	Circle Y or N	Y	N	Circle R or A	R	A

Circle **N** for No so that summarized payments are not sent in the interface. The default is No. Circle **Y** for Yes if you want to replace or add summarized payments in Horizon Performance Manager. If you answer Y for yes, circle **R** to include/replace summarized payments in Horizon Performance Manager. The default is **R.** Circle **A** to include/add summarized payments in Horizon Performance Manager.

Detail Pay/Adj	Circle Y or N	Y	N	Circle R or A	R	A

Circle **N** for No if you do not want detail payments in the Encounter Payer Actual payment record to be sent for AR/BD Add accounts. The default is No. Circle **Y** for Yes if you want to send detail payments and replace or add detail payments in Horizon Performance Manager. If you answer Y for yes, circle **R** to include/replace payments and adjustments Horizon Performance Manager. The default is **R.** Circle **A** to include/add payments and adjustments in Horizon Performance Manager.

Adj Transaction Code to Exclude	(Table Lookup-O)

Choose the codes to be excluded in the adjustments that are sent to Horizon Performance Manager. Enter the codes in the table below.

Adj Transaction Codes to Exclude

Converted Accounts	Circle Y or N	Y	N

This field determines whether or not converted accounts are included with Horizon Performance Manager. Circle Y for Yes to include converted accounts. Circle N for N to not include converted accounts. The default is No.

Summ Payments

Circle Y or N	Y	N	**Circle R or A**	R	A

Circle **N** for **No** if you do not want the summarized payment in field 19 of the Encounter Payor record to be sent for the converted accounts. Circle **Y f**or **Yes** if you want to include summarized payments and replace or add them.   If you answer Y for yes, circle **R** to include/replace summarized payments in Horizon Performance Manager. The default is **R.** Circle **A** to include/add summarized payments in Horizon Performance Manager.

Detail Pay/Adjs

Circle Y or N	Y	N	**Circle R or A**	R	A

Circle **N** for **No** if you do not want detailed payments in field 19 of the Encounter Payor record to be sent for the converted accounts. Circle **Y f**or **Yes** if you want to include detail payments and adjustments and replace or add them.   If you answer Y for yes, circle **R** to include/replace payments and adjustments in Horizon Performance Manager. The default is **R.** Circle **A** to include/add payments and adjustments in Horizon Performance Manager.

Inhouse Accounts At Conversion

Circle Y or N	Y	N

If you respond No to this field, the remaining fields on the screen cannot be edited. If you respond Yes to this field, accounts are processed as a separate interface file based on the remaining parameters on this screen.

Live Date

This field identifies the accounts that are inhouse at the time of the conversion. Enter the date that you want accounts admitted before or after to be considered inhouse accounts at the time of the conversion. The date fomat is MM/DD/YY.

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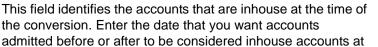| **Summ Payments**	**Circle Y or N**	Y	N	**Circle R or A**	R	A

Circle **N** for **No** if you do not want the summarized payment in field 19 of the Encounter Payor record to be sent for the converted accounts. Circle **Y f**or **Yes** if you want to include summarized payments and replace or add them.   If you answer Y for yes, circle **R** to include/replace summarized payments in Horizon Performance Manager. The default is **R.** Circle **A** to include/add summarized payments in Horizon Performance Manager.

Detail Payments	**Circle Y or N**	Y	N	**Circle R or A**	R	A

This field determines whether or not the detail payments are sent for inhouse accounts at conversion. Circle **N** for **No** if you do not want the detail payments sent. Circle **Y f**or **Yes** if you want to include detail payments. If you answer Y for yes, circle R for Include/Replace or A for Include/Add.

Charge Detail	**Circle R or A**	R	A			

This field determines whether charges are replaced or added to existing charges in the Horizon Performance Manager database.   Circle **R** (Replace) to replace the charges that currently exist in STAR or **A** (Add) to transfer only charges that have not been previously sent to Horizon Performance Manager.

Transaction Code to Exclude | Table Lookup |

Choose the transaction codes to be excluded from the adjustment amounts that the interface sends to Horizon Performance Manager. Enter the transaction codes in the following table.

Transaction Codes to Exclude

Transaction Codes to Exclude

SIM Department to Exclude | Table Lookup |

Choose the department that contain the charges from the previous system that you do not want transferred to Horizon Performance Manager with the account. Enter the SIM Departments in the following table.

SIM Department to Exclude

Trigger Events

These parameters determine how accounts will be triggered to Horizon Performance Manager.

INPATIENTS

Inhouse Accounts	**Circle Y or N**	Y	N	**Circle D or F**	D	F

This field determines whether or not in-house accounts should be processed. If you circle Y for Yes, when inhouse accounts are triggered to go to the interface, they are written to the standard interface index. If you circle N for No, indicate whether you want to transfer accounts based on D (Discharge) or F (Final bill) by circling D or F.

Trigger Events/Transfer Charges

Circle the trigger events you want to use for inpatients. Circle Y if you want charges transferred when the account is triggered. Circle N if you do not want charges transferred when the account is triggered

Adjustment Bill	Y	N

Abstract Flagged as Complete	Y	N
Archive	Y	N
Balance Transfer	Y	N
Charge Revision	Y	N
Charge/Credit	Y	N
Combine Bill	Y	N
Cycle Bill	Y	N
DPW Addition/Change/Deletion	Y	N
Final Bill	Y	N
Late Bill	Y	N
Late Charge	Y	N
Merge Patient	Y	N
OPPS	Y	N
Patient Admission	Y	N
Patient Discharge/Disposition	Y	N
Patient Registration	Y	N
Payment/Adjustment	Y	N
Refund	Y	N
Transfer Visits	Y	N
Transfer to Bad Debt	Y	N
Update Abstract General Information	Y	N
Update Abstract Newborn/Death Classification Information	Y	N
Update Additional Demographic Information	Y	N
Update Additional Episode Information	Y	N
Update Consultation Information	Y	N
Update DRG Information	Y	N
Update Demographic Information	Y	N
Update Guarantor Information	Y	N
Update ICD-9-CM Diagnosis Information	Y	N
Update ICD-9-CM Procedure Information	Y	N
Update Insurance Information	Y	N

Update Medical Information	Y	N
Update Medical Records HCPCS	Y	N
Update Miscellaneous Visit Information	Y	N
Update Patient Employer Information	Y	N
Update Previous Name	Y	N
Update Special Studies Information	Y	N
Update UB Data	Y	N
Update Used Defined MPI Fields	Y	N
Update User Defined Visit Fields	Y	N
Update Utilitzation Review Information	Y	N

OUTPATIENTS

Circle the trigger events you want to use for inpatients. Circle Y if you want charges transferred when the account is triggered. Circle N if you do not want charges transferred when the account is triggered

This field determines whether or not oupatient accounts that have not been discharged should be processed. If you circle **N** for No, then circle **D** for Discharge or **F** for Final Bill.

Trigger Events/Transfer Charges

Circle the trigger events you want to use for outpatients. Circle Y if you want charges transferred when the account is triggered. Circle N if you do not want charges transferred when the account is triggered

Adjustment Bill	Y	N
Abstract Flagged as Complete	Y	N
Archive	Y	N
Balance Transfer	Y	N
Charge Revision	Y	N
Charge/Credit	Y	N
Combine Bill	Y	N
Cycle Bill	Y	N
DPW Addition/Change/Deletion	Y	N
Final Bill	Y	N

Late Bill	Y	N
Late Charge	Y	N
Merge Patient	Y	N
OPPS	Y	N
Patient Admission	Y	N
Patient Discharge/Disposition	Y	N
Patient Registration	Y	N
Payment/Adjustment	Y	N
Refund	Y	N
Transfer Visits	Y	N
Transfer to Bad Debt	Y	N
Update Abstract General Information	Y	N
Update Abstract Newborn/Death Classification Information	Y	N
Update Additional Demographic Information	Y	N
Update Additional Episode Information	Y	N
Update Consultation Information	Y	N
Update DRG Information	Y	N
Update Demographic Information	Y	N
Update Guarantor Information	Y	N
Update ICD-9-CM Diagnosis Information	Y	N
Update ICD-9-CM Procedure Information	Y	N
Update Insurance Information	Y	N
Update Medical Information	Y	N
Update Medical Records HCPCS	Y	N
Update Miscellaneous Visit Information	Y	N
Update Patient Employer Information	Y	N
Update Previous Name	Y	N
Update Special Studies Information	Y	N
Update UB Data	Y	N
Update Used Defined MPI Fields	Y	N
Update User Defined Visit Fields	Y	N

Update Utilitzation Review Information	Y	N

PATIENT TYPE EXCEPTIONS

Identify the patient type for the patient type exception   (3-N-R)

Circle the trigger events you want to use for patient type exceptions. Circle Y if you want charges transferred when the account is triggered. Circle N if you do not want charges transferred when the account is triggered

Adjustment Bill	Y	N
Abstract Flagged as Complete	Y	N
Archive	Y	N
Balance Transfer	Y	N
Charge Revision	Y	N
Charge/Credit	Y	N
Combine Bill	Y	N
Cycle Bill	Y	N
DPW Addition/Change/Deletion	Y	N
Final Bill	Y	N
Late Bill	Y	N
Late Charge	Y	N
Merge Patient	Y	N
OPPS	Y	N
Patient Admission	Y	N
Patient Discharge/Disposition	Y	N
Patient Registration	Y	N
Payment/Adjustment	Y	N
Refund	Y	N
Transfer Visits	Y	N
Transfer to Bad Debt	Y	N
Update Abstract General Information	Y	N
Update Abstract Newborn/Death Classification Information	Y	N

Update Additional Demographic Information	Y	N
Update Additional Episode Information	Y	N
Update Consultation Information	Y	N
Update DRG Information	Y	N
Update Demographic Information	Y	N
Update Guarantor Information	Y	N
Update ICD-9-CM Diagnosis Information	Y	N
Update ICD-9-CM Procedure Information	Y	N
Update Insurance Information	Y	N
Update Medical Information	Y	N
Update Medical Records HCPCS	Y	N
Update Miscellaneous Visit Information	Y	N
Update Patient Employer Information	Y	N
Update Previous Name	Y	N
Update Special Studies Information	Y	N
Update UB Data	Y	N
Update Used Defined MPI Fields	Y	N
Update User Defined Visit Fields	Y	N
Update Utilitzation Review Information	Y	N

Encounter User Defined Attributes

Encounter User Define Attributes are STAR data that you can send to Horizon Performance Manager. Entering a "-" on the Encounter User Defined Attributes lists all available STAR data elements which are available to send to Horizon Performance Manager. Financial Class is automatically entered on the Encounter User Defined Attributes screen since there is no standard data element that will identify the financial class of the patient.

User Defined Attribute	Horizon Performance Manager Field Name

Service Item User Defined Attributes

Service Item User Define Attributes are STAR data that you can send to Horizon Performance Manager. Entering a "-" on the Encounter User Defined Attributes lists all available STAR data elements which are available to send to Horizon Performance Manager.

Circle the user defined attribute you want to send to Horizon Performance Manager and enter the Horizon Performance Manager field name.

User Defined Attribute	Horizon Performance Manager Field Name
Department	

Ordering Location (CRT Name)	
Ordering ID	
Revenue Department Code	
Detail Revenue Center	
Source of Charge	
Charge Location	
Order #	
Charge Type	
UB Revenue Code	
Baby Charge Indicator	
HCPCS Code	
R&B Minutes	
Proration Summary Code	
Out of Province Summary Code	
Type of Service	
Bill Sequence Number	
Alternate Bill Summary Code 1	
Alternate Bill Summary Code 2	
Alternate Bill Summary Code 3	
Metric Quantity	
ABN	
ABN Override	
Med Nec Dup HCPCS	
Med Nec Dup HCPCS Override	
Take Home Drug	
STAR Facility Code	
Department with facility code prefix	

Department with facility code suffix	
Late Charge Indicator	
Combined Bill Indicator	
GL Department Number	
Charge Sequence	

PRE-BILL EDIT USERS TABLE

System ID (5-AN-R)
Enter the System ID of the person defined by the
Hospital Information table.

Biller Code (5-AN-R)
Enter the code for the person as defined in the
Biller Table.

Registration Clerk
Is the biller a registration clerk?

Yes	No

PRE-BILL EDIT USER DEFINED EDIT GROUPS

The PBE User Defined Edit Groups table can be used to supplement the options available for Pre-bill Edit Worklist Assignment in Pre-bill Edit Parameters for a facility. The PBE User Defined Edit Groups provides added choices for Worker Assignment and for Default Group/Person. Also, the table can be used to provide other options for Transfer To User in the Transfer function.

Code   (3N)

Enter the code for the euser-defined edit group

Description

(30AN)

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PRE-BILL EDIT CATEGORY

Edit Type
Enter the edit type for the biller. You can enter
R for Registration, **I** for Insurance, **C** for
Charge, or **M** for Medical Records.

> s

Chapter 6 - LEVEL 4

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INTRODUCTION

This chapter contains worksheets to complete the following table. You should complete these worksheets before beginning the worksheets in Level 5.

- Collection Agency

- ERA Payment File Definition

- Payment File Definition and Bill Type Exceptions

COLLECTION AGENCY

Level 4	Matrix# 20	Facility:

This table contains collection agency demographic data.

Collection Agency Code   (6AN)

Description
(30AN)

Agency Type   (Circle P, C, I, or E)   P   C   I   E

Indicate if the agency is Internal Pre-Collection (P), CCI Pre-Collection (C), Internal Bad Debt (I), or External Bad Debt (E).

Address Line 1
(25AN)

Address Line 2
(25AN)

City
(20AN)

State   (2A)

Prov. (Canada)   (2A)   ☐☐

ZIP Code   (9N)   ☐☐☐☐☐☐☐☐☐ or

Post Code (Canada)   (6AN)   ☐☐☐☐☐☐

Data File Location   32-AN-R   ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Indicate the file path location to which
Agency Pre-collect, Notes Upload, and
Bad Debt Payments data files are
copied when they are uploaded to
STAR.

Contact   ☐☐☐☐☐☐☐☐☐☐☐☐☐

(25AN)   ☐☐☐☐☐☐☐☐☐☐☐☐

Phone Number   (10N)   ☐☐☐☐☐☐☐☐☐☐

Extension   (4N)   ☐☐☐☐

BD Fees Trans Code/Desc: V (type)   (4N code*)   ☐☐☐☐

BD Cash Trans Code/Desc: E (type)   (4N code*)   ☐ ☐ ☐ ☐

BD Transfer Trans Code/Desc: S (1A type)   (4N code*)   ☐ ☐ ☐ ☐

BD Collector Group Code/Desc   (2N*)   ☐ ☐

Follow-Up Schedule   (3N*)   ☐ ☐ ☐

Contains the code of the Pre-Collection Follow-Up or Agency Follow-Up schedule that will be assigned to accounts with this agency. This field is dependent on the Agency Type field.

If this agency type is Internal Pre-Collect then only Internal Pre-Collection Follow-Up Schedules will display. If the agency type is CCI then only CCI Pre-Collection Follow-Up Schedules will display. If the agency type is Internal Bad Debt then only the Internal Agency Follow-Up Schedules will display. If the agency type is External Bad Debt then only External Agency Follow-Up Schedules will display.

Pre-Collection Collector Group   (2N)   ☐ ☐

> Contains the code of the collector group that will be assigned to accounts that are being evaluated for Candidate/Pending and for accounts that transfer to Pre-Collection. This field should only be completed if the Agency Type field is set to CCI or Pre-Collect.

Insurance Follow-up Schedule   (Table Lookup)   ☐ ☐

Indicate the external follow-up schedule to be assigned when a claim is transferred to a collection agency.

BD Notification Format   (2AN)   ☐ ☐

Select from McKesson table.

BD Pass Adm Diag?   (Circle Y or N)   Y   N

Include admitting diagnosis on tape sent to collection agency?

BD Tape Format   (Circle A or E)   A   E

Enter ASCII (A) or EBCDIC (E) tape format. Circle A if the collection agency tape format is to be created in ASCII format. Circle E if the collection agency tape is to be created in EBCDIC format.

Select 4 COB or 9 COB Tape Format   (Circle 4 or 9)   4   9

Enter 4 or 9 tape layout. Circle 4 if up to 4 COB's are to be passed to the collection agency. Circle 9 if up to 9 COB's are to be passed to the collection agency.

      *   From a previously defined table.

ERA PAYMENT FILE DEFINITION

Level 4	Matrix# 79a	Facility:

This table is used to define the default values for each payment file. For the 835 A standard, this table also identifies how the payments for each provider are subdivided into individual batches and allow for bill type exceptions to be entered. The values that are entered for this table are displayed and can be modified on the Process Electronic RA Setup Processor screen. Any fields left blank in the Payment File Definition can be completed on the Process Electronic RA Setup Processor screen. This table is not split by facility.

Code   (3AN)

The payment file definition code.

Description

(30AN) |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

The description of the payment file definition.

Short Description   (10AN)

This description is the abbreviated payment file definition description used to create the batch description which is comprised of the payment file short description concatenated with the fiscal period and the bill type.

Source File Type   (1AN)

Enter **A** to indicate that the source file is in the Part A 835 format. Enter **B** to indicate that the source file is in the Part B 835 format. The default is **A**. Enter **V** to indicate that the source file is a vendor file. Enter C to indicate that the source file format is Combined (UB, Non Pro Fee 1500, and 1500 claims can be processed in the same file).

Svc Line Detail   (1AN)

Enter **Y** for Yes to indicate that service line detail is to be uploaded and posted from the 835 remittance advices. Enter N for No to indicate that service line detail should not be uploaded and posted**.**

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Insurance Type   (1AN)

The insurance type for the electronic payments that are received. Insurance types are: **B**-Blue Cross, **S**-CHAMPUS, **C**-Commercial, **N**-HMO, **X**-MEDICAID/Welfare, **M**-MEDICARE Part A, **P**-MEDICARE Part B, or **D**-Self Pay. If required, McKesson installation personnel can help select the proper insurance type.

Select   (1AN)
Insurance

Indicate whether payments are to be matched by Carrier (C) or Carrier/Plan (P).

FAR121 Adj Ind   (1AN)

Indicate how you want adjustments reported on the Electronic RA Cash Batch Audit Report, FAR121. Enter **C (Cont Adj),** to include contractual adjustments, **D (Detail),** to include contractual adjustments and adjustment detail**, or N (No Added Information)** to produce the report without additional information on adjustments.

FAR121 Sort   (1AN)

Indicate how you want the Electronic RA Cash Batch Audit Report, FAR121, to be sorted. Enter **N** for Name, to sort by patient name or **E** for ERA, to sort in ERA file sequence number order, or **S** for Sequence, to sort in batch sequence number order. The default is S.

Matching Criteria

Match Carrier(s)   (up to 4N)

(up to 4N)

(up to 4N)

(up to 4N)

The carrier code(s) for the insurance carrier sending electronic payments. This code
is used to identify the claim.

Type of Claim Form   (1A) ☐

                                                               (1A) ☐

                                                               (1A) ☐

                                                               (1A) ☐

                                                               (1A) ☐

For 835 Type of Source file, use **U** for UB82 and **X** for UB.

For Vendor Type of Source file, use **A** for MA 310, **D** for MA 319MS, **E** for MI1645, **F**
for MI1649, **I** for MCLI, **I** for CA25-1, **L** for 2360, **N** for NJMC19, **O** for MCLO, **R** for
MEDI-CAL UB82, **U** for UB82, **X** for UB, and **Z** for NON PRO FEE 1500.

Claim Type   (3A) ☐☐☐

The claim types to be included in the electronic payment batch. F for Final, A for Adjustment,
C for Cycle, L for Late, or All. The default is All.

Svc Date   (1AR) ☐

How do you want the service date to be used as a matching criterion?

For the Vendor File format, enter **E (Exactly)** to match service dates exactly, or **B (Bypass
Service Through Date)** or **R (Range of Service Dates)**.

For 835 A and 835 B formats, enter **E (Exactly)** to match service dates exactly, or **B (Bypass
Service Through Date).**

Select DTM RECS   What qualifiers are to
                           be used for selecting
                           dates in the DTM
                           Record? Enter one or
                           multiple qualifiers.

Account # Lengths   Define the account
                           number lengths
                           used when STAR
                           Patient Accounting
                           uses the account
                           number in the
                           CLP01 record for
                           matching. The
                           default length for an
                           account number is
                           ten.

Matching Criteria   Define one or more
                           items for matching
                           claims:

                           `1500 Dr`
                           `Non Pro Fee 1500`
                           `Dr`
                           `1500 HCPCS`
                           `Non Pro Fee`
                           `HCPCS`
                           `UB HCPCS`
                           `CLP03/Claim`
                           `Amount`
                           `CLP06/Claim`
                           `Filing Indicator`
                           `CLP09/Claim`
                           `Frequency Type`
                           `Code`
                           `NM103-5/Name`

Additional Criteria   Define one or more items for additional criteria for matching claims:

```
1500 Dr
Non Pro Fee 1500
Dr
1500 HCPCS
Non Pro Fee
HCPCS
UB HCPCS
CLP03/Claim
Amount
CLP06/Claim
Filing Indicator
CLP09/Claim
Frequency Type
Code
NM103-5/Name
```

Ref Qual   Enter the qualifiers for the REF segment when the 1500 Dr and Non-Pro Fee 1500 Dr IDs are selected as options in the Matching Criteria or Additional Matching Criteria.

Electronic RA Defaults

Allow Days Paid?   (Circle Y or N)   Y   N

Do you want the Days Paid to be uploaded from the payment file in the insurance cash batch detail record?

Allow DRG Paid?   (Circle Y or N)   Y   N

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Do you want the DRG Paid to be uploaded from the payment file into the insurance cash batch detail record?

Allow Outlier?   (Circle Y or N)   Y   N

Do you want the outlier type to be uploaded from the payment file into the insurance cash batch.

BD Pymt?   (Circle Y or N)   Y   N

Do you want paymentsto be posted automatically for accounts in a bad debt location.

Payment Trans Code Transaction Type = I   (4N)   ☐☐☐☐

If no entry is made in this field, the payment transaction code from the patient's insurance plan is used on the payment entry in the insurance cash batch. When complete, this code will be used as the payment transaction code for the insurance cash batch.

Contr Adj Trans Code Transaction Type = A   (4N)   ☐☐☐☐

If no entry is made in this field, the contract payment transaction code from the patient's insurance plan is used on the payment entry in the insurance cash batch. When complete, this code will be used instead of the transaction code for the patient's insurance plan.

Other Adj Trans Code Transaction Type = A   (4N)   ☐☐☐☐

If no entry is made in this field, the contract adjustment transaction code from the patient's insurance plan is used on the payment entry in the insurance cash batch. When complete, this code will be used instead of the transaction code for the patient's insurance plan.

.

C/A For COB1   Options:

                          Post

                          Do Not Post

                          Variance

                          Report

                          Reverse System Adjustment

        This field is used for the calculation of the contractual adjustment for the primary
        insurance.

POST/RPT C/A IF DEN   (Circle Y or N)   Y   N

Should a contractual adjustment or takeback adjustment should be processed (posted or
reported) for a denied claim.

        This field is used for the calculation of the contractual adjustment for the secondary
        insurances if the claim is for a non-primary COB.

C/A For PCON 1500   Options:

                          Post

                          Do Not Post

                          Variance

                          Report

                          Reverse System Adjustment

C/A For Sec   Options:

                          Post

                          Do Not Post

                          Variance

                          Report

                          Reverse System Adjustment

Analysis Report Def   3AN

> The codes from the ERA Payment Analysis Report Definition table that is used to define selection and format requirements for the ERA Payment Analysis Report by Account and the ERA Payment Analysis Report by Revenue Code. Space is allocated on this worksheet for up to four codes, but the actual number of codes that may be entered is unlimited.

Claim Disposition   (1A)

The claim disposition indicator that will be used as the default value for each entry in the resulting cash batches. Enter F - final, C - clear, P - partial payment, D - denied, T - transfer, or A - adjusted to zero.

Denied Claim Disposition   (1A)

Enter the claim disposition of F - final payment, C - clear disposition, P - partial payment, D - denied, T - transfer, or A - adjusted to zero that will be assigned to claims that are denied by the intermediary.

Claim Number   (Circle Y or N)   Y   N

This is the intermediaries' claim number. The claim number from the payment file updates the external claim number on the patient's claim information. Circle Y to update the external claim number. Circle N to not update the external claim number.

> If the type of source file is ANSI 835, there are entries to complete for selecting the date/bill type in the LX segment and the provider number location for the LX record in the ERA file.

Criteria For Splitting Batches
Define how batches should be split. Options are:
```
Check/BPR, Check/TRN02, Fiscal Period in LX01,
Provider Number,ST Segment,Bill Type Exception
in LX01, Claim Type (UB or non-UB)
```

Reference Designator
Enter the segment identifier followed by a two-digit number that defines the position of the provider number in that segmen.)

Position for Qualifier
Enter the position for the Qualifier for splitting batches (1-99).

Qualifier
Enter the position for the Qualifier for the provider number.

Facilities
Define the facilities for review for this ERA Payment File Definition table (for upload). The system uses the defined facilities to determine where to look when matching a claim (based upon the matching criteria selected)..

ERA Claim Status Table
Define how to maintain a Payment File Definition Claim Status table which is specific for this ERA Payment File Definition. Options are: Maintain, Copy (from ERA Claim Status Table), or Remove.

FAR 121 Adjustment Indicator
Define how adjustments are reported on the Electronic RA Cash
Batch Audit Report, FAR121. Options are: Include (C)ont Adj,
(D)etail Adj, or (N)o Added Information on FAR121 [N] --

FAR 121 Sort
Sort FAR121 report by patient (N)ame, (E)RA file sequence, or
batch (S)equence?[S]--

Analysis Report Def
Define the Payment Analysis Report Definition(s) used to
generate the Payment Analysis Report(s) for the resulting cash
batch

Beginning Batch
Define the first or first and second characters when the system
assigns batch numbers from the uploaded ERA file.

PAYMENT FILE DEFINITION AND BILL TYPE EXCEPTIONS

If the type of source file is ANSI 835, you can establish bill type exceptions.

Code   (3AN)

The payment file definition code.

Bill Type   (2N)

The bill type for which you want to establish an exception. A separate insurance cash batch is created for each bill type exception. Bill Type Exceptions can only be established if the type of source file is 835 A.

Matching Criteria

Match Carrier s)   (up to 4N)

(up to 4N)

(up to 4N)

(up to 4N)

The carrier code(s) for the insurance carrier sending electronic payments. This code is used to identify the claim.

Type of Claim Form   (1A)

(1A)

(1A)

(1A)

(1A)

For ANSI 835 Type of Source file, use **U** for UB82 and **X** for UB.

For Vendor Type of Source file, use **A** for MA 310, **D** for MA 319MS, **E** for MI1645, **F** for MI1649, **I** for MCLI, **I** for CA25-1, **L** for 2360, **N** for NJMC19, **O** for MCLO, **R** for MEDI-CAL UB82, **U** for UB82, **X** for UB, and **Z** for NON PRO FEE 1500.

Claim Type   (3A)

The claim types to be included in the electronic payment batch. F for Final, A for Adjustment, C for Cycle, L for Late, or All. The default is All.

Svc Date   (1AR)

How do you want the service date to be used as a matching criterion?

For 835 A and 835 B formats, enter **E (Exactly)** to match service dates exactly, or **B (Bypass Service Through Date).**

Electronic RA Defaults

Allow Days Paid?   (Circle Y or N)   Y   N

Do you want the Days Paid to be uploaded from the payment file
in the insurance cash batch detail record?

Allow DRG Paid?   (Circle Y or N)   Y   N

Do you want the DRG Paid to be uploaded from the payment file
into the insurance cash batch detail record?

Allow Outlier?   (Circle Y or N)   Y   N

Do you want the outlier type to be uploaded from the payment file
into the insurance cash batch.

Payment Trans Code Transaction Type = I   (4N)

If no entry is made in this field, the payment transaction code from the patient's insurance plan is used on the payment entry in the insurance cash batch. When complete, this code will be used as the payment transaction code for the insurance cash batch.

Contr Adj Trans Code Transaction Type = A   (4N)

If no entry is made in this field, the contract payment transaction code from the patient's insurance plan is used on the payment entry in the insurance cash batch. When complete, this code will be used instead of the transaction code for the patient's insurance plan.

C/A Method   (Circle Y, N, V, or R)   Y   N   V   R

This is the contractual adjustment posting method. Circle Y to post the contractual adjustment as it is received. Circle N to not post the contractual adjustment. Circle V to post the variance between the adjustment received and the adjustment posted at final billing. Circle R to not post the adjustment or variance.

Analysis Report Def   3AN

The codes from the ERA Payment Analysis Report Definition table that is used to define selection and format requirements for the ERA Payment Analysis Report by Account and the ERA Payment Analysis Report by Revenue Code. Space is allocated on this worksheet for up to four codes, but the actual number of codes that may be entered is unlimited.

Claim Disposition   (1A)

The claim disposition indicator that will be used as the default value for each entry in the resulting cash batches. Enter F - final, C - clear, P - partial payment, D - denied, T - transfer, or A - adjusted to zero.

Denied Claim Disposition   (1A)

Enter the claim disposition of F - final payment, C - clear disposition, P - partial payment, D - denied, T - transfer, or A - adjusted to zero that will be assigned to claims that are denied by the intermediary.

Claim Number   (Circle Y or N)   Y   N

This is the intermediaries' claim number. The claim number from the payment file updates the external claim number on the patient's claim information. Circle Y to update the external claim number. Circle N to not update the external claim number.

Chapter 7 - LEVEL 5

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INTRODUCTION

This chapter contains worksheets to complete the following table. You should complete these worksheets before beginning the worksheets in Level 6.

- Collection Agency Group

- Pre-Collection Information

COLLECTION AGENCY GROUP

Level 5	Matrix# 21	Facility:

This table is used to group collection agencies for automatic assignment to guarantors. When you run Bad Debt Prelisting, the system uses this table to assign the proper collection agency to a guarantor.

Collection Agency Group Code   (2N)

Description
(30AN)

Default Collection Agency   (6AN)

Description
(30AN)

Patient Indicator (1A)	Last Name (3A)			Collection Agency (6A)					

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Patient Indicator (1A)			Last Name (3A)			Collection Agency (6A)					

PRE-COLLECTION INFORMATION

Level 5	Matrix# 123	Facility:

The Pre-Collection Information table enables the facility to define criteria for transferring accounts to agency processing. Pre-Collection Information parameters consist of a required Master record, the optional Patient Indicator Exception records, and the Prioritization record.

Master Record - Inclusion Criteria

Min Days Discharge   (3N)

Contains the minimum number of days that must elapse following discharge in order for an account to qualify for pre-collection selection.

Min Days Final Bill   (3N)

Contains the minimum number of days that must elapse following final bill in order for an account to qualify for pre-collection selection.

Min Days Patient Payment   (3N)

Contains the minimum number of days that must elapse following receipt of a patient payment in order for an account to qualify for pre-collection selection.

Patient Payment Amount   (10N)

Contains the minimum amount the patient must pay in order for an account not to qualify for pre-collection selection.

Patient Payment %   (6N)

Contains the minimum percentage of the Last Follow-up amount that the patient must pay in order to not to qualify for pre-collection selection.

Min Patient Balance   (10N)   ┌──┬──┬──┬──┬──┬──┬──┐ **.** ┌──┬──┐

Contains the minimum patient balance in order for an account to qualify for pre-collection selection.

Max Patient Balance   (10N)   ┌──┬──┬──┬──┬──┬──┬──┐ **.** ┌──┬──┐

Contains the maximum patient balance in order for an account to qualify for pre-collection selection.

Min # of Paper F/U   (2N)   ┌──┬──┐

Contains the minimum number of patient paper follow-ups that must be generated either in the form of detail statements or letters, in order for an account to qualify for pre-collection selection.

Min Days Ins Payment   (3N)   ┌──┬──┬──┐

Contains the minimum number of days that must elapse following receipt of an insurance payment in order for an account to qualify for pre-collection selection.

Pend Ins Bal   (3N)   ┌──┬──┬──┐

Determines whether accounts with an insurance balance qualify for Pre-Collection Selection. Valid values are Y for yes and N for no. If this field contains a Y, the system allows accounts with an insurance balance to qualify for Pre-Collection selection. If this field contains a N, the system will not allow accounts with an insurance balance to transfer to pre-collection.   The default value is N.

Min Acct Balance   (10N)   ┌──┬──┬──┬──┬──┬──┬──┐ **.** ┌──┬──┐

Contains the minimum account balance in order for an account to qualify for pre-collection selection.

Max Acct Balance   (10N)

Contains the maximum account balance in order for an account to qualify for pre-collection selection.

Reselect Days   (3N)

Contains the number of days that the system will wait after the Pre-Collection Delete Date before allowing an account to be reselected for Pre-Collection. The default value is zero. This field is not used for Internal Pre-Collection and is only valid for CCI Pre-Collection.

Agency Trans Code/Desc   (4N)

Contains the transaction code for agency transactions. This transaction code is used to log agency events in the account's transaction history.   Enter the code, if known, or enter a hyphen (-) to select it from a table display.   Enter the code, or enter a hyphen (-) to display a list of valid transaction codes under transaction type M (System Memos).

Primary Sort for Reject Reports

The Primary Sort for Reject Reports field determines if primary sort of the Pre-Collection Rejection Report, FFR630, and the Pending/Candidate Rejection Report, FFR640, should be Guarantor Name or Rejection Reason Code.

Master Record - Exclusion Criteria

Patient Indicator   (Table Lookup)

Contains the patient indicators that are excluded from Pre-Collection Selection. This field is not included on the Patient Indicator Exception screen.

Patient Type   (Table Lookup)

Contains the patient types that are excluded from Pre-Collection Selection.

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Financial Class   (Table Lookup)

Contains the financial classes that are excluded from Pre-Collection Selection.

Insurance Carrier   (Table Lookup)

Contains the insurance carriers that are excluded from Pre-Collection Selection.

Insurance Plan   (Table Lookup)

Contains the insurance plans that are excluded from Pre-Collection Selection.

Occupation Code   (Table Lookup)

Contains the occupation codes that are excluded from Pre-Collection Selection.

Zip Code   (Table Lookup)

Contains the guarantor zip codes that are excluded from Pre-Collection Selection.

Church Code   (Table Lookup)

Contains the church codes that are excluded from Pre-Collection Selection.

When the Pre-Collection Information Master record is completed, the Exception and Prioritization records can be defined.

After the Inclusion and Exclusion criteria for the Master Record are entered, the following prompt is displayed:

   Enter Patient Indicator (E)xceptions or (P)riority Sequence--

Enter E for patient indicator exceptions. Enter P for prioritization. Both of these records are discussed below.

Patient Indicator Exception Record

The Patient Indicator Exception record contains two screens: Inclusion Criteria and Exclusion Criteria. The screens are similar to the Master Record screens except that Patient Indicator is not included under the Exclusion criteria. Refer to the explanation of the Master Record for an explanation of these fields.

INCLUSION CRITERIA

Min Days Discharge   (3N)

Min Days Final Bill   (3N)

Min Days Patient Payment   (3N)

Patient Payment Amount   (10N)

Patient Payment %   (6N)

Min Patient Balance   (10N)

Max Patient Balance   (10N)

Min # of Paper F/U   (2N)

Min Days Ins Payment   (3N)

Pend Ins Bal   (3N)

Min Acct Balance   (10N)

Max Acct Balance   (10N)

Reselect Days   (3N)

Agency Trans Code/Desc   (4N)

EXCLUSION CRITERIA

Patient Type   (Table Lookup)

Financial Class   (Table Lookup)

Insurance Carrier   (Table Lookup)

Insurance Plan   (Table Lookup)

Occupation Code   (Table Lookup)

Zip Code   (Table Lookup)

Church Code   (Table Lookup)

Prioritization Record

This record allows the facility to set priorities for rejection reasons.

Pre-Collection Information			
Rejection Reason	**Priority Sequence**		
64 - AR/BD Status Block (*)			
78 - F/U Hold Block (*)			
33 - Insurance Balance Block (*)			
29 - Step or Schedule Change Block (*)			
25 - Account Balance Too High Block (*)			
23 - Account Balance Too Low Block			
46 - Church Code Block			
35 - Days Final Bill Low Block			
34 - Days from Discharge Low Block			
39 - Days Ins Payment Low Block			
62 - Financial Class Block			
57 - Insurance Carrier Block			
58 - Insurance Carrier-Plan Block			
30 - Minimum Reselect Days Block			
59 - Occupation Code Block			

Pre-Collection Information			
Rejection Reason	**Priority Sequence**		
22 - Patient Balance Too High Block			
12 - Patient Balance Too Low Block			
40 - Patient F/U Count Low Block			
88 - Patient Indicator Block			
42 - Patient Payment Block			
48 - Patient Type Block			
16 - Wait One Cycle			
87 - Zip Code Block			

Chapter 8 - LEVEL 6

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INTRODUCTION

This chapter contains worksheets to complete the following table. You should complete these worksheets before beginning the worksheets in Level 7.

- Follow-Up Schedules (AR)

- Follow-Up Schedules (PA)

FOLLOW-UP SCHEDULES (AR)

Level 6	Matrix# 50	Facility:

This table, which is not split by facility, contains information regarding the type and frequency of follow-up on patient and guarantor accounts. Individual follow-up schedules can also be established for specific patients and guarantors.

In the case of new or inactive guarantors, the patient's financial class determines the follow-up schedule assignment. There is no assignment for active guarantors since a follow-up schedule for them already exists.

Schedule #   (3N)

Description

(30AN)

Wait Days   (2N)

Enter the minimum number of days from admission date to wait before beginning follow-up. The default is 0.

Defining Follow-Up Frequency

The system provides three ways for you to define follow-up frequency:

- Day of month (for example, the 1st of the month)

- Day of week within a given week of the month (for example, Tuesday of the second week of the month)

- Interval, or a specified number of days between each follow-up (for example, every 24 days)

Complete the following worksheet fields keeping these guidelines in mind:

- If you select *Day of Month*:

    - Leave the Day of Week and Week of Month entries blank

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- Leave the interval for each sequence blank

- If you select *Day of Week* and *Week of Month*:

    - Leave the Day of Month entry blank

    - Leave the interval for each sequence blank

- If you select *Interval*:

    - Leave the Day of Month, Day of Week, and Week of Month entries blank

Day of Month   (2N)

The day follow-up should be sent. Optional entries are 1-28 or L for Last day of the month.

Day of Week   (1N)

The day of the week follow-up should be sent, where Sunday=1, Monday=2, ... Saturday=7.

Week of Month   (1N)

The week of the month on which follow-up should be sent. Optional entries are 1-4. This field is not required if a value is entered to the Day of Month field.

Due Days   (2N)

The number of days used in calculating the due date.

Grace Days   (2N)

The number of grace days before the account is delinquent.

Defining Follow-Up Criteria

Three types of follow-up can be defined for insurance pending account. These are:

- Bill (request patient for money)

- Memo (send FYI to patient regarding account)

- Suppress (follow-up is suppressed while insurance is still pending)

If Bill is selected two types of requested are provided. These are:

- Account - Request the entire account balance.

- Patient - Request the patient liability portion if it exists, otherwise, send nothing.

Complete the following worksheet fields keeping the guidelines in mind:

- If you select Bill - Enter A or P in the Bill Balance field.

- If you select Memo or Suppress - Leave the Bill Balance field blank.

Ins Pending   (1A)   ☐

The type of follow-up criteria for insurance pending accounts. Optional entries are B or M.

Bill Balance   (1A)   ☐

The dollar amount requested when the Bill option is selected. The optional entries are P or A.

The Restart % and Restart Amount Fields

The Restart % and Restart Amount fields identify the sequence number in the follow-up schedule on which the system should restart the follow-up type and message.

The system compares the guarantor's payment to the amount in the Restart % and Restart Amount fields. If the payment is *greater than* the percentage or amount, the system does not consider the account delinquent, resuming the following at the restart resequence number indicated. If the payment is *less than* the percentage or amount, system considers the account delinquent and follow-up continues with the next sequence number.

Restart %   (5N)

Enter the percentage of the patient or account balance that must be received as a patient payment before restarting the statement sequence.

Restart Amount   (8N)

Enter the dollar amount that must be received as a patient payment before restarting the statement sequence.

Min. Balance   (8N)

Enter the minimum balance required to continue sending statements. This field sets the upper limit for small balance write-off.

In the worksheet on the following page, complete the fields as follows:

Seq #
This is the line of this sequence in the follow-up schedule. The number of lines is unlimited.

Follow Type
Identify the type of paper follow-up for this step in the schedule. Circle L for Follow-Up Letter or D for Detail Statement.

Follow-Up Message
Enter the four-digit code identifying the follow-up message associated with the follow-up type identified in the Follow Type field.

Memo Message
Enter the four-digit code identifying the message that displays on the follow-up statement or letter.

Restart Seq #
Enter the two-digit number of the next sequence in the collection schedule if the amounts defined in the Restart % or Restart Amount fields is met. This must be less then the current sequence number.

Interval
Enter the number of days, up to 999, the system must wait before continuing to the next sequence number in the follow-up schedule. Complete this field only if the Day of Month, Day of Week, and Week of Month fields are blank.

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PreCol Group
Enter the Pre-Collection Agency Group table code for CCI, Internal Pre-collect or External Pre-collect. If an agency group code is entered in this field, accounts receive a maintenance code of flagged when this follow-up step is processed. Follow-up steps that contain an agency code are called Pre-Collection steps. There can be multiple Pre-Collection steps defined on the follow-up schedule.

Seq #	Follow Type (Circle One)			Follow-Up Message (4N code)				Memo Message (4N code)				Restart Seq # (2N)		Interval (3N)			PreCol Agency (5A)				
01	L	D	W																		
02	L	D	W																		
03	L	D	W																		
04	L	D	W																		
05	L	D	W																		
06	L	D	W																		
07	L	D	W																		
08	L	D	W																		
09	L	D	W																		
10	L	D	W																		
11	L	D	W																		
12	L	D	W																		
13	L	D	W																		
14	L	D	W																		
15	L	D	W																		
16	L	D	W																		
17	L	D	W																		
18	L	D	W																		
19	L	D	W																		
20	L	D	W																		

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FOLLOW-UP SCHEDULES (PA)

Level 6	Matrix# 50a	Facility:

This table, which is not split by facility, contains information regarding the type and frequency of follow-up on patient and guarantor accounts. Individual follow-up schedules can also be established for specific patients and guarantors.

In the case of new or inactive guarantors, the patient's financial class determines the follow-up schedule assignment. There is no assignment for active guarantors since a follow-up schedule for them already exists.

Schedule #   (3N)

Description

(30AN)

Wait Days   (2N)

Enter the minimum number of days from final billing to wait before beginning follow-up. The default is 0.

Defining Follow-Up Frequency

The system provides three ways for you to define follow-up frequency:

- Day of month (for example, the 1st of the month)

- Day of week within a given week of the month (for example, Tuesday of the second week of the month)

- Interval, or a specified number of days between each follow-up (for example, every 24 days)

Complete the following worksheet fields keeping these guidelines in mind:

- If you select *Day of Month*:

  - Leave the Day of Week and Week of Month entries blank

- Leave the interval for each sequence blank

- If you select *Day of Week* and *Week of Month*:

    - Leave the Day of Month entry blank

    - Leave the interval for each sequence blank

- If you select *Interval*:

    - Leave the Day of Month, Day of Week, and Week of Month entries blank

Day of Month   (2N)

The day follow-up should be sent. Optional entries are 1-28 or L for Last day of the month.

Day of Week   (1N)

The day of the week follow-up should be sent, where Sunday=1, Monday=2, ... Saturday=7.

Week of Month   (1N)

The week of the month on which follow-up should be sent. Optional entries are 1-4. This field is not required if a value is entered to the Day of Month field.

Due Days   (2N)

The number of days used in calculating the due date.

Grace Days   (2N)

The number of grace days before the account is delinquent.

Defining Follow-Up Criteria

Two types of follow-up can be defined for insurance pending account. These are:

- Bill (request patient for money)

- Memo (send FYI to patient regarding account)

If Bill is selected two types of requested are provided. These are:

- Account - Request the entire account balance.

- Patient - Request the patient liability portion if it exists, otherwise, send nothing.

Complete the following worksheet fields keeping the guidelines in mind:

- If you select Bill - Enter A or P in the Bill Balance field.

- If you select Memo or Suppress - Leave the Bill Balance field blank.

Ins Pending   (1A)   ☐

The type of follow-up criteria for insurance pending accounts. Optional entries are B or M.

Bill Balance   (1A)   ☐

The dollar amount requested when the Bill option is selected. The optional entries are P or A.

The Restart % and Restart Amount Fields

The Restart % and Restart Amount fields identify the sequence number in the follow-up schedule on which the system should restart the follow-up type and message.

The system compares the guarantor's payment to the amount in the Restart % and Restart Amount fields. If the payment is *greater than* the percentage or amount, the system does not consider the account delinquent, resuming the following at the restart resequence number indicated. If the payment is *less than* the percentage or amount, system considers the account delinquent and follow-up continues with the next sequence number.

Restart %   (5N)   ☐☐☐ . ☐☐

Enter the percentage of the patient or account balance that must be received as a patient payment before restarting the statement sequence.

Restart Amount   (8N)   ☐☐☐☐☐☐ . ☐☐

Enter the dollar amount that must be received as a patient payment before restarting the statement sequence.

Reseq. Balance   (8N)   ☐☐☐☐☐☐ . ☐☐

Enter the minimum balance required to cause resequencing of the guarantor follow-up schedule if a new account is added to the guarantor schedule.

Max Paper Balance   (8N or U)   ☐☐☐☐☐☐ . ☐☐

The maximum balance for paper follow-up. If the carrier balance is greater than the maximum paper balance, telephone follow-up will be done. The default is U for unlimited.

Min. Balance   (8N)   ☐☐☐☐☐☐ . ☐☐

Enter the minimum balance required to continue sending statements. This field sets the upper limit for small balance write-off.

Transfer Balance Pymt Plan to AR   (Circle one)   ☐ Y ☐ N

Should the system transfer accounts on a balance payment plan with this schedule number to a specific AR schedule and remain on a separate payment plan?

AR Payment Plan Schedule #   (3N)

Enter the AR payment plan schedule number to which to transfer a balance
payment plan account. Only fill this out if previous question is Y.

Transfer Advanced Payment Plan to AR?   (Circle Y or N)   Y   N

Should the system transfer accounts on an advanced payment plan with this schedule
number to a specific AR schedule and remain on a separate payment plan?

AR Payment Plan Schedule #   (3N)

Enter the AR payment plan schedule number to which to transfer advanced
payment plan accounts. Only fill this out if previous question is Y.

Transfer Customized Account to AR?   (Circle Y or N)   Y   N

Should a custom account with this schedule number transfer to a specific customer
account in AR?

AR Custom Schedule #   (3N)

Enter the AR custom schedule number to which to transfer accounts on a PA
custom schedule with this schedule number. Only fill this out if the previous
question is Y.

Delinquent F/U Types   (Circle D or L)   D   L

Circle D for detail statement or L for follow-up letter.

Delinquent F/U Message   (4N)   ☐ ☐ ☐ ☐

Enter the follow-up message code.

Partial Payment F/U Type   (Circle D or L)   D   L

Circle D for detail statement or L for follow-up letter.

Partial Payment F/U Message   (4N)   ☐ ☐ ☐ ☐

Enter the follow-up message code.

In the worksheet on the following page, complete the fields as follows:

Seq #
This is the line of this sequence in the follow-up schedule. The number of lines is unlimited.

Follow Type
Identify the type of paper follow-up for this step in the schedule. Circle L for Follow-Up Letter or D for Detail Statement.

Follow-Up Message
Enter the four-digit code identifying the follow-up message associated with the follow-up type identified in the Follow Type field.

Memo Message
Enter the four-digit code identifying the message that displays on the follow-up statement or letter.

Restart Seq #
Enter the two-digit number of the next sequence in the collection schedule if the amounts defined in the Restart % or Restart Amount fields is met. This must be less than the current sequence number.

Interval
Enter the number of days, up to 999, the system must wait before continuing to the next sequence number in the follow-up schedule. Complete this field only if the Day of Month, Day of Week, and Week of Month fields are blank.

Seq #	Follow Type (Circle One)			Follow-Up Message (4N code)				Memo Message (4N code)				Restart Seq # (2N)		Interval (3N)		
01	L	D	W													
02	L	D	W													
03	L	D	W													
04	L	D	W													
05	L	D	W													
06	L	D	W													
07	L	D	W													
08	L	D	W													
09	L	D	W													
10	L	D	W													
11	L	D	W													
12	L	D	W													
13	L	D	W													
14	L	D	W													
15	L	D	W													
16	L	D	W													
17	L	D	W													
18	L	D	W													
19	L	D	W													
20	L	D	W													

Chapter 9 - LEVEL 7

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INTRODUCTION

This chapter contains worksheets to complete the following table. You should complete these worksheets before beginning the worksheets in Level 8.

• Financial Classes

FINANCIAL CLASSES

Level 7	Matrix# 44	Facility:

The financial class code is used as an element in GL revenue posting, to split AR and BD control accounts, in collecting statistics, and in reporting. Financial classes are not split by facility but have facility-specific information associated with them. This information must be established for each facility to make the financial classes valid.

Code   (2AN)

Description

(30AN)

Restricted To   (Circle response)   S   V   No Restriction

Is this financial class restricted to Self-Pay (S), Vendor (V), or the default response of No Restriction. The Vendor option is not implemented at this time.

Allow Insurance Time Out?   (Circle Y or N)   Y   N

Allow insurance time-out for accounts with this financial class? The default is Y.

Payment Transaction: P   (4N code)

Enter the default transaction code used for posting patient cash.

Refund Transaction: R   (4N code)

Enter the transaction code used as the refund approval code when a guarantor is approved for a refund and the patient account has this financial class.

PA Collector   (2N)
Group

Enter the code identifying the collector group assigned to a guarantor's accounts that are in a PA location.

PA Collector Group   (2N) | Y | N |
Exceptions

This field provides the option of defining PA collector group exceptions by patient type. To add exceptions, enter **Y** for Yes. Then, enter patient type exceptions in the table below.

Patient Type Exceptions

AR Collector Group   (2N)

Enter the code identifying the collector group assigned to accounts in AR follow-up.

AR Collector Group   (2N) | Y | N |
Exceptions

This field provides the option of defining AR collector group exceptions by patient type. To add exceptions, enter **Y** for Yes. Then, enter patient type exceptions in the table below.

Collection Agency Group   (2N)

Enter the code identifying the collection agency group to which accounts with this financial class are sent.

Biller Group   (2N)   [ ][ ]

Enter the code identifying the billing group assigned to this financial class.

Statistical Group   (2N)   [ ][ ]

Enter the code for the financial class statistics group used for reporting.

Sales Commission   (Circle Y or N)   Y   N

Is the financial class eligible for capturing sales commission data?

> **Sales Commission (Display Only)**
> Refer to the Tables section of the *Maintenance Functions* volume of the *STAR Laboratory Reference Guide* for more information on this field.

ICD-10 Eff Date   Date Format

> Enter the date that this financial class should begin using ICD-10 coding if it differs from the date in the US ICD-10 Effective Date field in the STAR Admissions and General Parameters.

Inpatient

Cycle Bill Parm   (3C)   [ ][ ][ ]

Enter the code identifying the cycle billing schedule for an inpatient account assigned to this financial class. This parameter is used for self pay financial classes.

Final Bill Parm   (3C)   [ ][ ][ ]

Enter the code identifying the final billing schedule for an inpatient account assigned to this financial class. This parameter is used for self pay financial classes.

PA Follow-Up Schedule   (3C)   ☐☐☐

Enter the code identifying the PA follow-up schedule for an account with this financial class.

AR Follow-Up Schedule   (3C)   ☐☐☐

Enter the code identifying the follow-up schedule for an AR account or guarantor with this financial class.

Outpatient

Cycle Bill Parm   (3C)   ☐☐☐

Enter the code identifying the cycle billing schedule for an outpatient account assigned to this financial class. This parameter is used for self pay financial classes.

Final Bill Parm   (3C)   ☐☐☐

Enter the code identifying the final billing schedule for an outpatient account assigned to this financial class. This parameter is used for self pay financial classes.

Follow-Up Schedule   (3C)   ☐☐☐

Enter the code identifying the follow-up schedule for an account or guarantor with this financial class.

Do you wish to Add /Revise Patient   (Circle Y or N)   Y   N
Type Exceptions for AR Follow-up?

Patient type exceptions within the financial class should be defined when you want the account to be placed on a follow-up schedule that is separate from the guarantor's follow-up schedule.

Patient Type Exceptions   (3AN)

Patient Type Exceptions   (3AN)

Chapter 10 - LEVEL 8

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INTRODUCTION

This section contains worksheets to complete the following tables. You should complete these worksheets before beginning the worksheets in Level 9.

- Facility Information Demographics/Defaults (US ONLY)

- Facility Information Demographics/Defaults (CN ONLY)

- Facility Information Active Patient Worklist Control

- Facility Information Retention

- Facility Information Balances

- Facility Information Insurance Time Out

- Insurance Coverage

- Report Aging Code

FACILITY INFORMATION DEMOGRAPHICS/DEFAULTS - (US ONLY)

Level 8	Matrix# 32	Facility:

This table, which must be split by facility, contains demographic information about the facility.

Hospital Name

(20AN)

Area Code   (3N)

Phone   (10-AP)

Address

(25AN)

Address Line 2

(25AN)

City

(18AN)

State   (2A)

ZIP Code   (5AN) ☐☐☐☐☐   **ZIP Extension**   (4N) ☐☐☐☐

County   (5N) ☐☐☐☐☐

Geo. Code/Census Tract   (6AN) ☐☐☐☐☐☐

Country   (2A) ☐☐

Language   (2A) ☐☐

Fax Number   (12-AN) ☐☐☐ - ☐☐☐ - ☐☐☐☐

Tax ID # (15-N) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

NPI # (10-N) ☐☐☐☐☐☐☐☐☐☐

Default Financial Class Code   (2AN) ☐☐

Default Admitting Physician Code   (5N) ☐☐☐☐☐

Default Medical Service Code   (3N)   [ ][ ][ ]

Default Clinic, Unit, Team (CUT)   (5AN)   [ ][ ][ ][ ][ ]

(if Program Management is installed.)

Default Provincial Insurance Plan   (6N)   [ ][ ][ ][ ][ ][ ]

(CN ONLY)

Default Newborn Adm Type   (2AN)   [ ][ ]

Default Newborn Adm Source   (1N)   [ ]

Default Newborn Service   (4A)   [ ][ ][ ][ ]

Default Newborn Clinic, Unit, Team (CUT)   (5AN)   [ ][ ][ ][ ][ ]

Default Newborn Patient Type   (2A)   [ ][ ]

Default O/P Auto Discharge Status   (2N)   [ ][ ]

Default I/P Auto Discharge Status   (2N)   [ ][ ]

Override Employer Code   (6N)   ☐☐☐☐☐☐

Override Physician Code   (6N)   ☐☐☐☐☐☐

Override Insurance Type   (1N)   ☐

Insurance Code   (6N)   ☐☐☐☐☐☐

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FACILITY INFORMATION DEMOGRAPHICS/DEFAULTS - (CN ONLY)

Level 8	Matrix# 32a	Facility:

This table, which must be split by facility, contains demographic information about the facility.

Hospital Name

(20AN)

Area Code   (3N)

Phone   (10-AP)

Address

(25AN)

Address Line 2

(25AN)

City

(18AN)

Province   (2A)

Post Code   (6AN)   ☐☐☐☐☐☐

County   (5N)   ☐☐☐☐☐

Residence Code   (5AN)   ☐☐☐☐☐

Country   (2A)   ☐☐

Language   (2A)   ☐☐

Default Financial Class Code   (2AN)   ☐☐

Default Admitting Physician Code   (5N)   ☐☐☐☐☐

Default Medical Service Code   (3N)   ☐☐☐

Default Clinic, Unit, Team (CUT)   (5AN)   ☐☐☐☐☐

(If Program Management is installed.)

Default Provincial Insurance Plan   (6N)   ☐☐☐☐☐☐

Default Newborn Adm Type   (2AN)

Default Newborn Adm Source   (1N)

Default Newborn Service   (4A)

Default Newborn Clinic, Unit, Team (CUT)   (5AN)

Default Newborn Patient Type   (2A)

Default O/P Auto Discharge Status   (2N)

Default I/P Auto Discharge Status   (2N)

Override Employer Code   (6N)

Override Physician Code   (6N)

Override Insurance Type   (1N)

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Insurance Code　　(6N)　　☐☐☐☐☐☐

FACILITY INFORMATION - ACTIVE PATIENT WORKLIST CONTROL

Level 8	Matrix# 37a	Facility:

This table establishes criteria for creating the online worklists for active patient (PA) accounts.

Minimum Balance   (11N)   □□□□□□□□□ . □□

Enter the minimum balance for an account to be considered for inclusion in the active patient account telephone workfile.

Payment Days   (3N)   □□□

Enter the minimum number of days since the last payment for an account to be considered for inclusion to the workfile.

Last Bill Sequence   (2N)   □□

Enter the minimum bill sequence number needed for an account to be considered for inclusion to the workfile.

Telephone Follow-Up Transaction Code: T   (4N)   □□□□

Excluded Patient Types   (3AN)   □□□

□□□

□□□

□□□

□□□

□□□

Enter the patient type(s) to be excluded from the workfile. The system displays a table for this selection.

Excluded Financial Classes   (2AN)

Enter the financial class(es) to be excluded from the workfile. The system displays a table for this selection.

Default Telephone Collector   (2N)

Identify the default collector for the worklist. The system displays a table for this selection.

Use the fields in the following table to define alphabetic categories for active patient workfile telephone follow-up, based on the patient's last name. For example, if you enter HZZ to the first Last Name field, the collector in the Telephone Collector field is responsible for all accounts whose last names begin with AAA to all accounts whose last names begin with HZZ (for example, from A through H). The collector on the next line would be responsible for all patients whose last names begin with I.

Last Name (3A)			**Telephone Collector** (2N)		**Last Name** (3A)			**Telephone Collector** (2N)	

Financial Class Exceptions

Use the following fields to identify exceptions for workfiles by financial class.

Financial Class   (2AN)

Enter the financial class for which you are creating exceptions.

Use the fields in the following table to define alphabetic categories for active patient workfile telephone follow-up financial class exceptions, based on the patient's last name. For more information on completing these fields, see the explanation on page 15.

Default Telephone Collector   (2N)

Last Name (3A)			Telephone Collector (2N)		Last Name (3A)			Telephone Collector (2N)	

Financial Class   (2AN)

Enter the financial class for which you are creating exceptions.

Use the fields in the following table to define alphabetic categories for active patient workfile telephone follow-up financial class exceptions, based on the patient's last name. For more information on completing these fields, see the explanation on page 15.

Default Telephone Collector   (2N)

Last Name (3A)			Telephone Collector (2N)	

Last Name (3A)			Telephone Collector (2N)	

FACILITY INFORMATION RETENTION

Level 8	Matrix# 38	Facility:

Data Retention Parameters

This parameter, which can be split by facility, indicates how long accounts remain on the system after zero balance and how long are retained on the system. It is used by the purge and archive functions.

Archive Days   (2N)

The number of days after zero balance before the account PAAR detail is purged. The range is 1-99.

Max AR Accts   (5N)

The maximum number of AR accounts the system can archive. Enter U for Unlimited.

Max BD Accts   (5N)

The maximum number of BD accounts the system can archive. Enter U for Unlimited.

FPI Months   (2N)

The number of months to retain an account in the FPI after the account has been archived.
This field is not currently used.

Carrier Pay Days   (2N)

The number of days after full carrier payment before claim data is purged. The range is 1-99.

Max Claims   (5N)   ☐☐☐☐☐

The maximum number of claims the system can archive at a time. Enter U for Unlimited.

BD Charge Delete Days   (3N)   ☐☐☐

The number of days, from 0-365, the system retains detail charges once an account transfers to bad debt. The default is 0.

BD Charge Delete Transaction Code: M   (4N)   ☐☐☐☐

The transaction code recorded in the transaction history when detail charges are purged.

Archive Method   (Circle response)   T   M   B

Circle T to archive to Tape, M to archive to Microfiche, or B for Both. This is a memo - only field.

Contract Charge Delete Days   (3N)   ☐☐☐

The new number of days, from 0-365 the system retains detail contract charges once the balance on the contract becomes zero and the account is in AR.

Retain Guarantor Payment History?   (Circle one)   Y   N

Do you want the payments form your archived accounts to be
displayed when you select Guarantor Payment History screen?

Financial Class Exceptions

Financial Class Exception   (2A)

Archive Days   (2N)

Enter the number of days after zero balance before the account PAAR detail is purged. The range is 1-99.

Carrier Pay Days   (2N)

Enter the number of days after full carrier payment before claim data is purged. The range is 1-99.

Clear Balances?   (Circle one)   Y   N

Do you want to clear insurance and patient balances if account balance goes to zero but there are offsetting debits and credits?

Guarantor Follow Up Type   (Circle D or L)   D   L

Enter the type of follow-up to be sent to the guarantor, detail statement or letter, once all insurance liability has been met.

Guarantor Follow Up Message Code   (3N)

Enter the message code associated with the follow-up type defined in guarantor follow-up type.

Pre-Collect Follow Up Type   (Circle D or L)   D   L

Enter the precollect type of follow-up to be sent to the guarantor, detail statement or letter, once all insurance liability has been met.

Pre Collect Follow Up Message Code   (3N)

Enter the message code associated with the follow-up type defined
in precollect follow-up type.

CCI Follow Up Type   (Circle D or L)   D   L

Enter the CCI type of follow-up to be sent to the guarantor, detail statement or letter,
once all insurance liability has been met.

CCI Follow Up Message Code   (3N)

Enter the message code associated with the follow-up type defined
in CCI follow-up type.

Zero Insurance Follow Up Day Range   (2N)

Enter the number of days from next follow up in which you do
not want the zero insurance liability follow up to occur.

Patient Type Exceptions Within Financial Class

Financial Class   (2A)

Patient Type Exception   (3AN)

Archive Days   (2N)

Enter the number of days after zero balance before the account PAAR detail is purged. The range is 1-
99.

Carrier Pay Days   (2N)

Enter the number of days after full carrier payment before claim data is purged. The range is 1-99.

FPI Months   (2N)

Enter the number of months to keep an account in the FPI after it has been archived. The range is 1-99.
This field is not implemented at this time.

Archive Method   (Circle response)   T   M   B

Circle T to archive to Tape, M to archive to Microfiche, or B for Both.

FACILITY INFORMATION BALANCE DESIGNATION

Level 8	Matrix# 39	Facility:

Balance Designation Parameters

This parameter, which is split by facility, is used during insurance cash posting to indicate how any money remaining after a full carrier payment should be handled.

Transfer Liability To   (Circle response)   C   P

Should unpaid insurance liability be transferred to the next Carrier (C) or the Patient (P)?

Claim Type   (Circle Y or N)   Y   N

Should the system only transfer balances resulting from insurance cash posting to carriers of the same claim type classification? The default is Y.

Transfer Transaction Code: B   (4N code)   ☐☐☐☐

New Financial Class   (2A)   ☐☐

If liability is transferred to the patient, the system will change the financial class to your entry. Leave this field blank to keep the same financial class. This must be a self-pay financial class. Changing the financial class in the field does not reclassify revenue

FC Change Transaction Code: S   (4N code)   ☐☐☐☐

Use Ins Financial Class   (Circle Y or N)   Y   N

Should the financial class change to the financial class of the current insurance on an account after a final carrier payment? The default is No.

Ins FC Change Transaction Code: M   (4N code)   ☐☐☐☐

Clear Balances   (Circle Y or N)   Y   N

Should the system clear all buckets (patient and insurance) if the account balance goes to zero with offsetting balances? The default is Y.

Financial Class Exceptions

Financial Class Exception   (2A)   ☐☐

Transfer Liability To   (Circle response)   C   P

Should unpaid insurance liability be transferred to the next Carrier (C) or the Patient (P)?

Claim Type   (Circle Y or N)   Y   N

Should the system only transfer balances resulting from insurance cash posting to carriers of the same claim type classification? The default is Y.

Transfer Transaction Code: B   (4N code)   ☐☐☐☐

New Financial Class   (2A)   ☐☐

FC Change Transaction Code: M   (4N code)   ☐☐☐☐

Use Ins Financial Class   (Circle Y or N)   Y   N

Should the financial class change to the financial class of the current insurance on an account after a final carrier payment? The default is No.

Ins FC Change Transaction Code: M   (4N code)   ☐☐☐☐

Clear Balances   (Circle Y or N)   Y   N

Should the system clear all buckets (patient and insurance) if the account balance goes to zero with offsetting balances? The default is Y.

Guarantor Follow Up Type   (Circle D or L)   D   L

Enter the type of follow-up to be sent to the guarantor, detail statement or letter, once all insurance liability has been met.

Guarantor Follow Up Message Code   (3N)   [ ][ ][ ]

Enter the message code associated with the follow-up type defined in guarantor follow-up type.

Pre-Collect Follow Up Type   (Circle D or L)   D   L

Enter the precollect type of follow-up to be sent to the guarantor, detail statement or letter, once all insurance liability has been met.

Pre Collect Follow Up Message Code   (3N)   [ ][ ][ ]

Enter the message code associated with the follow-up type defined in precollect follow-up type.

CCI Follow Up Type   (Circle D or L)   D   L

Enter the CCI type of follow-up to be sent to the guarantor, detail statement or letter, once all insurance liability has been met.

CCI Follow Up Message Code   (3N)

Enter the message code associated with the follow-up type defined
in CCI follow-up type.

Zero Insurance Follow Up Day   (2N)
Range

Enter the number of days from next follow up in which you do
not want the zero insurance liability follow up to occur.

Financial Class Exception   (2A)

Transfer Liability To   (Circle response)   C   P

Should unpaid insurance liability be transferred to the next Carrier (C) or the Patient (P)?

Claim Type   (Circle Y or N)   Y   N

Should the system only transfer balances resulting from insurance cash posting to
carriers of the same claim type classification? The default is Y.

Transfer Transaction Code: B   (4N code)

New Financial Class   (2A)

FC Change Transaction Code: M   (4N code)

Clear Balances   (Circle Y or N)   Y   N

Should the system clear all buckets (patient and insurance) if the account balance goes to zero with offsetting balances? The default is Y.

Patient Type Exceptions Within Financial Class

Financial Class   (2A)   ☐☐

Patient Type Exception   (3AN)   ☐☐☐

Transfer Liability To   (Circle response)   C   P

Should unpaid insurance liability be transferred to the next Carrier (C) or the Patient (P)?

Claim Type   (Circle Y or N)   Y   N

Should the system only transfer balances resulting from insurance cash posting to carriers of the same claim type classification? The default is Y.

Transfer Transaction Code: B   (4N code)   ☐☐☐☐

New Financial Class   (2A)   ☐☐

FC Change Transaction Code: M   (4N code)   ☐☐☐☐

Financial Class   (2A)   ☐☐

Clear Balances   (Circle Y or N)   Y   N

Should the system clear all buckets (patient and insurance) if the account balance goes to zero with offsetting balances? The default is Y.

Guarantor Follow Up Type   (Circle D or L)   D   L

Enter the type of follow-up to be sent to the guarantor, detail statement or letter, once all insurance liability has been met.

Guarantor Follow Up Message Code   (3N) | | | |

Enter the message code associated with the follow-up type defined
in guarantor follow-up type.

Pre-Collect Follow Up Type   (Circle D or L)   D   L

Enter the precollect type of follow-up to be sent to the guarantor, detail statement or letter, once all insurance liability has been met.

Pre Collect Follow Up Message Code   (3N) | | | |

Enter the message code associated with the follow-up type defined
in precollect follow-up type.

CCI Follow Up Type   (Circle D or L)   D   L

Enter the CCI type of follow-up to be sent to the guarantor, detail statement or letter, once all insurance liability has been met.

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CCI Follow Up Message Code   (3N)   ☐☐☐

Enter the message code associated with the follow-up type defined
in CCI follow-up type.

Zero Insurance Follow Up Day   (2N)   ☐☐
Range

Enter the number of days from next follow up in which you do
not want the zero insurance liability follow up to occur.

Patient Type Exception   (3AN)   ☐☐☐

Transfer Liability To   (Circle response)   C   P

Should unpaid insurance liability be transferred to the next Carrier (C) or the Patient (P)?

Claim Type   (Circle Y or N)   Y   N

Should the system only transfer balances resulting from insurance cash posting to
carriers of the same claim type classification? The default is Y.

Transfer Transaction Code: B   (4N code)   ☐☐☐☐

New Financial Class   (2A)   ☐☐

FC Change Transaction Code: M   (4N code)   ☐☐☐☐

Clear Balances   (Circle Y or N)   Y   N

Should the system clear all buckets (patient and insurance) if the account balance goes to zero with offsetting balances? The default is Y.

FACILITY INFORMATION INSURANCE TIME OUT

Level 8	Matrix# 41	Facility:

Insurance Time-Out Parameters

This parameter indicates whether insurance time out should take place for a specific financial class. It also indicates the new financial class, if any, updating the patient record when time out takes place.

Transfer Liability To   (Circle response)   C   P

Should liability be transferred to the next Carrier (C) or the Patient (P)?

Claim Type   (Circle Y or N)   Y   N

Should the system only transfer balances resulting from insurance cash posting to carriers of the same claim type classification? The default is Y.

Transfer Transaction Code: B   (4N code)   ☐☐☐☐

New Financial Class   (2A)   ☐☐

If liability is transferred to the patient, the system will change the financial class to your entry. Leave this field blank to keep the same financial class. This must be a self-pay financial class. Changing the financial class in the field does not reclassify revenue.

FC Change Transaction Code: M   (4N code)   ☐☐☐☐

Financial Class Exceptions

Financial Class Exception   (2A)   ☐☐

Transfer Liability To   (Circle response)   C   P

Should liability be transferred to the next Carrier (C) or the Patient (P)?

Claim Type   (Circle Y or N)   Y   N

Should the system only transfer balances resulting from insurance cash posting to carriers of the same claim type classification? The default is Y.

Transfer Transaction Code: B   (4N code)   ☐☐☐☐

New Financial Class   (2A)   ☐☐

FC Change Transaction Code: M   (4N code)   ☐☐☐☐

Financial Class Exception   (2A)   ☐☐

Transfer Liability To   (Circle response)   C   P

Should liability be transferred to the next Carrier (C) or the Patient (P)?

Claim Type   (Circle Y or N)   Y   N

Should the system only transfer balances resulting from insurance cash posting to carriers of the same claim type classification? The default is Y.

Transfer Transaction Code: B   (4N code)   ☐☐☐☐

New Financial Class   (2A)   ☐☐

FC Change Transaction Code: M   (4N code)   ☐☐☐☐

Patient Type Exceptions Within Financial Class

Financial Class   (2A)   ☐☐

Patient Type Exception   (3AN)   ☐☐☐

Transfer Liability To   (Circle response)   C   P

Should liability be transferred to the next Carrier (C) or the Patient (P)?

Claim Type   (Circle Y or N)   Y   N

Should the system only transfer balances resulting from insurance cash posting to carriers of the same claim type classification? The default is Y.

Transfer Transaction Code: B   (4N code)   ☐☐☐☐

New Financial Class   (2A)   ☐☐

FC Change Transaction Code: M   (4N code)   ☐☐☐☐

Financial Class   (2A)   ☐☐

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Patient Type Exception   (3AN)

Transfer Liability To   (Circle response)   C   P

Should liability be transferred to the next Carrier (C) or the Patient (P)?

Claim Type   (Circle Y or N)   Y   N

Should the system only transfer balances resulting from insurance cash posting to carriers of the same claim type classification? The default is Y.

Transfer Transaction Code: B   (4N code)

New Financial Class   (2A)

FC Change Transaction Code: M   (4N code)

INSURANCE COVERAGE

Level 8	Matrix# 64	Facility:

This master defines the coverages of a carrier plan: basic, room, ancillary, major medical, daily/blood deductibles, flat rate, summary code exceptions, medical service exceptions, diagnosis code exceptions, procedure code exceptions, plus plan comments, attachments and facility options.

Basic Coverage

Inpatient

Benefits Assigned?   (Circle Y or N)   Y   N

Baby Covered?   (Circle Y or N)   Y   N

Days Before Coverage Begins   (3N)   ☐☐☐

The default is 0 days.

Days Coverage is Active   (3N or U)   ☐☐☐

Enter U for Unlimited. The default is Unlimited.

Professional Fee Coverage   (Circle Response)   I   E   O

Circle I if professional fees are Included, E if they are Excluded, or O if only professional fees are covered. The default is I.

Coordinate Benefits?   (Circle Y or N)   Y   N

Circle Y if benefits will be coordinated with other insurance plans. Circle N if benefits will not be coordinated with other plans; each insurance will prorate as if no other coverage exists. The default is Y.

Duplicating?   (Circle Y or N)   Y   N

Circle Y if benefits are duplicated when determining coordination of benefits. Circle N if benefits are not duplicated. The default is Y.

Outpatient

Benefits Assigned?   (Circle Y or N)   Y   N

Baby Covered?   (Circle Y or N)   Y   N

Days Before Coverage Begins   (3N)   ▢▢▢

The default is 0 days.

Days Coverage is Active   (3N or U)   ▢▢▢

Enter U for Unlimited. The default is Unlimited.

Professional Fee Coverage   (Circle Response)   I   E   O

Circle I if professional fees are Included, E if they are Excluded, or O if only professional fees are covered. The default is I.

Coordinate Benefits?   (Circle Y or N)   Y   N

Circle Y if benefits will be coordinated with other insurance plans. Circle N if benefits will not be
coordinated with other plans; each insurance will prorate as if no other coverage exists. The default is Y.

Duplicating?   (Circle Y or N)   Y   N

Circle Y if benefits are duplicated when determining coordination of benefits. Circle N
if benefits are not duplicated. The default is Y.

Room Coverage

Inpatient

Ward Room Allowance   (6N, W, S, U, or N)   [   ][   ][   ][   ] . [   ][   ]

Enter the amount, W for Ward, S for Semi-private, U for Unlimited, or N for Not
Covered.

NOTE: This field must be maintained with each price increase if a dollar amount is
entered.

Percent Cvd   (3N)   [   ][   ][   ] %

Enter the percent coverage for a ward room.

Difference to   (Circle response)   M   P

Send the non-covered room charges to Major Medical (circle M) or the Patient (circle P)? The default is
P.

Transfer Limit   (6N or U)   [ ][ ][ ][ ] . [ ][ ]

> Enter the transfer limit to major medical. You can enter a dollar amount or U for Unlimited. If you circled M in Difference To above, enter a dollar amount. If you circled P, enter U for Unlimited.

SP Room Allowance   (6N, S, U, or N)   [ ][ ][ ][ ] . [ ][ ]

Enter the amount or S for Semiprivate, U for Unlimited, or N for Not Covered.

> **NOTE:**   This field must be maintained with every price increase of a dollar amount is entered.

Percent Cvd   (3N)   [ ][ ][ ] %

Enter the percent coverage for a semiprivate room.

Difference to   (Circle response)   M   P

Send the non-covered room charges to Major Medical (circle M) or the Patient (circle P)? The default is P.

Transfer Limit   (6N or U)   [ ][ ][ ][ ] . [ ][ ]

Enter the transfer limit to major medical. You can enter a dollar amount or U for Unlimited. If you circled M in Difference To above, enter a dollar amount. If you circled P, enter U for Unlimited.

Private Room Allowance   (6N, S, U, or N)   [ ][ ][ ][ ] . [ ][ ]

Enter the amount or S for Semiprivate, U for Unlimited, or N for Not Covered.

Percent Cvd   (3N)   [ ][ ][ ] %

Enter the percent coverage for a private room.

Difference to   (Circle response)   M   P

Send the non-covered room charges to Major Medical (circle M) or the Patient (circle P)? The default is P.

Transfer Limit   (6N or U)   ☐ ☐ ☐ ☐ . ☐ ☐

Enter the transfer limit to major medical. You can enter a dollar amount or U for Unlimited. If you circled M in Difference To above, enter a dollar amount. If you circled P, enter U for Unlimited.

ICU Room Allowance   (6N, S, U, or N)   ☐ ☐ ☐ ☐ . ☐ ☐

Enter the amount or S for Semiprivate, U for Unlimited, or N for Not Covered.

Percent Cvd   (3N)   ☐ ☐ ☐ %

Enter the percent coverage for an ICU room.

Difference to   (Circle response)   M   P

Send the non-covered room charges to Major Medical (circle M) or the Patient (circle P)? The default is P.

Transfer Limit   (6N or U)   ☐ ☐ ☐ ☐ . ☐ ☐

Enter the transfer limit to major medical. You can enter a dollar amount or U for Unlimited. If you circled M in Difference To above, enter a dollar amount. If you circled P, enter U for Unlimited.

Maximum Room/Bed Days Covered   (3N)   ☐☐☐

Enter the total number of days of room/bed charges covered. Enter U for Unlimited.

Maximum ICU Days Covered   (3N)   ☐☐☐

Enter the maximum number of ICU days covered; enter U for Unlimited. This value cannot exceed the value entered to the Maximum Room/Bed Days Covered above.

Maximum Ancillary Days Covered?   (Circle Y or N)   Y   N

Does the room/bed day limit apply to ancillary charges? The default is No. This option is not currently available.

Accommodation Code/Description   (1AN)   ☐

(19AN)   ☐☐☐☐☐☐☐☐☐
                ☐☐☐☐☐☐☐☐

Same as Room Type   (Circle response)   S   P   I   None

Circle S for Semi-Private, P for Private, I for ICU, or None.

>   Complete the following fields only if you select None from the Same as Room Type field.

Room Coverage Allowance   (6N, S, U, or N)   ☐☐☐☐ . ☐☐

Enter the amount or S for Semiprivate, U for Unlimited, or N for Not Covered.

Percent Covered   (3N)   ⬚⬚⬚ %

Enter the percent coverage for this room.

Difference to   (Circle response)   M   P

Send the non-covered room charges to Major Medical (circle M) or the Patient (circle P)? The default is P.

Transfer Limit   (6N or U)   ⬚⬚⬚⬚ . ⬚⬚

Enter the transfer limit to major medical. You can enter a dollar amount or U for Unlimited. If you circled M in Difference To above, enter a dollar amount. If you circled P, enter U for Unlimited.

Outpatient

Ward Room Allowance   (6N, W, S, U, or N)   ⬚⬚⬚⬚ . ⬚⬚

Enter the amount, W for Ward, S for Semi-private, U for Unlimited, or N for Not Covered.

NOTE: This field must be maintained with each price increase if a dollar amount is entered.

Percent Cvd   (3N)   ⬚⬚⬚ %

Enter the percent coverage for a ward room.

Difference to   (Circle response)   M   P

Send the non-covered room charges to Major Medical (circle M) or the Patient (circle P)? The default is P.

Transfer Limit   (6N or U)   [ ][ ][ ][ ] . [ ][ ]

         Enter the transfer limit to major medical. You can enter a dollar amount or U for
         Unlimited. If you circled M in Difference To above, enter a dollar amount. If you circled
         P, enter U for Unlimited.

SP Room Allowance   (6N, S, U, or N)   [ ][ ][ ][ ] . [ ][ ]

Enter the amount or S for Semiprivate, U for Unlimited, or N for Not Covered.

        NOTE: This field must be maintained with every price increase of a dollar amount is
                entered.

Percent Cvd   (3N)   [ ][ ][ ] %

Enter the percent coverage for a semiprivate room.

Difference to   (Circle response)   M   P

Send the non-covered room charges to Major Medical (circle M) or the Patient (circle P)? The default is
P.

Transfer Limit   (6N or U)   [ ][ ][ ][ ] . [ ][ ]

Enter the transfer limit to major medical. You can enter a dollar amount or U for Unlimited. If you circled
M in Difference To above, enter a dollar amount. If you circled P, enter U for Unlimited.

Private Room Allowance   (6N, S, U, or N)   [ ][ ][ ][ ] . [ ][ ]

Enter the amount or S for Semiprivate, U for Unlimited, or N for Not Covered.

Percent Cvd   (3N)   [ ][ ][ ] %

Enter the percent coverage for a private room.

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Difference to   (Circle response)   M   P

Send the non-covered room charges to Major Medical (circle M) or the Patient (circle P)? The default is P.

Transfer Limit   (6N or U)   [ ][ ][ ][ ] . [ ][ ]

Enter the transfer limit to major medical. You can enter a dollar amount or U for Unlimited. If you circled M in Difference To above, enter a dollar amount. If you circled P, enter U for Unlimited.

ICU Room Allowance   (6N, S, U, or N)   [ ][ ][ ][ ] . [ ][ ]

Enter the amount or S for Semiprivate, U for Unlimited, or N for Not Covered.

Percent Cvd   (3N)   [ ][ ][ ] %

Enter the percent coverage for an ICU room.

Difference to   (Circle response)   M   P

Send the non-covered room charges to Major Medical (circle M) or the Patient (circle P)? The default is P.

Transfer Limit   (6N or U)   [ ][ ][ ][ ] . [ ][ ]

Enter the transfer limit to major medical. You can enter a dollar amount or U for Unlimited. If you circled M in Difference To above, enter a dollar amount. If you circled P, enter U for Unlimited.

Maximum Room/Bed Days Covered   (3N)   [ ][ ][ ]

Enter the total number of days of room/bed charges covered. Enter U for Unlimited.

Maximum ICU Days Covered   (3N)   [ ][ ][ ]

Enter the maximum number of ICU days covered; enter U for Unlimited. This value cannot exceed the value entered to the Maximum Room/Bed Days Covered above.

Maximum Ancillary Days Covered?   (Circle Y or N)   Y   N

Does the room/bed day limit apply to ancillary charges? The default is No. This option is not currently available.

Accommodation Code/Description   (1AN)   [ ]

(19AN)   [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]
                [ ][ ][ ][ ][ ][ ][ ][ ][ ]

Same as Room Type   (Circle response)   S   P   I   None

Circle S for Semi-Private, P for Private, I for ICU, or None.

> Complete the following fields only if you select None from the Same as Room Type field.

Room Coverage Allowance   (6N, S, U, or N)   [ ][ ][ ][ ] . [ ][ ]

Enter the amount or S for Semiprivate, U for Unlimited, or N for Not Covered.

Percent Covered   (3N) | | | | %

Enter the percent coverage for this room.

Difference to   (Circle response)   M   P

Send the non-covered room charges to Major Medical (circle M) or the Patient (circle P)? The default is P.

Transfer Limit   (6N or U) | | | | | . | | |

Enter the transfer limit to major medical. You can enter a dollar amount or U for Unlimited. If you circled M in Difference To above, enter a dollar amount. If you circled P, enter U for Unlimited.

Ancillary Coverage

Include Room Charges in Ancillary Coverage?   (Circle Y or N)   Y   N

Limits Are   (Circle response)   C   B

Are limits Covered Charges (circle C) or Benefits (circle B)? The default is C.

FIRST ANCILLARY COVERAGE

Deductible Amount   (6N) | | | | | | |

Enter the first ancillary coverage deductible amount.

Co-Pay   (7-N) | | | | | | | |

Enter the first ancillary coverage co-pay amount..

Percent Covered   (3N)   ☐☐☐ %

Dollar Limit   (10N)   ☐☐☐☐☐☐☐☐ . ☐☐

Enter the ancillary dollar limit or enter U for Unlimited.

SECOND ANCILLARY COVERAGE

Complete this section only if a dollar limit has been set in the first ancillary coverage.

Deductible Amount   (6N)   ☐☐☐☐☐☐

Enter the first ancillary coverage deductible amount.

Percent Covered   (3N)   ☐☐☐ %

Dollar Limit   (10N)   ☐☐☐☐☐☐☐☐ . ☐☐

Enter the ancillary dollar limit or enter U for Unlimited.

> **NOTE:** When ancillary coverage is exhausted, responsibility is transferred to major medical coverage.

Major Medical Coverage

Inpatient

Room Charges Included?   (Circle Y or N)   Y   N

Should Room & Bed difference go toward satisfying the deductibles? The default is Y.

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Room Chgs in Limits?   (Circle Y or N)   Y   N

This field is required only if you selected No for Room Charges Included above. It determines whether the Room & Bed differences should be included in calculating the limits. This field defaults to Y if Room Charges Included is Yes. The default is Y.

Limits Are   (Circle response)   C   B

Circle C to use Covered Charges as limits; circle B to use Benefits. The default is C.

Ancillary Charges Included?   (Circle Y or N)   Y   N

This field determines whether ancillary charges are included in satisfying major medical deductibles and limits.

FIRST MAJOR MEDICAL

Deductible Amount   (8N) | | | | | | | | |

Percent Coverage   (3N) | | | | %

Dollar Limit   (10N or U) | | | | | | | | . | | |

Enter the ancillary dollar limit or enter U for Unlimited.

SECOND MAJOR MEDICAL

Deductible Amount   (8N)

Percent Coverage   (3N)   %

Dollar Limit   (10N or U)

Enter the ancillary dollar limit or enter U for Unlimited.

THIRD MAJOR MEDICAL

Deductible Amount   (8N)

Percent Coverage   (3N)   %

Dollar Limit   (10N or U)

Enter the ancillary dollar limit or enter U for Unlimited.

> **NOTE:** When major medical coverage is exhausted, responsibility is transferred to another insurance or to the patient.

Outpatient

Room Charges Included?   (Circle Y or N)   Y   N

Should Room & Bed difference go toward satisfying the deductibles? The default is Y.

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Room Chgs in Limits?   (Circle Y or N)   Y   N

This field is required only if you selected No for Room Charges Included above. It determines whether the Room & Bed differences should be included in calculating the limits. This field defaults to Y if Room Charges Included is Yes. The default is Y.

Limits Are   (Circle response)   C   B

Circle C to use Covered Charges as limits; circle B to use Benefits. The default is C.

Ancillary Charges Included?   (Circle Y or N)   Y   N

This field determines whether ancillary charges are included in satisfying major medical deductibles and limits.

First Major Medical

Deductible Amount   (8N)

Percent Coverage   (3N)   %

Dollar Limit   (10N or U)   .

Enter the ancillary dollar limit or enter U for Unlimited.

Second Major Medical

Deductible Amount   (8N) | | | | | | | | |

Percent Coverage   (3N) | | | | %

Dollar Limit   (10N or U) | | | | | | | | | . | | |

Enter the ancillary dollar limit or enter U for Unlimited.

Third Major Medical

Deductible Amount   (8N) | | | | | | | | |

Percent Coverage   (3N) | | | | %

Dollar Limit   (10N or U) | | | | | | | | | . | | |

Enter the ancillary dollar limit or enter U for Unlimited.

> **NOTE:**   When major medical coverage is exhausted, responsibility is transferred to another insurance or to the patient.

Daily/Blood Deductibles

Inpatient

First Daily Deductible

Start After Days   (3N)   ☐☐☐

Enter the number of days from admission to wait before starting the deductible.

Days Active   (3N or U)   ☐☐☐

Enter the number of days to take the deductible. Enter U for Unlimited.

Deductible Amount   (6N)   ☐☐☐☐ . ☐☐

Enter the amount to deduct each day.

Second Daily Deductible

Start After Days   (3N)   ☐☐☐

Enter the number of days from admission to wait before starting the deductible.

Days Active   (3N or U)   ☐☐☐

Enter the number of days to take the deductible. Enter U for Unlimited.

Deductible Amount   (6N)   ☐☐☐☐ . ☐☐

Enter the amount to deduct each day.

Third Daily Deductible:

Start After Days   (3N)   ☐☐☐

Enter the number of days from admission to wait before starting the deductible.

Days Active   (3N or U)   ☐☐☐

Enter the number of days to take the deductible. Enter U for Unlimited.

Deductible Amount   (6N)   ☐☐☐☐ . ☐☐

Enter the amount to deduct each day.

Blood Deductible

Deductible Pints   (2N)   ☐☐

Enter the number of deductible pints of blood.

Furnished in Replaced?   (Circle Y or N)   Y   N

Should units furnished be included in units replaced on the UB claim form? The default is Y.

Blood Summary Code   (3N)   ☐☐☐

Enter the appropriate UB Revenue code.

Outpatient

First Daily Deductible

Start After Days   (3N)

Enter the number of days from admission to wait before starting the deductible.

Days Active   (3N or U)

Enter the number of days to take the deductible. Enter U for Unlimited.

Deductible Amount   (6N)

Enter the amount to deduct each day.

Second Daily Deductible

Start After Days   (3N)

Enter the number of days from admission to wait before starting the deductible.

Days Active   (3N or U)

Enter the number of days to take the deductible. Enter U for Unlimited.

Deductible Amount   (6N)

Enter the amount to deduct each day.

Third Daily Deductible:

Start After Days   (3N)

Enter the number of days from admission to wait before starting the deductible.

Days Active   (3N or U)

Enter the number of days to take the deductible. Enter U for Unlimited.

Deductible Amount   (6N)

Enter the amount to deduct each day.

Blood Deductible

Deductible Pints   (2N)

Enter the number of deductible pints of blood.

Furnished in Replaced?   (Circle Y or N)   Y   N

Should units furnished be included in units replaced on the UB claim form? The default is Y.

Blood Summary Code   (3N)

Enter the appropriate UB Revenue code.

Flat Rate Coverage

Flat Rate Coverage takes priority over any other ancillary benefits that exist for the insurance plan.

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INPATIENT

Flat Rate Per   (Circle response)   D   S

Circle D if you are defining a flat rate per Day; S if a flat rate per Stay.

Maximum Days   (3N or U)   [ ][ ][ ]

Enter the maximum number of days the rate is effective or U for Unlimited. Complete this field only if you selected D in Flat Rate Per above.

Flat Rate Amount   (8N)   [ ][ ][ ][ ][ ][ ] . [ ][ ]

Deductible Amount   (9N)   [ ][ ][ ][ ][ ][ ][ ] . [ ][ ]

Enter the flat rate deductible amount. The default is 0.

OUTPATIENT

Flat Rate Per   (Circle response)   D   S

Circle D if you are defining a flat rate per Day; S if a flat rate per Stay.

Flat Rate Amount   (8N)   [ ][ ][ ][ ][ ][ ] . [ ][ ]

Deductible Amount   (9N)   [ ][ ][ ][ ][ ][ ][ ] . [ ][ ]

Enter the flat rate deductible amount. The default is 0.

Summary Code Exceptions

Summary Code/Description   (3N)   ☐ ☐ ☐

(30AN, from
Proration Summary
Code Table)

Inpatient

Summary Code Covered?   (Circle Y or N)   Y   N

Is this summary code covered by the plan?

Covered Percentage   (3N)   ☐ ☐ ☐

Deductible Per   (Circle response)   C   T

Circle C if the deductible is per Charge; circle T if the deductible is per category Total.

Deductible %   (3N)   ☐ ☐ ☐

Deductible Amount   (6N)   ☐ ☐ ☐ ☐ . ☐ ☐

Greater/Lesser   (Circle response)   G   L

Is deductible the Greater (circle G) or Lesser (circle L) of the percent or amount?

OUTPATIENT

Summary Code Covered?   (Circle Y or N)   Y   N

Is this summary code covered by the plan?

Covered Percentage   (3N)   [ ][ ][ ]

Deductible Per   (Circle response)   C   T

Circle C if the deductible is per Charge; circle T if the deductible is per category Total.

Deductible %   (3N)   [ ][ ][ ]

Deductible Amount   (6N)   [ ][ ][ ][ ] . [ ][ ]

Greater/Lesser   (Circle response)   G   L

Is deductible the Greater (circle G) or Lesser (circle L) of the percent or amount?

Plan Comments

Comment Number   (3AN)   ▢▢▢

Comment Enter up to four lines of 60 characters each

1

2

3

4

Attachments

Claim Attachments Code   (2A)   ▢▢

In/Out/All   (Circle response)   I   O   A

Circle I to include only Inpatients, O to include only Outpatients, or A to include All patients. The default is A.

Exclude Patient Types   (3AN)   ☐☐☐

Select from table display.   (3AN)   ☐☐☐

(3AN)   ☐☐☐

(3AN)   ☐☐☐

(3AN)   ☐☐☐

(3AN)   ☐☐☐

(3AN)   ☐☐☐

(3AN)   ☐☐☐

(3AN)   ☐☐☐

(3AN)   ☐☐☐

Facility Options

BILLING/CLAIMS PARAMETERS

Billing Parameters

Billing Group   (2N)   ☐☐

Valid Financial Classes   (2A)   ☐☐

(2A)   ☐☐

(2A)   ☐☐

(2A)   ☐☐

(2A)   ☐☐

(2A)   ☐☐

Default Financial Class   (2A)   ☐☐

I/P Final Billing Parameter Code   (3AN)   ☐☐☐

I/P Cycle Billing Parameter Code   (3AN)   ☐☐☐

O/P Final Billing Parameter Code   (3AN)   ☐☐☐

O/P Cycle Billing Parameter Code   (3AN)   ☐☐☐

Patient Type Billing Parameter Exceptions

Actual selections are made from table displays.

Patient Type (3AN)	Final Billing Parameters (3AN)	Cycle Billing Parameters (3AN)	Biller Group (2N)

Claim Parameters

Claim Form Type   (Circle response)   UB   1500   Non Pro Fee 1500   State
(US ONLY)

Claim Form Type   (Circle response)   MOH   UNV   WCB
(CN ONLY)

Produce Claim?   (Circle Y or N)   Y   N

The default is Y.

Print On UB   (Circle Y or N)   Y   N

Circle Y to indicate that insurance plan iinformation should
be printed on the UB claim form in Locators 50 through
66. Circle N if insurance plan information should not be
printed in these locators.

Print on UB?   (Circle Y or N)   Y   N

(Enter N in Canada.)

Prorate I/P Claim?   (Circle Y or N)   Y   N

Circle Y to prorate according to coverage and limits established in the insurance plan. Circle N to
prorate subsequent insurance plans assigned to the patient at 100%. The default is Y. (Enter Y in
Canada.)

Prorate O/P Claim?   (Circle Y or N)   Y   N

Circle Y to prorate according to coverage and limits established in the insurance plan. Circle N to prorate subsequent insurance plans assigned to the patient at 100%. The default is Y. (Enter Y in Canada.)

Load Separate Claim?   (Circle Y or N)   Y   N

Circle Y to create separate claim if plan is not primary. The default is Y. (Enter Y in Canada.)

Hold Claim for Prior Payment?   (Circle Y or N)   Y   N

Enter Y to hold claim until prior plans pay, if this is not the primary carrier. The default is N. Claims can be held for prior payment only if you load separate claims. (Enter N in Canada.)

ASB/Crossover Hold Exceptions

Select one or more insurance plans, that, when the selected carrier/plan is COB 1, this plan that you are updating, if it is the secondary UB plan (claim type X), does not Hold for Prior Payment, and follows the ASB/Crossover Claim logic.

Print Paper Claim Label?   (Circle Y or N)   Y   N

(Does not apply to MOH or WCB claims.)

Suppress?   (Circle Y or N)   Y   N

Suppress pending claim(s) if paid in full? Enter Y if unproduced claims are to be suppressed when a payment or adjustment is posted which leaves the carrier or account with a zero balance. Enter N if unproduced claims are not to be suppressed when a payment or adjustment is posted which leaves the carrier or account with a zero balance. The default is Y.

Electronic Claims

Electronic Media   (Circle response)   A   B   C   D   E   T

Circle A for Electronic Media A, B for Electronic Media B, C for Electronic Media C (CPU-to-CPU), D for Electronic Media D, E for Electronic Media E, or T for Electronic Media T (Magnetic Tape). In Canada only applicable for Universal claims (UNV).

Print Electronic Claim Label   (Circle Y or N)   Y   N

Payor ID   (5N)

Sub ID   (4N)

Primary Payor Code   (1AN)

Source of Payment   (1A)

Claim Processing

		Primary			**Secondary**		
I/P Claim Load/Edit Parameter (3AN)							

Enter the Claim Parameter code from the valid Claim Load and Edit Parameters for the claim type for when the insurance is primary vs secondary (COB 2 through 9).

Primary   **Secondary**

I/P Claim Charge Control   (3N)   ☐☐☐   ☐☐☐

Enter the Charge Control Parameter code. (US ONLY)

I/P Claim Generation Parameter   (4A)   ☐☐☐☐

From the Claim Generation Parameter table.

I/P Provider Number   (22AN)   ☐☐☐☐☐☐☐

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Enter the Provider Number at the insurance level for when the patient has an
inpatient patient indicator.

Primary   **Secondary**

O/P Claim Load/Edit Parameter   (3AN)   ☐☐☐   ☐☐☐

Enter the Claim Parameter code from the valid Claim Load and Edit Parameters for the claim type for
when the insurance is primary vs secondary (COB 2 through 9).

Primary   **Secondary**

O/P Claim Charge Control   (3N)   ☐☐☐   ☐☐☐

Enter the Charge Control Parameter code.   (US ONLY)

O/P Claim Generation Parameter   (4A)   ☐☐☐☐

From the Claim Generation Parameter table.

O/P Provider Number (22AN)

Enter the Provider Number at the insurance level for when the patient has an outpatient patient indicator.

I/P Provider Master (6N)

Exceptions only.

O/P Provider Master (6N)

Exceptions only.

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Patient Type Exceptions

Pat Type (3AN)	Claim Load/Edit (3AN)		Claim Charge Control (3N) (US ONLY)		Claim Generation Parameters (4A)
	Primary	Secondary	Primary	Secondary	

Pat Type (3AN)	Provider Number (22AN)

Pat Type (3AN)			Provider Number (22AN)																					

COLLECTION PARAMETERS

These parameters, which are split by facility, define the collection procedures used for a specific insurance plan. Information includes the collector group and the insurance follow-up dollar definition table schedule. These parameters also include transaction codes for insurance refund, payment, and contractual adjustments.

Inpatient

I/P Payment Transaction Code   (4N)

I/P Contractual Adj Code at Payment   (4N)

I/P Primary F/U Schedule Dollar Definition   (3NR)

Secondary F/U Schedule Dollar Definition   (3NR)

Collector Group (2N) ☐☐

I/P Insurance Refund Transaction Code: D (4N code) ☐☐☐☐

Outpatient

Payment Transaction Code: I (4N code) ☐☐☐☐

O/P Contractual Adj Trans Code at Payment (4N) ☐☐☐☐

Primary F/U Schedule Dollar Definition (3NR) ☐☐☐

Secondary F/U Schedule Dollar Definition (3NR) ☐☐☐

Collector Group (2N) ☐☐

O/P Insurance Refund Transaction Code: D (4N code) ☐☐☐☐

Patient Type Collection Exceptions

Payment Transaction Code: I   (4N code)   ☐☐☐☐

Contractual Adjustment Trans Code at Payment   (4N code)   ☐☐☐☐

Primary F/U Schedule Dollar Definition   (3NR)   ☐☐☐

Secondary F/U Schedule Dollar Definition   (3NR)   ☐☐☐

Collector Group   (2N)   ☐☐

Insurance Refund Transaction Code: D   (4N code)   ☐☐☐☐

LOG IDENTIFIERS (US ONLY)

Log Identifier   (2AN)   ☐☐

Carrier Status   (Circle response)   A   P   S

Identify the carrier status to be included. Circle A for Any, P for Primary Only, or S for Secondary Only. The default is A.

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In/Out/All Patients   (Circle response)   I   O   P

Circle I to include only Inpatients, O to include only Outpatients, or A to include All patients. The default is A.

Excluded Patient Types   (3AN)

Select from table display.   (3AN)

(3AN)

(3AN)

(3AN)

(3AN)

(3AN)

(3AN)

(3AN)

(3AN)

REIMBURSEMENT

This table defines the reimbursement parameters identified with a specific carrier plan for inpatients, outpatients and patient type exceptions. Information included is the patient type, reimbursement master payor, reimbursement type and the contractual adjustment transaction code.

Inpatients

Post Cont. Adj. at Bill?   (Circle Y or N)   Y   N

The default is N.

Reimbursement Master Payor   (2A)

From the Reimbursement Payor table.

Reimbursement Type   (Circle   A   A   D   G   M   O   P   S   I   J
                            response)

Circle A for ASC Payment Group, C for Major Diagnostic Category, D for ICD-9 Diagnosis Code, G
for DRG Code, M for Medical Service, O for Overall Plan, P for ICD-9 Procedure Code, S for
Specified DRG Code, I for Pathways Contract Management (**"I"** must be the only reimbursement
type if used), or J for PCON/Cycle ("**J**" must be the only reimbursement type if used).

Contractual Adj. Transaction Code: A   (4N code) | | | | |

Reimbursement Type   (Circle response)   A   C   D   G   M   O   P   S

Circle A for ASC Payment Group, C for Major Diagnostic Category, D for ICD-9 Diagnosis Code, G for
DRG Code, M for Medical Service, O for Overall Plan, P for ICD-9 Procedure Code, or S for Specified
DRG Code.

Contractual Adj. Transaction Code: A   (4N code) | | | | |

Reimbursement Type   (Circle response)   A   C   D   G   M   O   P   S

Circle A for ASC Payment Group, C for Major Diagnostic Category, D for ICD-9 Diagnosis Code, G for
DRG Code, M for Medical Service, O for Overall Plan, P for ICD-9 Procedure Code, or S for Specified
DRG Code.

Contractual Adj. Transaction Code: A   (4N code) | | | | |

Reimbursement Type   (Circle response)   A   C   D   G   M   O   P   S

Circle A for ASC Payment Group, C for Major Diagnostic Category, D for ICD-9 Diagnosis Code, G for
DRG Code, M for Medical Service, O for Overall Plan, P for ICD-9 Procedure Code, or S for Specified
DRG Code.

Contractual Adj. Transaction Code: A   (4N code)   ☐ ☐ ☐ ☐

Outpatients

Post Cont. Adj. at Bill?   (Circle Y or N)   Y   N

The default is N.

Reimbursement Master Payor   (2A)   ☐ ☐

From the Reimbursement Payor table.

Reimbursement Type   (Circle response)   A   C   D   G   M   O   P   S   I   J

Circle A for ASC Payment Group, C for Major Diagnostic Category, D for ICD-9 Diagnosis Code, G for DRG Code, M for Medical Service, O for Overall Plan, P for ICD-9 Procedure Code, S for Specified DRG Code, I for Pathways Contract Management ("I" must be the only reimbursement type if used) or J for PCON/Cycle.

Contractual Adj. Transaction Code: A   (4N code)   ☐ ☐ ☐ ☐

Reimbursement Type   (Circle response)   A   C   D   G   M   O   P   S

Circle A for ASC Payment Group, C for Major Diagnostic Category, D for ICD-9 Diagnosis Code, G for DRG Code, M for Medical Service, O for Overall Plan, P for ICD-9 Procedure Code, or S for Specified DRG Code.

Contractual Adj. Transaction Code: A   (4N code)   ☐ ☐ ☐ ☐

Reimbursement Type (Circle response) A C D G M O P S

Circle A for ASC Payment Group, C for Major Diagnostic Category, D for ICD-9 Diagnosis Code, G for DRG Code, M for Medical Service, O for Overall Plan, P for ICD-9 Procedure Code, or S for Specified DRG Code.

Contractual Adj. Transaction Code: A (4N code) ☐☐☐☐

Reimbursement Type (Circle response) A C D G M O P S

Circle A for ASC Payment Group, C for Major Diagnostic Category, D for ICD-9 Diagnosis Code, G for DRG Code, M for Medical Service, O for Overall Plan, P for ICD-9 Procedure Code, or S for Specified DRG Code.

Contractual Adj. Transaction Code: A (4N code) ☐☐☐☐

Patient Type Exceptions

Patient Type (3AN) ☐☐☐

Post Cont. Adj. at Bill? (Circle Y or N) Y N

Reimbursement Master Payor (2A) ☐☐

From the Reimbursement Payor table.

Reimbursement Type   (Circle   A   C   D   G   M   O   P   S   I   J
response)

Circle A for ASC Payment Group, C for Major Diagnostic Category, D for ICD-9 Diagnosis Code, G
for DRG Code, M for Medical Service, O for Overall Plan, P for ICD-9 Procedure Code, S for
Specified DRG Code, I for Pathways Contract Management, or J for PCON/Cycle.

Contractual Adj. Transaction Code: A   (4N code) | | | | |

Reimbursement Type   (Circle response)   A   C   D   G   M   O   P   S

Circle A for ASC Payment Group, C for Major Diagnostic Category, D for ICD-9 Diagnosis Code, G for
DRG Code, M for Medical Service, O for Overall Plan, P for ICD-9 Procedure Code, or S for Specified
DRG Code.

Contractual Adj. Transaction Code: A   (4N code) | | | | |

Reimbursement Type   (Circle response)   A   C   D   G   M   O   P   S

Circle A for ASC Payment Group, C for Major Diagnostic Category, D for ICD-9 Diagnosis Code, G for
DRG Code, M for Medical Service, O for Overall Plan, P for ICD-9 Procedure Code, or S for Specified
DRG Code.

Contractual Adj. Transaction Code: A   (4N code) | | | | |

Reimbursement Type   (Circle response)   A   C   D   G   M   O   P   S

Circle A for ASC Payment Group, C for Major Diagnostic Category, D for ICD-9 Diagnosis Code, G for DRG Code, M for Medical Service, O for Overall Plan, P for ICD-9 Procedure Code, or S for Specified DRG Code.

Contractual Adj. Transaction Code: A   (4N code) | | | | |

REPORT AGING CODE

Level 8	Matrix# 6	Facility:

This parameter establishes the end day aging categories that are used when the Account Selection Reports and the Aged Trial Balance (ATB) Reports are produced.

Report Aging Code   (2N)   ☐☐

Code Description

(30AN)

Aging Category 1

Ending Day   (4N)   ☐☐☐☐

Inpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Outpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Aging Category 2

Ending Day   (4N)   ☐☐☐☐

Inpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Outpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Aging Category 3

Ending Day   (4N)   ☐☐☐☐

Inpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Outpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Aging Category 4

Ending Day   (4N)   ☐☐☐☐

Inpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Outpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Aging Category 5

Inpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Outpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Aging Category 6

Inpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Outpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Aging Category 7

Inpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Outpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Aging Category 8

Inpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Outpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Aging Category 9

Inpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Outpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

If you press ENTER in one of the aging category field (after Aging Category 1 field), the field value for that aging category is implemented by one. The entry also displays with a plus sign (+), signifying this number of days and beyond. For example, if the value of the Aging Category 1 field is 30 and you press ENTER in the Aging Category 2 field, 31 DAYS+ displays in the Aging Category 2 field.

Financial Class Exceptions

Financial Class Code   (3AN)   ☐☐☐

Aging Category 1

Ending Day   (4N)   ☐☐☐☐

Inpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Outpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Aging Category 2

Ending Day   (4N)   ☐☐☐☐

Inpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Outpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Aging Category 3

Ending Day   (4N)   ☐☐☐☐

Inpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Outpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Aging Category 4

Ending Day   (4N)   ☐☐☐☐

Inpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Outpatient Reserve Percentage   (5N)   ☐☐☐ . ☐☐ %

Aging Category 5

Inpatient Reserve Percentage   (5N)   [ ][ ][ ] . [ ][ ] %

Outpatient Reserve Percentage   (5N)   [ ][ ][ ] . [ ][ ] %

Aging Category 6

Inpatient Reserve Percentage   (5N)   [ ][ ][ ] . [ ][ ] %

Outpatient Reserve Percentage   (5N)   [ ][ ][ ] . [ ][ ] %

Aging Category 7

Inpatient Reserve Percentage   (5N)   [ ][ ][ ] . [ ][ ] %

Outpatient Reserve Percentage   (5N)   [ ][ ][ ] . [ ][ ] %

Aging Category 8

Inpatient Reserve Percentage   (5N)   [ ][ ][ ] . [ ][ ] %

Outpatient Reserve Percentage   (5N)   [ ][ ][ ] . [ ][ ] %

Aging Category 9

Inpatient Reserve Percentage   (5N)   [ ][ ][ ] . [ ][ ] %

Outpatient Reserve Percentage   (5N)   [ ][ ][ ] . [ ][ ] %

Aging Category 10

Inpatient Reserve Percentage   (5N)   [ ][ ][ ] . [ ][ ] %

Outpatient Reserve Percentage   (5N)   [ ][ ][ ] . [ ][ ] %

Aging Category 11

Inpatient Reserve Percentage   (5N)   [ ][ ][ ] . [ ][ ] %

Outpatient Reserve Percentage   (5N)   [ ][ ][ ] . [ ][ ] %

Aging Category 12

Inpatient Reserve Percentage   (5N)   [ ][ ][ ] . [ ][ ] %

Outpatient Reserve Percentage   (5N)   [ ][ ][ ] . [ ][ ] %

Aging Category 13

Inpatient Reserve Percentage   (5N)   [ ][ ][ ] . [ ][ ] %

Outpatient Reserve Percentage   (5N)   [ ][ ][ ] . [ ][ ] %

Chapter 11 - LEVEL 9

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STAR Financials Patient Accounting Reference Guide - Worksheets Volume
11–2   *Release 18.0*   *October 2012*
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INTRODUCTION

This section contains worksheets to complete the following tables. These tables are used by the system to define the mapping of information between the Patient Accounting and General Ledger systems. For the mapping key type listed, you determine:

- If the key component(s) provided should be included in the key

- The value(s) of the key components included

- The department and subaccount number to which they are mapped

NOTE: The functions used to define these mappings do not display on a STAR Patient Accounting system screen. These functions reside on the STAR General Ledger system.

TRANA - ADJUSTMENT ACCOUNT

Level 9	Matrix# 53	Facility:
Table		Entity

Circle Y for Yes or N for No to include the following key components in the key.

Patient Indicator   Y   N

Financial Class   Y   N

Patient Type   Y   N

Transaction Code   Y   N

Department   (10N)   [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Subaccount   (10N)   [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.

Patient Indicator   (Circle response)   E   I   O   ALL

Financial Class   (2AN)   [ ][ ]   [ ][ ]   [ ][ ]

ALL

Enter the financial class(es) or circle ALL for all financial classes.

Patient Type   (3AN)

ALL

Enter the patient type(s) or circle ALL for all patient types.

Transaction Code   (4N)

TRANE - AGENCY CASH

Level 9	Matrix# 53	Facility:
Table		Entity

Circle Y for Yes or N for No to include the following key components in the key.

Patient Indicator   Y   N

Transaction Code   Y   N

Department   (10N)

Subaccount   (10N)

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.

Patient Indicator   (Circle response)   E   I   O   ALL

Transaction Code   (4N)

TRANV - AGENCY FEES

Level 9	Matrix# 53	Facility:
Table		Entity

Circle Y for Yes or N for No to include the following key components in the key.

Transaction Code　　　Y　　　　　　　　N

Department　(10N)

Subaccount　(10N)

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.

Transaction Code　　　(4N)

AR - AR CONTROL ACCOUNT

Level 9	Matrix# 53	Facility:
Table		Entity

Circle Y for Yes or N for No to include the following key components in the key.

Patient Indicator   Y   N

Financial Class   Y   N

Patient Type   Y   N

Department   (10N) | | | | | | | | | | |

Subaccount   (10N) | | | | | | | | | | |

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.

Patient Indicator   (Circle response)   E   I   O   ALL

Financial Class   (2AN)

ALL

Enter the financial class(es) or circle ALL for all financial classes.

Patient Type   (3AN)

ALL

Enter the patient type(s) or circle ALL for all patient types.

BDAL - BAD DEBT ALLOWANCE

Level 9	Matrix# 53	Facility:
Table		Entity

Circle Y for Yes or N for No to include the following key components in the key.

Patient Indicator   Y   N

Financial Class   Y   N

Patient Type   Y   N

Department   (10N) | | | | | | | | | | |

Subaccount   (10N) | | | | | | | | | | |

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.

Patient Indicator   (Circle response)   E   I   O   ALL

Financial Class   (2AN)

ALL

Enter the financial class(es) or circle ALL for all financial classes.

Patient Type   (3AN)

ALL

Enter the patient type(s) or circle ALL for all patient types.

BD - BAD DEBT ASSET ACCOUNT

Level 9	Matrix# 53	Facility:
Table		Entity

Circle Y for Yes or N for No to include the following key components in the key.

Patient Indicator   Y   N

Financial Class   Y   N

Department   (10N)

Subaccount   (10N)

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.

Patient Indicator   (Circle response)   E   I   O   ALL

Financial Class   (2AN)

ALL

Enter the financial class(es) or circle ALL for all financial classes.

BDWO - BAD DEBT CONTRA ASSET ACCOUNT

Level 9	Matrix# 53	Facility:
Table		Entity

Circle Y for Yes or N for No to include the following key components in the key.

Patient Indicator   Y   N

Financial Class   Y   N

Department   (10N)

Subaccount   (10N)

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.

Patient Indicator   (Circle response)   E   I   O   ALL

Financial Class   (2AN)

ALL

Enter the financial class(es) or circle ALL for all financial classes.

BDRC - BAD DEBT RECOVERY

Level 9	Matrix# 53	Facility:
Table		Entity

Circle Y for Yes or N for No to include the following key components in the key.

Patient Indicator   Y   N

Financial Class   Y   N

Patient Type   Y   N

Department   (10N) | | | | | | | | | | |

Subaccount   (10N) | | | | | | | | | | |

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.

Patient Indicator   (Circle response)   E   I   O   ALL

Financial Class   (2AN)

ALL

Enter the financial class(es) or circle ALL for all financial classes.

Patient Type   (3AN)

ALL

Enter the patient type(s) or circle ALL for all patient types.

DPRF - DEPARTMENT PROFESSIONAL FEES

Level 9	Matrix# 53	Facility:
Table		Entity

Circle Y for Yes or N for No to include the following key components in the key.

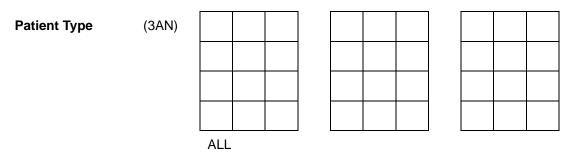|		
Patient Indicator	Y	N
Financial Class	Y	N
Patient Type	Y	N
Medical Service	Y	N
Revenue Center	Y	N

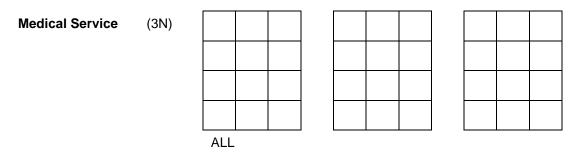**Department**   (10N)

Subaccount   (10N)

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.

Patient Indicator   (Circle response)   E   I   O   ALL

Financial Class   (2AN)

ALL

Enter the financial class(es) or circle ALL for all financial classes.

Patient Type   (3AN)

ALL

Enter the patient type(s) or circle ALL for all patient types.

Medical Service   (3N)

ALL

Enter the medical service(s) or circle ALL for all medical services.

Revenue Center   (4N)

ALL

Enter the revenue center(s) or circle ALL for all revenue centers.

DPRV - DEPARTMENT REVENUE

Level 9	Matrix# 53	Facility:
Table		Entity

Circle Y for Yes or N for No to include the following key components in the key.

Patient Indicator   Y   N

Financial Class   Y   N

Patient Type   Y   N

Medical Service   Y   N

Revenue Center   Y   N

Department   (10N)   [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Subaccount   (10N)   [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.

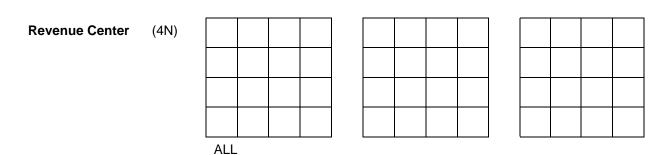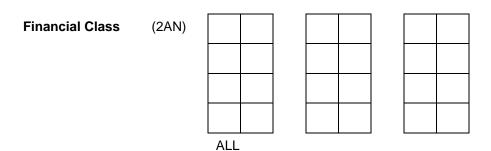**Patient Indicator**   (Circle response)   E   I   O   ALL

Financial Class   (2AN)

ALL

Enter the financial class(es) or circle ALL for all financial classes.

Patient Type   (3AN)

ALL

Enter the patient type(s) or circle ALL for all patient types.

Medical Service   (3N)

ALL

Enter the medical service(s) or circle ALL for all medical services.

Revenue Center   (4N)

ALL

Enter the revenue center(s) or circle ALL for all revenue centers.

TRANI - INSURANCE PAYMENT

Level 9	Matrix# 53	Facility:
Table		Entity

Circle Y for Yes or N for No to include the following key components in the key.

Patient Indicator   Y   N

Transaction Code   Y   N

Department   (10N)

Subaccount   (10N)

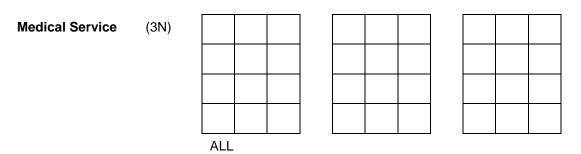|									

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.

Patient Indicator   (Circle response)   E   I   O   ALL
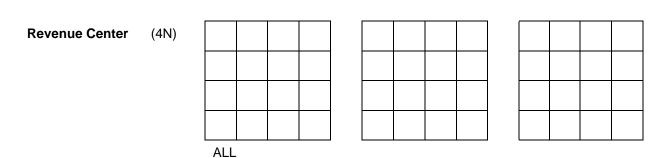
Transaction Code   (4N)

TRAND - INSURANCE REFUNDS

Level 9	Matrix# 53	Facility:
Table		Entity

Circle Y for Yes or N for No to include the following key components in the key.

Patient Indicator   Y   N

Transaction Code   Y   N

Department   (10N)

Subaccount   (10N)

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.

Patient Indicator   (Circle response)   E   I   O   ALL

Transaction Code   (4N)

TRANF - MISCELLANEOUS CASH

Level 9	Matrix# 53	Facility:
Table		Entity

Circle Y for Yes or N for No to include the following key components in the key.

Transaction Code   Y   N

Department   (10N)

Subaccount   (10N)

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.

Transaction Code   (4N)

TRANN - NONPATIENT CASH

Level 9	Matrix# 53	Facility:
Table		Entity

Circle Y for Yes or N for No to include the following key components in the key.

Patient Indicator   Y   N

Transaction Code   Y   N

Department   (10N)

Subaccount   (10N)

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.

Patient Indicator   (Circle response)   E   I   O   ALL

Transaction Code   (4N)

REG - OP REGISTRATIONS

Level 9	Matrix# 53	Facility:
Table		Entity

These values are used for posting GL statistics.

Circle Y for Yes or N for No to include the following key components in the key.

Financial Class   Y   N

Medical Service   Y   N

Department   (10N)   [   ]
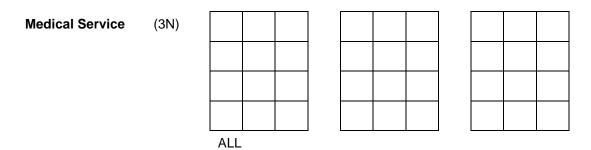
Subaccount   (10N)   [   ]

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.

Financial Class   (2AN)
                                              ALL

Enter the financial class(es) or circle ALL for all financial classes.

Medical Service   (3N)

<table>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
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<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

ALL

Enter the medical service(s) or circle ALL for all medical services.

TRANG - OTHER ADJUSTMENTS

Level 9	Matrix# 53	Facility:
Table		Entity

Circle Y for Yes or N for No to include the following key components in the key.

Patient Indicator   Y   N

Transaction Code   Y   N

Department   (10N) | | | | | | | | | | |

Subaccount   (10N) | | | | | | | | | | |

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.

Patient Indicator   (Circle response)   E   I   O   ALL

Transaction Code   (4N) | | | | |

TRANJ - OTHER REFUNDS

Level 9	Matrix# 53	Facility:
Table		Entity

Circle Y for Yes or N for No to include the following key components in the key.

Patient Indicator   Y   N

Transaction Code   Y   N

Department   (10N)

Subaccount   (10N)

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.

Patient Indicator   (Circle response)   E   I   O   ALL

Transaction Code   (4N)

OPV - OUTPATIENT VISITS

Level 9	Matrix# 53	Facility:
Table		Entity

These values are used for posting GL statistics.

Circle Y for Yes or N for No to include the following key components in the key.

Financial Class   Y   N

Patient Type   Y   N

Medical Service   Y   N
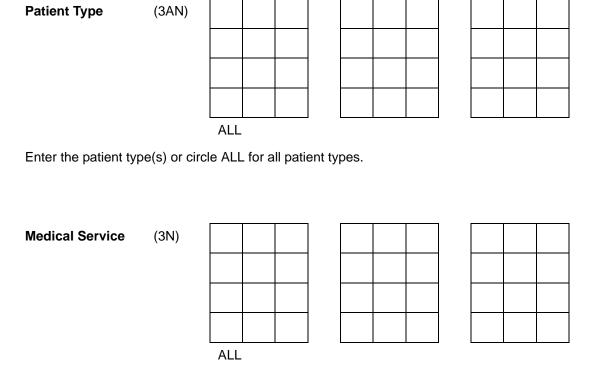
Department   (10N)

Subaccount   (10N)

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.

Financial Class   (2AN)

ALL

Enter the financial class(es) or circle ALL for all financial classes.

Patient Type   (3AN)

ALL

Enter the patient type(s) or circle ALL for all patient types.

Medical Service   (3N)

ALL

Enter the medical service(s) or circle ALL for all medical services.

PTD - PATIENT DAYS

Level 9	Matrix# 53	Facility:
Table		Entity

These values are used for posting GL statistics.

Circle Y for Yes or N for No to include the following key components in the key.

Financial Class	Y	N
Patient Type	Y	N
Medical Service	Y	N
Revenue Center	Y	N

Department   (10N)

Subaccount   (10N)

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.

Financial Class   (2AN)

ALL

Enter the financial class(es) or circle ALL for all financial classes.

Patient Type   (3AN)

ALL

Enter the patient type(s) or circle ALL for all patient types.

Medical Service   (3N)

ALL

Enter the medical service(s) or circle ALL for all medical services.

Revenue Center   (4N)

ALL

Enter the revenue center(s) or circle ALL for all revenue centers.

TRANP - PATIENT PAYMENTS

Level 9	Matrix# 53	Facility:
Table		Entity

Circle Y for Yes or N for No to include the following key components in the key.

Patient Indicator   Y   N

Transaction Code   Y   N

Department   (10N) | | | | | | | | | | |

Subaccount   (10N) | | | | | | | | | | |

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.
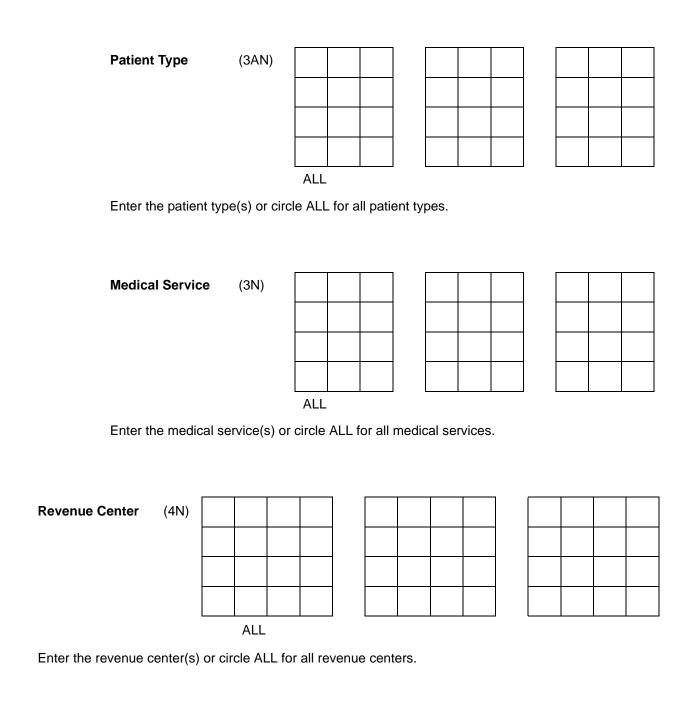
Patient Indicator   (Circle response)   E   I   O   ALL

Transaction Code   (4N) | | | | |

RFCASH - REFUND CASH ACCOUNT

Level 9	Matrix# 53	Facility:
Table		Entity

Department   (10N) | | | | | | | | | | |

Subaccount   (10N) | | | | | | | | | | |

TRANR - REFUNDS

Level 9	Matrix# 53	Facility:
Table		Entity

Circle Y for Yes or N for No to include the following key components in the key.

Patient Indicator   Y   N

Transaction Code   Y   N

Department   (10N)

Subaccount   (10N)

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.

Patient Indicator   (Circle response)   E   I   O   ALL

Transaction Code   (4N)

TRANU - UNAPPLIED CASH

Level 9	Matrix# 53	Facility:
Table		Entity

Circle Y for Yes or N for No to include the following key components in the key.

Transaction Code   Y   N

Department   (10N)

Subaccount   (10N)

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.

Transaction Code   (4N)

UACASH - UNAPPLIED CASH CONTROL

Level 9	Matrix# 53	Facility:
Table		Entity

Department   (10N) | | | | | | | | | | |

Subaccount   (10N) | | | | | | | | | | |

UACHRG - UNAPPLIED CHARGES CONTROL

Level 9	Matrix# 53	Facility:
Table		Entity

Department   (10N)   ☐☐☐☐☐☐☐☐☐☐

Subaccount   (10N)   ☐☐☐☐☐☐☐☐☐☐

VB - VENDOR AR CONTROL

Level 9	Matrix# 53	Facility:
Table		Entity

This table is not implemented at this time.

Department   (10N)   ☐☐☐☐☐☐☐☐☐☐

Subaccount   (10N)   ☐☐☐☐☐☐☐☐☐☐

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VA - VENDOR PA CONTROL

Level 9	Matrix# 53	Facility:
Table		Entity

This table is not implemented at this time.

Circle Y for Yes or N for No to include the following key components in the key.

Patient Indicator   Y   N

Department   (10N)

Subaccount   (10N)

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.

Patient Indicator   (Circle response)   E   I   O   ALL

VR - VENDOR REVENUE

Level 9	Matrix# 53	Facility:
Table		Entity

This table is not implemented at this time.

Circle Y for Yes or N for No to include the following key components in the key.

Patient Indicator	Y	N
Financial Class	Y	N
Revenue Center	Y	N

Department   (10N)   [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

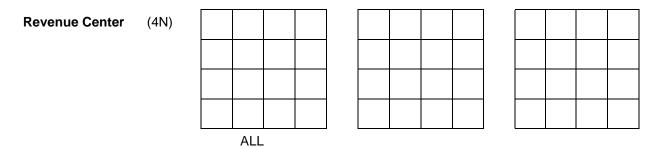**Subaccount**   (10N)   [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Use the following fields to define the key component(s). Complete the following fields according to the key components selected at the top of this worksheet.

Patient Indicator   (Circle response)   E   I   O   ALL

Financial Class   (2AN)

ALL

Enter the financial class(es) or circle ALL for all financial classes.

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Revenue Center   (4N)

ALL

Enter the revenue center(s) or circle ALL for all revenue centers.

■ **R e a d e r   C o m m e n t   F o r m** ■

We value your suggestions for improving our documentation. Please use this form to evaluate the *Worksheets Volume* of the *STAR Financials Patient Accounting Reference Guide* for Release 18.0.

Topic	Poor	Fair	Good	Excellent
Organization of information	❏	❏	❏	❏
Accuracy of information	❏	❏	❏	❏
Completeness of information	❏	❏	❏	❏
Clarity of information	❏	❏	❏	❏
Amount of overview information	❏	❏	❏	❏
Explanation of processes	❏	❏	❏	❏

Are there parts of this manual that could be made more helpful to you? Please explain.

_____

_____

_____

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Other Comments:

_____

_____

_____

Thanks for your help in improving the documentation.

Your Name and Position

Hospital/Organization
Name

Telephone Number

May we contact you?   Yes or No (circle one)

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

- -

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