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STAR 2000™

STAR FINANCIALS PATIENT ACCOUNTING REFERENCE GUIDE
Enhancement Summaries

Release 18.0
October 2012

F18000111

Publication date

October 2012

Produced in Cork, Ireland.

Product and version

STAR 2000 Release 18.0

Publication number

F18000111

Reader comments

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

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Documentation Conventions

Enhancement summary documentation for McKesson's STAR 2000™ line of products follows these conventions:

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

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

Prompts
System prompts are displayed at the bottom of many STAR screens when the system requests an entry or displays a message. These prompts are displayed in this document indented from the rest of the text and in *italic* letters. For example:

Enter patient name--

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

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

Table of Contents

About This Document

Purpose/Scope

This document contains technical and user information about new features available in Release 18.0 of STAR Financials Patient Accounting. It is meant to be used in conjunction with the *STAR Financials Patient Accounting Reference Guide*.

Audience

This document is intended to inform hospital personnel concerned with STAR Financials Patient Accounting about the Release 18.0 enhancements. Personnel may include individuals from different departments within the facility, such as the accounting and finance departments.

Chapter Overview

The following information is included in each chapter:

Heading	Information under this heading...
Overview	• provides a concise explanation of the enhancement, • explains its purpose and benefits to the STAR user, • defines pertinent terms, and • lists the relevant *Reference Guide* sections that are affected by the enhancement.
Implementation Considerations	• describes the impact of implementing the enhancement, identifying issues (if any) regarding system and storage, performance, procedures, and support.
Implementation Guidelines	• lists the steps necessary to implement the enhancement, • identifies tables, files, and reports that are no longer available, and • estimates the resources needed to implement the enhancement.
Testing Guidelines	• outlines scenarios for testing the enhancement once it is implemented.

This document contains information about each enhancement.

Chapter 1: ERA Enhancements (F10670)

This chapter provides information on the updates to Electronic Remittance Advice.

Chapter 2: Insurance Follow-up Updates (F10679)

This chapter provides information about the updates to Insurance Follow-up.

Chapter 3: Receivables Workstation Enhancements (F10683)

This chapter provides information on the updates to Receivables Workstation.

Chapter 4: Additional STAR Patient Accounting Enhancements

This chapter lists other STAR Patient Accounting enhancements.

System Requirements

All Release 18.0 STAR Financials Patient Accounting character-based enhancements require MSE Enterprise Release 18.0 or later. Any additional system requirements are provided in the enhancement summary chapter, when applicable.

Chapter 1 - Receivables Workstation Enhancements (F10970, F10862)

OVERVIEW

Purpose

This enhancement included the following:

- Updated the Referral process so that so that the user can elect to key in a name or number in the To field for Referrals and go directly to the specified collector. Currently, the user can key in a collector number/name but the system takes you to the first collector in the range. For example, if the user is referring an account to collector 94 and types in 94 then currently the first collector in the 90 range displays instead of 94.

- Added an option to allow users to enter a Refer To Collector (Direct Referral Work Collector) and add the collector to the Refer To list of any of the selected collectors. This option is needed so that when a new collector is added, the hospital doesn't have to go into every existing collector that sends referrals and add the new collector to their refer to list under the direct referral collector option. This new option will be called Add Collector to Refer To Lists.

- Updated transaction history with a better audit trail regarding the collector who is receiving a referral. Currently the system includes the collector who sent the referral but not the collector who is receiving the referral. The potential to choose another collector name in the drop down list is there, and there is no documentation in transaction history to show the collector number or name to verify who the referral went to. For auditing and productivity reasons, hospitals need to be able to show the user information of the collector receiving the referral in transaction history. Hospitals have had instances where a collector stated to their manager that they did not receive the referral, and they have no way to audit this since the wrong collector could have been chosen from the collector drop down list. Add a new value called Referral to the existing Status Type field in transaction history. The existing old status field in transaction history will be populated with the referral from and the existing new status field will have the referral to collector.

- Enhanced the Refer Again functionality so that the collector has an option to Refer Again when receiving a reply. For example, when a collector sends a referral to a manager for assistance and the manager replies back to the collector and gives the direction to refer the account to the coding department, the collector receives the reply from her manager and wants to refer the account again to a different department, but cannot as the "refer again" button is grayed out. The collector can't use the refer again function when working a reply. The collector has to pull up the account again and then refer the account to coding. Update transaction history when the account is referred again through the reply logic.

- Added an option for completed referrals. A complete option would allow the user to complete the referral and remove it from the referral list without having to use the delete option. Also generate a transaction history when a deletion or completion is processed in referrals.

- Added a new report and an online view of Referral activity for referrals that are deleted. Also include the new option for completing referrals on the referral activity screen and report. The report for deleted and completed referrals can be downloaded to Excel. This update will provide a tool to monitor referrals that are deleted and completed by the recipient.

- Updated Referrals to allow the user to refer any account that is displayed in the Account/Guarantor Look Review screen without going back through Look. Currently, after pulling up a patient/account # using Look within RWS, a visit list appears. The user selects the account and is taken to the 'Account Look Review' screen which displays a list of all the patient accounts. The user can refer the active account (i.e. the one currently selected) but cannot refer any of the patient's other accounts listed on the screen. The user has to go back out, repeat the search and select another account to refer. This is a time consuming process and being able to refer accounts directly from the account look review screen is more efficient.

- Updated the Collector Code to handle a 4 digit numeric field. All screens, tables and reports were updated to accommodate this change.

- Updated the Collector Group Code to handle a 3 digit numeric field. All screens, tables and reports were updated to accommodate this change.

- Increased the maximum length for Collector Phone Extension from 4 to 5 digits.

Benefits

- Allowing the user to directly select the collector by name or number will provide a more efficient way to access the Refer To collector.

- Adding a new option called Add Collector to Refer To Lists will reduce the time it takes to add a new collector to the refer to list of existing collectors and therefore improve the new hire process.

- Adding more information to transaction history related to the collector that receives a referral will assist hospitals in auditing the referral process. Hospitals need to be able to show the user information of the collector receiving the referral in transaction history so if a collector states to their manager that they did not receive a referral, they can audit to determine who received the referral.

- Updating the Refer Again functionality so that the collector has an option to Refer Again when receiving a reply will reduce the time it takes to send a referral and there improve collector productivity.

- Enhancing referrals with a new option for completions, additional transaction history and a report for completions/deletions. These updates will allow the hospital to have better audit trails and assist with monitoring productivity.

- Increasing the length of the collector code, collector group code and collector phone extension will allow hospitals to meet their needs for these updated fields.

- Updating Referrals to allow the user to refer any account that is displayed in the 'Account/Guarantor Look Review' screen without going back through Look is a more efficient process and will increase collector productivity.

Terms

No new terminology is associated with this enhancement.

Related Documents

Documentation for Release 18.0 indicates text revisions with a change bar in the left margin. The following STAR Financials Patient Accounting documentation has been updated for this enhancement.

Enhancement Topic	Document	Chapter or Topic
Initiating a Referral Refer Again Add Collector to Refer to List Transaction History	Receivables Workstation Online Help	

IMPLEMENTATION CONSIDERATIONS

Training Guidelines

Users should be trained on the updated functionality.

IMPLEMENTATION GUIDELINES

REFERRAL REMOVED REPORT- COMPLETIONS AND DELETIONS

- Review access to the Volume/HCP stats and Volume HCP Stat purge options under Manager Options in Collector Access.
- Review where the FFREF report downloads to- it downloads to the directory defined in User Preferences for the Collector, in the Download Defaults parameter.
- Access to view, print and download the referral statistics will be using the same access flags that the regular RWS statistics and download statistic files use (so if you don't have volume stats access, you can only view your own stats).
- The View all volume/HCP stats checkbox on Manager Options in Collector Access allows the collector to view all referral statistics. If this is not checked the collector can only see their own referral statistics.
- The Volume/HCP Stat purge info check box on Manager Options in Collector Access allows the collector to purge referral statistics.
- The collectors in the report/grid/download will be sorted by name or code based on that same user preference that indicates whether you want the dropdown for collector by name or code. This is located in Collector Preferences, Collector Select.
- Determine how you would like to retain the report data. The report for completed/ deleted referrals include options for a delimited download file, standard spooled report, or local downloaded report file.

REVIEW AND UPDATE THE REFERRAL PURGE PARAMETERS.

- This screen contains the Retention Days for Completion/Deletion parameter which determines when to purge the referral completion and deletion data associated with collectors. The referral completion and deletion data is used to generate the Referrals Removed Report- Completions and Deletions, FFRREF and to view the online Referral information related to completions and deletions. If the data has been purged then it can't be included on the FFRREF report or viewed online.
- Hospitals should determine how long they need the data to be reported on. Procedurally, hospitals can save their downloaded files to access data that has been purged. If the user does not have access to purging volume statistics, then the'apply' button is not enabled on the Referral History Purge Parameters.

DETERMINE PROCESS FOR WORKING REFERRALS USING NEW COMPLETION AND EXISTING DELETION LOGIC.

- A new complete button was added to the referral list and refer screens. The complete button will allow the user to click on complete which will delete the referral from the list and associate a referral status of complete with it. Completed referrals can be reported on using the FFREF report.

TESTING GUIDELINES

Go directly to specified referral collector

- The user will need to test all of the Refer screens and enter the name and the number of the refer to collector and verify that when the name or number is entered that the specified collector displays.

Add collector to refer to lists

- Verify the new sub-menu item called Add Collector to Refer To Lists was added to the Referral Work menu.

- Verify that the collector entered in the Add Direct Referral Work field is automatically added to the refer to lists of all of the selected collectors.

Transaction history for refer to collector

- Verify that the Referred To Collector field has been added the transaction history detail screen.

- Verify that the transaction history detail field displays the new values for referred to collector, status type, old status and new status correctly in both the RWS and in character base transaction history.

Update to Refer Again

- Verify that the Refer Again button is enabled for a Referral Reply screen.

- Access a referral reply and click on the refer again button. After clicking refer again, the system will display the refer screen. The short notes field on the refer screen should include the notes from the referral reply.

- Verify that the Clear Reply Message button is included on the refer screen and that if the Clear Reply Message button is clicked then the notes included in the short notes section from the previous reply should be removed from this referral instance.

- Verify that a transaction history message is generated for the referral reply.

Add Completed Referrals

- Verify that the Referral, Reply and Referral list screens have a Complete button added to them.

- Verify that when the complete button is clicked that it removes the referral entry from the referral list.

- Verify that the completed referrals have a referral status of completed on the FFRREF report.

New Referral Report and Transaction History for Completions/Deletions/Refer/ Refer Again

- Verify that the report includes the referrals that were associated with the criteria defined on the Referrals Removed Report-Completions and Deletions on the RWS.

- Verify that the FFRREF report can print and be downloaded as a report, a delimited report and a standard report spooled report. The FFREF report downloads to the directory defined User Preferences for the Collector, in the Download Defaults parameter.

Chapter 2 - Add HNE/EPN Number as a Search Option (F10485)

OVERVIEW

Purpose

This enhancement added the option to search for accounts in account look-up by HNE/EPN number, in addition to corporate number, SSN, unit number, and name.

The new prompt is:

Enter account, `C`corporate, `S`social security or `U`unit number, name, `-` name for soundex or `/`EPN--

The user will key in the `/` along with the EPN number to search for the account.

The patient lookup is used in multiple functions within STAR Patient Accounting. Since this change is simply the addition of /EPN as a search option, the enhancement will apply to all patient lookups.

The search/lookup prompts in GUI for Account Inquiry and Account Revision will not be updated. If the user clicks on the button for either Account Inquiry or Account Revision the user is emulated back to character base functionality.

No changes were made to the Guarantor lookup in Account Inquiry or Account Revision. The user must select the Patient lookup in order to have the ability to search by HNE/EPN number.

Benefits

With the addition of a search by EPN number, this will allow both STAR Patient Accounting users an additional search option as well as STAR Patient Processing users who may need to pull an account up in STAR Patient Accounting once the account is inactive on Patient Care.

Terms

No new terminology is associated with this enhancement.

Related Documents

Documentation for Release 18.0 indicates text revisions with a change bar in the left margin. STAR Financials Patient Accounting documentation has been updated for this enhancement wherever the account lookup is presented..

IMPLEMENTATION CONSIDERATIONS

Training Guidelines

Users should be trained on the updated functionality.

IMPLEMENTATION GUIDELINES

This enhancement is available when F10485 is loaded onto your system.

TESTING GUIDELINES

Verify a patient with an EPN number assigned from Horizon Passport may be accessed via the EPN number in Patient Accounting functions with the patient lookup. Examples of these functions are Account Inquiry, Account Revision and Claims Management.

Chapter 3 - Horizon Performance Manager Interface Enhancements (F10964)

OVERVIEW

Purpose

This enhancement added the following:

- Added a parameter to Facility Parameters, Practitioner Enterprise Code. This is a table look up and will allow the user to select from the Physician code number or the NPI number. This will allow customers the ability to send one physician identifier code through the interface for physicians such as the NPI. The physician code selected in this table will be sent in the interface in the following fields:
    - "PRAHDR~ 11 Practitioner Enterprise Code
    - "ENCHDR~39 Practitioner of Record Enterprise Code
    - "ENCNTR~87 Checkin Practitioner Enterprise Code
    - "ENCNTR~88 Referring Practitioner Enterprise Code
    - "ENCPXPR~14 Clinical Procedure Practitioner Enterprise Code
    - "ENCSI~48 Ordering Practitioner Enterprise Code
    - "ENCSIPRA~11 Service Item Practitioner Enterprise Code
    - "ENCPRAC~11 Other Encounter Practitioner Enterprise Code
    - "ENCBIRTH~31 Mother's Practitioner of Record Enterprise Code
- Added a parameter to Facility Parameters to allow users to suppress sending Responsible Party records and/or Insured Person records. If the user wants to suppress Responsible Party records (RESPHDR), then ENCNTR fields 38-44 would also be suppressed and not populated. If the user wants to suppress Insured Person information, INSURHDR and ENCPAYOR fields 8-14 would be suppressed and not populated.
- Added a parameter to Facility Parameters to suppress the SSN (social security number) for babies. Since newborns do not have a social security number and it takes awhile for a SSN to be assigned, the parameter will allow the facility to send a blank or null record for SSN. For this purpose, a baby will be defined with age of less than one year old.
- Added a parameter to Facility Parameters to suppress the SSN (social security number) for SSN values that contain the same digit repeated for patient's older than one year old. For example if a SSN value of 999999999 is entered as a default, the new parameter will allow suppression of a default SSN. The parameter allows the facility to define the default SSN used.

- Added new internal elements for the interface. These are for Insurance Refunds as well as DRG information for both ICD9 and ICD10's.
    - H/T AMT OF REFUNDS. For the COB selected per the Set-Up Routine, total insurance refunds will be determined from the balances and totals saved per insurance.
    - H/T I9 INITIAL DRG
    - H/T I9 INITIAL DRG REIMB AMOUNT
    - H/T I10 INITIAL DRG
    - H/T I10 INITIAL DRG REIMB AMOUNT
- Updated logic so the Source Code System is sent only if the Source Code exists.

Benefits

- The new field for Practitioner Enterprise Code will allow for one physician identifier to be sent to Horizon Performance Manager and enhanced reporting in Horizon Performance Manager.
- By allowing suppression of the Responsible Party and/or Insured Person Data, this will keep inaccurate or unverified information from flowing to Horizon Performance Manager and increase data accuracy in Horizon Performance Manager.
- By allowing suppression of the SSN for newborn babies and for those with a default SSN where all digits are the same, this will increase data accuracy in Horizon Performance Manager.
- By adding logic to determine when to generate the Insured Person and Responsible Person Data, this will increase the accuracy of data in Horizon Performance Manager.
- The addition of new Internal Elements will assist Horizon Performance Manager users with identifying refunds and netting out the correct balance for an account as well as collecting more information on Initial DRG's for ICD-9's and ICD-10's.
- By sending the Source System only if the Source Code exists, this will increase data accuracy in Horizon Performance Manager.

Terms

No new terminology is associated with this enhancement.

Related Documents

Documentation for Release 18.0 indicates text revisions with a change bar in the left margin. The following STAR Patient Accounting documentation has been updated for this enhancement.

Enhancement Topic	Document	Chapter or Topic
Practitioner Enterprise Code Suppress SSN if all digits match Suppress Responsible Party/ Insured Person or Both Add a parameter to blank out values for SSN for babies and for SSN values that are all 0's or 9's	*Horizon Performance Manager Interface Guide*	1: Facility Parameters
New Internal Elements	*Horizon Performance Manager Interface Guide*	Appendix A: User Defined Fields

IMPLEMENTATION CONSIDERATIONS

Review and update the new parameters for Practitioner Enterprise Code, SSN and when to send Responsible Party and Insured Person data. Also review and add new UDAs for Insurance Refunds and I/9 and I/10 DRG and DRG Reimbursement Amounts if desired.

Training Guidelines

Users should be trained on the updated functionality.

IMPLEMENTATION GUIDELINES

In order to use the new field 'Practitioner Enterprise Code' customers must be using Horizon Performance Manager Interface Version 16.0 or higher.

A conversion will run to rebuild the alpha indexes so the new Internal Elements will appear in the UDA's.

TESTING GUIDELINES

Practitioner Enterprise Code

Test the new parameter on the 4th screen of the Facility Parameters table.

- Test to verify the Physician code is sent in the interface based upon the parameter.
- Test to verify the NPI code is sent in the interface based upon the parameter.
- Verify the field is not populated if the new parameter is left blank.

Suppress Responsible Party and/or Insured Person Data

- Test the new parameter on the screen for the R, I and B values.
- Test to verify the records are sent/not sent based on the parameter to suppress Insured information
    - R to suppress Responsible Party information
    - B to suppress both Responsible Party and Insured information
- Verify a test patient with a SSN where all digits are equal, the new parameter is defined to suppress this default SSN, and this SSN is suppressed and sent as Null in all places where SSN is sent in the interface.
- Verify a test patient less than one year of age with all digits of the SSN are the same, the parameter is set to suppress these digits, the SSN is suppressed and sent as Null in all places where SSN is sent in the interface.

New Internal Elements

- Review the documentation for each internal element.
- Verify the existence of each internal element in the interface when selected.

Chapter 4 - Patient Accounting Updates for ICD-10 Updates for 3M Coding and Reimbursement System-DRGs (F10864)

OVERVIEW

Purpose

This enhancement is to support ICD-10 DRGs, while concurrently supporting ICD-9 DRGs when grouping on a third party system such as 3M.

When grouping on STAR, only one DRG will be supported per account, based on the COB 1 insurance. The account will have only an ICD-10 or an ICD-9 DRG, and not both. Also, STAR will no longer update the ICD-9 DRGs once ICD-10 DRGs will be in place for discharges of 10/01/2013 and later.

The following was added to STAR Patient Accounting for this enhancement:

- When accessing Account Inquiry and the DRG display screen, the system will now display a list of the DRGs that exist for the account, and allow the user to select the DRG to view. The possible DRGs are: the Primary ICD-10 DRG (based on COB 1), the Primary ICD-9 DRG (based on COB 1), the Secondary ICD-10 DRG (not yet available), the Secondary ICD-9 DRG, and the Non Reimbursed APR ICD-9 DRG. The Non Reimbursed APR ICD-10 DRG is not yet available.

- The ICD indicator for the DRG has been added to each DRG Inquiry screen. Placement may differ based on the screen that displays.

- For any Billing Requirements that use the Data Element "Final DRG" or "Secondary DRG", and that have the data element set as Required, the system will look to the Final Bill ICD indicator for the account.

  If the Final Bill ICD indicator is 9, the system will require a Primary DRG or a Secondary DRG (depending on Billing Requirement) with an ICD-9 indicator (9) in order to pass.

  If the Final Bill ICD indicator is 10, the system will require a Primary DRG or a Secondary DRG (depending on Billing Requirement) with an ICD-10 indicator (0) in order to pass.

- When a DRG based reimbursement method is used on STAR, then the logic needs to be updated to use the ICD-9 or the ICD-10 DRG information for the Primary DRG based on the ICD indicator for the Final/Adjustment Bill.

  The following STAR reimbursement methods are affected:

  - A - ASC Reimbursement using the 3M Estimated Reimbursement

  - C - Major Diagnostic Category

- G - DRG
- L - DRG+Alt Level of Care
- S - Specified DRG Codes

- The patient Final Bill parameter has a field for Auto Adj Rebill DRG/Dx/Proc. If this field is set to A for Automatic Adjustment Bill, R for Report Only, or B for Both, then if the DRG is updated, this will only produce an adjustment bill and be reflected on the report if the ICD indicator for the changed DRG matches the Bill ICD indicator for the account.

- The DRG/PROC/DX Modification Rpt (FBR400) was updated for reporting on and producing an auto adjustment bill based on a changed DRG.

- Added the DRG ICD indicator to the transaction history message for changed DRG. Therefore, the format would be DRG Code/ICD/DRG Indicator/Version.

  The DRG Indicator is not new, but the possible values are listed here:

  - M - Medicare MS DRG
  - C - Medicare Classic DRG
  - O - Other DRG
  - T - TRICARE/Champus DRG
  - A - Reimbursed APR DRG

- Updated the Internal Elements for Claims for the DRG internal elements to pull the DRG based on the Claim ICD indicator. The Internal Elements are:

  - FINAL DRG
  - DRG COST OUTLIER INDICATOR
  - DRG DISCHARGE STATUS
  - DRG HIGH STAY OUTLIER INDICATOR
  - DRG PAID
  - DRG REIMBURSEMENT AMOUNT
  - DRG TABLE NUMBER
  - DRG, APR (NO REIMBURSEMENT)

- DRG, CLASSIC ONLY
- DRG, MS ONLY
- DRG, MS/CLASSIC
- APR-DRG (REIMB) CODE+SOI+ROM
- APR-DRG (REIMB) CODE+SOI/PRIM DRG
- APR-DRG (REIMB) CODE+SOI
- APR-DRG (REIMB) CODE
- APR-DRG (REIMB) DESCRIPTION
- APR-DRG (REIMB) RISK OF MORTALITY
- APR-DRG (REIMB) SEVERITY OF ILLNESS
- APR-DRG (REIMB) WEIGHT
- APR-DRG CODE
- APR-DRG DESCRIPTION
- APR-DRG RISK OF MORTALITY
- APR-DRG SEVERITY OF ILLNESS
- APR-DRG WEIGHT

- Logs will display the ICD indicator for the reimbursed DRG in the Log Reimbursement and Reconcilliation screen, and on the Selected Log Account Report.
- The Selected Log Account Report (FLRx where x is the facility), reports based on the criteria entered when requesting the report. The DRG field will print the DRG ICD indictor of 9 for ICD-9 and 10 for ICD-10.
- The following Internal Elements are currently used for Billing Requirements, in Claims, and in Horizon Performance Manager/TRENDSTAR. They were updated to use the ICD-9 or ICD-10 information based on the ICD indicator of the bill or claim. They will also be updated so they cannot be used for Horizon Performance Manager/TRENDSTAR.
  - FINAL DRG

- DRG REIMBURSEMENT AMOUNT

The following new internal elements will be developed for HPM/Trendstar:

- HPM/TRD I9 FINAL DRG
- HPM/TRD I10 FINAL DRG
- HPM/TRD I9 DRG REIM AMOUNT
- HPM/TRD I10 DRG REIM AMOUNT

Post-processing with the STI will convert any UDF or UDA set-ups using Final DRG to use HPM/TRD ICD9 Final DRG and using DRG REIMBURSEMENT AMOUNT to use HPM/TRD ICD9 DRG REIMBURSEMENT AMOUNT.

The following Internal Elements are marked to be used for Trendstar/HPM and use ICD9 information. They will be re-labeled to identify them as ICD9 and a corresponding ICD10 Internal Element will be created. The assumption is that the internal elements would not be selected to be used in claims.

- CCA/RUA/PDS DRG CST OTL PR(DRG PYR)
- CCA/RUA/PDS DRG CST OTL PR(FIRST)
- CCA/RUA/PDS DRG CST OTL PR(OTH PYR)
- CCA/RUA/PDS STAY OUTL PRI (DRG PYR)
- CCA/RUA/PDS OUTLIER PRI (DRG PYR)
- CCA/RUA/PDS OUTL DESC PRI (DRG PYR)
- CCA/RUA/PDS DRG/DESC (DRG PYR)
- CCA/RUA/PDS DRG/DESC (FIRST)
- CCA/RUA/PDS DRG/DESC (OTH PYR)
- CCA/RUA/PDS DRG DESC (DRG PYR)
- CCA/RUA/PDS DRG DESC (FIRST)
- CCA/RUA/PDS DRG DESC (OTH PYR)
- CCA/RUA/PDS HAC PROC REQ (HCFA DRG)
- CCA/RUA/PDS HAC STATUS (HCFA DRG)

- CCA/RUA/PDS DRG NUMBER
- CCA/RUA/PDS DRG (DRG PYR)
- CCA/RUA/PDS DRG (FIRST)
- CCA/RUA/PDS DRG (OTH PYR)
- CCA/RUA/PDS DRG IND (DRG PYR)
- CCA/RUA/PDS DRG IND (OTH PYR)
- CCA/RUA/PDS DRG WEIGHT (DRG PYR)
- CCA/RUA/PDS DRG WEIGHT (FIRST)
- CCA/RUA/PDS DRG WEIGHT (OTH PYR)
- CCA/RUA/PDS MDC (DRG PYR)
- CCA/RUA/PDS MDC/DESC (DRG PYR)
- CCA/RUA/PDS MDC DESC (DRG PYR)
- DRG table number
- HPM/TRD I9 DRG TABLE NUMBER
- Final DRG Assignment Date
- ADMITTING DRG NUMBER
- Provisional DRG number
- Major Diagnosis Category for the assigned DRG

The following Internal Elements are being added to be used as UDFs for TRENDSTAR and as UDA's for Horizon Performance Manager.

- HPM/TRD I9 DRG VERSION (FIRST)
- HPM/TRD I10 DRG VERSION (FIRST)
- CCA/RUA/PDS Paired DRG
- CCA/RUA/PDS Paired DRG Version

- For claim information in the PCON interface, the primary and secondary DRGs are sent to PCON. The interface was updated so the DRGs included in the interface are limited to those with the same ICD indicator as the ICD indicator for the claim. This means that the primary ICD9 or ICD10 DRG can be sent and an existing secondary ICD9 DRG may not be sent.

NOTE: Refer to the ICD-10 Implementation Guide for detailed information on setup and changes and additions for this enhancement.

Benefits

ICD-10 DRGs will be supported, while also supporting ICD-9 DRGs, if both are supported and returned from a third party system such as 3M. Note that Medicare will no longer update the ICD-9 DRGs once ICD-10 DRGs will be in place for discharges of 10/01/2013 and later.

Terms

No new terminology is associated with this enhancement.

Related Documents

Documentation for Release 18.0 indicates text revisions with a change bar in the left margin. The following STAR Financials Patient Accounting documentation has been updated for this enhancement.

Enhancement Topic	Document	Chapter or Topic

IMPLEMENTATION CONSIDERATIONS

System Considerations

HARDWARE

Hardware performance for this enhancement is not affected.

SOFTWARE

This is a multi-product enhancement. See “IMPLEMENTATION GUIDELINES” on page 4-10 for a list of associated STAR STIs that should be loaded concurrently with F10864 for STAR Patient Accounting.

Training Guidelines

IMPLEMENTATION GUIDELINES

The following STIs should be loaded concurrently with F10864 for STAR Patient Accounting: .

M24872 (ICD-10 Updates for 3M Coding and Reimbursement System

F10941 ECS Updates for ICD-10 Updates for 3M Coding and Reimbursement System DRGS

Procedural Considerations

TESTING GUIDELINES

For testing guidelines, refer to the *ICD-10 DRG Implementation Guide.*

Chapter 5 - ERA ENHANCEMENTS (F 10971, F10972)

OVERVIEW

Purpose

There are two enhancements for ERA. They are discussed separately.

STI F10972

This enhancement:

- Adds the ability to use transaction code exceptions for secondary insurances.
- Adds reimbursement type as a contractual adjustment method exception.
- Excludes the contractual adjustment amount from ERA reports when the contractual adjustment amount is suppressed.
- Adds the ability to review and link patient related information from the PLB segment back to a patient account.

STI F10971

This enhancement:

- Adds the ability to delete cash and adjustment batches in character base. In order to not change current functionality in cash batches for those who use scripting, the ability to delete cash and adjustment batches will be added as a separate menu item. By adding this as a menu item, this will also allow the facility to determine where this is placed for users with appropriate security levels.
- The following menu items were added to the Account Transactions Input Options Menu:
    - Delete Cash Batch
    - Delete Line Item Cash Batch
    - Delete Guarantor Cash Batch
    - Delete BD Agency Cash Batch
    - Delete AR Agency Cash Batch
    - Delete Patient Pymt/Adj Interface Pymt Batch
    - Delete Adjustment Batch

NOTE: Post Window Cash is not an option here. Since the payment is posted immediately to the patient's account, Post Window Cash batches cannot be deleted if the batch contains any entries. Users will not have access to Post Window Cash from this menu.

- Added the ability to keep posted cash and adjustment batches in the system for a defined period of time after the batch is posted. Currently the posted cash and adjustment batch information is removed with MNP. By keeping this batch information around this will allow for greater flexibility with SQL reporting as well as for auditing purposes. Added a new parameter "Retain Pymt/Adj Detail after Batch Processing. to the screen for Data Retention Parameters found under Maintain Facility Information. Information from cash and adjustment batches is retained for the number of days indicated in this parameter in a separate global for SQL reporting.

- Added messages that display during Midnight Processing to alert the operator of the open cash batch so the appropriate user may be notified to exit the batch or to determine the job number if the cash batch was left open by mistake.

- In order to assist users with posting insurance payments, added the claim sequence to the Insurance Cash Posting screen. The actual claim sequence is selected on the previous screen and it will be beneficial to see the claim sequence on the cash screen. For example, with denials and viewing results of the Claim Disposition Rules it will be helpful to know what the claim sequence is, since denials are for the primary COB only. Added a new parameter to the 5th screen of PAAR Control as field 16. The field is named 'PCI or CS for Batch Header' and when the field is accessed the user will be prompted to select PCI or Claim Sequence in the header for insurance cash batches.

Benefits

- By adding the ability to post different transaction codes for secondary insurances, this will allow the hospital greater flexibility in reporting differences in primary and secondary payments. Many hospitals use different transaction codes and use SQL or Vista for reporting and trending and with these exceptions, this will allow for better reporting.

- By adding the ability to use reimbursement types as a contractual adjustment method, this will allow facilities to handle adjustments based on how a reimbursement adjustment was posted or not posted.

- For facilities that choose to suppress the contractual adjustment until payment of the claim is reached which is not denied, the current ERA reports include the contractual adjustment amount in the calculation as it will be written off. With this enhancement, facilities can exclude that amount and have a clearer picture of what the new account and new insurance balances will be when the cash batch is posted. The Patient Balance has also been added to the FAR121, FXRERACD and FXRERACDM reports.

- ERA PLB segments have traditionally been reporting non-patient related monetary amounts, however payors are now sending patient related information within these PLB segments. Some send information on future payments and facilities need a way to link the PLB segment information to the patient's account. A new report will be added to assist with this issue and an Excel version of the report will be available also.

Terms

No new terminology is associated with this enhancement.Related Documents

Documentation for Release 18.0 indicates text revisions with a change bar in the left margin. The following STAR Patient Accounting documentation has been updated for this enhancement.

Enhancement Topic	Document	Chapter or Topic
Transaction code defaults for secondary insurance Add Reimbursement Type to Contractual Method Exceptions Exclude Cont Adj Amount from ERA Reports when the C/A is Suppressed	*Electronic Payments Volume*	1: ERA Payment File Definition
FAR121x, FXRERACDx and FXRERACDMx	*Reports Volume*	4: Billing and Claims Reports
Midnight Processing messages	*Account Transactions*	5: Midnight Processing
Delete Cash/Adjustment Batches	*Account Transactions*	5: Delete Cash Batches
Retain Posted Cash and Adjustment Batches	*General Information Volume*	5: Data Retention Parameters

IMPLEMENTATION CONSIDERATIONS

Procedural Guidelines

Facilities will need to determine if they wish to suppress the contractual adjustment amount from the three ERA reports: FAR121x, FXRERACDx and FXRERACDMx. If so, users will need to be trained how to review and understand the new balances.

Review new functionality and if currently suppressing the contractual adjustment amount per denial tracking or claim disposition rules, determine if this amount will be suppressed from the ERA reports.

Training Guidelines

Training is required for reporting if the facility decides to suppress the contractual adjustment amount from the three ERA reports. Users will need to be trained how to review and understand the new balances.

TESTING GUIDELINES

Transaction Code Exceptions for Secondary Insurances

- Verify the new fields to the screens for the ERA Payment File Definition table.
- Verify the changes to the report for the ERA Payment File Definition (with the new table changes).
- Verify the existing logic for transaction code exceptions works for all insurances when none of the new transaction code exceptions are defined for the secondary insurance.
- Verify the existing logic for transaction code exceptions works for the primary insurance only when transaction code exceptions are defined for the secondary insurance.
- Verify the new logic for transaction code exceptions works for the secondary insurances when transaction code exceptions are defined for the secondary insurance.
- Verify Reverse System Adjustment method works with PCON 1500 when none of the new transaction code exceptions are defined for the secondary insurance.
- Verify Reverse System Adjustment method works with a PCON 1500 insurance as the primary insurance and transaction code exceptions are defined for the secondary insurance.
- Verify Reverse System Adjustment method works with a PCON 1500 insurance as the secondary insurance and transaction code exceptions are defined for the secondary insurance.

Add Reimbursement Type to Contractual Adjustment Method Exceptions

- Verify the changes to the ERA Payment File Definition table for contractual adjustment method exceptions. Make sure that all fields work as expected for all insurances and the warning for a duplicate entry appears.
- Review the report for the ERA Payment File Definition table and verify the new fields.
- Setup and verify each of the items (patient indicator, patient type, and reimbursement type) cause an exception for C/A for COB1. Also check for patient indicator/reimbursement type and patient type/reimbursement type. Verify patient indicator and patient type cause an exception for C/A for Prim 1500, C/A for Sec and C/A for PCON 1500.

Exclude Cont Adj Amount from ERA Reports when the C/A is Suppressed

- Verify the new parameter set to No (and also left blank) in the ERA PFD table includes the suppressed cont adj amounts in the ERA reports: FAR121x, FXRERACDx and FXRERACDMx.

- Verify the new parameter set to Yes in the ERA PFD table excludes the suppressed cont adj amounts in the ERA reports: FAR121x, FXRERACDx and FXRERACDMx. Testing should include cases where the contractual adjustment is suppressed via a denial and a test where the contractual adjustment is suppressed via a claim disposition rule.

- Verify the patient balance appears correctly on the three reports.

- Verify all of the balance fields and contractual adjustment amount fields on the three reports (FAR121x, FXRERACDx and FXRERACDMx) to ensure all is calculating correctly.

- Testing will need to include transactions with payments and takebacks when the contractual adjustment amount is suppressed. The reports will need to be reviewed to verify the subsequent transactions do not include the suppressed amount.

PLB Segments with Patient Related Data

- Set up an ERA test file where the CLP07 ICN number is reported in a PLB segment.

- Verify the new FXRERAPLB report produces with the upload of the test file.

- Verify the new FXRERAPLB report may be downloaded into Excel.

- Verify the results on the STAR and the Excel report

- Review the new field 'Adjustment Reason Codes to Exclude from FXRERAPLB' in the ERA Payment File Definition table and on the FTFPFD report (which is the printout of the ERA PFD table).

- Confirm an excluded code does not appear on the FXRERAPLB report.

Chapter 6 - Claims Enhancements (F11010)

OVERVIEW

Purpose

This enhancement includes the following:

- Type of Bill 1500 Claims
    - When using Instant Adjustment Bill, Single Bill Request, or Add Claim to Insurance in order to load a 1500 or Non Pro Fee 1500 adjustment claim, allow the user to select the type of bill that prints on the top of the paper claim form.
- Edit for Existence of NDC Code
    - An edit for the NDC code was added to the UB, 1500, and Non Pro Fee 1500 claim load logic. The NDC code edit is specified on the UB Charge Control Parameter, the 1500 Charge Control Parameter, and the Non Pro Fee 1500 Charge Control Parameter.
    - The display field for NDC Qual/Unit Errors was renamed to NDC Cd/Qual/Unit Errors.This field contains the number of errors for NDC Code, NDC Qualifier and NDC Unit.
    - The Error field at the claim charge line level displays any errors concerning NDC Code, NDC Qualifier or NDC Units.
    - Users can clear the NDC code error by entering the NDC code (and NDC Unit Qualifier and NDC UOS) into the existing NDC fields in Claims Management.
    - The Failed Claims Requirement Report (FCR250x) will report the NDC Code errors.
    - The new edits for the claim NDC Code were mapped to Pre-bill Edit and a new PBE error message of *NDC Code* was added.
- Allow Up to Two HCPCS Modifiers in the Payer HCPCS Cross Reference Table
    - Updated the Payer HCPCS Cross Reference Table to allow up to two 2-digit HCPCS Modifiers in the HCPCS and the Alternate HCPCS fields.
    - Add Claim to Insurance for 1500s
        - Updated the Add Claim to Insurance function, for 1500 and Non Pro Fee 1500 claims that are set to split, which allows the user to select the 1500 claims to load.
- Additional UB Edits

- Added three additional UB edits to allow the user to edit charges outside the billing dates. These new edits will assist with issues with inbound charges. The UB edits are:
    - Charges with a Service Date not within the From Date and Through Date in UB Locator 6
    - Charges with a Service Date after the Discharge Date
    - Charges with a Service Date before the Admission Date
- Added the new UB charge service date errors to the FCR250 Failed Claims Requirement Report and to Pre-bill Edit.

- Additional Bill Edits
    - Added two new Billing Requirements that can be assigned to the appropriate Final Billing Parameters:
        - Bill Chg Serv Date Before Admit Date
        - Bill Chg Serv Date After Disch Date
    - The new billing edits for Chg Serv Date Before Admit Date and Chg Serv Date After Disch Date were mapped to Pre-bill Edit.
    - The new billing edits were added to the Failed Billing Requirements Report (FBR210x) and the Failed Billing Requirements Controlled by Report (FBR220x).
- Unbilled Charge Worklist
    - Added an Account Inquiry option and a Combine Bill Indicator to the Unbilled Charge Worklist.
        - Users can access Account Inquiry after selecting an account from the Unbilled Charge Worklist.
    - A new field, Comb Bill/DPW Link, was added to the Unbilled Charge Worklist screen. The field displays the linked accounts for Combine Billing Accounts, and also Diagnostic Payment Window Links.

Benefits

- Type of Bill 1500 Claims
    - The enhancement for type of bill 1500 claims is needed when adding a 1500 or Non Pro Fee 1500 once the account is already in AR, and then using Instant

Adjustment Bill, Single Bill Request, or Add Claim to Insurance to add a claim for the new insurance. Before this enhancement, if an adjustment bill was used to load the claim, the claim has “Adjustment” on the top of the paper claim form. Some payers are rejecting this claim if they have not first received a claim that has “Final” on the top of the paper claim form.

- Edit for Existence of NDC Code
  - The system can now edit UB, 1500, and Non Pro Fee 1500 claims for the Unit Qualifier, Units, and NDC code.
  - Users can view failed claim edits for NDC code and clear the errors by entering the NDC code (and NDC Unit Qualifier and NDC UOS) into the existing NDC fields in Claims Management.
- Allow up to Two HCPCS Modifiers in the Payer HCPCS Cross Reference Table
  - More exact HCPCS mappings can be set up in the Payer HCPCS Cross Reference Table for claims.
- Add Claim to Insurance for 1500’s
  - When a user is in the Add Claim to Insurance function, when loading claims for a 1500 or a Non Pro Fee 1500 that is set to load separate claims, the user can select the claims to load so that a claim can be added for a specific physician or department, but not all.
- Additional UB Edits
  - Users can edit issues with inbound charges and correct the claims. Additional Bill Edits
  - Users can edit issues with inbound charges and correct the account level charge data for the bill.
- Unbilled Charge Worklist
  - Combine Bill and DPW linked accounts are easily identified.
  - Users can more easily look up account information via the Account Inquiry option without leaving the Unbilled Charge Worklist.

Terms

No new terminology is associated with this enhancement.

Related Documents

Documentation for Release 18.0 indicates text revisions with a change bar in the left margin. The following STAR Financials Patient Accounting documentation has been updated for this enhancement.

Enhancement Topic	Document	Chapter or Topic
Billing Requirements Billing Parameters Claim Parameters UB Charge Control Parameters (NDC updates, new Charge Service Date Edits) 1500 Charge Control Parameters (NDC updates) Non Pro Fee Charge Control Parameters (NDC updates) Payer HCPCS Cross Reference Table (allow up to 2 HCPCS modifiers)	*Tables, Masters, and Parameters*	3: PA/AR Parameter File Maintenance
Instant Adjustment Bill (1500/ Non Pro Fee 1500 Type of Bill, select which 1500/Non Pro Fee 1500 claims to load) Single Bill Request (1500/Non Pro Fee 1500 Type of Bill, select which 1500/Non Pro Fee 1500 claims to load)	*Account Transactions*	2: Other Account Management Functions

Enhancement Topic	Document	Chapter or Topic
Unbilled Charge Worklist UB Claim Charge Data Screen (NDC edits, new Charge Service Date Edits) 1500 Claim Charge Data Screen (NDC edits) Non Pro Fee 1500 Claim Charge Data Screen (NDC edits) Add Claim to Insurance (1500/ Non Pro Fee 1500 Type of Bill, select which 1500/Non Pro Fee 1500 claims to load) Single Bill	*Billing and Claims*	2: Patient Billing 3: Claims 3: Claims
Online		Billing Internal Elements
Reports - FMRCCX UB Charge Control Parameters - FCR15CC 1500 Charge Control Parameters - FMRCCZ Non Pro Fee 1500 Charge Control Parameters - FCRHCP Payer HCPCS Cross Reference Table - FCR250 Failed Claims Requirement	Reports Volume	4: Billing and Claims Reports

IMPLEMENTATION CONSIDERATIONS

Training Guidelines

Users should be trained on the updated functionality. Please refer to the User Implementation steps on STI F11010.

IMPLEMENTATION GUIDELINES

This enhancement is available when F11010 is loaded onto your system.

TESTING GUIDELINES

- Please refer to the Testing Steps in the STI documentation for F11010.

■ Reader Comment Form ■

We value your suggestions for improving our documentation. Please use this form to evaluate the Enhancement Summaries 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.

Other Comments:

Thanks for your help in improving the documentation.

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