STAR 2000™

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

Copyright notice

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Trademarks

CPT®

Preface

The *STAR Financials Patient Accounting Reference Guide* is a multi-volume document written for all users of the system. The *Reports Volume* contains reports used with the STAR Financials Patient Accounting System.

This volume includes documentation for Canadian users of this product. The documentation for Canadian users appears in the online version with blue highlighting. Canadian documentation is further identified by (CN) or by (CN Only).

Documentation Conventions

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

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

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

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

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

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

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

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

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

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

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

> *Enter patient name--*

Field Characteristics

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

- DISPLAY ONLY for a field you cannot edit.

- For X-YY-Z field types, where:

  - X is the maximum number of characters permitted in the field:

    - P for a field length determined by a Parameter

    - T for a field length determined by a Table

    - U for a field having an Undefined length

  - YY is the type of entry technique permitted in the field:

    - A for Letters only

    - N for Numerals only

    - C for Characters (including punctuation)

    - AC for Letters and Punctuation only (no numbers)

    - NC for Numerals and Punctuation only (no letters)

    - AN for Numerals and Letters only (no punctuation)

  - Z is the requirement indicator of the field:

    - R if an entry is required to complete the function

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

    - O if an entry is Optional to complete the function

    - C if an entry is Conditionally required or optional

  - For YY-Z field types, where YY is:

    - TABLE LOOKUP for a field that enables you to select from a displayed table. See the *General Information Volume* for more information regarding this entry technique.

    - SPECIAL FORMAT for a field having data entry requirements not conforming to standard format. The field definition contains the specific data entry requirements for the field.

    - DATE for a field subject to the date entry conventions described in the *General Information Volume*.

    - TIME for a field subject to the time entry conventions described in the *General Information Volume*.

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

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Introduction

This document contains information about creating and using the reports available with the base Patient Accounting system. The book contains the following chapters:

Chapter 1: Generating and Printing Reports

This chapter explains how to use the Patient Accounting system to generate and print reports.

Chapter 2: Account Management Reports

This chapter contains a description, example, and details on how to generate and print account management reports.

Chapter 3: Account Follow-Up Reports

This chapter contains a description, example, and details on how to generate and print account follow-up reports.

Chapter 4: Billing and Claims Reports

This chapter contains a description, example, and details on how to generate and print billing and claims reports.

Chapter 5: Transaction Reports

This chapter contains a description, example, and details on how to generate and print transaction reports.

Chapter 6: Statistics Reports

This chapter contains a description, example, and details on how to generate and print statistics reports.

Chapter 7: Third Party Log Reports

This chapter contains a description, example, and details on how to generate and print third party log reports.

Chapter 8: Contract Billing Reports

This chapter contains a description, example, and details on how to generate and print contract billing reports.

Chapter 1 - GENERATING AND PRINTING REPORTS

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GENERATING YOUR REPORTS

Reports can be generated in various locations throughout the Patient Accounting system. For example, the PA Daily Balancing Report is generated in PA Daily Balancing which is part of Financial System Management. Statistic reports are generated in the Financial Statistics Function, which is also a part of Financial System Management. Refer to individual report explanations in this volume for details on generating specific reports.

NOTE: Although a report may be generated through the batch process or generated manually, it does not print automatically if the print parameter is Demand; however, it remains spooled for as long as the retention parameter is set.

Generating A Report Through Batch

Patient Accounting reports can be grouped to generate and print during daily processing using the Define Report Groups Function option under Financial System Management. Grouping reports to process as an optional batch job is done at the hospital's discretion. Once processed, the report can be printed on demand if the Print parameter is set for demand.

Generating A Report Through Optional Batch

Selected Patient Accounting Reports can be generated using the Optional Batch Job processor. The Optional Batch Job processor allows a report to be generated at a set Interval, Day of the Month or on a specific Day-Week of Month combination. Reports can be set up to automatically print, for example, on the First Monday of the Month or the Second of every month or Every fifth day. For more information on the selection and generation of Optional Batch Jobs refer to the Financial System Management section of the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide*.

PRINTING YOUR REPORTS

Each facility can define the printing parameters of their reports in Reports
Maintenance, which is a part of Financial System Management. The options available
include I(mmediately), D(emand) or Time.

SPOOLER FUNCTIONS

Demand Print

The Demand Print function enables you to print or reprint reports that have been spooled to the disk using the system spooler.

If the report is specified to be a Demand Report in the report definition process, it is available for Demand Printing as soon as the report has finished spooling to disk.

If the report is specified to be an Immediate Print Report, it is available for Demand Printing if it is spooled to disk and the Immediate Print has completed.

Demand Print can be used for:

- Controlling the print order of reports. This permits you to define batches of reports in an order that best suits your needs.

- Reprinting of reports. This permits you to reprint up to a specified number of days after the report is created.

When a report is spooled it is placed in a queue. There are two queues in the system:

- The Print queue holds all reports waiting to print on a device. Once that device is available and all print criteria are satisfied (criteria such as: the queue is running, the report and printer are defined as active, any specified print time has been reached and the correct form is on the printer), the system prints the report and moves it to the demand queue for that printer.

- The Demand queue contains reports available for reprint. Reports specified as demand reports go directly to the demand queue rather than passing through the print queue. The demand queue consists of previously printed reports and reports specified as demand reports. These are the reports available to the demand print process and are deleted from the demand queue when the retention time specified in the report definition is exceeded.

To access the Demand Print function, select the Demand Print option from the Spooler Management menu.

```
                    General Hospital Output Management Processor
                                               Wed Aug 11, 1993 09:27 am
Output Management Input Options

              Option No.   Option
              ----------------------------------------
                  1        Reports Maintenance
                  2        Printer Maintenance
                  3        Forms Maintenance
                  4        Assign a Form to a Printer
                  5        Define Batch Report Groups
                  6        Print Control Maintenance

                  7        Queue Control
                  8        Print Job Control
                  9        Disabled printer display

                 10        Demand Print
                 11        View Spooled Reports
                 12        Write Reports to Tape
                 13        Print Special Forms
                 14        Spooler Control Reports
Enter option number--10
```

Once you select the demand print option, the system displays the following screen. The system uses the parameters you set on this screen to build this demand print set.

```
                      General Hospital Demand Print Processor
                              Sat May 17, 1991 05:27 pm

  ( 1)Source Printer     : FIN
  ( 2)Report / Batch     : FSR9/0A
  ( 3)Starting date      : 02/05/91
  ( 4)Starting time      : 11:00 am
  ( 5)Ending date        : 02/16/91
  ( 6)Ending time        : 12:00 am
  ( 7)Queue Name         : System
  ( 8)Destination        : HSP








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

Field Explanations

1. SOURCE PRINTER (T-C-R) or (TABLE LOOKUP-R)
Enter the printer to which the report(s) were originally directed.

2. REPORT/BATCH (1-A-O)

Enter B to specify batch or R to specify reports. If you specify batch you can select predefined report batches. If you specify reports you can select report name(s) for all reports currently available for printing.

3. STARTING DATE (DATE-O)

Enter the date to begin searching for the selected reports. The report must have completed generating on or after this date to be included in your selection criteria.

4. STARTING TIME (TIME-O)

Enter the time to begin searching for the selected reports. The report must have completed generating at or after this time to be included in your selection criteria.

5. ENDING DATE (DATE-O)

Enter the date to stop searching for the selected reports. The report must have completed generating on or before this date to be included in your selection criteria. The default is the current date.

6. ENDING TIME (TIME-O)

Enter the time to stop searching for the selected reports. The report must have completed generating at or before this time to be included in your selection criteria. The default is the current time.

7. QUEUE NAME (U-C-O)

Enter the name of the queue where you want to place the selected report(s). The default is the SYSTEM queue.

8. DESTINATION (T-C-O) or (TABLE LOOKUP-O)

This field specifies the destination to which you want to route the selected report(s). This may differ from the original destination to which the report was routed. The default is the source printer.

If fax capability is enabled, when you access this field the system displays the following prompt:

Enter printer(P), or fax report(F)--

Enter **P** to route the report to printer(s). Enter **F** to fax the report.

If fax capability is not enabled or if you enter P to route the report to a printer, the system prompts you to select a printer.

If you enter F to fax the report, the system displays the following prompt:

First letters`-` for list, or NL to enter information--

Enter a hyphen (-) to select a fax destination from a distribution list, or press **ENTER** to enter the fax destination manually.

After you specify the fax destination, the system displays the following prompt:

Enter override comment--

The override comment appears in the Fax audit trail, which is reviewed regularly by the Fax Administrator. Suggested information to enter for this comment would be your name and phone extension and some brief description.

Once you enter these parameters and accept the screen, the system searches the available reports and displays the following message:

Compiling list! Please wait!

Once the report completes, it is placed in a temporary file for review.

NOTE: If the Batch option is selected, all reports defined for the batch must have completed before processing can begin (except for reports marked as not required for completion in the batch definition). If any of the reports are incomplete, each report name displays on the screen so you can see which reports still need to be completed before the batch is available. If there was a problem with a report during generation, the system error displays with an asterisk (*) to indicate that you should contact your McKesson representative to correct and re-run the report.

When displaying the incomplete reports, any comment associated with the report at generation displays in dim video. Otherwise, the system displays the report description.

If you want to print some of the reports which have completed, choose the Reports option to select those reports.

The system displays the selected report(s) for review. You can delete report(s) from the batch or sort the reports into a specific order for printing:

Move (M), Change number of copies (C) or Remove from list (R)--

Upon completion of the sort/copy option, the system queues the selected reports, in the specified order, to the destination printer. As the system reviews the queue, it determines if the printer is available, prints the reports and displays the following:

Queueing!

Reports Maintenance

The Reports Maintenance function enables you to add and edit information about reports in the system, including:

•   when the report prints (on demand, immediately, or at a specified time)

- where the report is sent (to a printer(s) or a fax)
- whether the report requires special forms
- if the report can be downloaded to a PC
- the security level required to demand print the report
- whether the report uses printer-based overlays
- what distribution list and cover page to use for a faxed report

When you select this function the system displays the following prompt:

Enter report name to add/edit or first letters and a dash (-) --

Enter the system name of the report or use a hyphen (-) to display and select from a table of report names. If the report does not exist the system displays the following prompt:

REPORTNAME Does not exist   Add this report (Y/N)?--

Where REPORTNAME is the name of the report you identified at the preceding prompt. Enter **Y** to begin defining this report. Enter **N** to return to the preceding prompt.

When you identify the report you want to add or edit, the system displays the following screen:

```
              General Hospital Reports Maintenance Processor
                                        Wed Aug 11, 1993 03:55 pm

  1 Report Name           2 Description
    %ERTRAP                  SPOOLER ERROR TRAP-DON'T DELETE
  3 Base Report           4 Release #      5 Owner
    No
  6 When Printed          7 Report Status   8 Retention Days
    Demand                  Active            7 days
  9 Restart Method       10 PC Download     11 Security Level
    Demand                  No                0
 12 Special Form         13 Overlay         14 Page Index  15 Max # Pages
                                             Yes
 16 List Update Routine  17 Distribution List          18 Cover Page

 19 Printer     Description          Copies  Default type  Start time End time
    %MVXLIP     Landscape mode          1     Demand        10:00AM    01:00PM
    1N          1 North                 1     Both          01:01PM    09:59AM




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

Field Explanations

1. REPORT NAME (DISPLAY ONLY)
This field contains the system name of the report.

2. DESCRIPTION (30-AN-R)
This field identifies the text name of the report.

3. BASE REPORT (1-A-R)
This field identifies this report as being available in the base product. Enter Y if the report is available in the base product. Enter N if the report is available only on this system. The default is Y.

4. RELEASE # (5-N-R)
This field identifies the release number of the base product in which this report is available. This system does not allow you to access this field unless you entered Y in the Base Report field.

5. OWNER (1-A-O)
This field identifies the product code that *owns* this report. Enter the code of the product from which this report is available.

6. WHEN PRINTED (1-A-R) or (5-AN-R)
This field determines when the report should begin to print. Enter I to cause the system to begin printing this report immediately after it is generated. Enter D to cause the system to place this report into the Demand Print queue after it is generated. To cause the system to hold this report for printing until a specific time, enter the time in the HH:MM format. The default is I.

NOTE: To download a report to a PC, this field must be set to Demand. In addition, the Report Status must be Active.

7. REPORT STATUS (1-A-R)
This field determines the status of the report in the system. Enter A to make this report active in the system. Enter I to make this report inactive in the system. The default is A.

NOTE: Reports must have an Active status to be faxed or downloaded to a PC.

8. RETENTION DAYS (1-AN-R)
This field determines how long after the report is generated it should be retained in the system. To retain the report in the system from zero to nine days after it is generated, enter the number of days. To delete the report from the system immediately after it is printed, enter D. The default is 0.

9. RESTART METHOD (1-A-R)
This field determines alternative demand print methods. The only method currently supported is restart on demand (D).

10. PC DOWNLOAD (1-A-R)
This field enables the user to download the report. Enter **Y** to enable this option; enter **N** if this ability should not be enabled. The default is N.

11. SECURITY LEVEL (2-N-R) or (30-AN-R)
This field determines the minimum security level to demand print a report. You can enter a number between 0 and 99 or an at (@) sign, followed by a logical MUMPS expression. The standard security level variable must be established prior to choosing the Spooler menu.

12. SPECIAL FORM (10-AN-O)
This field identifies any special paper forms on which this report should print. Enter the name of the form or a hyphen (-) to display and select from a list of report forms. Special forms cannot be used with fax reports at this time.

13. OVERLAY (10-C-O)
This field identifies any printer overlay commands to be sent when this report is printed. Printer overlays contain special end of page commands, enabling you to print specific information on every page of reports printed at a specified printer.

When you access this field, the system prompts you for the name of the overlay to use. Enter the overlay name or use a hyphen (-) to display and select from a list of overlays.

14. PAGE INDEX (1-A-O)
This field determines whether the system should build a page index when this report is spooled. Enter Y to cause the system to build a page index, thus making the report immediately available to the View Spooled Reports function. Enter N if no page index is desired. The default is N.

If this field is set to N (for No) and the report is sent to a fax, the fax download manager builds the page index in order to determine if the page limit for the fax server has been reached.

15. MAX # PAGES (4-N-O)
This field identifies the maximum length of this report in number of pages. When generating the report, the system counts the pages as it generates them, comparing the count to this number. When the page count for the report reaches this number, the system suspends the job, thus preventing abnormally large spooler files from being created. The default is 300 pages.

16. LIST UPDATE ROUTINE (17-C-O) or (TABLE LOOKUP-O)
This field identifies the name of a routine, specified in the application, that dynamically builds the fax distribution list for the report. The routine name must be preceded by a caret (^). You cannot edit this field if a Distribution List is specified.

Enter the list update routine or select a list update routine from a list. Which list update routines display in the list is determined by the contents of the Owner field.

The system uses the distribution list built by the list update routine specified here only if the report is set up in the When Printed field to print Immediately or at a specified time. If the report is faxed using Demand Print (that is, the When Printed field is Demand) or via the View Spooled Reports function, this routine is not used.

17. DISTRIBUTION LIST (8-AN-O) or (TABLE LOOKUP-O)
This field specifies a distribution list to use for fax distribution for the report. Select a distribution list. You cannot edit this field if a routine is specified in the List Update Routine field.

The system uses the distribution list specified here only if the report is set up in the When Printed field to print Immediately or at a specified time. If the report is faxed using Demand Print (that is, the When Printed field is Demand) or via the View Spooled Reports function, this routine is not used.

Fax distribution lists are maintained by the Fax Administrator.

18. COVER PAGE (4-C-O) or (TABLE LOOKUP-O)
This field specifies a cover page to use when faxing a report. Enter the cover page code or enter a hyphen (-) and select a cover page from a list. The cover page specified here overrides any cover page defined in the distribution list. If you do not specify a cover page, the default system cover page is used.

Fax cover pages are maintained by the Fax Administrator.

Printer Assignments

19. NAME DESCRIPTION COPIES   DEFAULT TYPE   START TIME   END TIME
This field defines the printer assignments for the report. When you access this field, a scrolling screen displays at the bottom of the Reports Maintenance screen.

NOTE: If you assign multiple printers to a report, be sure to read Multiple Printer Assignments (refer to Chapter 1: Multiple Printer Assignments).

NAME (8-AN-R) OR (TABLE LOOKUP-R)
This field identifies the name of the logical printer to be assigned to this report. Enter the printer name or a hyphen (-) to display and select from a list of logical printers.

DESCRIPTION (DISPLAY ONLY)
This field contains the printer description. The printer description is defined in the Printer Maintenance function.

COPIES (2-N-R)
This field identifies the number of copies of the report to create on the defined printer. The default is 1.

NOTE: This field is not supported for fax queue processing. Fax processing sends one copy of a faxed report per destination.

DEFAULT TYPE (1-A-O)
This field is used to determine which printers output can be directed to.

If you press **ENTER**, this field displays DEMAND/BATCH. The printer is included on the list of available alternate printers. If the report runs in batch, the report prints at this printer. If the report is printed using the Demand Print function, the user can select this printer from a list of available alternate printers.

NOTE: If you press **ENTER** for this field, the system functions as it did prior to the 12.1 release.

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If you enter **N** (for None), there is no default printer. If the report is printed using the Demand Print function, this printer is included on the list of available alternate printers.

If you enter **B** (for Batch), the report prints at this printer when the report is run in batch mode only.

If you enter **D** (for Demand), when a user runs the report as a demand report, they can select this printer from a list of available alternate printers.

START TIME (TIME-C)
This field and the End Time field determine the times during which the printer is available for printing this report. This field is required if an End Time is entered. If this field is left blank, the printer is always available.

END TIME (TIME-C)
This field and the Start Time field determine the times during which the printer is available for printing this report. This field is required if a Start Time is entered. If this field is left blank, the printer is always available.

After you complete the fields the system asks if you want to accept your entries to this screen. Enter Y to accept the current contents of the screen. Enter N to return to the screen without accepting your changes.

FORMS MAINTENANCE

Forms Maintenance enables you to define special forms to be routed through the spooler. Forms defined in this function are attached for a report in the Reports Maintenance function. When you select this option, the system displays the following prompt:

   Enter form name to add/edit or first letters and a dash (-) --

Enter the name of the form that you want to add or edit, or enter a hyphen (-) to display and select from a list of existing forms.

When you identify the desired form, the following screen displays:

```
                    General Hospital Forms Maintenance Processor
                                              Fri Mar 13, 1992 02:23 pm

( 1)Form Name               : UB82
( 2)Description             : UB82 Claim Forms
( 3)Alignment Program       : U^FCBCPF













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

Field Explanations

1. FORM NAME (10-AN-DISPLAY ONLY)
This field displays the form used by the system to reference this form.

2. DESCRIPTION (20-AN-R)
This field contains the external description of this form.

3. ALIGNMENT PROGRAM (9-AN-R)
This field contains the name of a program used to align a form prior to printing special forms. This program is supplied by McKesson as it applies to the base application.

After you complete the fields, the system asks if you want to accept your entries to this screen. Enter **Y** to accept the current contents of the screen. Enter **N** to return to the screen without accepting your changes.

Printer Maintenance

Printer Maintenance allows you to maintain the information for the logical printer names used as output devices from the spooler. When you select this option, the system displays the following prompt:

Enter printer name to add/edit or first letters and a dash (-) --

Enter the name of the logical printer that you want to add or edit, or enter a hyphen (-) to display and select from a list of existing printers. When you identify the desired printer, the following screen is displayed:

```
                General Hospital Printer Maintenance Processor
                                          Thu Jun 23, 2011 04:40 pm

Last edit by #99999 Hope,Tom on 04/22/09 16:09

 1 Printer Name    2 Description
   137               Printer 137

 3 Driver Name                  4 Port Number(s)
   SPOOLER                         100







 Edit 'A'bove data or 'P'orts assigned--
```

The header includes the facility and date and time the screen was accessed. The header line immediately above the fields contains information regarding the last time the screen was edited. It includes employee ID, employee name and the date and time the screen was edited.

At the bottom of the screen the system displays the following prompt:

Edit 'A'bove data or 'P'orts assigned--

To edit the information displayed, enter **A**. To edit the port assignments, enter **P**. Editing port assignments is discussed following the explanations of the fields on this screen.

Field Explanations

1. PRINTER NAME (10-AN-DISPLAY ONLY)
This field displays the logical printer name used by the system to reference this printer.

2. DESCRIPTION (30-AN-R)
This field contains the external description of this printer.

3. DRIVER NAME (TABLE LOOKUP-R)
This field contains the background driver used for this device. When you access this field, the system displays the following prompt:

> *Use Spooler driver (Y)--*

Enter **Y** or press ENTER to use the Spooler driver. Enter **N** to display and select from a table of alternative background drivers.

4. PORT NUMBER(S) (DISPLAY ONLY)
This field displays the ports currently assigned to the printer definition.

After you complete the fields, the system asks if you want to accept your entries to this screen. Enter **Y** to accept the current contents of the screen. Enter **N** to return to the screen without accepting your changes.

Editing Port Assignments

When you access the Printer Maintenance processor, at the bottom of the screen the system displays:

> *Edit 'A'bove data or 'P'orts assigned--*

Enter **P** to edit port assignments for the printer.

NO PORTS ASSIGNED

If there are no ports assigned to the printer, the system displays:

> *No Ports Assigned, Add Ports (Y/N) [Y] --*

Enter **N** to return to the preceding prompt. Enter **Y** to begin adding ports.

The system then displays the following screen:

```
                    General Hospital Printer Maintenance Processor
                                              Wed Sep 01, 2011 05:14 pm
 Last edit by #19589 Ding,William D   on 09/01/11 1710
 1 Printer Name   2 Description
   BED             BED CONTROL 1

 3 Driver Name                  4 Port Number(s)
   SPOOLER                        153

Page:01
     Ports Assigned to Logical Printer BED,  Inactive ports denoted by (*)
    Port  Type                     Location
( 1)  153 HP LaserJet              CINDY'S DESK
```

At the bottom of the screen the system displays:

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Enter port number, 'T'ape drive, 'B'it bucket or define 'N'etwork printer --

Selecting the special devices has the following effects:

- **Tape Drive** - all reports spool and must be written to tape by the computer operator, using the Write to Tape function.

- **Bit Bucket** - all reports print to the bit bucket, no printed output is retained. If the report is spooled (because it is forced to do so in the spooler call), it is available for assignment to another printer later using the Demand Print function.

- **Network Printer** - if the system is connected via the McKesson network software, the report spools to disk on the host system and be transferred to the destination CPU via the network software. If the network is not installed, an error occurs whenever a report is spooled to this printer.

To edit a port, enter the number of the port or enter a hyphen (-) to select from a table of ports defined as printers. After a port number has been entered or selected, the system displays the following screen:

```
                    General Hospital Printer Maintenance Processor
                                               Wed Sep 07, 2011 05:14 pm
 Last edit by #19589 Ding,William D   on 09/01/11 1710
 1 Printer Name   2 Description
   BED               BED CONTROL 1
  1 Port  Device Type         Location                Status      Answerback
    153   HP LaserJet         CINDY'S DESK            Active      No


  2 Page handling (size)     3 Lines/page (download)

  4 Lines/inch (download)    5 Chars/inch (download)

  6 Print quality (download)
    **
            7 Variable one ${1}

            8 Variable two ${2}

            9 Variable three ${3}


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

The selected port's characteristics are displayed as a line above the editable fields and includes the following information:

DEVICE TYPE
The name of the configuration for the device at the port.

LOCATION
The free-text description of the device's location.

STATUS
The status (Active or Inactive) of the device at the port.

ANSWERBACK
Whether answerback is active (Yes) or not (No).

When defining a printer, you may specify download values for lines/inch, lines/page, characters/inch, and print quality for those printers with the capability to support them.

The following printers have the indicated download capabilities:

Printer	LPI	LPP	CPI	Print Quality
TP2	x			
4433	x	x		
6215	x	x	x	x
6425	x	x	x	x
LIPS	x	x	x	x
6594	x	x	x	x
Epson Protocol	x	x	x	x
Kyocera	x	x	x	x
HP LaserJet	x	x	x	x
IBM Proprinter	x	x	x	x

Field Explanations

Depending upon the device in use, the fields in the lower part of the screen may be edited as follows:

NOTE: The system displays two asterisks (**) in fields that cannot be edited (for example, the Print Quality field in the preceding screen).

1. PORT
Enter a new port number, or a hyphen (-) to list all ports defined as printers, or **N** to define the port as a network printer port..

2. PAGE HANDLING (SIZE)
Enter the number of lines on a page or **A** for Automatic (if supported).

3. LINES/PAGE (DOWNLOAD)
Enter lines per page. The default is none.

4. LINES/INCH (DOWNLOAD)
Enter lines per inch (type-dependent options) or **D** for Disabled. The default is none.

5. CHARS/INCH (DOWNLOAD)
If the physical printer supports this, you may specify the characters per inch (usually 10 or 12).

6. PRINT QUALITY (DOWNLOAD)
The style of print to be used for this logical printer. It may be *Bold*, *NLQ*, *Draft*, and so on, depending upon the physical printer type specified.

7. VARIABLE ONE ${1}
Enter a string to be passed as variable 1 if the port is of the type that prints to a host file or host spooler queue name.

8. VARIABLE TWO ${2}
Enter a string to be passed as variable 2 if the port is of the type that prints to a host file or host spooler queue name.

9. VARIABLE THREE ${3}
Enter a string to be passed as variable 3 if the port is of the type that prints to a host file or host spooler queue name.

NOTE: See Microfiche for magnetic tape drive parameters.

When you accept the screen, the system returns to the preceding screen.

Ports Assigned

If one or more ports have been assigned to the printer, for each port assigned the system displays:

• Number
• Type
• Location

At the bottom of the screen the system displays:

Enter printer number to add/edit or 'A' to add --

Enter A to add a port assignment, or enter the corresponding option number to edit a port assignment.

MULTIPLE PRINTER ASSIGNMENTS

If you assign multiple ports to a printer, the report only prints at one printer. Typically multiple printer assignments are made to ensure the speedy printing of reports.

The Spooler attempts to print the report at the first assigned printer.

If the first printer is busy, the Spooler attempts to print the report at the second assigned printer.

If the second printer is busy, the Spooler attempts to print the report at the third assigned printer, and so on.

The Spooler continues to cycle through the list of printer assignments until it finds a printer that is not busy.

WARNING: If you include a *Bit Bucket* printer in the printer assignments, if previous assigned printers are busy, your report does not print at all. Do not include Bit Bucket printer assignments with other printers.

View Spooled Reports

The View Spooled Reports function enables you to view reports that have been spooled and not yet deleted from the system. A spooled report must be either a *Demand Report* or is *force-spooled* by the application. You can view these reports online from your terminal, then send the report to a printer, if desired.

When you select this option from the Spooler menu the system displays the following prompt:

Enter report name or leading chars '-' for a list--

Enter the system name of the report that you want to view, or use a hyphen (-) to display and select from a list of reports, as in the following screen:

```
                    General Hospital View Reports Processor
                                             Tue Mar 17, 1992  08:43 am
 Page:01
                         Reports defined in ID 97
     Name         Description                    Retention Time   Print Queue
 ( 1) FARDBL       PA Daily Balancing Report      3 day(s)        Demand
 ( 2) FARDBLM      PA Daily Balancing Report (M)  until midnight  Demand
 ( 3) FARDBLP      PA Daily Balancing Report (P)  2 day(s)        Demand
 ( 4) FARDLRASU    -ASU                           until midnight  Demand
 ( 5) FARDLRASUP   -ASU (P)                       until midnight  Demand
 ( 6) FARDLRATP    -ATP                           until midnight  Demand
 ( 7) FARDLRATPP   -ATP (P)                       until midnight  Demand
 ( 8) FARDLRBLB    -BLB                           until midnight  Demand
 ( 9) FARDLRBLBP   -BLB (P)                       until midnight  Demand
 (10) FARDLRCAR    -CAR                           3 day(s)        Immediate
 (11) FARDLRCARP   -CAR (P)                       until midnight  Demand
 (12) FARDLRCPD    -CPD                           until midnight  Demand
 (13) FARDLRCPDP   -CPD (P)                       until midnight  Demand
 (14) FARDLRCRN    -CRN                           until midnight  Demand
 (15) FARDLRCRNP   -CRN (P)                       until midnight  Demand
 (16) FARDLRCSR    -CSR                           until midnight  Demand

 Enter choice--
                         next page(/)
```

After you identify the report you want to view, the system displays the following screen:

```
                      General Hospital View Reports Processor
                                               Tue Mar 17, 1992  08:43 am
Report : FARDBL  PA Daily Balancing Report

Report Search Constraints

( 1)Starting date: Tue Mar 17
( 2)Starting time: 12:00 midnight
( 3)Ending date  : Tue Mar 17
( 4)Ending time  : 8:43 am
( 5)Printer Name : BIT







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

Use this screen to define the search constraints for the time period in which the report
was generated and the device to which it was generated.

Field Explanations

1.   STARTING DATE (DATE)
This field determines the first date to be used in searching the system for generated
copies of the selected report.

2.   STARTING TIME (TIME)
This field determines the earliest time to be used in searching the system for generated
copies of the selected report.

3.   ENDING DATE (DATE)
This field determines the last date to be used in searching the system for generated
copies of the selected report.

4.   ENDING TIME (TIME)
This field determines the latest time to be used in searching the system for generated
copies of the selected report.

5.   PRINTER NAME (8-AN-R)
This field identifies the destination printer(s) to be included in the search criteria. Enter
the name of the printer. You can also enter a hyphen (-) to include all printers *for all
system IDs* in the search. Search across all printers can be costly in time and system
resources.

After you complete the fields the system asks if you want to accept your entries to this
screen. Enter **Y** to accept the current contents of the screen. Enter **N** to return to the

screen without accepting your changes. The system then begins the search according to the criteria you defined, displaying the following screen:

```
                    General Hospital View Reports Processor
                                          Tue Mar 17, 1992  08:43 am
Report : FARDBL  PA Daily Balancing Report
Page:01

Copy Spooled        Last Printed      Pages  Comment
( 1) 03/17/92 0740  Not Printed          2
( 2) 03/16/92 1122  Not Printed          2
( 3) 03/16/92 1004  03/16/92 1004        3
( 3) 03/15/92 1545  03/16/92 0740        3







 Enter choice--
```

If the system does not find any reports matching the search criteria, the following message displays at the bottom of the screen:

   No Entries Defined

For each report matching the search criteria the system displays the date and time the report was generated, the date and time the report was last printed, the length of the report in pages, and any comments entered.

To view a report, enter the option number of the report. The system displays the following:

```
                        General Hospital View Reports Processor
                                              Tue Mar 17, 1992  08:43 am
Report : FARDBL  PA Daily Balancing Report        Position|##################|
Spooled: 03/17/92 0740                            Last Printed: Not Printed


Date: 03/17/92                      GENERAL HOSPITAL                      Page: 1
Time: 07:40 am                   PA Daily Balancing Report            Report: FARDBL
                                      for 03/16/92


 Fin  Pre-                      Total        Unbilled      Billed                    Account
 Cls  Disch Pre-Discharge Disch   Discharged Accts  LOS    Charges      Charges      Payments    Adjustments    Balance

Emergency:
  02  99999 99,999,999.99 99999 99,999,999.99 99999 99999 9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  999,999,999.99
  08  99999 99,999,999.99 99999 99,999,999.99 99999 99999 9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  999,999,999.99
  18  99999 99,999,999.99 99999 99,999,999.99 99999 99999 9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  999,999,999.99
  XX  99999 99,999,999.99 99999 99,999,999.99 99999 99999 9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  999,999,999.99
  YY  99999 99,999,999.99 99999 99,999,999.99 99999 99999 9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  999,999,999.99
 Tot: 99999 99,999,999.99 99999 99,999,999.99 99999 99999 9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  999,999,999.99
Inpatient:
  02  99999 99,999,999.99 99999 99,999,999.99 99999 99999 9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  999,999,999.99
  08  99999 99,999,999.99 99999 99,999,999.99 99999 99999 9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  999,999,999.99
  28  99999 99,999,999.99 99999 99,999,999.99 99999 99999 9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  999,999,999.99
  30  99999 99,999,999.99 99999 99,999,999.99 99999 99999 9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  999,999,999.99
  XX  99999 99,999,999.99 99999 99,999,999.99 99999 99999 9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  999,999,999.99
  YY  99999 99,999,999.99 99999 99,999,999.99 99999 99999 9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  999,999,999.99
Outpatient:
  02  99999 99,999,999.99 99999 99,999,999.99 99999 99999 9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  999,999,999.99
  08  99999 99,999,999.99 99999 99,999,999.99 99999 99999 9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  999,999,999.99
  Page: 1 - 3            Display Columns:  1  through  132  Maximum: 132
  F1 Page Up F2 Page Dn F3 GoTo   F4 Skip 10%  F5 Print  F6 Nxt Rpt F7 Exit   ?
```

At the bottom of the screen the system displays the following function keys. Use these function keys to view, print, or exit this report.

F1 Page Up
Press the **F1** key to view the preceding page of the report.

F2 Page Dn
Press the **F2** key to view the next page of the report.

F3 GoTo
Press the **F3** key to go to the first, last, middle, or a specified page of the report display. The system displays the following prompt:

GO TO `T`op page, `B`ottom page, `M`iddle page, or page number [T]--

Enter **T**, or press **ENTER** to go to the first page of the report. Enter **B** to go to the last page of the report. Enter **M** to go to the middle page of the report. To go to a specific page, enter the number of the page.

F4 Skip 10%
This key operates differently depending on the size of the report. If there are less than 10 pages for this report, when you press the **F4** key, the system scrolls down 18 lines to display the next screen of report information. If there are 10 or more pages for this report when you press the F4 key, the system scrolls down 10% through the report or the total number of report pages divided by 10. For example, if there are 100 pages in the report when you press the F4 key, the system displays page 10.

F5 Prt
Press the **F5** key to print the report. The system displays the following prompt:

Enter range of pages to print (i.e. 4-7, 8) (max 2)--

To print a single page, enter the number of the page. To print multiple pages, enter a range of page numbers by entering the first page to print, a hyphen (-), then the last page to print. The system then displays:

Print page X? (Y/N) [Y]--

Where X is the number(s) of the pages you identified in the preceding prompt. Enter **Y**, or press **ENTER** to print the pages, or press **N** to return to the preceding prompt.

If your system has fax capability, the following prompt is displayed:

Would you like to fax this report? (Y/N) [N]--

Enter **Y** to route the report to a fax machine. See Routing to a Fax Machine below.

Press **ENTER**, or enter **N** to route the report to a printer. The following prompt displays:

Enter printer name or partial name '-' for list [DEFAULT]--

You can either enter the printer name or perform a table lookup and select the printer from the list. The default that displays in the prompt is the printer that is associated with the report you are viewing.

ROUTING TO A PRINTER

If you route the report to a printer or your system does not have fax capability, the system then displays one or more screens of printers on which you can print the report. Enter the option number of the desired printer, or press **ENTER** to print the report on the default printer for the report. The system then returns you to the report viewing screen.

ROUTING TO A FAX MACHINE

If you route the report to a fax machine the system displays the following screen:

```
                        General Hospital View Reports Processor
                                          Mon Jun 08, 1992 09:45 am
Report : PSPCHGA  Vendor Price Change Report      Position|##################|
Spooled: 06/08/92 0919                            Last Printed: Not Printed
 1 Sending Information     2 Override Comment        3 Cover Page
 ->














 Enter cover page code, or first letters`-` to list--
```

Field Explanations

1. SENDING INFORMATION (TABLE LOOKUP-R)
This field identifies sending information for the fax report (To, From, and Phone number). To select sending information from an existing distribution list, enter a hyphen (-).

Press **ENTER** to display a screen where you can specify sending information manually.

After you enter each item of sending information, press **ENTER** to advance to the next field.

To move between fields, use the arrow keys.

To insert another line of sending information, press the **F3** key.

To delete a line of sending information, press the **F4** key.

To exit and save the sending information, press the **F7** key.

2.   OVERRIDE COMMENT (20-C-O)
This field specifies an override comment. The override comment appears in the Fax audit trail, which is reviewed regularly by the Fax Administrator. Suggested information to enter for this comment would be your name and phone extension and some brief description.

3.   COVER PAGE (4-C-O) or (TABLE LOOKUP-O)
This field specifies a cover page to use when faxing a report. Enter the cover page code or enter a hyphen (-) and select a cover page from a list. If you do not specify a cover page, the default system cover page is used.

Fax cover pages are maintained by the Fax Administrator.

F6 Nxt Rpt
Press the **F6** key to view the next report meeting the search criteria.

F7 Exit
Press the **F7** key to exit this screen and return to the preceding screen.

You can also move up or down in viewing the report using the following keys:

*   The up arrow key on your keyboard moves the screen display up one line
*   The down arrow key on your keyboard moves the screen display down one line
*   ENTER moves the screen display down 18 lines to display the next screen of report information
*   The PAGE DOWN key moves the screen display down 18 lines to display the next screen of report information
*   The PAGE UP key moves the screen display up 18 lines to display the preceding screen of report information

When you finish viewing the report, press **F7**. The system returns you to the screen used to define search constraints.

Chapter 2 - ACCOUNT MANAGEMENT REPORTS

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Illustrations

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This chapter contains screens, field explanations, and other documentation for Canadian usage of this product. Generally, the documentation reflects the base (US) product. Documentation for the Canadian version appears in the online version with blue highlighting. Canadian documentation is further identified by (CN) or by (CN Only).

AR BALANCE CONTROL REPORT - FARBAL2

Description/Purpose

The AR Balance Control Report provides a daily AR balance summary and reconciliation. It lists the opening AR balance, a total for all final billed accounts, the total of all AR cash, and the ending unapplied subsidiary balance and GL control balance (for comparison). If the ending AR balance and the subsidiary balance are not the same, the Bal field is filled with an N indicating the AR must be reconciled for that day. This report serves as a daily auditing tool for the balancing and reconciliation of AR.

Generating and Printing This Report

This report is sorted by day of the month from the Daily Balancing functions for AR with the desired reporting period selected using the online screen. It is set up as a demand report and printed through the Demand Print function.

The following is an example of the AR Balance Control Report.

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Figure 2.1 FARBAL2 - AR Balance Control Report

```
Date: 06/12/00                                Model Hospital A                            Page  : 1
Time: 10:42                              A/R Balance Control Report                       Report: FARBAL2A
                                            MO:  06  YEAR:  00

     Open AR Bal          Cash          Refunds            PMA        BD/AR X-fer        End AR Bal      G/L Ctrl Bal
Day           F/B Total            Adjs          L Chg/CR      AR/BD X-fer      Fac X-fer          Subs Bal                Bal
         Reconciliation Comments

     10,051,381.44-         0.00          0.00            0.00            0.00    10,051,381.44-    10,900,672.97-
01                0.00          0.00          0.00            0.00            0.00        N/A        10,051,381.44-              N


     10,051,381.44-         0.00          0.00            0.00            0.00    10,051,381.44-    10,900,672.97-
02                0.00          0.00          0.00            0.00            0.00        N/A        10,051,381.44-              N


     10,051,381.44-         0.00          0.00            0.00            0.00    10,051,381.44-    10,900,672.97-
03                0.00          0.00          0.00            0.00            0.00        N/A        10,051,381.44-              N


     10,051,381.44-         0.00          0.00            0.00            0.00    10,048,622.64-    10,897,914.17-
04            2,758.80          0.00          0.00            0.00            0.00        N/A        10,048,622.64-              N


     10,048,622.64-         0.00          0.00            0.00            0.00    10,048,622.64-    10,897,914.17-
05                0.00          0.00          0.00            0.00            0.00        N/A        10,048,622.64-              N


     10,048,622.64-         0.00          0.00            0.00            0.00    10,048,622.64-    10,897,914.17-
06                0.00          0.00          0.00            0.00            0.00        N/A        10,048,622.64-              N


     10,048,622.64-        30.00          0.00            0.00          859.48    10,045,425.84-    10,894,717.37-
07            2,362.32          5.00          0.00            0.00            0.00        N/A        10,045,425.84-              N


     10,045,425.84-         5.00          0.00            0.00            0.00    10,044,902.85-    10,894,194.38-
08                0.00        527.99          0.00            0.00            0.00        N/A        10,044,902.85-              N


     10,044,902.85-         0.00          0.00            0.00            0.00     9,744,257.94-    10,593,549.47-
09          300,644.91          0.00          0.00            0.00            0.00        N/A         9,744,257.94-              N


      9,744,257.94-         0.00          0.00            0.00            0.00     9,587,155.93-    10,436,447.46-
10          157,102.01          0.00          0.00            0.00            0.00        N/A         9,587,155.93-              N


        out of balance                                          Reconciled by: Store,Lani S
        need to investigate
                                                            End of Report
```

Each report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

DAY
This field contains the day of the month.

OPEN AR BAL
This field contains the previous day's subsidiary balance.

F/B TOTAL
This field contains the account balance of all accounts final billed for the day. This amount comes from the Billed Accounts report (FBR200).

CASH
This field contains the daily total of cash posted to accounts in Accounts Receivable. This amount is the AR Total on the Cash Posting Detail report (FAR130).

ADJS
This field contains the daily total of adjustments posted to accounts in Accounts Receivable. This amount is the AR Total on the Adjustment Posting Detail report (FAR210).

REFUNDS
This field contains the amount for patient refunds that were approved and/or deleted for that day for accounts that are in location AR. This amount can be verified using the Refunds Approved/Deleted report (FPREPPR).

L CHG/CR
This field contains the dollar amount of any late charges in Accounts Receivable. This amount is the AR Total on the Late Charge/Credit report (FARAJR1).

PMA
This field contains the amount of post-midnight activity (the overflow charges) for accounts in location AR that have passed to Patient Accounting. Overflow charges are charges that are posted to the subsidiary balance but not the GL Control accounts during midnight processing. This figure is normally zero. This amount comes from the Overflow Charge report (FCRCHG).

AR/BD X-FER
This field contains the dollar amount of accounts transferred from Accounts Receivable to Bad Debt. This amount comes from the Accounts Receivable to Bad Debt Transfer report (FFR210).

BD/AR X-FER
This field contains the dollar amount of accounts transferred from Bad Debt back to Accounts Receivable. This amount is taken from the Bad Debt to Accounts Receivable Transfer report (FFR220).

FAC X-FER
This figure comes from moving charges from an account in one facility to an account in a different facility using the Cross Facility Combine Billing functions.

END AR BAL
This field contains the system-supplied ending balance which is calculated by adding and subtracting daily activity from the opening balance. The calculation follows:

```
    OPEN AR BAL
   + F/B TOTAL
   - CASH
+/- ADJS
+/- REFUNDS
   + L CHG/CR
   + PMA
   - AR/BD X-FER
   + BD/AR X-FER
+/- FAC X-FER
_____

    END AR BAL
```

SUBS BAL
This field contains the amount that was calculated during Midnight Processing that represents the total of all accounts in account location AR. Tomorrow, this amount is used as the Opening Balance.

G/L CTRL BAL
This field contains the General Ledger control balance which is the result of adding all AR Control Account balances in the General Ledger. The General Ledger Control Balance should match the Subsidiary and Ending balances.

BAL
This field contains an N if the daily balance requires reconciliation.

RECONCILIATION COMMENTS
This field contains comments explaining why Accounts Receivable does not balance and the solution to solve the discrepancy. These comments are user-defined and entered on the AR Balance Control screen.

RECONCILED BY
This field is only displayed if someone has updated the screen. It prints the name of the last person to make a change to the screen.

ADJUSTMENT POSTING DETAIL REPORT - FAR210

Description/Purpose

The Adjustment Posting Detail Report lists all accepted adjustment batches posted for the day. Detail for each batch is listed. The report is subtotaled by patient type indicator within account location for inpatient, outpatient, and emergency accounts. System-generated small balance write-offs are reported during batch processing and are reported in batch 0 (zero). Automatic contractual adjustments open the next available batch. This report can be used to audit posted adjustment batches and in daily balancing.

Generating and Printing This Report

This report, which is produced in nightly batch processing, is set up as a demand report and printed through the Demand Print function. It is sorted by sequential batch number and subsorted by account number within the batch run.

Pages break by batch and a total page recaps all the batches.

The following is an example of the Adjusted Posting Detail Report.

Figure 2.2 FAR210 - Adjusted Posting Detail Report - Page 1

```
Date: 04/01/98                              Model Hospital A                           Page  : 1
Time: 01:02am                     Adjustment Posting Detail for 03/31/98               Report: FAR210A
                                  Batch 0 - System Generated Adjustments


Date: 04/01/98                              Model Hospital A                           Page  : 2
Time: 01:02am                     Adjustment Posting Detail for 03/31/98               Report: FAR210A
                                  Batch 67 - NYHCRA Adjustments

Account #        Account Name              Post     Trans Amount  TCode Transaction Description    Loc Clm Adj Type    Disposn
Carrier/Plan     Carrier Name              Date                                                                       Disp Cd
---------------------------------------------------------------------------------------------------------------------------------
9721700001       HARDCASTLE,FELICIA        03/31/98      463.81   A0001 I/P MEDICARE PART A ALLOWANCE PA     Patient    Final
                                                                                                        A
9721700002       HODGSON,ROBERT F          03/31/98      463.81   A0001 I/P MEDICARE PART A ALLOWANCE PA     Patient    Final
                                                                                                    A
9724500004       JAMES,TERESA              03/31/98      100.84   A0001 I/P MEDICARE PART A ALLOWANCE PA     Patient    Final
                                                                                                    A
9722700003       JAMES,RITA M              03/31/98        1.35   A0001 I/P MEDICARE PART A ALLOWANCE PA     Patient    Final
                                                                                                    A
9722500006       JOHNSON,MARCUS            03/31/98      100.84   A0001 I/P MEDICARE PART A ALLOWANCE PA     Patient    Final
                                                                                                    A
9722500007       JOHNSON,MICHAEL R         03/31/98       84.22   A0001 I/P MEDICARE PART A ALLOWANCE PA     Patient    Final
                                                                                                    A
9800700002       JOHNSON,TIMOTHY T         03/31/98      128.31   A0001 I/P MEDICARE PART A ALLOWANCE PA     Patient    Final
                                                                                                    A
9804100003       KING,HARVEY               03/31/98      677.58   A0001 I/P MEDICARE PART A ALLOWANCE PA     Patient    Final
                                                                                                    A                    A
9804200001       KING,GEORGE               03/31/98       22.40   A0001 I/P MEDICARE PART A ALLOWANCE PA     Patient    Final
                                                                                                    A
9804500001       LIMMONS,MARK P            03/31/98       94.43   A0001 I/P MEDICARE PART A ALLOWANCE PA     Patient    Final
                                                                                                    A
9805400004       LIPOSVSKY,LYNN            03/31/98      463.81   A0001 I/P MEDICARE PART A ALLOWANCE PA     Patient    Final
                                                                                                    A
9805400007       MILLER,JANNETTE           03/31/98      938.66   A0001 I/P MEDICARE PART A ALLOWANCE PA     Patient    Final
                                                                                                    A
9805400015       MILLER,WILLIAM R          03/31/98      938.66   A0001 I/P MEDICARE PART A ALLOWANCE PA     Patient    Final
                                                                                                    A
9807200011       NEWTON,JENNIFER P         03/31/98      173.83   A0001 I/P MEDICARE PART A ALLOWANCE PA     Patient    Final
                                                                                                    A
9806100012       PATTON,ALLYSON            03/31/98      534.17   A0001 I/P MEDICARE PART A ALLOWANCE PA     Patient    Final
                                                                                                    A
9806100016       PAUL,JENNIFER L           03/31/98      478.53   A0001 I/P MEDICARE PART A ALLOWANCE PA     Patient    Final
                                                                                                    A
```

Figure 2.3 FAR210 - Adjusted Posting Detail Report - Page 2

```
Date: 08/23/89                                  General Hospital                           Page  : 3
Time: 12:01am                          Adjustment Posting Detail for 08/22/89              Report: FAR210
                                                  Report Totals


Transaction Code                   Count          Amount
---------------------------------------------------------------
8111 Returned Check                3             2,550.00
0001 Small Balance Write-off       1             1,000.00


Patient Type   Count          Amount
---------------------------------
Inpatient        4         3,550.00
Outpatient       0             0.00
Contract         0             0.00


Location       Count          Amount
---------------------------------
PA               0             0.00
AR               4         3,550.00
BD               0             0.00
BD Arc'd Accts   0             0.00
Contract PA      0             0.00
Contract AR      0             0.00


Grand Total      4         3,550.00


                                              End of Report
```

Each report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

POST DATE
This field contains the date the adjustment was posted.

TRANS AMOUNT
This field contains the total dollar amount of the adjustment posted.

TCODE/TRANSACTION DESCRIPTION
This field contains the transaction adjustment code number and associated transaction description.

LOC
This field contains the location of the account when the adjustment was posted.

CLAIM ADJUSTMENT TYPE
This field contains the adjustment type. Valid types include contractual adjustment, insurance patient, patient discount, and small balance write-off (system-generated).

DISPOSN
This field indicates whether the disposition of the claim is final or not.

CARRIER PLAN/CARRIER NAME
This field contains the carrier/plan code number and description indicated for the insurance adjustment posted.

DISP CD
This field indicates the selected disposition code for final disposition claims.

USER ID
This field identifies the person who posted the batch.

BATCH TOTAL
This field contains the total dollars entered in the batch.

TOTALS PAGE
The system provides a totals page that includes count and amount totals by patient indicator and account location along with a total dollar amount for all adjustments entered for the day.

ADJUSTMENT POSTING DETAIL EXCEPTION REPORT - FAR220

Description/Purpose

The Adjustment Posting Detail Exception Report lists all adjustment exceptions reported for adjustment batches posted for the day and for balance transfers for accounts in location PA. The system reports an adjustment exception for the following reasons:

- The amount of an adjustment exceeds the account balance. The exception reason is *Adjustment amount exceeds account balance.*

- The amount of an adjustment exceeds the patient balance for a patient adjustment. The exception reason is *Adjustment amount exceeds patient balance.*

- The amount of an adjustment exceeds the carrier balance for a carrier adjustment. The exception reason is *Adjustment amount exceeds carrier balance*

- The amount originally entered in the Batch Total field when the batch is created is changed. The exception reason is *Batch total changed*

- Accounts in a PA location that have a balance transfer that final dispositions the last outstanding claim and for which there are no outstanding claims (with expected payments sitting at zero) and no unbilled charges. This exception appears only when the balance transfer final dispositions the last outstanding claim. It does not occur again if another balance transfer occurs on an account whose claims were all already final dispositioned. The exception reason is *"COBx" has a balance - all claims complete*.

- Accounts in a PA location that have a final adjustment posted and there are no outstanding claims (with expected payments sitting at zero) and no unbilled charges.

NOTE: If another final adjustment was posted to an account in PA that had no outstanding claims, no unbilled charges, and for which money remained on the carrier appears again as an exception. The exception reason is *"COBx" has a balance - all claims complete*.

This report provides an audit trail to verify daily adjustments and balance transfers. Since the report sorts by batch number, you can use the report to define significant batch variances that require review.

NOTE: Batch 0 displays Small Balance Write-offs and Archived accounts.

Generating and Printing This Report

The system generates this report during nightly batch processing, sorting by the posting sequence number. The report can also be set up as a demand report and be printed through the Demand Print function. If no adjustment exceptions exist, the system prints a report header without detail. Page breaks occur at the end of a page or end of the batch.

The following is an example of the Adjustment Posting Detail Exception Report.

Figure 2.4 FAR220 - Adjustment Posting Detail Exception Report

```
Date: 05/21/98                              General Hospital                        Page  : 1
Time: 12:46am                    Adjustment Posting Exceptions for 05/20/98         Report: FAR220A
                                          Batch 68 - TA INS

Seq   Account #     Account Name              LC  Exception Description
-----------------------------------------------------------------------------------------------------
1     57440-18556   SOUTHERLAND,PERRI         BD  Adjustment amount exceeds account balance
                                              BD  Adjustment amount exceeds carrier balance

_____


Date: 05/21/98                              General Hospital                        Page  : 2
Time: 12:46am                    Adjustment Posting Exceptions for 05/20/98         Report: FAR220A
                                          Batch 77 - ND INS

Seq   Account #     Account Name              LC  Exception Description
-----------------------------------------------------------------------------------------------------
1     57440-18556   PARKER,THERESA D          AR  Adjustment amount exceeds account balance
                                              AR  Adjustment amount exceeds patient balance

_____


Date: 05/21/98                              General Hospital                        Page  : 3
Time: 12:46am                    Adjustment Posting Exceptions for 05/20/98         Report: FAR220A
                                          Batch 83 - DD INS

Seq   Account #     Account Name              LC  Exception Description
-----------------------------------------------------------------------------------------------------
1     57440-18556   MILLER,CYNTHIA G          PA  COB 1 has a balance - All claims completed

_____


Date: 05/21/98                              General Hospital                        Page  : 4
Time: 12:46am                    Balance Transfer Exceptions for 05/20/98           Report: FAR220A
                                          Batch 96 - PMK

Seq   Account #     Account Name              LC  Exception Description
-----------------------------------------------------------------------------------------------------
1     9806500022    CAMDEN,ALAN               PA  COB 1 has a balance - All claims completed




                                          End of Report
```

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Each report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, the report name as used in the system, the batch number, and batch description.

SEQ
This field contains the posting sequence number from the Adjustment Detail report.

LC
This field indicates the location of the account.

EXCEPTION DESCRIPTION
This field contains a description of the adjustment posting exception.

ADMINISTRATIVE OPERATING SUMMARY - FSRAOS

Description/Purpose

The Administrative Operating Summary Report is a management report intended to provide a high level summary of census, registration, revenue, and AR activity. As a high level management report, it does not reflect cancelled or backdated ADT activities and does not use the statistics flag contained in the Patient Type table.

The first page of this report provides census information by nursing station. For each nursing station, the report displays the total number of beds. The report then displays the census summary for each nurse station, including the number of occupied beds and percent of occupancy, for the current date, period-to-date, and year-to-date. The number of occupied beds whose count flag is set to no and total occupied beds are also reported.

NOTE: Nurse stations are set up in STAR Patient Care.

The second page of this report displays an overview of activity. For the current date, period-to-date, and year-to-date the system displays the number of admissions, outpatient visits, emergency room visits, revenue, cash, adjustments, AR to BD transfers, BD to AR transfers, amount billed, and refunds. The report then displays information on the current date's account receivables, including nondischarged patients, patients discharged but not final billed, final billed patients, and total accounts receivable. Next, the report displays average daily revenue, AR days, bad debt amount, amounts billed and unbilled for vendors, and unapplied cash. The number of days used for Average Daily Revenue calculation is displayed at the end of the report.

The admission and registration information displayed on the report is not intended to balance to the other statistics reports available in STAR Patient Accounting. It is intended to provide management with a high level snapshot of the facility's registration activity.

Generating and Printing This Report

This report is generated during midnight processing. It can also be set up as a demand report and printed through the Demand Print function.

The following is an example of the Administrative Operating Summary Report.

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Figure 2.5 FSRAOS - Administrative Operating Summary Report - Page 1

```
Date: 05/27/97                              General Hospital                              Page  : 1
Time: 08:40am                   ADMINISTRATIVE OPERATING SUMMARY - 05/27/97              Report: FSRAOS


              No.    ------------Today------------      ---Period to Date--        --Year to Date-
              Beds   Occ     %     Cnt    Tot
                     Beds   Occ    Beds   Occ       Occ Beds     % Occ         Occ Beds   % Occ

1E 1 EAST      37     29    78.4    1      30          724       75.3            1383      58.4
AAA AAA                0     0.0    0       0            0        0.0               0       0.0
AAG AAG                0     0.0    0       0            0        0.0               0       0.0
BBB BBB                0     0.0    0       0            0        0.0               0       0.0
BOP BLAIR'S PLACE      0     0.0    0       0            0        0.0               0       0.0
CCU CORONARY CARE UNIT 10     1    10.0    1       2           26       10.0              55       8.6
DAD DAD                0     0.0    0       0            0        0.0               0       0.0
FFF FFF                0     0.0    0       0            0        0.0               0       0.0
GGG GGG                0     0.0    0       0            0        0.0               0       0.0
HHH HHH                0     0.0    0       0            0        0.0               0       0.0
ICU INTENSIVE CARE UNIT 13    6    46.2    0       6          178       52.7             305      36.7
JIM JIM                0     0.0    0       0            0        0.0               0       0.0
KLK KLK                0     0.0    0       0            0        0.0               0       0.0
LAA LABORATORY NSA     58     5     8.6    0       5          130        8.6             236       6.4
LAB LAB NURSING STATION 0     0.0    0       0            0        0.0               0       0.0
LD LABOR AND DELIVERY  10     0     0.0    0       0            0        0.0               0       0.0
LOV LOV                0     0.0    0       0            0        0.0               0       0.0
MCD MAUREENS PLACE     0     0.0    0       0            0        0.0               0       0.0
MH MENTAL HEALTH       40    15    37.5    0      15          390       37.5             883      36.3
MLO MIMI'S STATION     20     2    10.0    0       2           52       10.0             114       8.9
MOM MOM                0     0.0    0       0            0        0.0               0       0.0
NSY NURSERY            30     4    13.3    0       4          104       13.3             256      13.3
OB OBSTETRICS          10     4    40.0    0       4           92       35.4             192      30.0
OPA OUTPATIENT/BED NSA 20     0     0.0    0       0            0        0.0               0       0.0
PED PEDIATRICS         10     6    60.0    0       6          156       60.0             280      43.8
POP POP                0     0.0    0       0            0        0.0               0       0.0
PTA PATIENT CARE NSA   20     0     0.0    0       0            0        0.0               0       0.0
RAA RADIOLOGY NSA      20     0     0.0    0       0            0        0.0               0       0.0
RTR TERRY'S PLACE      0     0.0    0       0            0        0.0               0       0.0
RXA PHARMACY NSA       19     0     0.0    0       0            0        0.0               0       0.0
SFA STAR FIN NSA       26     1     3.8    0       1           26        3.8              42       2.5
TR1 TR1                0     0.0    0       0            0        0.0               0       0.0
TR2 TR2                0     0.0    0       0            0        0.0               0       0.0
TR3 TR3                0     0.0    0       0            0        0.0               0       0.0
TR4 TR4                0     0.0    0       0            0        0.0               0       0.0
TR5 TR5                0     0.0    0       0            0        0.0               0       0.0
TR6 TR6]               0     0.0    0       0            0        0.0               0       0.0


Totals        343     73    21.3    2      75         1878       21.1            3746      17.2
```

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Figure 2.6 FSRAOS - Administrative Operating Summary Report - Page 2

```
Date: 05/27/96                       General Hospital                       Page  : 2
Time: 08:40am              ADMINISTRATIVE OPERATING SUMMARY - 05/27/97       Report: FSRAOS

                       --------Today----------      ---Period to Date--       --Year to Date-


Admissions                            0                      10                     134

Registrations
 Outpatients                          0                       9                     269
 E/R                                  0                       4                      15

Revenue                       $17,985.00             $469,889.74             $975,909.60

Cash                               $0.00                  $45.00                  $45.00

Adjustments                        $0.00                   $0.00                   $2.00-

Transfers: AR -> BD                $0.00                   $0.00                   $0.00

Transfers: BD -> AR                $0.00                   $0.00                   $0.00

Amount Billed                     $16.50              $17,658.09              $41,939.41

Refunds                            $0.00                   $0.00                   $0.00

    Todays A/R

Inhouse (P/A)                $891,709.49
Discharged Not Billed         $29,219.95
Billed Accounts (A/R)         $49,132.41

Total Receivables            $970,061.85

Average Daily Revenue         $11,215.25
AR Days                           86.49

Bad Debt                           $0.00

Vendor Unbilled (PA)               $0.00
Vendor Billed (AR)                 $0.00

Unapplied Cash                     $0.00
```

The report header displays the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

On the first page of the report, the system prints the nurse station code and location description for each nurse station. This page of the report contains the following fields of information:

NO. BEDS
This field displays the number of beds for each nurse station where the CNT Bed flag is set to Yes.

TODAY
This field contains a census summary for each nurse station for the current date, including number of occupied beds, percent occupancy, count beds, and the total occupancy of the station.

OCC BEDS
This field displays the number of occupied beds for each nurse station where the CNT Beds flag is set to Yes.

% OCC
This field displays the calculation for the percentage of occupancy. The calculation is Occ Beds divided by No. Beds.

CNT BEDS
This field displays the number of occupied beds for each nurse station where the CNT Beds flag is set to No.

TOT OCC
This field contains the total number of occupied beds for each nurse station.

PERIOD TO DATE
This field contains a census summary for each nurse station for the period to date, including occupied beds, and the occupancy percentage of the station.

YEAR TO DATE
This field contains a census summary for each nurse station for the year to date, including occupied beds and the occupancy percentage of the station.

The second page of the report contains the following information:

ADMISSIONS
This field contains the number of new inpatient admissions for the day. It does not include backdated or cancelled admissions. Today's number should agree with the Total In Bed number on the facility's Patient Care Daily Admission Report (ADR). Period-to-date and year-to-date totals are also provided.

REGISTRATIONS

This field contains the number of new outpatient registrations and emergency room visits for the day. It does not include backdated or cancelled registrations. The total of the outpatient registrations and the emergency room visits should agree with the Total O/P Admissions on the facility's Patient Care Daily O/P Admission Report (RGR). Period-to-date and year-to-date totals are also provided.

NOTE: The Daily O/P Admission Report is subtotaled by patient type. E/R visits should balance to the total of the emergency room patient types on this report. The total of all other patient types should balance to the number of outpatient registrations.

REVENUE

This field displays the daily, period-to-date, and year-to-date revenue for the facility. It includes both patient and contract revenue. The daily amount can be balanced by adding the facility totals on the Financial Activity Journal (FARAJR) plus the Contract Activity Journal (FDRAJR) plus Today's Unapplied Charge Log (FAR011). You can alternatively use the facility total on the summary versions of the activity journals, FARAJR2 and FDRAJR2, respectively, plus Today's Unapplied Charge Log (FAR011).

CASH

This field contains the daily, period-to-date, and year-to-date cash for the facility. It includes PA, AR, BD, and Contract Cash. On a daily basis, it can be balanced to the sum of the grand totals on the Cash Posting Detail Report (FAR130) and the Guarantor Cash Posting Detail Report (FAR135).

ADJUSTMENTS

This field displays the daily, period-to-date, and year-to-date adjustments for the facility. It includes PA, AR, BD, and Contract Adjustments. On a daily basis, it can be balanced to the grand totals on the Adjustment Posting Detail Report (FAR210).

TRANSFERS AR - BD

This figure displays the daily, period-to-date, and year-to-date amounts transferred from AR (Accounts Receivable) to BD (Bad Debt). On a daily basis, the figure contains the account balance of all accounts transferred to BD from AR for the current date and may be balanced to the AR to BD Transfer Report (FFR210).

TRANSFER BD - AR

This figure displays the daily, period-to-date, and year-to-date amount transferred from BD (Bad Debt) to AR (Accounts Receivable). On a daily basis, the figure contains the account balance of all accounts transferred to AR from BD for the current date and may be balanced to the BD to AR Transfer Report (FFR220).

AMOUNT BILLED

This field contains the daily, period-to-date, and year-to-date amount billed for the facility. On a daily basis, it contains the account balances of accounts final billed for that date and may be balanced to the Facility Total of Account Balances for Final Bills on the Billed Accounts Report (FBR200).

REFUNDS
This field displays the daily, period-to-date, and year-to-date refund amount for the facility. On a daily basis, it contains the amount of refunds that were approved and deleted for that day, and may be balanced to the Refund Approved/Deleted Report (FPREPPRP).

INHOUSE (P/A)
This field contains the account balance of all accounts that have not been discharged.

DISCHARGED NOT BILLED
This field contains the account balance of all accounts who have a discharge date but who have not had a final bill.

NOTE: Adding Inhouse (P/A) and Discharged Not Billed amounts should tie to the subsidiary balance on the PA Daily Balancing screen. These fields do not balance to the Receivable Analysis Report (FSR910) because the amounts on the Administrative Operating Summary reflect the account balance whereas the amounts on the Receivable Analysis Report reflect unbilled versus billed charges.

BILLED ACCOUNTS (A/R)
This field contains the account balance of all accounts that have been final billed (i.e., in locator AR). It should balance to the subsidiary balance on the AR Daily Balancing Screen and to the Facility Totals - A/R on the Receivable Analysis Report (FSR910), which is an optional batch job.

TOTAL RECEIVABLES
This field contains the account balance of all accounts that are in locations PA and AR. This figure should tie to the total of the subsidiary fields on the PA and AR balancing screens, as well as to the Facility Totals on the Receivable Analysis Report (FSR910), which is an optional batch job.

AVERAGE DAILY REVENUE
This field displays the average daily revenue for the facility. The hospital uses the PAAR Control Table to define the number of days or months the system should use for the calculation of Average Daily Revenue. For more information, refer to the discussion of PAAR Control Table in the Financial System Management section in the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide*. This figure should equal the Facility Total Average Daily Revenue on the Receivable Analysis Report (FSR910), which is an optional batch job.

AR DAYS
This field displays the average number of days an account is in accounts receivable. It is calculated by dividing the Total Receivables by the Average Daily Revenue. This figure should balance to the Facility Total AR Days on the Receivable Analysis Report (FSR910), which is an optional batch job.

BAD DEBT
This figure is the account balance of all accounts that are in location Bad Debt (BD). This figure should equal the subsidiary balance on the BD Daily Balancing Screen

VENDOR UNBILLED (PA)
This field contains the balance of all vendor contracts that have not been final billed. This amount should equal the subsidiary balance on the Contract PA Daily Balancing Screen.

VENDOR BILLED (AR)
This field displays the balance of all vendor contracts that have been final billed. This amount should equal the subsidiary balance on the Contract AR Daily Balancing Screen.

UNAPPLIED CASH
This field contains the total amount of the unapplied cash account. This figure should balance to the subsidiary balance on the Unapplied Cash Daily Balancing Screen.

UNAPPLIED CHARGE LOG - FAR010

Description/Purpose

The Unapplied Charge Log provides a cumulative listing of any Patient Care charges or credits that have not been applied to a specific patient account. Normally, this condition would not occur unless some type of network problem exists. The charge information for patients and ATD information are transmitted across different network lines and, at times, the charges for an account reach the financial system before they reach the patient's admission information. These *unapplied* charges/credits are placed in a holding file. During the financial batch process, the system checks each charge record to determine if the account information now exists. If the information exists, the system applies the charge to the account. If the system cannot locate the account master information on the financial system, the charge/credit is printed on this report.

Generating and Printing This Report

This report is generated during nightly batch processing and can be generated on demand using the Print Unapplied Charge Log function. The system references the spooler report definition to determine whether the report is printed immediately or on demand.

If the Unapplied Charge Log report is produced during midnight processing, the report prints for all available facilities. If the Unapplied Charge Log report is generated using the Print Unapplied Charge Log function, the report prints only for the facility selected.

The following is an example of the Unapplied Charge Log Report.

Figure 2.7 FAR010 - Unapplied Charge Log Report

```
Date: 07/19/90                        General Hospital                       Page  : 1
Time: 05:19                           Unapplied Charge Log                    Report: FAR010P

Seq #      Description                 Service Date   Qty      Amount
3          MRI ORBIT                   07/16/90       1                 584.30
4          MRI BRAIN STEM              07/18/90       1                 590.00
5          HEMOGLOBIN SERUM FREE       07/18/90       2                 100.44
6          HEMOGLOBIN SERUM FREE       07/18/90       -1                 50.22-

Total for account 90191-00001 HALL,SAMUEL :            Charges: 4    Amount:     $1,224.52


Total facility  P :                                    Charges: 4    Amount:     $1,224.52

                                      End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name (FAR010).

SEQ #
This field contains the sequence number of this charge/credit in the unapplied charge holding file.

DESCRIPTION
This field contains the SIM description of the charge/credit.

SERVICE DATE
This field contains the patient care service date.

QTY
This field contains the charge quantity.

AMOUNT
This field contains the total charge/credit amount.

TOTAL FOR ACCOUNT
This field contains the account number and name and the total unapplied charge quantity and the total unapplied charge/credit amount for the account.

TOTAL FACILITY
This field contains the facility indicator and lists the total unapplied charge quantity and the total unapplied charge/credit amount for the facility.

TODAY'S UNAPPLIED CHARGE LOG - FAR011

Description/Purpose

Today's Unapplied Charge Log provides a listing of any patient care charges or credits generated for the day that have not been applied to a specific patient account. Normally, this condition would not occur unless some type of network problem exists. The charge information for patients and ATD information are transmitted across different network lines and, at times, the charges for an account reach the financial system before they reach the patient's admission information. These *unapplied* charges/credits are placed in a holding file. During the financial batch process, the system checks each charge record to determine if the account information now exists. If the information exists, the system applies the charge to the account. If the system cannot locate the account master information on the financial system, the charge/credit is printed on this report.

Generating and Printing This Report

This report is generated during nightly batch processing. The system references the spooler report definition to determine whether the report is printed immediately or on demand.

The following is an example of the Unapplied Charge Log Report.

Figure 2.8 FAR011 - Today's Unapplied Charge Log Report

```
Date: 07/19/90                             General Hospital                          Page  : 1
Time: 05:19                            Todays Unapplied Charge Log                    Report: FAR011P

Seq #      Description                    Service Date   Qty       Amount
4          MRI BRAIN STEM                 07/18/90       1         590.00
5          HEMOGLOBIN SERUM FREE          07/18/90       2         100.44
6          HEMOGLOBIN SERUM FREE          07/18/90       -1         50.22-


Total for account 90191-00001 HALL,SAMUEL :          Charges: 3      Amount:     $640.22


Total facility  P :                                  Charges: 3      Amount:     $640.22

                                           End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

SEQ #
This field contains the sequence number of this charge/credit in the unapplied charge holding file.

DESCRIPTION
This field contains the SIM description of the charge/credit.

SERVICE DATE
This field contains the patient care service date.

QTY
This field contains the charge quantity.

AMOUNT
This field contains the total charge/credit amount.

TOTAL FOR ACCOUNT
This field contains the account number and name and the total unapplied charge quantity and the total unapplied charge/credit amount for the account.

TOTAL FACILITY
This field contains the facility indicator and lists the total unapplied charge quantity and the total unapplied charge/credit amount for the facility.

APPLIED/UNAPPLIED CHARGE REPORT - FAR012

Description/Purpose

The Applied/Unapplied Charge Report provides a listing of previous patient care charges or credits that were not applied that were *applied* to a specific patient account during batch processing. Each night batch processing checks all unapplied charges/ credits and attempts to match them with the appropriate patient account. This report lists those charge/credits that are successfully applied.

Generating and Printing this Report

The Applied/Unapplied Charge Report is generated during nightly batch processing. The system references the spooler report definition to determine whether the report is printed immediately or on demand.

The following is an example of the Applied/Unapplied Charge Report.

Figure 2.9 FAR012 - Applied/Unapplied Charge Report

```
Date: 07/30/90                              General Hospital                        Page  : 1
Time: 07:39                              Applied/Unapplied Charge Rpt                Report: FAR012

Seq #      Description                  Service Date   Qty        Amount
7          MRI BRAIN              70551 07/23/90       2              1,180.00
8          MRI BRAIN              70551 07/23/90       -1               590.00-
9          BARBITURATES                07/23/90       1                 46.85
10         BLOOD GAS PANEL             07/23/90       1                 50.00

Total for account 90170-00001 HALL,MICHAEL :       Charges: 4     Amount:      $686.85

Total facility  P :                                Charges: 4     Amount:      $686.85

                                          End of Report
```

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The report contains a header that includes the date and time the report is generated, the hospital name, the report title, the page number and the report name.

SEQ #
This field contains the sequence number of this charge/credit in the unapplied charge holding file.

DESCRIPTION
This field contains the SIM description of the charge/credit.

SERVICE DATE
This field contains the patient care service date.

QTY
This field contains the charge/credit quantity.

AMOUNT
This field contains the total charge/credit amount.

TOTAL FOR ACCOUNT
This field contains the account number and name and the total charge quantity and the total charge/credit amount applied to the specified account.

TOTAL FACILITY
This field contains the facility indicator and lists the total unapplied charge quantity and the total unapplied charge/credit amount for the facility.

ARCHIVE SELECTION REPORT - FBRAR

Description/Purpose

The Archive Selection Report lists all archived accounts. Archived accounts are those meeting the specific archive criteria defined by the hospital in the data retention parameters (accounts must have a zero balance and have passed the number of days specified to be eligible for archiving). Bad Debt accounts are eligible for archive when they reach the end of their agency follow-up schedule.

The report lists the patient name, account number, discharge date, patient type, financial class, account balance, zero balance date and account location/sub location. Totals by account location are provided for the number of accounts archived and total balance of all accounts archived.

Generating and Printing This Report

The Archive Selection Report is an Optional Batch Report. Options exist for the printing of the report by daily interval, day of the month, or day/week of the month. Refer to the Financial System Management section in the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide* for more information on requesting this report.

The report is sorted by patient name.

The following is an example of the Archive Selection Report.

Figure 2.10 FBRAR - Archive Selection Report

```
Date: 04/18/08                          Model Hospital A                          Page  : 1
Time: 2:14                      Archive Selection Report for 04/17/08              Report: FBRARA
                                      Facility Model Hospital A


Patient Name                 Acct Number   Disch Dt    PT    FC    Account Bal   Zero Bal Dt   Acct Loc


JONES,KIMBERLY               A0632000001   11/16/2006  LEC   S            0.00   03/29/2007    AR/ACCF
NADAL,JOSIE                  A0701800003   01/18/2007  ER    S            0.00   03/29/2007    AR/ACCF
NELSON,MARK                  A0702600004   01/26/2007  ER    S            0.00   03/29/2007    AR/ACCF
NETTLETON,CHARLES            A0701800001   01/18/2007  ER    S            0.00   03/29/2007    AR/ACCF
NORRIS,MORRIS                A0701100002   01/11/2007  LEC   S            0.00   03/29/2007    AR/ACCF
PAUL,JACKSON                 A0702200005   01/22/2007  OPO   S            0.00   03/29/2007    AR/ACCF
SANFORD,MICHAEL              A0703200007   02/01/2007  O/P   S            0.00   03/29/2007    AR/ACCF
SELLERS,RACHEL               A0702200008   01/22/2007  OPO   S            0.00   03/29/2007    AR/ACCF
SANDOWSKI,MEREDITH           A0631900005   11/15/2006  OP    S            0.00   03/29/2007    AR/ACCF
WILLIAMSON,MARY              A0701700001   01/17/2007  ER    O            0.00   03/29/2007    AR/ACCF


                             Number of Accounts Archived - AR:        10
                                                           BD:
                                                         Total:       10


                             Balance of Accounts Archived:       $0.00


                                          End of Report
```

BAD DEBT ARCHIVE SELECTION REPORT - FBRARCP

Description/Purpose

The Bad Debt Archive Selection Report lists all archived bad debt accounts by collection agency. Bad Debt accounts are eligible for archive when they reach the end of their agency follow-up schedule.

The report lists the patient name, account number, patient type, financial class, and account balance. The report displays totals for number of accounts and dollar amounts for the collection agency and facility.

Generating and Printing This Report

The Bad Debt Archive Selection Report is created by the Bad Debt to Archive Pre-List Selection and Bad Debt to Archive Pre-List Report optional batch jobs. Options exist for the printing of the report by daily interval, day of the month, or day/week of the month. Refer to the Financial System Management section in the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide* for more information on requesting this report.

The report is sorted by collection agency code and patient name.

The following is an example of the Bed Debt Archive Selection Report.

Figure 2.11   FBRARCP - Bad Debt Archive Selection Report

```
Date: 08/06/90                          General Hospital                        Page  : 1
Time: 12:54                   BD Archive Selection Report for 08/06/90          Report:  FBRARCP
                                          Facility P

                                   ***Collection Agency:CPLCR***

Patient Name                   Account Number   Pat Type   Fin Cls   Balance

SMITH,HAROLD                   90163-00003        E/R        80        26.75

                                Number of Accounts Archived :        1
                                Balance of Accounts Archived:     $26.75

                                Total Number of Accounts Archived :        1
                                Total Balance of Accounts Archived:     $26.75


                                       End of Report
```

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Chapter 2 - ACCOUNT MANAGEMENT REPORTS

ARCHIVE EXCEPTION REPORT - FARAER

Description/Purpose

The Archive Exception Report provides a list of accounts that are eligible for account archive but could not be archived because claims still exist on the account that have not been archived or purged. The report includes the account number, account location, patient name, zero balance date, the reason the account could not be archived, the carrier/plan, and the claim sequence number.

Generating and Printing This Report

The system creates the Archive Exception Report when the optional batch job Account Archive Selection is run. The report is sorted by patient account number. Refer to "Optional Batch Jobs" in Chapter 2: Financial System Management of the *General Information Volume* in the *STAR Financials Patient Accounting Reference Guide* for more information.

The following is an example of the Archive Exception Report.

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Figure 2.12 FARAER - Archive Exception Report

```
Date: 07/10/92                          GENERAL HOSPITAL                         Page  : 1
Time: 01:41am                       Archive Exceptions Report                    Report: FARAER
                                          for 07/09/92

Patient No. Loc Patient Name              ZERO BAL    EXCEPTION                   CARR/PLN    CLM SEQ
-----------------------------------------------------------------------------------------------------

A9217100103 AR  ROBINSON,THELMA           07/09/92    Claim not Archived         85/0021     1
A9217100152 AR  ACKERMAN,EDWARD           06/30/92    Claim not Archived         85/0121     1
                                                      Claim not Archived         85/0003     2
                                                      Claim not Archived         50/0002     3
                                                      Claim not Archived         85/0001     4
A9217500013 AR  MEYERS,NAOMI              06/28/92    Claim not Archived         22/0000     1
                                                      Claim not Archived         22/0000     2
                                                      Claim not Archived         85/0003     3
                                                      Claim not Archived         85/0001     4
                                                      Claim not Archived         22/0000     5
                                                      Claim not Archived         02/0010     6
                                                      Claim not Archived         85/0003     7
                                                      Claim not Archived         50/0023     8
                                                      Claim not Archived         50/0023     9
                                                      Claim not Archived         85/0003     10
A9217700012 AR  SORENSON,BILL             06/25/92    Claim not Archived         22/0000     1
                                                      Claim not Archived         02/0002     2
                                                      Claim not Archived         85/0003     3
                                                      Claim not Archived         85/0099     4
                                                      Claim not Archived         85/0003     5
                                                      Claim Archived, Not Purged 85/0099     6
A9218200009 BD  GROVER,WENDELL            07/10/92    Claim not Archived         44/0001     1

                                          End of Report
```

A full page of the report is provided for each facility for which accounts were processed for archiving. Each page contains a header including the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

PATIENT NO.
This field contains the patient account number.

LOC
This field displays the account location (AR or BD).

PATIENT NAME
This field contains the patient name.

ZERO BAL
This field displays the date on which the account balance was set to zero.

EXCEPTION
This field displays the exception message, or the reason the account could not be archived. Possible exception messages are:

- **Claim not Archived**
  The system displays this message if the account claim has not been archived.

- **Claim Archived, not Purged**
  The system displays this message if the account claim has been archived, but has not been purged.

CARR/PLAN
This field contains the carrier/plan code.

CLM SEQ
This field contains the claim sequence number of the claim which has not been archived or purged.

BD BALANCE CONTROL REPORT - FARBAL3

Description/Purpose

This report provides a daily BD balance summary and reconciliation. It lists a beginning balance for the day and a summary total for each category of transactions effecting the BD balance.

An Ending Bad Debt Balance, Subsidiary Balance and GL Control balance are calculated and provided for reconciliation purposes. If the ending Bad Debt Balance and Subsidiary Balance are not the same, the Bal Flag field displays an N indicating an out of balance condition and the need for bad debt account reconciliation.

This report serves as an daily audit tool for the balancing and reconciliation of the Bad Debt account.

Generating and Printing This Report

This report is generated through the daily Bad Debt balancing functions. Online selection of this report enables you to select by period. It is set up as a demand report and printed through the Demand Print function.

This report is sorted by the day of the month.

The following is an example of a Bad Debt Balance Control Report.

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Figure 2.13 FARBAL3 - Bad Debt Control Report

```
Date: 06/12/00                                    Model Hospital A                              Page  : 1
Time: 10:43                                   BD Balance Control Report                         Report: FARBAL3A
                                                MO:  06  YEAR:  00

      Open BD Bal            Adjs           L Chg/CR          Deletions          BD/AR X-fer         Subs Bal
Day                  Cash            Refunds                    PMA          AR/BD X-fer         End BD Bal        G/L Ctrl Bal  Bal
        Reconciliation Comments
01     196,926.73            0.00             0.00            0.00            0.00            0.00        196,926.73
               0.00             0.00            0.00            0.00            196,926.73          196,121.73    N


02     196,926.73            0.00             0.00            0.00            0.00            0.00        196,926.73
               0.00             0.00            0.00            0.00            196,926.73          196,121.73    N


03     196,926.73            0.00             0.00            0.00            0.00            0.00        196,926.73
               0.00             0.00            0.00            0.00            196,926.73          196,121.73    N


04     196,926.73            0.00             0.00            0.00            0.00            0.00        196,926.73
               0.00             0.00            0.00            0.00            196,926.73          196,121.73    N


05     196,926.73            0.00             0.00            0.00            0.00            0.00        196,926.73
               0.00             0.00            0.00            0.00            196,926.73          196,121.73    N


06     196,926.73            0.00             0.00            0.00            0.00            0.00        196,926.73
               0.00             0.00            0.00            0.00            196,926.73          196,121.73    N


07     196,926.73            0.00             0.00            0.00          859.48        196,067.25
               0.00             0.00            0.00            0.00            196,067.25          195,262.25    N


08     196,067.25            0.00             0.00            0.00            0.00            0.00        196,067.25
               0.00             0.00            0.00            0.00            196,067.25          195,262.25    N


09     196,067.25            0.00             0.00            0.00            0.00            0.00        196,067.25
               0.00             0.00            0.00            0.00            196,067.25          195,262.25    N


10     196,067.25            0.00             0.00            0.00            0.00            0.00        196,067.25
               0.00             0.00            0.00            0.00            196,067.25          195,262.25    N


 195,262.25   N
        gl out of balance                                        Reconciled by: Store,Lani S
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

DAY
This field contains the day of the month.

OPEN BD BAL
This field contains the system-supplied prior day's subsidiary balance.

CASH
This figure represents cash posted for the day to accounts in Bad Debt. It comes from the Cash Posting Detail report (BD Total) - FAR130.

ADJS
This figure represents adjustments posted for the day to accounts in Bad Debt. It comes from the Adjustment Posting Detail report (BD Total) - FAR210.

REFUNDS
This field contains the amount for patient refunds that were approved and/or deleted for that day for accounts that are in location BD. This amount can be verified using the Refunds Approved/Deleted report (FPREPPR).

L CHG/CR
This figure represents the dollar amount of any late charges/credits that were entered against accounts that are in location BD. It comes from the Financial Late Charge report (BD Total) - FARAJ1.

PMA
This field contains the amount for post-midnight activity (the overflow charges) for accounts in location BD that have passed Patient Accounting. Overflow charges are charges that are posted to the subsidiary balance but not the GL Control accounts during midnight processing. This figure is normally zero. This amount comes for the Overflow Charge report (FCRCHG).

DELETIONS
This figure represents the dollar amount of accounts being purged from Bad Debt. It is updated from the Archive Selection report - FBRAR.

AR/BD X-FER
This figure represents the dollar amount of accounts transferred from Accounts Receivable to Bad Debt. It comes from the AR To BD Transfer report - FFR210.

BD/AR X-FER
This figure represents the dollar amount of accounts transferred from Bad Debt back to Accounts Receivable. It comes from the BD To AR Transfer report -FFR220.

END BD BAL

This field contains the system-supplied ending balance calculated by adding and subtracting daily activity from the opening balance. The calculation is:

```
    OPEN BD BAL
  - CASH
+/- ADJS
+/- REFUNDS
  + L CHG/CR (-Late credits)
  + PMA
  - DELETIONS
  + AR/BD X-FER
  - BD/AR X-FER
 _____

    END BD BAL
```

SUBS BAL

This field contains the system-supplied subsidiary balance. The subsidiary balance is calculated during midnight processing by adding the balances of all accounts in account location Bad Debt. This figure becomes tomorrow's opening balance.

G/L CTRL BAL

This figure represents the General Ledger control balance and should match the subsidiary balance as well as the ending Bad Debt balance. Any day where the ending, subsidiary and GL total balances do not match requires reconciliation.

BAL

This field contains an N if the daily balance requires reconciliation.

RECONCILIATION COMMENTS

This field contains any comments entered to explain why Bad Debt does not balance and the solution to solve the discrepancy.

RECONCILED BY

This is only displayed if someone has updated the screen. It prints the name of the last person to make a change to the screen.

BAD DEBT ARCHIVE PRELIST REPORT - FBRBDPL

Description/Purpose

The Bad Debt Archive Prelist report lists all accounts in Bad Debt which qualify to be archived. It is used by the hospital to verify accounts to be deleted from Bad Debt by the account selection process. Accounts which the hospital does not wish to be deleted can be put on hold or resequenced in their assigned follow up schedule.

An account is eligible for the Bad Debt Prelist report when it reaches the end of the assigned follow up schedule and meets the established write off criteria.

Accounts are listed in alphabetical order by collection agency. Reported information includes patient name, number, financial class, patient type, collection agency, collection agency transfer date and amount, last payment date, number of payments received, account balance and selection flag. Totals by collection agency are provided.

Generating and Printing This Report

This report is generated as a result of optional batch. A report is generated for each facility available. Separate pages and totals are produced for each collection agency reported. It can be printed using the demand report function. Refer to "Optional Batch Jobs" in Chapter 2: Financial System Management of the *General Information Volume* in the *STAR Financials Patient Accounting Reference Guide* for more information.

The following is an example of the BD Archive Prelist Report.

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Figure 2.14 FBRBDPL - BD Archive Prelist Report - Page 1

```
Date: 11/11/89                              General Hospital                            Page  : 1
Time: 08:40am                             BD Archive Prelist Report                     Report: FBRBDPL
                                               Facility A


                                           Coll   Transfer to Agency      Last        #      Current    Sel
Patient Name            Account Number   F/C  P/T  Agency    Date    Amount   Payment   Payments  Balance   Flag

BARROWS,BRENDA          89255-00007       80  O/P  HCC    10/19/89   300.00   10/20/89    3      100.00    MS
CLARKE,WILLIAM          89234-00024       86  I/P  HCC    10/19/89   240.00   09/17/89    4      125.89    SS
DEVLIN,ROBERTA          89243-00010       85  O/P  HCC    10/19/89    50.00   09/18/89    2      100.00     H


                                       COLLECTION AGENCY TOTALS

                      Selection Flag           No. Accts       Amount
                       Manually Selected           1           100.00
                       System Selected             1           125.89
                       Hold                        1           100.00


                      Patient Indicator
                       Inpatient                   1           125.89
                       Outpatient                  2           200.00
                       Emergency                   0


                       TOTAL                       3           325.89
```

Figure 2.15 FBRBDPL - BD Archive Prelist Report - Page 2

```
Date: 11/11/89                              General Hospital              Page  : 2
Time: 08:40am                             BD Archive Prelist Report       Report: FBRBDPL
                                               Facility A

                                        FACILITY TOTALS

                      Selection Flag           No. Accts       Amount
                       Manually Selected           1           100.00
                       System Selected             1           125.89
                       Hold                        1           100.00

                      Patient Indicator
                       Inpatient                   1           125.89
                       Outpatient                  2           200.00
                       Emergency                   0

                       TOTAL                       3           325.89
                                      End of Report
```

Each report contains a header that contains the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

PATIENT NAME
This is the patient name.

ACCOUNT #
This is the patient account number.

F/C
This is the financial class of the selected account.

P/T
This is the patient type of the selected account.

COLL AGENCY
This is the collection agency to which the account is assigned.

TRANSFER TO AGENCY - DATE
This is the date that the account was transferred to the collection agency.

TRANSFER TO AGENCY - AMOUNT
This is the balance of the account at the time it was transferred to the collection agency.

LAST PAYMENT
This is the date of the last patient payment posted to the selected account.

 # PYMTS
This is the total number of patient payments posted to the selected account.

CURRENT BALANCE
This is the current account balance of the selected account.

SEL FLAG
This is the selection flag indicating how the account was selected for the report. Possible selection flags are SS (system selected), MS (manually selected) and H (hold).

TOTALS
Subtotals are provided by selection flag and patient indicator. A grand total for the collection agency is reported. A separate page is printed which provides facility totals for the same criteria.

BAD DEBT ARCHIVE SELECTION REPORT - FBRBDA

Description/Purpose

The Bad Debt Archive Selection Report lists all accounts in Bad Debt that have been archived. It is produced in conjunction with the Archive Selection Report.

The report is separated by collection agency and is provided so that the collection agencies know to delete the archived accounts from their files.

Accounts are listed in alphabetical order by collection agency. Reported information includes patient name, number, patient type, financial class and account balance. Totals by collection agency are provided.

Generating and Printing This Report

This report is generated as a result of optional batch. A report is generated for each facility available. Separate pages and totals are produced for each collection agency reported. It can be printed using the demand report function. Refer to "Optional Batch Jobs" in Chapter 2: Financial System Management of the *General Information Volume* in the *STAR Financials Patient Accounting Reference Guide* for more information.

The following is an example of the BD Archive Selection Report.

Figure 2.16 FBRBDA - BD Archive Selection Report

```
Date: 08/06/90                     General Hospital                    Page  : 1
Time: 12:54              BD Archive Selection Report for 08/06/90      Report: FBRARCP
                                     Facility P

                            ***Collection Agency:CPLCR***

Patient Name                          Account Number    Pat Type    Fin Cls       Balance

SMITH,HAROLD                          90163-00003        E/R          80           26.75

                       Number of Accounts Archived :          1
                       Balance of Accounts Archived:       $26.75

                       Total Number of Accounts Archived :          1
                       Total Balance of Accounts Archived:       $26.75


                                   End of Report
```

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The report contains a header that contains the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

COLLECTION AGENCY
This field contains the collection agency code being reported.

PATIENT NAME
This field contains the patient's name.

ACCOUNT #
This field contains the patient's account number.

PAT TYPE
This field contains the patient type of the archived account.

FIN CLS
This field contains the financial class of the archived account.

BALANCE
This field contains the account balance of the account at the time it was archived.

TOTALS
These fields contain totals of the number of accounts archived and their total account balance. Each collection agency prints its own report with separate totals. Facility totals of all accounts archived and their total balance are provided on a separate page. A total for the collection agency is reported. A separate page is printed which provides facility totals for the same criteria.

CASH POSTING DETAIL REPORT - FAR130

Description/Purpose

The Cash Posting Report lists all cash batches posted for the day. This report includes all cash batches approved by the hospital and window cash batches automatically posted during batch processing.

NOTE: This report also includes cash batches that are generated in STAR Financials Patient Accounting as a result of the HorizonWP® Patient Portal Account Management Interface. These batches appear at the end of the report.

The report includes the account number, carrier/plan, account name, carrier name, posting date, transaction code, contractual adjustment amount, amount transaction description, remittance/check/card number, account location, DRG days paid, outlier, and final claim status.

All unapplied cash transferred is listed under Batch 0. Totals are provided for the number and amounts posted by patient type and location. Totals for contractual adjustment amounts are provided by patient type and location. A grand total is provided for balancing purposes.This total incorporates the transfers from unapplied cash. This value is displayed through a line item description "Transfers From Unapplied Cash." This was added to aid in the balancing of cash receipts with the bank statement. The cash balance is only affected when the cash is originally entered into the Unapplied Cash batch or when an unapplied cash refund checked is printed rather than when the refund is approved.

The report also includes a summary of agency fees, broken down by collection agency. The agency fee summary is provided for information only and is not included in the grand total.

Generating and Printing This Report

This report is generated during midnight processing. It is set up and printed as a demand report, and sorted by batch number by day.

The following is an example of a Cash Posting Detail Report.

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Figure 2.17 FAR130 - Cash Posting Detail Report - Page 1

```
Date: 07/20/07                                 General Hospital                              Page  : 1
Time: 1:03                                 Cash Posting Detail for 07/19/07                  Report: FAR130A
                                               Batch 736 - INS CASH

Account #      Account Name              --Date-- Trans Amount  TCode Transaction Description     Loc Days DRG Out Final Claim
Sq   CR/PL     Carrier Name              Post/Pay Cont Adj Amt  TCode Cont Trans Description               Remittance/Check/Card #
Payor Clm ID   Clm Status                         Deductible         Coinsurance       Co-Pay    Pt Resp
   Denial Codes            Clm Adj Group    Den Amt  HCPCS          Charge Amount   Pymt Amount   Total Denial Amount
----------------------------------------------------------------------------------------------------------------------------
0719200003     KANE, MARY                07/19/07     20.00     I0008 COMMERCIAL INSURANCE PAYMENT    AR                    1
1    918/100   PCON PRIMARY              07/19/07      0.00
                                                  15.00             10.00
         18               CO           30.00
         18               CO           10.00
         35               CO           35.00                                                     75.00


User ID: Smith, Betty                 Batch Tot:       20.00   C/A Tot:        0.00   Ded Tot:         15.00
                                      Coins Tot:       10.00   Co-Pay Tot:     0.00   Pt Resp Tot:      0.00
```

Figure 2.18 FAR130 - Cash Posting Detail Report - Page 2

```
Date: 07/20/07                                General Hospital                          Page : 3
Time: 1:03                               Cash Posting Detail for 07/19/07               Report: FAR130A
                                                Report Totals

Transaction Code                  Type  Count          Amount      Count     Adj Amount
----------------------------------------------------------------------------------------------

0008 COMMERCIAL INSURANCE PAYMENT    I    2             30.00

Grand Total                               2             30.00                    0.00


Patient Type            Count        Amount      Count      Adj Amount
-----------------------------------------------------------------------
Inpatient                             0.00                    0.00
Outpatient                2          30.00                    0.00
Contract                              0.00                    0.00


Location                Count        Amount      Count      Adj Amount
-----------------------------------------------------------------------
PA                                    0.00                    0.00
AR                        2          30.00                    0.00
BD                                    0.00                    0.00
Miscellaneous                         0.00                    0.00
Contract PA                           0.00                    0.00
Contract AR                           0.00                    0.00


Agency Fees                          Amount
---------------------------------------------


Unapplied               Count        Amount
---------------------------------------------

Unapplied                             0.00
Transfers from Unapplied              0.00

* Contractual adjustment code was modified or added
```

Each report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

ACCOUNT #
This field contains the patient's account number.

ACCOUNT NAME
This field contains the patient's name.

POST DATE
This field contains the date on which this cash item is posted.

PAY DATE
This field indicates the date the payment was received.

TRANS AMOUNT
This field contains the amount of cash posted.

COUNT ADJ AMT
This field contains the contractual adjustment amount.

TCODE
This field contains the transaction code associated with the payment.

TCODE
This field contains the transaction code associated with the contractual adjustment.

TRANSACTION DESCRIPTION
This field contains a transaction description of the type of transaction posted, for example, patient payment or insurance payment.

CONT TRANS DESCRIPTION
This field contains a transaction description of the type of contractual adjustment transaction.

LOC
This field contains the location of the account to which the transaction was posted, for example PA, AR, or BD.

PAID - DAYS
This field contains the number of days paid. This field is used only when the cash type is insurance and the paid days is entered during the posting.

DRG
This field contains the number of the DRG paid. This field is used only when the cash type is insurance and the paid DRG is entered during the posting and is zero for guarantor cash posting.

OUT

This field is used only when the cash type is insurance and the outlier is entered during the posting and is blank for guarantor cash posting.

FINAL CLAIM

This field is used only when the cash type is insurance and the final claim is entered during the posting and is blank for guarantor cash posting.

SQ

This field contains the system-generated sequence assigned to the cash item in the batch.

CR/PL

This field contains the carrier/plan identification.

CARRIER NAME

This field contains the carrier name.

REMITTANCE/CHECK/CARD #

This field contains the remittance number entered for the account.

PAYOR CLAIM ID

This field displays the Payor Claim ID for the claim, which is the Facility Indicator + Account Number + Original Claim Sequence Number.

CLM STATUS

This field contains the claim work status code and description. The claim status is either D (deleted), M (manually released), A (awaiting payment), F (failed), R (released), E (edit), H (hold), or S (suppressed).

COINSURANCE (DISPLAY ONLY)

This column displays the coinsurance amount for the service line.

DEDUCTIBLE (DISPLAY ONLY)

This column displays the deductible amount for the service line.

CO-PAY

This field contains the amount of the first coverage period's co-pay.

PT RESP

This field contains the amount of the patient's responsibility.

DENIAL CODES

This field contains the payor's denial reason.

CLM ADJ GROUP

This field contains the claim adjustment group code which is the general grouping of reasons for denials. The standard ANSI X12 835 codes are CO for Contractual

Obligations, CR-Correction and Reversals, OA-Other Adjustments, PI-Payor Initiated Reductions, Pr-Patient Responsibility.

DENIAL AMT
This field contains the denial amount for this denial reason code.

HCPCS
This field contains the HCPCS procedure code with any attached HCPCS modifiers for the charge. This field is used only for ERA claims.

CHARGE AMT
This field contains the charge amount that is related to the service line on the claim. This field is used only for ERA claims.

PYMT AMT
This field contains the payment that is related to the service line on the claim. This field is used only for ERA claims

TOTAL DENIED AMOUNT
 This field contains the total denied amount of all denial reason codes.

USER ID
This field contains the user identification.

BATCH TOTAL
This field contains the total for this batch.

CONT. ADJ. TOTAL
This field contains the total contractual adjustment for the batch.

COUNT
This field contains the number of postings made to a location (PA, AR, BD), patient indicator (inpatient, outpatient) or contractual adjustment.

AMOUNT
This field contains the total dollars posted by location or patient indicator.

ADJ AMOUNT
This field contains the total adjustment amount by transaction code, patient indicator or location.

LOCATION
This field contains the accounting location (PA, AR, BD) to which dollars are posted.

GRAND TOTAL
This field contains the total number of transactions posted during the day to all locations and the total dollar amount.

TOTAL ENTERED
This field contains the total amount entered during this batch.

BATCH TOTAL
This field contains the total amount entered during this batch plus the starting balance.

CASH POSTING EXCEPTION REPORT - FAR140

Description/Purpose

The Cash Posting Exception report lists accounts having payment amounts that differ from the expected amount. It is used as an audit trail to verify daily payments. Since the report sorts by batch number, you can use this report to define significant batch variances that require action. For example, payments exceeding account balances may indicate misapplied payments. By verifying the transactions on this report, you can ensure proper application and confirmation of overpayments.

The following exceptions could print on your report, depending upon how your Cash Posting Exception Parameters are defined.

- Paid DRG does not match final DRG
- Day outlier
- Cost outlier
- Payment amount exceeds account balance
- Payment amount exceeds patient balance
- Payment amount exceeds carrier balance
- Insurance payment amount less than expected
- Payment made to a paid claim
- Window batch out of balance
- Agency Cash Posted to Account not in BD
- RA Adg forced bal xfer of
- No balance transfer - Expected payments greater than one

The exception *COB(x) has a balance - All claims completed* is not dependent on the Cash Posting Exception Parameters. It is included as an adjustment exception on the report for accounts in a PA location that have a final payment and for which there are no outstanding claims (with expected payments sitting at zero) and no unbilled charges.

NOTE: If another final payment is posted to an account in PA with no outstanding claims and no unbilled charges, and if money remains on the carrier, it appears as an exception. Please refer to the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide* for additional information on the exception reasons defined in the Cash Posting Exception Parameters.

Batch 0 is the default batch number for unapplied cash and should be reconciled daily.

This report indicates when a DRG paid does not match a DRG billed and lists the sequence number, account number, account name, and exception description.

Generating and Printing This Report

The Cash Posting Exception report is generated during midnight processing and can be printed through the Demand Print procedure. It is sorted by batch number and sequence number.

The following is an example of the Cash Posting Exception Report.

Figure 2.19 FAR140 - Cash Posting Exception Report

```
Date: 11/24/89                          General Hospital                        Page  : 1
Time: 05:10                    Cash Posting Exceptions for 11/23/89             Report: FAR140
                                      Batch 68 - TA INS

Seq   Account #     Account Name       LC P/I  Acct Balance    Payment Amt   Exception Description
                                               Exp Pymt Amt    Pymt Variance
-----------------------------------------------------------------------------------------------------
1    00125-48001   SMITH,MARY A        PA  I   19,252.45       100.00-       Patient payment amount less than expected
                                                  383.00          283.00
2    89292-00004   LEWIS,NORWOOD E     PA  I      16.50-         20.00       Payment amount exceeds account balance
                                                    3.50          16.50-

3    89291-00001   CORCORAN,DONALD S   AR  I    1,000.00       100.00-       Agency cash received on an AR account
                                                  500.00          400.00

4    89211-00233   LEWIS,NORWOOD E     PA  I        0.00         20.00       Payment amount exceeds account balance
                                                   20.00          20.00-




                                      End of Report
```

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CASH POSTING EXCEPTION REPORT - FAR140

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

SEQ
This field contains the order in which the cash posting exception was entered in the batch.

ACCOUNT #
This field contains the patient account number.

ACCOUNT NAME
This field contains the account name.

LC
This field indicates the location of the account.

P/I
This field contains the type of the line item cash batch. The types are P for patient or I for insurance.

EXP PYMT AMT
This field contains the expected payment amount. The expected payment amount equals the Carrier Est. Amount - Transaction Amount - Claim Total Payment Amount + Contractual Adjustment Amount + Claim Total Adjustment Amount.

PAYMENT VARIANCE
This field contains the difference between the expected payment amount and the actual payment.

EXCEPTION DESCRIPTION
This field contains a description of the cash posting exception.

GUARANTOR CASH POSTING DETAIL REPORT - FAR135

Description/Purpose

The Guarantor Cash Posting Detail Report lists all guarantor batches approved for the day.

Generating and Printing This Report

This report is generated during midnight processing. It can be set up and printed as a demand report, and is sorted by batch number by day.

The following is an example of the Guarantor Cash Posting Detail Report.

NOTE: Since guarantor cash batches are not facility specific, this report does not have a facility indicator in the report name.

Figure 2.20 FAR135 - Guarantor Cash Posting Detail Report - Page 1

```
Date: 10/07/93                                  General Hospital                              Page  : 1
Time: 03:28pm                         Guarantor Cash Posting Detail for 10/07/93              Report: FAR135
                                             Batch 5 - GUARANTOR BATCH
Account #       Account Name        --Date-- Trans Amount  TCode Transaction Description   Loc --Paid-- Out Final Claim
Sq   CR/PL      Carrier Name        Post/Pay                     Remittance/Check/Card #        Days DRG
-----------------------------------------------------------------------------------------------------------------------
A9304000003     WEATHERFORD,AVI     10/07/93        10.00- P0001 PERSONAL PAYMENT-CHECK    AR
1                                   10/07/93
C009324300002   WEATHERFORD,AVI     10/07/93        40.00  P0001 PERSONAL PAYMENT-CHECK    PA
2                                   10/07/93
A9304600001     WEATHERFORD,AVI     10/07/93         1.00  P0001 PERSONAL PAYMENT-CHECK    AR
3                                   10/07/93
B9305300001     WEATHERFORD,AVI     10/07/93         2.30  P0001 PERSONAL PAYMENT-CHECK    AR
4                                   10/07/93
B9305300001     WEATHERFORD,AVI     10/07/93         2.30  P0001 PERSONAL PAYMENT-CHECK    AR
4                                   10/07/93
A9304000003     WEATHERFORD,AVI     10/07/93         1.00  P0001 PERSONAL PAYMENT-CHECK    AR
5                                   10/07/93
A9318100001     HALL,CLAIMS         10/07/93        50.00  P0001 PERSONAL PAYMENT-CHECK    AR
6                                   10/07/93                     2345A
A9304200001     HALLS,SAM           10/07/93         2.00  P0001 PERSONAL PAYMENT-CHECK    AR
7                                   10/07/93
A9327000001     IRCONV,PT FACA      10/07/93        23.00  P0001 PERSONAL PAYMENT-CHECK    PA
8                                   10/07/93
A9323700002     SIMMONS,ANDRA       10/07/93        23.00  P0001 PERSONAL PAYMENT-CHECK    PA
9                                   10/07/93
C009325600001   SMITH,SUSAN         10/07/93        10.00  P0001 PERSONAL PAYMENT-CHECK    PA
10                                  10/07/93
A9304600002     SMITH,SUSAN         10/07/93        10.00- P0001 PERSONAL PAYMENT-CHECK    PA
11                                  10/07/93
User ID: ADAMS,NANCY             Batch Total Facility A:  80.00
                                 Batch Total Facility B:   2.30
                                 Batch Total Facility C:  57.00
                                 Batch Total:            139.30
```

Figure 2.21 FAR135 - Guarantor Cash Posting Detail Report - Page 2

```
Date: 10/07/93                              General Hospital                        Page  : 2
Time: 03:28pm                    Guarantor Cash Posting Audit Detail for 10/07/93   Report: FAR135
                                         Batch 5 - GUARANTOR BATCH


Transaction Code                   Type  Count          Amount
-------------------------------------------------------------------
0001 PERSONAL PAYMENT-CHECK          P    12            139.30

Grand Total               12        139.30

Patient Type            Count       Amount    Count       Amount
-------------------------------------------------------------------
Total I/P                                       8         118.00
  Fac A I/P               7         78.00
  Fac C I/P               1         40.00
Total O/P                                       4          21.30
  Fac A O/P               1          2.00
  Fac B O/P               1          2.30
  Fac C O/P               2         17.00


Location                Count       Amount    Count       Amount
-------------------------------------------------------------------
Total PA                                        6          93.00
  Fac A PA               3         36.00
  Fac C PA               3         57.00
Total AR                                        6          46.30
  Fac A AR               5         44.00
  Fac B AR               1          2.30
Total BD                                                    0.00


Grand Total                                    12         139.30
  Total Facility A       8         80.00
  Total Facility B       1          2.30
  Total Facility C       3         57.00

                                      End of Report
```

This report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

ACCOUNT #
This field contains the patient's account number.

ACCOUNT NAME
This field contains the patient's name.

POST DATE
This field contains the date on which this cash item is posted.

PAY DATE
This field indicates the date the payment was received.

TRANS AMOUNT
This field contains the amount of cash posted.

TCODE
This field contains the transaction code associated with the payment.

TRANSACTION DESCRIPTION
This field contains a transaction description of the transaction posted, for example, patient payment by check.

LOC
This field contains the location of the account to which the transaction was posted. Valid codes are PA, AR, or BD.

PAID - DAYS
This field contains the number of days paid. This field is used only when the cash type is insurance and the paid days is entered during the posting and is blank for guarantor cash posting.

DRG
This field contains the number of the DRG paid. This field is used only when the cash type is insurance and the paid DRG is entered during the posting and is blank for guarantor cash posting.

OUT
This field is not applicable to the Guarantor Cash Posting Detail report. This field is used only when the cash type is insurance and the outlier is entered during the posting and is blank for guarantor cash posting.

FINAL CLAIM
This field is not applicable to the Guarantor Cash Posting Detail report. This field is used only when the cash type is insurance and the final claim is entered during the posting and is blank for guarantor cash posting.

SQ
This field contains the system-generated sequence assigned to the entry in the batch.

CR/PL
This field is not applicable to the Guarantor Cash Posting Detail report.

CARRIER NAME
This field is not applicable to the Guarantor Cash Posting Detail report.

REMITTANCE/CHECK/CARD #
This field contains the remittance number entered for the account.

USER ID
This field contains the user identification.

BATCH TOTAL FACILITY X (A, B, C . . .)
This field contains the batch total for facility X (A, B, C . . .).

BATCH TOTAL
This field contains the total for this batch.

COUNT
This field contains the number of postings made to a location (PA, AR, BD) or patient type account (inpatient, outpatient).

AMOUNT
This field contains the total dollars posted by location or patient type accounts.

LOCATION
This field contains the accounting location (PA, AR, BD) to which dollars are posted.

GRAND TOTAL
This field contains the total number of transactions posted during the day to all locations and the total dollar amount.

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GUARANTOR CASH POSTING EXCEPTION REPORT - FAR145

Description/Purpose

The Guarantor Cash Posting Exception Report lists accounts having payment amounts that differ from the expected amount. It is used as an audit trail to verify daily payments.

Generating and Printing This Report

This report is generated during midnight processing. It can be set up and printed as a demand report, and is sorted by batch number by day.

The following is an example of the Guarantor Cash Posting Exception Report.

NOTE: Since guarantor batches are not facility specific, this report does not have a facility indicator at the end of the report name.

For each payment, the system uses the Cash Exception Parameters for each facility to determine which accounts qualify to be included on the report.

Figure 2.22 FAR145 - Guarantor Cash Posting Exception Report

```
Date: 11/03/93                          General Hospital                         Page  : 1
Time: 05:10                     Cash Posting Exceptions for 11/03/93             Report: FAR145
                                        Batch 68 - TA INS

Seq   Account #      Account Name       P/I   Acct Balance    Payment Amt    Exception Description
                                              Exp Pymt Amt    Pymt Variance
-----------------------------------------------------------------------------------------------------------
1     A9330100001    HALL,RUSSELL        O        39.00            1.00       Patient payment amount less than expected
                                                  40.00           39.00


                                         End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

SEQ
This field contains the order in which the cash posting exception was entered in the batch.

ACCOUNT #
This field contains the patient account number.

ACCOUNT NAME
This field contains the account name.

P/I
This field contains the patient indicator of I for inpatient, O for outpatient, and E for emergency.

ACCOUNT BALANCE
This field contains the account's balance before the transaction was posted.

PAYMENT AMOUNT
This field contains the amount of the payment.

EXP PYMT AMT
This field contains the expected payment amount.

PAYMENT VARIANCE
This field contains the difference between the expected payment amount and the actual payment.

EXCEPTION DESCRIPTION
This field contains a description of the cash posting exception.

ACTIVITY JOURNAL DETAIL REPORT - FARAJR

Description/Purpose

The Activity Journal Detail Report lists, by patient, all charges posted for the day. It can be used as an audit trail to check detailed patient charges and is used in balancing.

This report provides subtotals of charges by revenue center and type of charge, flags both late and automatic charge items, and lists the number of days elapsed to post a charge for a facility. Facility totals are provided by patient indicator.

The facility total on this report is used to balance to the Revenue Amount on the Administrative Operating Summary report (FSRAOS).

Generating and Printing This Report

This report is generated during midnight processing and can be set up and printed as a demand report. It is sorted by patient name.

The following is an example of the Activity Journal Detail Report.

Figure 2.23 FARAJR - Activity Journal Detail Report

```
Date: 08/23/07                Model Hospital A           Page  : 14
Time: 1:06          Activity Journal Detail for 08/22/07   Report: FARAJRA



Patient #    Name                               Rm/Bed  F/C  IND  Pat Type
 Code    Item Description                        Int Order  Qty   Chg Amt
   Dept  FIM Code   RC    Srv Dt/Tm   P Day  To/From#   R/B Auto  Chg Typ
-------------------------------------------------------------------------------

0722900005   THOMAS,ADAM  (cont.)                 101-01   M    I     I/P
  1050   SEMI-PRIVATE ROOM CHARGE                  *** 000009   1     645.00
   RMB   6020-1100  6020  08/22/07 23:59  0                R/B
                                   Patient Total     1     1    645.00

0723200001   MORE,FRED                            2127-01   S    I     I/P
  1050   SEMI-PRIVATE ROOM CHARGE                  *** 000005   1     645.00
   RMB   6020-1100  6020  08/22/07 23:59  0                R/B
                                   Patient Total     1     1    645.00

0723300003   DISMUKE,JANE                         214-1    M    O     OPO
  0666   M19076 INCREMENTAL CHARGE                 *** 000002   1    1620.00
   RMB   5366-6     6022  08/22/07 23:59  0                R/B
                                   Patient Total     1     1   1620.00


                        Facility Average Days to Post     2

                        Facility Totals I/P              47006.42
                                        O/P              21671.89
                                        E/R                   .00
                                        Total            68678.31

                        End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

PATIENT #
This field contains the patient's account number.

NAME
This field contains the patient's name.

RM/BED
This field contains the patient's room-bed number.

F/C
This field contains the hospital-defined financial class code assigned to this patient's account.

IND
This field contains the patient indicator. Indicators are I-inpatient, O-outpatient, and E-emergency.

PAT TYPE
This field contains the patient type code used to categorize the patient. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, and series patients.

CODE ITEM DESCRIPTION
This field contains the SIM (Service Item Master) code and description of the item ordered.

INT
This field contains the initials of the person entering the order.

ORDER
This field contains the order number.

QTY
This field contains the quantity of the item ordered.

PRICE
This field contains the price of the item ordered.

DEPT
This field contains the SIM (Service Item Master) department for this item.

FIM CODE
This field contains the FIM (Financial Item Master) code for the item ordered.

RC
This field contains the revenue center to which the charges are mapped.

TO/FROM #
This field contains the charge to or from account number. If accounts are combined when the charge is placed, the from account number displays in this field under the charge to account. The system also displays the to account number in this field under the charge from account. The system displays *F* before the from account and *T* before the to account. This provides an audit trail of combine billing activity.

For example, in the example report account number 9216400001 is the charge from account. This field indicates the account number to which the charges are going. A bill has been generated; thus the charges post as debits for the *to* account (92160600020) and as credits for the *from* account (9216400001). Charges from account number 9217300012 are charged to account number 9217300104, but no bill has been generated. The report displays two charges on the from account (9217300012) being posted to the to account (9217300104); these charges were placed after the charge from/to link was created using the Combine Bills function. The charges displayed for 9217300012 were placed before the link was created and do not transfer to 9217300104 until a bill request is made on both accounts. At that time, charges are credited on 9217300012 and debited on 9217300104.

SRV DT/TM
This field contains the date and time the service was performed.

P DAY
This field contains the number of days elapsed to post the charge.

AUTO
This field contains Auto if this is an automatic charge, indicating this is an auto daily charge.

R/B
This field contains R/B if this is a room/bed charge.

LATE
This field contains Late if this is a late charge/credit.

ACTIVITY JOURNAL SUMMARY REPORT - FARAJR2

Description/Purpose

This report summarizes all daily revenue charges. Charges are summarized by room & bed; revenue charges and late charges/credits by revenue center; and charge counts by department. A total revenue center summary is provided that accumulates room & bed, late charges/credits and charges by department.

This report can be used as a management summary of revenue by revenue center. The total dollars amount on this report is used to balance to the Revenue Amount on the Administrative Operating Summary report (FSRAOS).

Generating and Printing This Report

This report, which is sorted by revenue center, is a daily batch report automatically generated as a result of midnight processing. It is set up as a demand report and printed through the Demand print function. Page breaks occur at the end of the page or after each revenue center summary.

The following is an example of an Activity Journal Summary Report.

Figure 2.24 FARAJR2 - Activity Journal Summary Report

```
Date: 10/05/89                  General Hospital           Page  : 1
Time: 12:07am           Activity Journal Summary for 10/04/89   Report: FARAJR2


                   Revenue Center Summary - Room & Bed Charges

                       Total  Total    Charge Charge    Credit Credit   Zero
Department             Dollars Count   Dollars Count    Dollars Count   Count
-------------------------------------------------------------------------------
 312 2 EAST            1098.00     5   1098.00     5       .00     0      0

     Total            1098.00     5   1098.00     5       .00     0      0


                   Revenue Center Summary - Late Charges/Credits

                       Total  Total    Charge Charge    Credit Credit   Zero
Department             Dollars Count   Dollars Count    Dollars Count   Count
-------------------------------------------------------------------------------
 339 100 WEST             2.20     1      2.20     1       .00     0      0
 490 DIETARY              .00     1       .00     0       .00     0      1

     Total                2.20     2      2.20     1       .00     0      1


                   Revenue Center Summary - Revenue Department

                       Total  Total    Charge Charge    Credit Credit   Zero
Department             Dollars Count   Dollars Count    Dollars Count   Count
-------------------------------------------------------------------------------
 312 2 EAST            1098.00     5   1098.00     5       .00     0      0
 339 100 WEST             2.20     1      2.20     1       .00     0      0
 378 EMERGENCY ROOM     60.00     2     60.00     2       .00     0      0
 402 LABORATORY        221.63    10    221.63    10       .00     0      0
4110 PRO FEES-EKG        7.50     1      7.50     1       .00     0      0
 412 EKG               120.00     5    120.00     5       .00     0      0
 490 DIETARY              .00     1       .00     0       .00     0      1

     Total            1509.33    25   1509.33    24       .00     0      1


                              End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

The following fields are represented for room & bed charges, revenue charges, and late charges/credits by department.

TOTAL DOLLARS
This field is the sum of charge dollars less credit dollars for this revenue center.

TOTAL COUNT
This field is the sum of the charge count, credit count and zero count for this revenue center. For example, if you have five charges, two credits, and one zero count, the total count is eight.

CHARGE DOLLARS
This field contains the total charges for this revenue center.

CHARGE COUNT
This field contains the total charges count for this revenue center.

CREDIT DOLLARS
This field contains the total credit dollars for this revenue center.

CREDIT COUNT
This field contains the total credit charges count for this revenue center.

ZERO COUNT
This field contains the number of SIM items charged with a price of $00.00.

DEPARTMENT LOG DETAIL REPORT - FARDLR

Description/Purpose

This report lists, by department, all charges placed on patient accounts for the day. It includes automatic and late charge items, the number of days elapsed to post a charge, and the department average. Department totals are provided by patient indicator.

Generating and Printing This Report

This report, which is sorted by department and subsorted by patient account number, is generated during midnight processing. It can also be set up and printed as a demand report. If it is set up as a batch report, this report is printed and totals provided, by department.

The following is an example of a Department Log Detail Report.

Figure 2.25 FARDLR - Department Log Detail Report

```
Date: 11/15/89                    General Hospital              Page  : 1
Time: 12:27am                  Financial Department Log         Report: FARDLR
                            Department Log Detail for 11/14/89

Patient #    Name                               Sta/Rm/Bed      F/C   IND  P/T
 Code  Item Description                         Int Order#     Qty         Price
  FIM Code    RC    Srv Dte  P Day   Charge Location           Auto   Late
-----------------------------------------------------------------------------

01001-73178   PRESLEY,DIANE                                     06    I   ECU
  8263511 DEOXYCORTISOL BLOOD                   SLC 000012      1         63.00
   82635      402   11/14/89    0   5 NORTH
  8321017 HYDROXY.                              SLC 000011      1         37.00
   83210      402   11/14/89    0   5 NORTH
  8321017 HYDROXY.                              SLC 000013      1         37.00
   83210      402   11/14/89    0   5 NORTH
  8325317 HYDROXYPROGESTERONE                   SLC 000014      1         40.00
   83253      402   11/14/89    0   5 NORTH
                                   Totals              4        4        177.00

01001-73228   BROWN,JACKSON                                     03    I   ADM
  85060MD FEE-BLOOD SMEAR  PERI HHY INTE    DKT 000003      1             30.00
   85060      4130  11/14/89    0   5 NORTH
                                   Totals              1        1         30.00

01001-73244   SOUTHERLAND,NATALIE                               20    I   ADM
  85015CBC W DIFF (PLATELET CT INCLUDED)    FBH 000001      1             21.15
   85015      402   11/14/89    0   2 NORTH
                                   Totals              1        1         21.15

                                   Dept Average Days to Post      0

                                   Department Totals I/P           228.15
                                                    O/P              .00
                                                    E/R              .00
                                                    Total          228.15
```

Each report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system. The department abbreviation is appended to the system report name.

PATIENT #
This field contains the patient's account number.

NAME
This field contains the patient's name.

STA/RM/BED
This field contains the patient's nurse station and room-bed number.

F/C
This field contains the hospital-defined financial class code assigned to this patient's account.

IND
This field contains the patient indicator. Indicators are I-inpatient, O-outpatient, and E-emergency.

P/T
This field contains the patient type code used to categorize the patient. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, and series patients.

CODE ITEM DESCRIPTION
This field contains the SIM (Service Item Master) code and description of the item ordered.

INT
This field contains the initials of the person entering the order.

ORDER#
This field contains the order number.

QTY
This field contains the quantity of the item ordered.

PRICE
This field contains the price of the item ordered.

FIM CODE
This field contains the FIM (Financial Item Master) code for the item ordered.

RC
This field contains the revenue assigned to the charges.

SRV DTE
This field contains the date the service was performed.

P DAY
This field contains the number of days required to post the charge, comparing the service date and the posting date.

CHARGE LOCATION
This field contains the location (nursing station, etc.) from which the charge was placed.

AUTO
If this is an automatic charge, Auto prints in this field.

LATE
If this is a late charge/credit, Late prints in this field.

DEPARTMENT LOG SUMMARY REPORT - FARDLR

Description/Purpose

This report summarizes daily charges by department and serves as a summary recap of the Department Log report.

Generating and Printing This Report

This report prints with the Department Log report.

The following is an example of the Department Log Summary Report.

Figure 2.26 FARDLR - Department Log Summary Report

```
Date: 11/15/89              General Hospital           Page  : 2
Time: 12:27am           Financial Department Log        Report: FARDLR
                     Department Log Summary for 11/14/89

Item Description              ----Inpatient-----   ----Outpatient----
               -------E/R--------   ------Vendor------   ------Total-------
--------------------------------------------------------------------------------
82635 11 DEOXYCORTISOL BLOOD     1        63.00        0          .00
                     0        .00        0          .00    1       63.00
83210 17 HYDROXY.                2        74.00        0          .00
                     0        .00        0          .00    2       74.00
83253 17 HYDROXYPROGESTERONE     1        40.00        0          .00
                     0        .00        0          .00    1       40.00
85015 CBC W DIFF (PLATELET CT IN 1        21.15        0          .00
                     0        .00        0          .00    1       21.15
85060 MD FEE-BLOOD SMEAR   PERI P 1       30.00        0          .00
                     0        .00        0          .00    1       30.00


          Facility Totals   # Pts   Quantity         Amount
             Inpatient        3         6           228.15
             Outpatient       0         0              .00
             E/R              0         0              .00
             Vendor           0         0              .00
             Total            3         6           228.15

                      End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

ITEM DESCRIPTION
This field contains the quantity and dollar amount, by patient indicator, of each item charged for the department for the business day.

FINANCIAL REVIEW REPORT - FARFRR

Description/Purpose

The Financial Review Report lists all nondischarged inpatient, pre-admit testing, and outpatient accounts. Using the Financial Review Report function, you can exclude or include OR and/or ER patients from the report. For more information on this function, refer to the Financial Review Report in the Account Reports section in the *Account Transactions Volume* of the *STAR Financials Patient Accounting Reference Guide*. Basic demographic data is reported for each account including the account number and patient name, admit or registration date, LOS, patient's age, financial class, patient type, medical service, provider number and the last bill day if the patient was cycle billed.

Financial data reported for each account includes the insurance carrier/plan, COB code, the estimated amount due from each insurance carrier and the patient, payments, adjustments and the current balance per insurance and patient. The expected reimbursement and contractual adjustments amounts are reported for the primary carrier/plan. Biller numbers are reported for audit purposes. Facility totals are provided for the number of accounts and amount for the total balance due, estimated contractual adjustments and expected reimbursement. The report also prints, by carrier/plan, the total balance due, estimated contractual adjustment, and expected reimbursement.

The hospital can set up selection criteria for this report. For example, a report can be requested that includes only inpatient accounts having a balance above a certain dollar amount. You define this amount using the Financial Review Report function.

NOTE: You can use the STAR Audit Service to audit user requests for this report. The Audit Service collects and stores information such as report request date and time, the name of the user requesting the report and the criteria selected for the report. For more information, see the STAR Audit Service Reference Guide.

Generating and Printing This Report

The Financial Review Report, which can also be set up as an Optional Batch Report, is generated as a demand report and requested through the Accounts Report Processor screen. It is sorted by patient account number.

The following is an example of the Financial Review Report.

Figure 2.27 FARFRRA - Financial Review Report - Page 1

```
Date: 12/03/92                              General Hospital A                         Page  : 1
Time: 2:31am                         Financial Review Report for 12/02/92              Report: FARFRRA
Patient     Patient                     Admit/  Days            Hosp              Last Bill    Bill
Number      Name                        Reg Date Stay  Age  FC  P/T  Serv  Provider   Date     Hold   Reim
-----------------------------------------------------------------------------------------------------------
9230000108   EDWARDS,WENDY               10/26/92  38   32Y  19  IP   MED   1        11/30/92
             Carrier/Plan     500005   85 0001    85 0003   22 0001   Patient       Total
             COB Code           1          2           3           4
             Est Due          797.64    5650.76       .00         .00   23613.97   30062.37
             Payment/Adj        .00        .00         .00         .00      .00        .00
             Balance          797.64    5650.76       .00         .00   23613.97   30062.37
             Est Contractual Adj .00       .00         .00         .00                 .00
             Exp Reimbursement 797.64    5650.76       .00         .00   23613.97   30062.37
             Biller/Initials   4 DB
9221100281   LORING,MYRTLE               07/29/92       33Y
             Carrier/Plan                                       Patient       Total
             COB Code
             Est Due                                          19718.91   19718.91
             Payment/Adj                                         .00        .00
             Balance                                          19718.91   19718.91    * Out of Balance *
             Est Contractual Adj                                            .00
             Exp Reimbursement                               19718.91   19718.91
             Biller/Initials
9230800602   OGLETHORPE,J R             11/03/92  30   81Y   A  IP   MED   1        12/02/92
             Carrier/Plan     98 0001   16 0001    16 0002            Patient       Total
             COB Code           1          2           3
             Est Due          295.00-    295.00-      .00            295.00      295.00-
             Payment/Adj        .00        .00         .00             .00         .00
             Balance          295.00-    295.00-      .00            295.00      295.00-
             Est Contractual Adj .00       .00         .00                         .00
             Exp Reimbursement 295.00-    295.00-      .00            295.00      295.00-
             Biller/Initials   3 CT
                                             Totals for Emergency Patients
                                                    # Accts          Amount
                            Total Balance Due          5           $172,745.48
                            Estimated Contractual Adj  0              $0.00
                            Expected Reimbursement     0           $172,745.48
```

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Figure 2.28 FARFRR - Financial Review Report - Page 2

```
Date: 12/03/92                        General Hospital A                    Page  : 35
Time: 2:31am                   Financial Review Report for 12/02/92         Report: FARFRR
                                       Totals by Carrier
                                Carrier - 50 BLUE CROSS OF GEORGIA


Carrier Plan
-----------------------------------------------------------------------------------------------------


500005 BLUE CROSS 1500
                                                  # Accts              Amount
                                Total Balance Due      4            $12,447.40
                                Estimated Contractual Adj   0            $0.00
                                Expected Reimbursement      0        $12,447.40


501234 BLUE CROSS GEORGIA POWER
                                                  # Accts              Amount
                                Total Balance Due      4            $61,565.50
                                Estimated Contractual Adj   0            $0.00
                                Expected Reimbursement      0        $61,565.50


                                     End of Report
```

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Each page of the report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

PATIENT NUMBER
This field contains the patient's account number.

PATIENT NAME
This field contains the patient's name.

ADMIT/REG DATE
This field contains the date the patient was admitted or registered.

DAYS STAY
This field contains the number of days the patient stayed in the hospital.

AGE
This field contains the patient's age in years (Y) or months (M).

F/C
This field contains the hospital-defined financial class code assigned to this patient's account.

P/T
This field contains the patient type code used to categorize the patient. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, and series patients.

HOSP SERV
This field contains the type of service provided to this patient at admission. This information is from the STAR Patient Care system.

PROVIDER
This field contains the code of the provider associated with this insurance carrier/plan.

LAST BILL DATE
This field contains the date of the last bill.

BILL HOLD
This field contains YES if the bill is on hold for the account. If the bill is not on hold for the account, the field is blank.

REIM
This field displays whether reimbursement has been set up on the primary carrier but there is no expected reimbursement on the account. If this field is blank, reimbursement is expected on the account for the primary carrier or there is no reimbursement set up for the primary carrier. If this field contains *N*, reimbursement has been set up on the primary carrier but there is no expected reimbursement on the account.

CARRIER/PLAN
This field contains the carrier and plan numbers associated with this patient.

COB CODE
This field identifies the coordination of benefits for this account. Up to four plans can be printed and used for proration calculation. A value between 1 and 4 prints here.

EST DUE
This field contains the amount estimated as due from the carrier/plan. Up to four plans and the patient portion of the account responsibility can be printed.

PAYMENT/ADJ
This field contains the total amount of payments and adjustments, printed by carrier/plan.

BALANCE
This field contains the estimated amount due minus any payments or adjustments, printed by carrier/plan.

EST CONTRACTUAL ADJ
This field contains the estimated contractual adjustment calculated as the difference between covered charges for the insurance plan and the reimbursement amount.

EXP REIMBURSEMENT
This field contains the amount the hospital expects to be reimbursed by the carrier/plan.

BILLER/INITIALS
This field contains the code and initials of the biller assigned to this patient account.

The report then displays the number of accounts and the dollar amount for the patient type for the Total Balance Due, Estimated Contractual Adjustment, and the Expected Reimbursement. After displaying information for each patient type, the report prints total values for number of accounts and dollar amount for each carrier/plan for the Total Balance Due, Estimated Contractual Adjustment, and Expected Reimbursement, as shown on the second example page of this report.

INSURANCE COVERAGE TABLE AUDIT REPORT - FTINSAUD

Description/Purpose

The Insurance Coverage Table Audit Report (FTINSAUDx) provides a Before and After picture for any changed field in the Insurance Coverage Table. This report matches the Insurance Master List Report (FTINMx). The system prints a Before image of the value that was changed and then a Current image of the changed value. For example, if the only value in the insurance coverage table for a given insurance was a Claim Load and Edit Parameter, the report includes the insurance and the original or "Before" value of the parameter, as well as the changed or "Current" value of the parameter. When a value in the insurance coverage changes, all of the field headings for the area (e.g., all the headings for Room Coverage or Ancillary Coverage) print, but only the values that have changed print on the report. The Edit Date and Edit By fields and values also print on the report for the changed screen(s).

Generating and Printing This Report

This report is a daily batch report automatically generated as a result of midnight processing. The changed information is stored by the system only until the report runs, after which the report is deleted.

Each report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

The following is an example of the Insurance Coverage Table Audit Report.

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Figure 2.29 FTINSAUD - Insurance Coverage Table Audit Report

```
Date: 04/24/98                              General Hospital                        Page  : 1
Time: 01:52am                         Insurance Master Audit Report                 Report: FTINSAUD

 CARRIER: 100-MEDICARE                         General Hospital A
 PLAN   : 100-MEDICARE PART A


---------------------------------------------CLAIM ATTACHMENTS----------------------------------------------------------

BEFORE IMAGE AT 01:20pm

        CC-Crippled Children Certificatio              NO INFORMATION EXISTED

CURRENT

        CC-Crippled Children Certificatio              PATIENT TYPE: ALL

        EDIT BY: Masterson,Julie M                     EDIT DATE: 04/24/98 01:52am


FACILITY SPECIFIC-------------------------------COLLECTIONS--------------------------------------------------------------

BEFORE IMAGE AT 01:21pm


        --TRAN CODES--                           INPATIENTS               OUTPATIENTS
                                           SEC FOLLOWUP                   2-COMMERCIAL INSURANCE SCHEDULE

    EDIT BY: Masterson,Julie M             EFFECTIVE DATE: 03/11/98 09:22am

CURRENT


        --TRAN CODES--                           INPATIENTS               OUTPATIENTS
                                           SEC FOLLOWUP                   1-WORKER'S COMPENSATION SCHEDULE

    EDIT BY: Masterson,Julie M             EFFECTIVE DATE: 04/23/98 01:21pm
```

INSURANCE MASTER LIST REPORT - FTINM

Description/Purpose

The Insurance Master List Report lists coverages associated with a carrier/plan and provides a means of verifying plan information.

This report includes (as applicable) each plan's basic coverage, room coverage, ancillary coverage, daily/blood deductibles, room coverage exceptions, summary code exceptions, the billing and claims parameters, the collection parameters, the third-party log ID, all facility-specific parameter exceptions, and all facility specific reimbursement parameters.

Generating and Printing This Report

This is a demand report that can be generated when exiting from the Insurance Plan Coverage table. The system displays the following prompt:

> *Do you want a printed list? (Y/N) [N]--*

Enter **Y** if you want to generate the report. The system then displays a list of all carriers in the Insurance Carrier table. Highlight the carrier that should print on the report, or enter **A** for All. If a carrier is selected the system then displays a list of all plans for the selected carrier. Highlight the plans that should print on the report.

The system then displays the following prompt:

> *Do you want to print plans that are filed as deleted? (Y/N) [N]--*

Enter **N** to only print active plans, and enter **Y** to print active and inactive plans.

The system then displays the following prompt:

> *Do you want to print all of your valid facilities ... A,B,C,D (Y/N) [N]--*

where A, B, C, and D are your facility indicators. If you enter **Y** for Yes, the report spools to FTINM without a facility. If you enter **N** for No, the system displays a list of the facilities available. Highlight the appropriate facility. The report spools to FTINMx where x is the facility indicator.

The following is an example of an Insurance Master List Report.

Figure 2.30 FTINM - Insurance Master List Report - Page 1

```
DATE: 06/11/08                              GENERAL HOSPITAL                                           Page:   1
TIME: 08:57 am                            INSURANCE MASTER LIST                                    Report:   FTINMC

  CARRIER: 500-COMMERCIAL                       GENERAL HOSPITAL                        CURRENTLY IN EFFECT
  PLAN  : 999-COMMERCIAL


FACILITY SPECIFIC--------------------------------BILLING PARAMETERS--------------------------------------------------
BILLING GROUP                   VALID F/C   BILLING PARMS        INPATIENT               OUTPATIENT
  3-biller group 3                  C        F/B PARM    3-COMMERCIAL INSURANCE, FINA  3-COMMERCIAL INSURANCE, FINA
                                             CYCLE PARM  7-COMMERCIAL INSURANCE, CYCL  7-COMMERCIAL INSURANCE, CYCL
  DEFAULT F/C: C-CHAMPUS
  EDIT BY: New, Nancy                    EFFECTIVE DATE: 06/11/03 04:56pm

CLAIM TYPE: UB                          CLAIM LOAD PRIMARY:    01-COMM IP          02-COMM OP
PRODUCE CLAIMS: YES                     CLAIM LOAD SECONDARY:  01-COMM IP          02-COMM OP
PRINT ON UB IF NOT PRIMARY: YES         CHG CONTROL PRIMARY:   99-COMM IP CHG      98-COMM OP CHG
PRORATE I/P: YES                        CHG CONTROL SECONDARY: 99-COMM IP CHG      98-COMM OP CHG
PRORATE O/P: YES                        CLAIM GENERATION:      UB-UB CLAIM         UB-UB CLAIM
LOAD SEP CLAIM IF NOT PRIMARY: YES      PROVIDER NUMBER:       IP12345             OP98765
HOLD FOR PRIOR PAYMENT: YES             PROVIDER MASTER:       1-GENERAL HOSP      1-GENERAL HOSP
ASB/CROSSOVER HOLD EXCEPTIONS: 100100, 300100, 901901
PRINT PAPER CLAIM LABEL: NO
SUPPRESS IF $0: NO
EOB INDICATOR: NO
ELECTRONIC MEDIA: ELECTRONIC MEDIA C
PRINT ELECTRONIC CLAIM LABEL: NO
PRIMARY PAYOR:
SOURCE OF PAYMENT:
CLAIM PARAMETERS EDIT BY: Hansen,Johnny                 EFFECTIVE DATE: 06/01/07
CLAIM PROCESSING EDIT BY: Hansen,Johnny        EFFECTIVE DATE: 01/12/07

FACILITY SPECIFIC--------------------- BILLING AND CLAIMS PARAMETER EXCEPTIONS-------------------------------------

      BILLING PARAMETERS                            CLAIM PARAMETERS

PATIENT TYPE **ER**

      F/B PARM:                               PRIM CLAIM LOAD: 95-PARMS
      CYCLE PARM:                             SEC CLAIM LOAD: 95-PARMS
      BILLER GROUP:                           PRIM CHG CONTROL: 02-COMMERCIAL O/P
                                              SEC CHG CONTROL: 03-COMMERCIAL I/P
                                              PROVIDER NUMBER: erprovider123456789123
                                              PROVIDER MASTER: 44-OTHERPROVIDERNAMEEEE
                                              CLAIM GENERATION: UB-UB92 CLAIM GENERATION

                                              CLAIM GENERATION: UB-UB92 CLAIM GENERATION


EDIT BY: New, Nancy                      EFFECTIVE DATE: 06/11/03 03:08pm
                                              End of Report
```

Each report contains a header that includes the date and time the report is generated, your hospital's name, the report title, page number, and the report name as used in the system.

For more information about the Insurance Master, refer to the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guid*e.

LATE CHARGE/CREDIT REPORT - FARAJR1

Description/Purpose

The Late Charge/Credit Report lists all charges/credits posted to accounts in Accounts Receivable (AR) or Bad Debt (BD). A transaction is late if it is posted to an account after that account is final billed (transferred from PA to AR).

Charges are reported by patient account and include the patient name, patient type, financial class, service date, department, SIM code, quantity and charge amount. Totals are reported for each patient account, and grand totals for inpatients, outpatients and emergency room patients. Total amounts are reported by account location (AR or BD).

This report can be used to monitor the type and amount of late charges submitted (by revenue department).

Generating and Printing This Report

This report, which is sorted by patient number, is generated during midnight processing. It is set up and printed as a demand report.

The following is an example of a Late Charge/Credits Report.

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Figure 2.31 FARAJR1- Late Charge/Credits Report

```
Date: 08/23/07                               Model Hospital A                         Page  : 1
Time: 1:03                          Late Charge/Credit Report for 08/22/07            Report: FARAJR1A



Patient #    Name                           Acct Balance   PT   F/C  Srv Dt/Time   Dept  Sim Code  Qty    Amount   C/B Chg
------------------------------------------------------------------------------------------------------------------------

0721200002   NETWORK,FRED                     6,197.73    I/P   C   07/30/07 11:15  CSR   0123     1      57.56


                                              Patient Late Charges/Credits          1     1      57.56


                        |----------- Late Charges ------------|
                            # Chgs      Qty         Amount        Account Balance
          Facility Late Charges/Credits  I/P     1       1         57.56            6,197.73
                                         O/P     0       0           .00                 .00
                                         E/R     0       0           .00                 .00

                                         Total   1       1         57.56

                                         Late Chg Stats Upd       57.56
                                         Combined Bill Chgs         .00

                Total by Location        AR      1       1         57.56            6,197.73
                                         BD      0       0           .00                 .00



                        End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

PATIENT
This field contains the patient's account number.

NAME
This field contains the patient's name.

ACCT BALANCE
This field contains the account balance.

P.T.
This field contains the patient type code used to categorize the patient. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, and series patients.

F/C
This field contains the hospital-defined financial class code assigned to this patient's account.

SRV DT/TIME
This field contains the date and time the service was received.

DEPT
This field contains the SIM (Service Item Master) department for this item.

SIM CODE
This field contains the Service Item Master code assigned to the charge/credit.

QTY
This field contains the quantity of the item ordered.

AMOUNT
This field contains the amount charged for the item.

C/B CHG
This field contains the flag for the combined bill charges for the account. An asterisk (*) appears in this field if the charges in the Amount field are from combined bill charges.

PATIENT LATE CHARGES/CREDITS
This field contains the patient totals by department, SIM code, quantity and dollar amount for the late charges or credits assigned to this patient's account.

FACILITY LATE CHARGES/CREDITS
This field contains the total number of charges and quantities, the account balance, and the facility grand total summarized by patient indicator.

LATE CHG STATS UPD
This field contains the total facility dollar amount of charges updated that were not results of the combined billed function.

COMBINED BILL CHGS
This field contains the total facility dollar amount of charges updated that apply to combined billed patient accounts. These charges are flagged via the C/B Chg field.

TOTAL BY LOCATION
This field contains facility totals summarized by account location (PA, AR, BD).

PA BALANCE CONTROL REPORT - FARBAL1

Description/Purpose

The PA Balance Control Report provides a daily PA balance summary and reconciliation. It lists the beginning daily balance, daily PA transactions and calculates a new PA daily balance. The daily subsidiary balance and GL control balance are listed for comparison.

If the ending PA balance and the subsidiary balance are not the same, the Bal Flag field contains an N indicating that PA needs to be reconciled for that day.

This report serves as a daily auditing tool for the balancing and reconciliation of Patient Accounting (PA).

Generating and Printing This Report

This report is sorted by day of the month from the Daily Balancing functions for PA with the desired reporting period selected using the online screen. It is set up as a demand report and printed through the Demand Print function.

The following is an example of the PA Balance Control Report.

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Figure 2.32 FARBAL1 - PA Balance Control Report

```
Date: 06/12/00                              Model Hospital A                              Page  : 1
Time: 10:42                            PA Balance Control Report                          Report: FARBAL1A
                                         MO:  06  YEAR:  00

      Open PA Bal           F/B Total        Adjs            L Chg/CR        Fac X-fer        Subs Bal
Day                   Rev               Cash            Refunds         PMA          End PA Bal       G/L Ctrl Bal  Bal
         Reconciliation Comments

   16,128,643.33              0.00      0.00            0.00           N/A       16,154,113.38
01              25,275.05         0.00            0.00            0.00      16,153,918.38      4,066,135.54  N


   16,154,113.38              0.00      0.00            0.00           N/A       16,235,146.33
02              80,826.95         0.00            0.00       53,011.00      16,234,940.33      4,094,146.49  N


   16,235,146.33              0.00      0.00            0.00           N/A       16,235,121.33
03              52,827.00         0.00            0.00       26,516.50      16,234,962.33      4,120,651.99  N


   16,235,121.33          2,758.80      0.00            0.00           N/A       16,258,868.03
04              52,827.00         0.00            0.00       26,516.50      16,258,673.03      4,144,398.69  N


   16,258,868.03              0.00      0.00            0.00           N/A       16,258,868.03
05              26,321.50         0.00            0.00            0.00      16,258,673.03      4,170,890.19  N


   16,258,868.03              0.00      0.00            0.00           N/A       16,285,373.53
06              26,310.50         0.00            0.00            0.00      16,285,178.53      4,197,395.69  N


   16,285,373.53          2,362.32      0.00            0.00           N/A       16,312,890.72
07              29,694.51        10.00            0.00            0.00      16,312,695.72      4,224,912.88  N
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

DAY
This field contains the day of the month.

OPEN PA BAL
This field contains the previous day's subsidiary balance.

REV
This field contains the total charges and credits entered for the day. The system adds any overflow from the preceding day to this amount.

F/B TOTAL
This field contains the account balance of all accounts final billed for the day. This amount comes from the Billed Accounts report (FBR200).

CASH
This field contains the daily total of cash posted to accounts in Patient Accounting. This amount is the PA Total on the Cash Posting Detail report (FAR130).

ADJS
This field contains the daily total of adjustments posted to accounts in Patient Accounting. This amount is the PA Total on the Adjustment Posting Detail report (FAR210).

REFUNDS
This field contains the amount for patient refunds that were approved and/or deleted for that day for accounts that are in location PA. This amount can be verified using the Refunds Approved/Deleted report (FPREPPR).

L CHG/CR
This field contains the dollar amount of any late charges in Patient Accounting.

This amount is the PA Total on the Late Charge/Credit report (FARAJR1).

PMA
This field contains the amount of Post Midnight Activity (the overflow charges) for accounts in location PA that have passed to Patient Accounting. Overflow charges are charges that are posted to the subsidiary balance but not the GL Control accounts during midnight processing. This figure is normally zero. This amount comes from the Overflow Charge report (FCRCHG).

FAC X-FER
This figure comes from moving charges from an account in one facility to an account in a different facility using the Cross Facility Combine Billing functions.

END PA BAL
This field contains the system-supplied ending balance which is calculated by adding and subtracting daily activity from the opening PA balance. The calculation follows:

```
    OPEN PA BAL
  + REV
  - F/B TOTAL
  - CASH
+/- ADJS
+/- REFUNDS
  + L CHG/CR (- Late credits)
  + PMA
+/- FAC X-FER
_____
  END PA BAL
```

SUBS BAL
This field contains the amount, calculated during Midnight Processing, representing the total of all accounts in account location PA. Tomorrow, this amount is used as the Opening PA Balance.

G/L CTRL BAL
This field contains the General Ledger control balance which is the result of adding all PA Control Account balances in the General Ledger. The General Ledger Control Balance should match the Subsidiary and Ending PA balances.

BAL
This field contains an N if the daily balance requires reconciliation.

RECONCILIATION
This field contains comments explaining why Patient Accounting does not balance and the solution to solve the discrepancy. These comments are user-defined and entered on the PA Balance Control screen.

RECONCILED BY
This field is only displayed if someone has updated the screen. It prints the name of the last person to make a change to the screen.

RECLASSIFICATION REPORT - FSREVRC

Description/Purpose

The Reclassification Report lists all patient accounts in which revenue has been reclassified but does not affect revenue posted to the general ledger. It is used to monitor changes reflected in the sources of revenue due to reclassification.

Revenue can be reclassified when the admitting physician and/or attending physician is changed. Changes to patient type, patient indicator, medical service, financial class, or a combination of these items also reflect on this report if the GL mapping keys have not been established.

There are three possible sections on this report, but a section is present only if there are charges that required reclassification that met the definition for the section. The three sections are:

- Reclassification Report

  Changes in revenue are listed by patient name and include the patient account number, admission date, discharge date, last bill date, reclassification effective date, location, type of reclassification, old reclassification revenue type, and new reclassification type. Totals are listed for the number of accounts.

- Reclassification Report for Accounts Using Service Time Processing

  This section contains revenue reclassification that has occurred for accounts that qualify for service time processing. Changes in revenue are listed by patient name and include the patient account number, admission date, discharge date, last bill date, reclassification effective date and time, location, type of reclassification, old reclassification revenue type, and new reclassification type. Totals are listed for the number of accounts.

- Reclassification Report for Individual Charges

  This section contains revenue reclassification that has occurred for charges that had a service time changed so that the revenue that was originally mapped now needs to be reclassified. Changes are listed by patient name and include the patient account number, last bill date, service date and time, charge amount, ICD-9 code and description of the charge, location, type of reclassification, old reclassification revenue type and new reclassification revenue type. Totals are listed for the number of accounts.

Generating and Printing This Report

The report is generated during midnight processing. It is set up as a demand report and printed through the Demand Print function. The report can contain up to three sections

if data is present for each section. Each section contains its own header and is sorted by patient name.

Figure 2.33 FSREVRC - Reclassification Report

```
Date: 09/25/07                                  Model Hospital A                              Page  : 1
Time: 10:10                                 Reclassification Report                           Report: FSREVRCA


                                                        Last    Effective
Patient Name                    Account #    Admit    Dsch  Bill    Date      Loc  Type       Old      New
--------------------------------------------------------------------------------------------------------------
ADAMS,JOSEPH                    0711500012   04/25/07       09/23/07 08/01/07  PA   PI          O         I
FILBERT,NANCY                   0711500012   04/25/07       09/23/07 08/01/07  PA   PT         OPO       I/P
JENKINS,JOHN                    0719900002   07/31/07       09/24/07 08/01/07  PA   PI          O         I
JENKINS,JOHN                    0719900002   07/31/07       09/24/07 08/01/07  PA   PT         LOB       I/P




                                                                     Total Accounts          4
```

Figure 2.34 FSREVRC - Reclassification Report for Accounts
Using Service Time Processing

```
Date: 09/25/07                                  Model Hospital A                              Page  : 2
Time: 10:10                  Reclassification Report for Accounts Using Service Time Processing   Report: FSREVRCA


                                                    Last    Effective
Patient Name                    Account #    Admit    Dsch  Bill    Date     Time   Loc  Type     Old      New
--------------------------------------------------------------------------------------------------------------
JOHNSON,JAMES                   0719900003   07/31/07 07/31/07 09/14/07 07/18/07 03:00P  PA   PI       O        I
JOHNSON,JAMES                   0719900003   07/31/07 07/31/07 09/14/07 07/18/07 03:00P  PA   PT      LOB      I/P




                                                                     Total Accounts          2
```

Figure 2.35 FSREVRC - Reclassification Report for Individual Charges

```
Date: 09/25/07                              Model Hospital A                            Page  : 3
Time: 10:10                       Reclassification Report for Individual Charges        Report: FSREVRCA

                                 Last
Patient Name          Account #  Bill    Serv Dt/Tm       Amt  Code/Description            Loc  Type  Old  New
-------------------------------------------------------------------------------------------------------------
NIELSON,FRANCES       0721200002 08/11/07 07/31/07 0239A  253.00  7293-CT PELVIS WITH CONTRAST 7 AR  MS   CAR   PUL
                                                                                          PI   I     O
                                                                                          PT   I/P   LOR


                                                 Total Accounts        3


                                        End of Report
```

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Each report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

PATIENT NAME
This field contains the patient's name.

ACCOUNT #
This field contains the patient's account number.

ADMIT
This field contains the date the patient was admitted.

DSCH
This field contains the date the patient was discharged.

LAST BILL
This field contains the date this patient's account was last cycle billed, final billed, late billed, or rebilled.

EFFECTIVE DATE
This field contains the effective date of this reclassification request.

LOC
This field contains the location of the account (AR, PA or BD).

TYPE
This field contains the type code representing what was reclassified in the patient's account. For example:

DRA - Admitting Physician
DRT - Attending Physician
MS - Medical Service
FC - Financial Class
PT - Patient Type
PI - Patient Indicator

OLD
Depending on the type of reclassification indicated in the Type field, the code displayed in this field represents the type prior to the reclassification.

NEW
Depending on the type of reclassification indicated in the Type field, the code displayed in this field represents the type after the reclassification.

COMMENT
This field contains the reason reclassification was not allowed, if any. The following are the comments that may appear in this field:

- Reclassification not allowed for BD accounts - If reclassification is attempted for a Bad Debt account that has had charge detail purged, the system displays this message on the report.

- Reclassification not allowed, charges do not exist, account in location PA - If reclassification is attempted on a PA account with no charges posted to it, the system displays this message on the report.

EFFECTIVE DATE TIME
This field on the Reclassification Report for Accounts Using Service Time Processing contains the effective date and time for the reclassification.

SERV DT/TM
This field on the Reclassification Report for Individual Charges contains the service date and time for the reclassification.

AMOUNT
This field on the Reclassification Report for Individual Charges contains amount of the charge.

CODE/DESCRIPTION
This field on the Reclassification Report for Individual Charges contains the ICD-9 code and description.

G/L REVENUE RECLASSIFICATION REPORT - FSRVRCG

Description/Purpose

The G/L Revenue Reclassification Report lists all patients accounts which have had a reclassification of revenue that affects the general ledger. It is used to monitor changes in the sources of revenue due to reclassification.

Revenue can be reclassified when the patient indicator, financial class, patient type, medical service, or a combination of these items is changed. When a reclassification takes place, the system's general ledger component reclassifies the GL revenue and statistics revenue during midnight processing.

Change in revenue is listed by patient name and includes patient account number, admission date, discharge date, last bill date, reclassification effective date, account location, type of reclassification (FC, MS, PI, PT), old reclassification revenue type, new classification revenue type, general ledger period of reclassification, general ledger account numbers affected, and dollar amount of the reclassification.

Totals are listed for the number of accounts reclassified.

Generating and Printing This Report

The report, which is sorted by patient name, is generated during midnight processing. It is set up as a demand report and printed through the Demand Print function.

The following is an example of a G/L Revenue Reclassification Report.

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Figure 2.36 FSRVRCG - G/L Revenue Reclassification Report

```
Date: 08/21/90                                  GENERAL HOSPITAL                              Page  : 1
Time: 05:11                        G/L Revenue Reclassification Report for 08/20/90           Report:FSRVRCGP
                                             GENERAL MEDICAL CENTER


                                                         Last   Effective
Patient Name                      Account #    Admit    Dsch   Bill    Date      Loc  Type      Old         New
----------------------------------------------------------------------------------------------------------------------

DEASY,EDWARD M                    90232-00003 08/20/90 08/20/90 08/20/90 08/20/90  PA   FC        80          86

Period     Account       Debit         Credit

  8        1121-02105    400.00
  8        1121-02105                   400.00

                         400.00         400.00


HOWELL,JULIA                      90223-00001 08/11/90 08/11/90          08/11/90  PA   PI        I           E
    Reclassification not allowed for BD accounts

HOWSER,DANIEL                     90223-00001 08/11/90 08/11/90          08/11/90  PA   PT        ADV         E/R

Period     Account       Debit         Credit

  8        1121-02105    29.75
  8        1121-02105                   29.75

                         29.75          29.75


HOYT,JONATHAN                     90229-00010 08/17/90                   08/17/90  PA   FC        80          85

Period     Account       Debit         Credit

  8        1121-02105    9,532.26
  8        1121-02105                   9,532.26

                         9,532.26       9,532.26


                                               End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, the date the reclassification report is for, and the report name as used in the system.

PATIENT NAME
This field contains the patient's name.

ACCOUNT #
This field contains the patient's account number.

ADMIT
This field contains the date the patient was admitted.

DSCH
This field contains the date the patient was discharged.

LAST BILL
This field contains the date this patient's account was last cycled billed, final billed, late billed or rebilled.

EFFECTIVE DATE
This field contains the effective date for this reclassification request.

LOC
This field contains the location of the account (AR, PA or BD).

TYPE
This field contains the type code representing what was reclassified in the patient's account. For example:

FC - Financial Class
MS - Medical Service
PT - Patient Type
PI - Patient Indicator

OLD
Depending on the type of reclassification indicated in the Type field, the code displayed in this field represents the type prior to reclassification.

NEW
Depending on the type of reclassification indicated in the Type field, the code displayed in this field represents the type after reclassification.

PERIOD
This field contains the general ledger period to which the revenue reclass was posted.

ACCOUNT
This field contains the general ledger number to which the revenue reclassification was debited or credited.

DEBIT/CREDIT
These fields contain the dollar amount of the revenue reclassification.

COMMENT
This field contains the reason reclassification was not allowed, if any.

NOTE: The example report contains the message *Reclassification not allowed for BD accounts.* If reclassification is attempted for a Bad Debt account that has had charge detail purged, the system displays this message on the report.

DAILY PA/GL DETAIL POSTING REPORT - FARGLD

Description/Purpose

The Daily PA/GL Detail Posting Report provides a detailed listing of the daily activity that affects the General Ledger. This report, which is separated by general ledger account number, also provides an explanation of each posting based on the general ledger mapping table of the facility.

This report is separated and subtotaled by General Ledger account number. Each subtotal provides a breakdown, by mapping key description, that shows the total debits and credits to this General Ledger account. If there are postings for multiple fiscal periods, separate totals are provided for the General Ledger account.

This report provides totals for the number of transactions and the dollar amounts of debits and credits (which should balance). Based on these totals, the report is either balanced or out of balance. Out of balanced conditions should be investigated and corrected as necessary.

Since every transaction has a debit and credit entry, the transaction appears on the report two times (once as a credit and once as a debit). The mapping key description indicates the other side of the General Ledger entry.

NOTE: As journal entries are posted throughout the day, the system records the entries for the report and assumes all entries are posted during batch. The system does not edit the report to exclude entries that do not post. Any journal entries that do not post during batch because of errors (such as attempting to post entries to a closed fiscal period), still appear on this report.

Generating and Printing This Report

This report is generated daily as a result of midnight processing.

The following is an example of the Daily PA/GL Detail Posting Report.

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Figure 2.37 FARGLD - Daily PA/GL Detail Posting Report

```
Date: 05/08/90                              General Hospital                              Page  : 1
Time: 08:34                       Daily PA G/L Detail Posting Report for 05/06/90         Report: FARGLD


Account No     Date      Qty   Code Transaction Description                Debit         Credit

******* G/L Account:1000-00101 SYST-O/P-REG STAT DEFAULT

90121-00006    05/06/90  001   S9999 Account Transfer PA to AR            383.00
90122-00003    05/06/90  001   S9999 Account Transfer PA to AR              1.60
90123-00003    05/06/90  001   S9999 Account Transfer PA to AR            176.50
90016-00016    05/06/90  008   2860  BENADRYL 25MG,CAPSULE                                  9.60

     AR CONTROL ACCOUNT/PA CONTROL ACCOUNT                                561.10
     PA CONTROL ACCOUNT/DEFAULT DEPARTMENT REVENUE                                           9.60

  Account 1000-00101 Total for 5-90                                     $551.50

******* G/L Account:1121-02102 PTAR-PA CONTROL

90121-00006    05/06/90  001   S9999 Account Transfer PA to AR                             383.00
90122-00003    05/06/90  001   S9999 Account Transfer PA to AR                               1.60
90123-00003    05/06/90  001   S9999 Account Transfer PA to AR                             176.50
90016-00016    05/06/90  008   2860  BENADRYL 25MG,CAPSULE                  9.60

     AR CONTROL ACCOUNT/PA CONTROL ACCOUNT                                                 561.10
     PA CONTROL ACCOUNT/DEPARTMENT REVENUE                                 9.60

  Account 1121-02102 Total for 5-90                                                       $551.50




                                      Posting Totals

                     Transactions:                    8

                         Debits:         $561.10

                         Credits:        $561.10


                                         Balanced

                                      End of Report
```

Each report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ACCOUNT NO
This field contains the patient account number that caused the GL activity to be generated.

DATE
This field contains the posting date of the activity. The posting date may differ from the processing date. For example, a charge or cash payment may be backdated to reflect the actual date the charge was serviced to the patient or the date on which the cash was received by the facility. If the posting date is in a different fiscal period, separate totals for the account are listed.

QTY
This field contains the quantity of the posted transaction. For charge and credit activity, this field contains the actual quantity. Activities that do not have associated quantities (for example, cash, adjustment, or account transfers) have a quantity of one (1) listed.

CODE
This field contains the code identifying the activity. The Service Item Number (SIM) is listed for charge and credit activity; the transaction code, preceded by the transaction type code, is listed for other transactions such as payments and adjustments.

TRANSACTION DESCRIPTION
This field contains the description of the SIM or transaction code.

DEBIT
This field contains the dollar amount that is debited to the GL account for this transaction.

CREDIT
This field contains the dollar amount that is credited to the GL account for this transaction.

GL ACCOUNT
This field contains the General Ledger account number and description to which the subtotal pertains.

TRANSACTION HISTORY REPORT - FARAIT

Description/Purpose

The Transaction History Report details, by patient account number, all transactions to a patient's account. Each transaction is listed by transaction type and transaction code. Transactions referencing another transaction are displayed with a flag for audit purposes.

Transactions are listed by patient name, and account number, and include transaction code, status type, patient type, billing information, balance information, collection information, and comments.

This report is useful tracing or auditing all activities on a patient's account.

Generating and Printing This Report

The Transaction History report is a demand report requested through the Account Reports option. This report, which is set up as a demand report and printed through the Demand Print function, is sorted by account number and transaction code.

The following is an example of the Transaction History Report.

Figure 2.38 FARAIT - Transaction History Report

```
Date: 06/19/06                           General Hospital                          Page  : 1
Time: 11:01am                          TRANSACTION HISTORY                         Report: FARAIT

ACCT NO     NAME                            TYPE    ADMIT     DISCHARGE       BALANCE    LOC

03868-10303  CLAYTON,KAY                    ERT    10/02/89   10/26/89      $15,270.16   AR

TRAN CD: S0100-Change Collector       BILL SEQ :         TRN AMT:          FROM INS:       REF TRANS:
DTE-TME: 12/05/89 4:27 P          BILL SEQ PRT ON:        NEW BAL:15,270.16  TO INS :        ORIGIN:   USER
POST DT: 12/05/89    TERM: FIN       PRI LOC  : AR        PRI BAL:15,270.16
                                     SUB LOC  : FCRV
STAT TY: Collector          OLD STATUS: 22           NEW STATUS: 10
COMMENTS:

TRAN CD: Y0000-Final Bill             BILL SEQ :         TRN AMT:0.00       FROM INS:       REF TRANS:
DTE-TME: 12/05/89 5:12 A          BILL SEQ PRT ON:        NEW BAL:15,270.16  TO INS :        ORIGIN:   SYSTEM
POST DT: 12/05/89    TERM: FIN       PRI LOC  : AR        PRI BAL:15,270.16
                                     SUB LOC  : FCRV
STAT TY: FB                 OLD STATUS:            NEW STATUS:
COMMENTS: Final Bill
                                          End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

TRAN CD
This field contains each transaction assigned to the patient's account. Included are the transaction type, transaction code and description.

DTE-TME
This field contains the date and time of the transaction assigned to this account.

POST DT
This field contains the posting date of this transaction.

PRI LOC
This field contains the location/sub location of the patient's account prior to the transaction.

TRN AMT
This field contains the amount of this transaction.

NEW BAL
This field contains the balance after the transaction was applied.

PRI BAL
This field contains the balance prior to the transaction.

TO INS
This field contains the carrier/plan to which the dollar amount is transferred. If there is no next carrier, the amount is transferred to the patient. If a balance transfer transaction takes place on this account, the insurance carrier plan number is printed in this field.

REF TRANS
If this transaction references another transaction, a Y prints in this field. For example, if insurance cash and a contractual adjustment are made to the same account simultaneously, a transaction reference is required.

ORIGIN
This field identifies the origin of this transaction as either System- or User-generated.

COMMENTS
This field contains any comments associated with this transaction.

STAT TY
This field contains the status type of the Key Data Revision transactions which are changes of information such as financial class, collector, or physician.

OLD STATUS
This field contains the old value of any data that has changed for this account.

NEW STATUS
This field contains the new value of any data that has changed for this account.

UNAPPLIED CASH BALANCE REPORT - FARBALU

Description/Purpose

The Unapplied Cash Balance Report lists, by day, the prior day's ending balance, daily cash postings to the unapplied account, cash transferred from the unapplied cash account, and the new unapplied cash ending balance. A subsidiary balance and GL control balance are included for auditing purposes (the GL control, subsidiary and ending balances should all be equal).

Any discrepancies between the subsidiary and ending balances should be reconciled. If the Ending Balance and Subsidiary Balance are not the same, the Bal Flag field contains an N indicating that Unapplied Cash needs to be reconciled for that day.

The report displays the name of the individual who reconciled the account. Two comment lines are featured for explaining why the Unapplied Cash Account does not balance and the solution to solve the discrepancy.

The Unapplied Cash Balance Report can be used to monitor and balance unapplied cash and unapplied cash transfers.

Generating and Printing This Report

This report, which is sorted by day of the month, is generated from the Daily Balancing functions for Unapplied Cash with the desired reporting period selected using the online function. It is set up as a demand report and printed through the Demand Print function.

The following is an example of the Unapplied Cash Balance Report.

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Figure 2.39 FARBALU - Unapplied Cash Balance Report

```
Date: 06/12/00                              Model Hospital A                           Page  : 1
Time: 10:43                           Unapplied Cash Balancing Rpt.                    Report: FARBALUA
                                        MO:  06  YEAR:  00

Day   Open UA Bal    Unapplied Cash    Applied Cash      Refunds      End UA Bal      Subs Bal     G/L Ctrl Bal    Bal
          Reconciliation Comments

01    1,145.80          0.00             0.00             0.00         1,145.80       1,145.80         845.80-      Y


02    1,145.80          0.00             0.00             0.00         1,145.80       1,145.80         845.80-      Y


03    1,145.80          0.00             0.00             0.00         1,145.80       1,145.80         845.80-      Y


04    1,145.80          0.00             0.00             0.00         1,145.80       1,145.80         845.80-      Y


05    1,145.80          0.00             0.00             0.00         1,145.80       1,145.80         845.80-      Y


06    1,145.80          0.00             0.00             0.00         1,145.80       1,145.80         845.80-      Y


07    1,145.80          0.00             0.00             0.00         1,145.80       1,145.80         845.80-      Y


08    1,145.80          0.00             0.00             0.00         1,145.80       1,145.80         845.80-      Y


09    1,145.80          0.00             0.00             0.00         1,145.80       1,145.80         845.80-      Y


10    1,145.80          0.00             0.00             0.00         1,145.80       1,145.80         845.80-      Y


11    1,145.80          0.00             0.00             0.00         1,145.80       1,145.80         845.80-      Y
      gl out of balance                                         Reconciled by: Store,Lani S



                                            End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

DAY
This field contains the day of the month.

OPEN UA BAL
This field contains the previous day's subsidiary balance.

UNAPPLIED CASH
This field contains the amount of cash received and posted to the Unapplied Cash account.

APPLIED CASH
This field contains the amount of cash transferred from the Unapplied Cash account.

REFUNDS
This field contains the amount for unapplied cash refund checks that were printed for that day (if using AP to print refund checks, the amount for approved refunds that were transferred to AP).

END UA BAL
This field contains the system-supplied ending balance calculated by this process:

```
  OPEN UA BAL
+UNAPPLIED CASH
- APPLIED CASH
- REFUNDS
———————————————————————————
  END UA BAL
```

SUBS BAL
This field contains the balance of the Unapplied Cash account.

G/L CTRL BAL
This field contains the General Ledger control balance of the Unapplied Cash account.

BAL
This field contains an N if the daily balance requires reconciliation.

RECONCILIATION
This field contains comments explaining why Unapplied Cash does not balance and the solution to solve the discrepancy. These comments are user-defined and entered on the UA Balance Control screen.

RECONCILED BY
This is only displayed if someone has updated the screen. It prints the name of the last person to make a change to the screen.

UNAPPLIED CASH REPORT - FAR110

Description/Purpose

The Unapplied Cash Report provides a detailed listing of all transactions in the Unapplied Cash Account applied to the proper account. Detailed information on each unapplied cash transaction includes the posting sequence number, transaction code and description, date posted, remittance number, DRG, outlier type, who the payment was for, the person posting the cash, who made the payment, and the payment date for the transaction.

Three lines of user-defined comments can be entered on the posting screen and printed on this report. Once an unapplied cash posting is transferred to an account, it does not print on this report.

Generating and Printing This Report

The Unapplied Cash Report is generated through the Print Unapplied Cash Log function. It is set up as a demand report and prints through the Demand Print function. This report is sorted by posting sequence number so the oldest transactions print first.

The following is an example of an Unapplied Cash Report.

Figure 2.40 FAR110 - Unapplied Cash Report

```
Date: 11/18/89                              General Hospital                              Page  : 1
Time: 05:36pm                             Unapplied Cash Report                           Report: FAR110

Seq #  ID     Amount          Trans Code/Description
Pst Date      Remittance Number            Payment By
Pay Date      Days Outlier DRG             Payment For        -------------------------Comments-------------------------

5     FBH    1433.59          U9999 UNAPPLIED CASH            Received payment from Equitable but unable to locate patient
11/17/89      EQ 987 11 3348               Equitable          by name of John Doe.  Called Mary Jones at Equitable.  She
11/17/89                 425               John Doe           is researching and will return call by 11/20/89.

6     FBH    47.50            U9999 UNAPPLIED CASH            Received check from Jerry Brown but cannot locate patient
11/17/89                                   Jerry Brown        or guarantor by this name.  Copy of check in Unapplied Cash
11/17/89                                   Jerry Brown        Log - Ph on Check 449-8844.  No answer, will recheck later.


Total Transactions and Amount
             2       1481.09

                                            End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

SEQ #
This field contains the system-assigned sequence number originally assigned to each cash entry when it was posted.

ID
This field contains the initials of the person who posted the cash.

AMOUNT
This field contains the amount of the payment.

TRANS CODE/DESCRIPTION
This field contains the transaction code and description assigned to this cash entry.

PST DATE
This field contains the date the unapplied cash transaction was posted.

REMITTANCE #
If this is an insurance payment, this field contains the remittance number.

PAYMENT BY
This field indicates who made the payment.

PAYMENT FOR
This field indicates for whom the payment was made.

COMMENTS
This field contains up to three lines of free-form text entered when posting the unapplied payments.

UNBILLED ACCOUNTS REPORT - FBR110

Description/Purpose

The Unbilled Accounts Report provides a list of discharged accounts not final billed. It can be used to help the hospital monitor unbilled accounts.

This report includes the patient number, patient name, financial class, patient type, admit/registration date, discharge date, unbilled amount, hold indicator, LOS, suspense days, and account balance. Summary totals are provided by patient and unbilled accounts. Both categories include inpatients, outpatients, and emergency room patients.

Generating and Printing This Report

This report is generated during midnight processing and can be set up and printed as a demand report. It is sorted by patient account number and name. Refer to the Financial System Management section of the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide* for more information on printing Optional Batch Jobs.

The following is an example of the Unbilled Accounts Report.

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Figure 2.41 FBR110 - Unbilled Accounts Report

```
Date: 12/04/89                            GENERAL HOSPITAL                                Page  : 1
Time: 05:12                            Unbilled Accounts Report                           Report: FBR110
                                    Unbilled Accounts For 12/03/89
                                         Admit/    Dsch                         Susp
        Account         Patient Name    F/C  P/T  Reg Date   Date    Unbilled Amt  Hold  Los  Days    Balance
     89314-00001 SISNEY,GARY ANDREW      08   E/R  11/10/89  11/10/89      0.00            1    25     383.00
     89234-00011 RADSMITH,FRANK D        80   I/P  08/22/89  10/30/89      0.00           69    35       0.00
     89237-00022 DEAN,ROBERT             80   I/P  08/25/89  11/14/89  40,800.00          81    21  40,800.00
     89244-00002 DEMAREST,JACKSON        91   I/P  09/01/89  11/10/89  11.107.00          70    25  36,880.15
     89244-00007 DEERFIELD,SAMUEL X      80   I/P  09/01/89  11/03/89  11,538.85          63    32  36,618.85
     89263-00003 ODEN,DANIEL L           80   I/P  09/20/89  11/17/89   9,500.00    Y     58    18  36,133.00
     89263-00004 ORESTIA,MARIA T         80   I/P  09/20/89  11/10/89   9,500.00          51    25  35,744.05
     89263-00005 SIMKA,SARA A            80   I/P  09/20/89  11/03/89   9,500.00          44    32  35,720.00
     89275-00001 CLAYTON,KAY             85   I/P  10/02/89  10/26/89   6,150.00          24    39  23,124.00
     89283-00006 CLAYTON,SARA            85   I/P  10/10/89  10/26/89  10,000.00          16    39  37,600.00
     89290-00001 OSBORNE,ROGER F         85   I/P  10/16/89  10/27/89   6,881.55          11    40  61,133.70
     89305-00002 ROHDE,MURPHY            80   I/P  11/01/89  11/02/89  10,000.00           1    32  36,000.00
     89306-00001 ROLAND,LENORA           80   I/P  11/02/89  11/06/89   7,192.95           4    28  33,603.05
     89306-00002 MARKS,CHARLOTTE         80   DAJ  11/02/89  11/06/89   5,235.05           4    28  21,729.05
     89306-00003 MARKS,ANDREW JONATHAN   80   ADM  11/02/89  11/03/89      0.00            1    31     137.00
     89306-00005 BARROWS,BRENDA          80   I/P  11/02/89  11/06/89   9,575.00           4    28  16,852.00
     89306-00006 SMITH,MARY A            80   DAJ  11/02/89  11/06/89   1,140.00           4    28   1,520.00
     89306-00007 KATZ,JOEL GRANT         85   ADM  11/02/89  11/03/89   1,520.00           1    31   1,520.00
     89312-00001 VELTINS,DENNIS A        66   I/P  11/08/89  11/14/89   1,140.00           6    21   1,520.00
     89317-00002 DEAN,STANLEY U          80   I/P  11/14/89  11/17/89   1,520.00           3    18   1,520.00
     89318-00005 JONES,GEORGE T          66   I/P  11/14/89  11/14/89     383.00    Y      1    21     383.00
     89319-00004 MASTERS,LORI W          80   I/P  11/15/89  11/15/89   1,040.70           1    20   1,040.70
     89319-00005 MASTERS,BABY GIRL       80   I/P  11/15/89  11/15/89      0.00            1    20       0.00
     89325-00001 HUDAHL,ALLEN R          86   I/P  11/21/89  11/22/89   9,818.50           1    13   9,718.50
     89234-00013 FERRIS,DARREL I         85   PSY  08/22/89  11/14/89   8,809.00          82    21  31,023.00
                                                Total             161,244.60                       500,703.05

       Patients: E   - Emergency           1          Unbilled Accounts:   E   - Emergency             383.00
                  I   - Inpatient          19                               I   - Inpatient         444,391.00
                  O   - Outpatient          5                               O   - Outpatient         55,929.05
                      Total                25                                   Total               500,703.05
                                                End of Report
```

Each report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ACCOUNT
This field contains the patient's account number.

PATIENT NAME
This field contains the patient's name.

F/C
This field contains the hospital-defined financial class code assigned to this patient's account.

P/T
This field contains the patient type code used to categorize the patient. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, and series patients.

ADMIT/REG DATE
This field contains the date the patient was admitted or registered.

DSCH DATE
This field contains the date the patient was discharged.

UNBILLED AMT
This field contains the amount of charges unbilled.

HOLD
A Y in this field indicates the bill is on hold for this account. Bills on hold are not generated until the hold flag is removed.

LOS
This field contains this patient's length of stay (LOS). This field is blank for outpatient accounts. The LOS should equal the discharge date less the admission date except for one day stays which equal 1.

SUSP DAYS
This field contains, from today's date, the number of days since the patient's discharge.

BALANCE
This field contains the account balance.

UNBILLED ACCOUNTS BY FINANCIAL CLASS REPORT - FBR111A

Description/Purpose

The Unbilled Accounts by Financial Class Report provides a list of discharged accounts not final billed. It can be used to help the hospital monitor unbilled accounts.

This report includes the patient number, patient name, financial class, patient type, admit/registration date, discharge date, unbilled amount, hold indicator, LOS, suspense days, and account balance. Summary totals are provided by financial class and number of unbilled accounts. Both categories include inpatients, outpatients, and emergency room patients.

Generating and Printing This Report

This report is generated during midnight processing and can be set up and printed as a demand report. It is sorted by financial class. Refer to the Financial System Management section of the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide* for more information on printing Optional Batch Jobs.

The following is an example of the Unbilled Accounts Report by Financial Class.

Figure 2.42 FBR111A - Unbilled Accounts by Financial Class Report

```
Date: 07/22/99                              Model Hospital A                          Page  : 2
Time: 0:31                             Unbilled Accounts by Fin Class                 Report: FBR111A
                                        Unbilled Accounts For 07/21/99
                                                 C - CHAMPUS


                                      Admit/      Dsch                              Susp
   Account          Patient Name       P/T  Reg Date    Date    Unbilled Amt  Hold  Los  Days      Balance

   9916100003  KING,SERIES             SER  06/10/99  07/09/99       5.00                  13         5.00
   9916900001  PALMER,JAMIN HEART      SD2  06/18/99  07/17/99      10.00                   5        10.00
   9918700006  SERIESTEST,EIGHT        CW1  07/06/99  07/06/99      50.00                  16        50.00

                                    Financial Class Total                0.00                        65.00

        Patients: O   - Outpatient         3              Unbilled Accounts:   O   - Outpatient       65.00
                    Total                  3                                      Total               65.00
```

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Each report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ACCOUNT
This field contains the patient's account number.

PATIENT NAME
This field contains the patient's name.

F/C
This field contains the hospital-defined financial class code assigned to this patient's account.

P/T
This field contains the patient type code used to categorize the patient. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, and series patients.

ADMIT/REG DATE
This field contains the date the patient was admitted or registered.

DSCH DATE
This field contains the date the patient was discharged.

UNBILLED AMT
This field contains the amount of charges unbilled.

HOLD
A Y in this field indicates the bill is on hold for this account. Bills on hold are not generated until the hold flag is removed.

LOS
This field contains this patient's length of stay (LOS). This field is blank for outpatient accounts. The LOS should equal the discharge date less the admission date except for one day stays which equal 1.

SUSP DAYS
This field contains, from today's date, the number of days since the patient's discharge.

BALANCE
This field contains the account balance.

UNBILLED ACCOUNTS WITH ZERO CHARGES REPORT - FBR112

Description/Purpose

The Unbilled Accounts with Zero Charges Report provides a list of unbilled accounts with zero charges that are pending forced billing based on the Zero Charge Bill Days parameter on the Billing Parameters screen.

This report includes the patient name, account number, financial class, patient type, medical service, admit/registration date, discharge date, registration initials, biller code, days since discharge, days to bill, combined billing indicator, error indicator, and zero charges indicator.

Generating and Printing This Report

This report is generated during midnight processing and can be set up and printed as a demand report. It is sorted by biller, patient type, medical service, discharge date, or patient name as defined in the sort options for the report. Refer to the Financial System Management section of the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide* for more information on printing Optional Batch Jobs.

The following is an example of the Unbilled Accounts with Zero Charges Report.

Figure 2.43 FBR112 - Unbilled Accounts with Zero Charges Report

```
Date: 04/21/98                           General Hospital A                         Page  : 1
Time: 12:40am                       Unbilled Accounts With Zero Charges                     Report: FBR112A



                                     Patient Type:   1
                                     Medical Service: MED MEDICAL


Patient Name                     Account        F/C P/T Med Admit    Disch    Pre/    Biller Days Days Comb Errors  No
                                 Number             Svc Date     Date     Reg By   Code  Since  To  Bill         Chgs
                                                                                         Disch Bill Ind
-------------------------------------------------------------------------------------------------------------------
WATSON,TERESA                    9810700001      S  1   MED 04/13/98 04/13/98 KCW/KCW   45    7    43    *       *

                        Patient Type total accounts with $0.00 charges:       1

                                  Patient Type: ADV Advance Admission Inpatient
                                     Medical Service: ERS EMERGENCY


Patient Name                     Account        F/C P/T Med Admit    Disch    Pre/    Biller Days Days Comb Errors  No
                                 Number             Svc Date     Date     Reg By   Code  Since  To  Bill         Chgs
                                                                                         Disch Bill Ind
-------------------------------------------------------------------------------------------------------------------
WILKINS,MARK W                   9808300005      S  ADV ERS 03/24/98 04/03/98    /MAJ   123   17    33    *       *

                                  Medical Service: MED MEDICAL

MILLER,TODD                      9807300003      S  ADV MED 03/12/98 03/22/98 K W/K W   123   29    21    *       *
MILLER,RANDA                     9807100030      S  ADV MED 03/12/98 03/22/98 K W/K W   123   29    21    *       *
MOORE,JOAN H                     9807100032      S  ADV MED 03/12/98 03/22/98    /K W   123   29    21    *       *
OSBORNE,JANICE P                 9807300002      S  ADV MED 03/12/98 03/22/98 K W/K W   123   29    21    *       *
PATTERSON,JOY                    9806500014      S  ADV MED 03/12/98 03/22/98 K W/K W   123   29    21    *       *
PATTERSON,TONYA                  9807100025      S  ADV MED 03/12/98 03/22/98 K W/K W   123   29    21
PETERS,LAURA N                   9807300001      S  ADV MED 03/12/98 03/22/98 K W/K W   123   29    21    *       *
PETERSON,HEATHER R               9807200016      S  ADV MED 03/13/98 03/23/98 K W/K W   123   28    22    *       *
WAITE,TRACY                      9808300001      S  ADV MED 03/15/98 03/25/98 K W/K W   123   26    24    *       *
WALTERS,ROYSTON                  9807500006      S  ADV MED 03/16/98 03/26/98 K W/***   123   25    25    *       *
WATSON,AUTUMN                    9807900003      S  ADV MED 03/20/98 03/30/98 K W/***   123   21    29    *       *
WATSON,REESE                     0000000004      S  ADV MED 03/26/98 04/05/98 MAJ/***   123   15    35    *       *

                        Patient Type total accounts with $0.00 charges:      13

                                      End of Report
```

Each report contains a header that includes the date and time the report is generated, the hospital's name, the report title, the page number, and the report name as used in the system.

PATIENT NAME
This field contains the patient's name.

ACCOUNT NUMBER
This field contains the patient's account number.

F/C
This field contains the patient's financial class.

P/T
This field contains the patient's patient type.

MED SVC
This field contains the patient's medical service.

ADMIT DATE
This field contains the patient's admission date.

DISCH DATE
This field contains the patient's discharge date.

PRE/REG BY
This field contains the initials of the person who registered the patient.

BILLER CODE
This field contains the patient's biller code.

DAYS SINCE DISCH
This field contains the number of days since the patient was discharged.

DAYS TO BILL
This field, updated daily, contains the number of days until the patient is forced to bill. Days to Bill is calculated as the lesser of the following:

a) Suspense Days + Zero Charge Bill Days - Days Since Discharge, or
b) Maximum Hold Days - Days Since Discharge

Accounts on hold continue to appear on the report with the Days To Bill as "Hold." Combined Accounts waiting for other linked accounts to bill continue to appear on the report with the Days To Bill as "Wait." Accounts with Days to Bill equaling 0 bill in the next midnight processing run.

COMB BILL IND
This field contains an asterisk (*) if the patient is linked to other accounts for combined billing. This field is blank if the account is not linked to other accounts for combined billing.

ERRORS
This field contains an asterisk (*) if the account has billing requirement failures (billing errors). This field is blank if the account has no billing errors.

NO CHGS
This field contains an asterisk (*) if the account has $0.00 in charges because no charges have been entered on the account. This field is blank if there are charges on the account that total $0.00, i.e., off-setting charges and credits.

UNVERIFIED INSURANCE REPORT - FAR310

Description/Purpose

The Unverified Insurance Report lists all accounts requiring insurance verification, certification, or approval. It is used to help the hospital complete insurance verification.

The online Insurance Plan Master has two fields controlling whether patients are included on this report: the Verification and Precertification fields. If a Y is entered in either field when this master is completed, accounts may be included on this report.

If a patient requires verification, a verification date must be entered to remove the requirement. If certification is needed, entering an approval date and code satisfies this requirement. A date entered in the Notified field during the admitting process removes the notification requirement but determines an approval date be entered. The notified date indicates the carrier has been notified but the approval date has not been received. The Total Inpatients or Total Outpatients fields at the end of the report represents the number of unique accounts on the report.

Generating and Printing This Report

This report is generated as an Optional Batch Job. Refer to the Financial System Management section in the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide* for more information on generating this type of report.

Separate reports are generated for inpatients (FAR310) and outpatients (FAR310O).

The following is an example of the Unverified Insurance Report.

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Figure 2.44 FAR310 - Unverified Insurance Report

```
Date: 11/27/89                          General Hospital                    Page  : 1
Time: 12:19am                       Unverified Insurance Report             Report: FAR310

                              02 OTHER GOVT (CHAMPUS, CRIP CH, VOC R)

Patient #   I/O Patient Name         Admitted Carrier  Plan Name            Reason    Notified
                                     Date     Plan                          Codes     Date

01001-75017  I  HALL,WILLIAM E       11-25-89  041577  CHAMPUS I/P          I,P
01500-00974  I  COLLIER,SAM          11-24-89  041577  CHAMPUS I/P          I,P


        I - Insurance Requires Verification:       2
        P - Insurance Requires Certification:      2
        A - Insurance Requires Approval:           0


_____


Date: 11/27/89                          General Hospital                    Page  : 2
Time: 12:19am                       Unverified Insurance Report             Report: FAR310

                                       85 COMMERCIAL
Patient #   I/O Patient Name         Admitted Carrier  Plan Name            Reason    Notified
                                     Date     Plan                          Codes     Date

01001-75074  I  HALL,WILLIAM E       11-25-89  041577  AETNA/BANKHEAD ENTERPRISE   I,P
01001-74994  I  HALL,FRED            11-24-89  041577  AETNA/BANKHEAD ENTERPRISE   I,P
01001-74986  I  DOUGLAS,STEVE        11-25-89  053005  ALLSTATE/SEARS-PLAN A       I
01001-74994  I  RUSE,ANNETTE         11-24-89  079836  LINCOLN NTL/GENERAL PLAN    I,P


        I - Insurance Requires Verification:       4
        P - Insurance Requires Certification:      3
        A - Insurance Requires Approval:           0



                                      End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

PATIENT #
This field contains the patient's account number.

I/O
This field contains the patient indicator, examples of which include I-inpatient, O-outpatient, and E-emergency.

ADMITTED DATE
This field contains the date the patient was admitted.

CARRIER PLAN
This field contains the carrier/plan code.

PLAN NAME
This field contains the plan name.

REASON CODES
The reason code explains why this patient's account appears on the unverified insurance report. Reason codes include I-insurance requires verification; P-insurance requires certification flag, and A-insurance requires approval.

NOTIFIED DATE
This field contains a date if the reason code A (insurance requires approval) is printed in the Reason Codes field on this report. The date represents when the patient's insurance carrier was notified an approval was required.

REIMBURSEMENT AUDIT REPORT - FBR250

Description/Purpose

The Reimbursement Audit Report provides a list of accounts that have either been final or adjustment billed and have an automatic contractual adjustment with the adjustment calculation procedure printed on the report.

The report lists the patient name, account number, payor code, type code (DRG code, overall plan, procedure code, medical service, and diagnosis code) reimbursement table number, transaction code, calculation method (flat rate, per diem, charges), admit date, posting date, covered days, covered charges, expected reimbursement, contractual adjustment, stop loss flag, and any exception codes.

Information is displayed by carrier and patient indicator. Carrier totals are provided by patient type for the number of accounts, covered charges, expected reimbursement, and contractual adjustment. Facility totals are provided by patient type for number of accounts, covered charges, expected reimbursement, and contractual adjustment.

Generating and Printing This Report

The Reimbursement Audit Report is generated during midnight processing and is printed as a demand report. It is sorted by carrier and subsorted by patient indicator, patient name, and patient number.

The following is an example of the Reimbursement Audit Report.

Figure 2.45 FBR250 - Reimbursement Audit Report

```
Date: 10/27/89                              General Hospital                        Page  : 1
Time: 12:19am                       Reimbursement Audit Report for 10/26/89         Report: FBR250


Carrier:  04 Aetna
Patient Indicator: Inpatient
Patient Name                      Account #    Payor  Type/   Table # /  Calc  Adm Dte/  Cvrd   Cvrd Charges   Exp. Reimb./
                                               Code   Code    Tran Code  Meth  Post Dte  Days                  Contr. Adj.

SMITH,MARY T                      8915-700-177  AE     O        08        F    06/06/89   1      1,210.50         968.40
                                                                A0001          08/11/89                          142.10
CLAREY,REBECCA S                  8915-982-100  AE     O        08        F    06/06/89   1      3,200.00       2,400.00
                                                                A0001          08/11/89                          800.00


JONES,MARTIN U                    8922-781-009  AE     P        08        F    05/23/89   13     5,019.99       5,600.00
                                                0102            A0001          08/14/89                          580.01-
                  Accommodation Code Exception:   ICU                                           1,907.80




Type:A-ASC Payment Group C-Major Diagnostic Cat D-Diagnosis Code G-DRG Table I-Pathways Contr Mgmt M-Medical Service O-Overall Plan P-Procedure
Code
    s1: Indicates a Stop Loss Table
Calc Meth: A-ASC Grp   C-Charge Level   D-By Days   F-Flat Rate I-Pathways Contract Management
_____
Date: 10/27/89                              General Hospital                        Page  : 2
Time: 12:19am                       Reimbursement Audit Report For 10/26/89         Report: FBR250

                                                 AETNA

     Carrier Totals    # Accounts   Cvrd Charges     Exp. Reimb.     Contr. Adj.

       Inpatient            3         9,430.49         8,968.40        162.09
       Outpatient           0             0.00             0.00          0.00
       Total                3         9,430.49         8,968.40        162.09
_____
Date: 10/27/89                              General Hospital                        Page  : 3
Time: 12:19am                       Reimbursement Audit Report For 10/26/89         Report: FBR250

     Facility Totals   # Accounts   Cvrd Charges     Exp. Reimb.     Contr. Adj.

       Inpatient            3         9,430.49         8,968.40        162.09
       Outpatient           0             0.00             0.00          0.00
       Total                3         9,430.49         8,968.40        162.09

                                             End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

CARRIER
This field contains the carrier code and name.

PATIENT INDICATOR
This field contains the patient indicator, for example I-inpatient, O-outpatient.

PATIENT NAME
This field contains the patient name.

ACCOUNT #
This field contains the patient account number.

PAYOR CODE
This field identifies the payor type.

TYPE CODE
This field identifies the reimbursement type. Valid types are A-ASC Payment Group, D-Diagnosis Code, M-Medical Service, O-Overall Plan, P-Procedure Code, G-DRG, S-Specified DRG Codes, C-Major Diagnostic Category, and I-Pathways Contract Management Interface.

TABLE #
This field identifies the table number corresponding to the reimbursement payor. If this is a stop loss table, an S prints next to the reimbursement table number.

CALC METH
This field identifies the reimbursement calculation method used. Valid methods are D-By Days, F-Flat Rate, C-Charge Level, A-ASC Group, and I-Pathways Contract Management Interface.

ADM DTE
This field contains the admission date.

CVRD DAYS
This field contains the number of covered days.

CVRD CHARGES
This field contains the dollar amount of covered charges.

EXP REIMB
This field identifies the expected reimbursement amount for the account.

TRAN CODE
This field contains the transaction type and code.

POST DTE
This field contains the date the transaction was posted.

CONTR. ADJ.
This field identifies the amount of the contractual adjustment for this account.

ACCOMMODATION CODE EXCEPTION
This field identifies the accommodation code exception (if any) for this account.

PRORATION SUMMARY EXCEPTION
This field identifies the proration summary code exception (if any) for this account.

REIMBURSEMENT TABLE REPORT - FTR140

Description/Purpose

The Reimbursement Table Report prints information for all or selected payors. The report includes the payor code and description; reimbursement type code; table number; effective dates for the payor; effective date type code; post reimbursement flag; ICD-9-CM code, Medical Service Code, DRG, or MDC code; Post Contractual by Department Flag; stop-loss threshold; maximum reimbursement amount; calculation method code and description; flat rate amount; day/charge range amount; percentage used; and the actual percent or dollar amount of the reimbursement.

The system sorts this report by payor code, if multiple payors are selected. Within each payor code, the system sorts the report by type, then table number, then code. The system prints all payor tables for the payor.

This report serves as an audit trail for the contents of your reimbursement tables.

Generating and Printing this Report

This report is generated using the Print Reimbursement Table option. When you select this processor the system asks which payor(s) you want to display on the report. Enter the payor code to create a Reimbursement Table Report for only one payor, enter a hyphen (-) to display and select one or more payor codes to include on the report, or enter **A** to create a Reimbursement Table Report for all payor codes.

If you enter **A** to include all payor codes on the report, the system asks if you want to include only those tables currently in effect. Enter **Y** to limit the report to only those tables currently in effect; enter **N** to include all tables. The system then asks if you want to include payors filed as deleted. Enter **Y** to include all payors; enter **N** to exclude payors filed as deleted from printing on the report. The system then begins to generate the report.

For more information on the Print Reimbursement Table option, refer to the Reimbursement Overview section in the *General Information Volume* in the *STAR Financials Patient Accounting Reference Guide*.

The following is an example of the Reimbursement Table Report.

Figure 2.46 FTR140 - Reimbursement Table Report

```
Date: 03/27/95  Date: 03/28/95                       General Hospital                    Page  : 1   Time: 2:20pm
                                                 REIMBURSEMENT TABLE REPORT                 Report: FTR140
PAYOR:CO COMMERCIAL REIMBURSE PAYOR CD    TYPE:A  TBL:001  EFF DATES:03/15/94 TO 03/15/96  DATE TYP:A  POST REIM:Y  POST BY DEPT:N
TYPE:ASC Payment Group
  GRP         AMOUNT                     MAX REIMB   CAL METH     FLAT RATE   DAY/CHARGE RANGE    % AMT      REIMBURSEMENT
                                        999,999.00   ASC GRP
   00          874.00
   01          950.00
   02        2,010.00
   03        2,795.00
   04        3,011.00
   05        3,451.00
   06        4,900.00
   07            0.00
   08            0.00
   09            0.00
-------------------------------------------------------------------------------------------------------------------
PAYOR:CO COMMERCIAL REIMBURSE PAYOR CD    TYPE:D  TBL:002  EFF DATES:01/01/92 TO 12/31/96  DATE TYP:A  POST REIM:Y  POST BY DEPT:N
TYPE:ICD-9 Diagnosis Code
  CODE DESCRIPTION                       MAX REIMB     CAL METH     FLAT RATE   DAY/CHARGE RANGE    % AMT     REIMBURSEMENT
  1234 DIPHYLLOBOTHRIAS INTEST        20,000,000.00   CHARGES                  99,999,999.99       A         1,000.00
  ICD9-D EXCEPTION TYPE:FEE SCHEDULE          DEPARTMENT:CENTRAL SERVICES
            ICD9-D CODE:1234
  NON INCL SIM    CAL TYPE FLAT/%    TRAN CODE  PRO SUMM  SIM  DESC                     % AMT     REIMBURSEMENT
  NORMAL                                                  340 KIT,CATH-MULTI LEMEN 20CM   A        100.00
-------------------------------------------------------------------------------------------------------------------
PAYOR:CO COMMERCIAL REIMBURSE PAYOR CD    TYPE:O  TBL:001  EFF DATES:01/01/92 TO 12/31/95  DATE TYP:A  POST REIM:Y  POST BY DEPT:Y
TYPE:Overall Plan
    MAX REIMB   CAL METH      FLAT RATE    DAY/CHARGE RANGE     % AMT      REIMBURSEMENT
32,232,323.00  DAYS                        99,999,999.99        A            60.00
  EXCEPTION TYPE:PRO SUMMARY CODE
   CODE DESCRIPTION                 CAL METH     FLAT RATE    DAY/CHARGE RANGE    % AMT      REIMBURSEMENT
   011                              FLAT RATE       3.00
  EXCEPTION TYPE:FEE SCHEDULE                 DEPARTMENT:Laboratory
  NON INCL SIM    CAL TYPE  FLAT/%    TRAN CODE  PRO SUMM  SIM  DESC               % AMT      REIMBURSEMENT
  NORMAL                                                   1009                     A           1.00
  NORMAL                                                   1111 TEST DESCRIPTION    A          40.00
                                                          End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

PAYOR
This field displays the payor code and description.

TYPE
This field displays the reimbursement type code.

TBL
This field displays the table number established for this type of reimbursement.

EFF DATES
This field displays the effective from and through dates for this table.

DATE TYP
This field displays the effective date type code. This is either A (admission) or D (discharge).

POST REIM
This field displays the post reimbursement flag.

POST BY DEPT
This field displays the Post Contractual by Department flag.

TYPE
This field displays the ASC payment group, ICD-9-CM code, medical service code, specific DRG codes, Pathways Contract Management interface, or MDC code describing the type of reimbursement defined.

MAX REIMB
This field displays the maximum reimbursement amount for this type and table number.

CAL METH
This field identifies the reimbursement calculation method used. Valid methods are D-By Days, F-Flat Rate, C-Charge Level, A-ASC Group, and I-Pathways Contract Management Interface.

FLAT RATE
This field displays the flat rate amount for this payor code.

DAY/CHARGE RANGE
This field displays the day or charge amount's defined reimbursement amounts.

%/AMT
This field display P if this payor code uses a percentage, or A if the code uses an amount.

REIMBURSEMENT
This field displays the percentage value (if the code uses a percentage) or amount (if the code uses an amount).

NOTE: Both the percentage and dollar amounts print in a dollar format. Unlimited prints as $9,999,999.99.

The next portion of the report displays exceptions for the payor code.

The following fields of information display for **Accommodation** or **Pro Summary** Exceptions:

EXCEPTION TYPE
This field displays *Accommodation* if this is an accommodation exception, or *Pro Summary* if this is a pro summary exception.

CODE
This field displays the code of this accommodation or pro summary exception.

DESCRIPTION
This field displays the description of this accommodation or pro summary exception.

CAL METH
This field displays the calculation method code and description of this accommodation or pro summary exception.

FLAT RATE
This field displays the flat rate amount of this accommodation or pro summary exception.

DAY/CHARGE RANGE
This field displays the day or charge amount of this accommodation or pro summary exception.

%/AMT
This field displays P if this accommodation or pro summary exception uses a percentage, or A if this accommodation or pro summary exception uses an amount.

REIMBURSEMENT
This field displays the percentage value (if the accommodation or pro summary exception uses a percentage) or amount (if the accommodation or pro summary exception uses an amount).

NOTE: Both the percentage and dollar amounts print in a dollar format.

The following fields of information display for **Fee Schedule** Exceptions:

EXCEPTION TYPE
This field displays *Fee Schedule*.

DEPARTMENT
This field displays the department description for the fee schedule exception.

NON-INCLUDED SIM
This field displays the non-included SIM items for the fee schedule exception. If there are none, the report displays *No Add.*

CAL TYPE
This field displays the calculation type code of this fee schedule exception.

FLAT/%
This field displays the flat rate amount or percentage of this fee schedule exception.

TRAN CODE
This field displays the Tran Type and Code for this fee schedule exception.

PRO SUMM
This field displays the Proration Summary Code for this fee schedule exception.

SIM
This field displays the SIM code for this fee schedule exception.

DESC
This field displays the description of the SIM item for this fee schedule exception.

%/AMT
This field displays P if this fee schedule exception uses a percentage, or A if this fee schedule exception uses an amount.

REIMBURSEMENT
This field displays the percentage value (if the fee schedule exception uses a percentage) or amount (if the fee schedule exception uses an amount).

NOTE: Both the percentage and dollar amounts print in a dollar format. Unlimited prints as $9,999,999.99.

The following fields of information display for **Stop Loss** Exceptions:

EXCEPTION TYPE
This field displays *Stop Loss.*

TBL
This field displays the table number for the stop loss exception.

DAYS
This field displays the number of days for the stop loss exception.

CHARGES
This field displays the amount of the charges for this stop loss exception.

STOP LOSS TRSHLD %

This field displays the stop loss threshold for this stop loss exception.

ADDL REIMB %

This field displays the percentage of the additional reimbursement for this stop loss exception.

MAX REIMB

This field displays the maximum reimbursement amount for this stop loss exception.

CAL METH

This field displays the calculation method and description for the stop loss exception.

FLAT RATE

This field displays the flat rate amount for this stop loss exception.

DAY/CHARGE RANGE

This field displays the day or charge amount for this stop loss exception.

%/AMT

This field displays P if this stop loss exception uses a percentage, or A if this stop loss exception uses an amount.

REIMBURSEMENT

This field displays the percentage value (if the stop loss exception uses a percentage) or amount (if the stop loss exception uses an amount).

NOTE: Both the percentage and dollar amounts print in a dollar format. Unlimited prints as $9,999,999.99.

CHARGE OVERFLOW REPORT - FCRCHG

Description/Purpose

The Charge Overflow Report lists accounts having charges included in the subsidiary but not posted to the GL during midnight processing. This situation can take place when charges are received by patient accounting for the next business day prior to the financial system running midnight processing.

This report includes the patient name, account number and location, order date, service date, charge quantity, and charge amount. Total overflow charges are printed for today, yesterday, and net by patient location and total facility. The net amount printed is reported on the Daily Balancing screen for balance control and auditing.

Generating and Printing This Report

The Charge Overflow Report is generated during nightly batch processing and is printed through the demand print function. The report is generated daily for all overflow charges occurring that day. It is sorted by patient name.

NOTE: Accounting locations on this report are represented under the Location heading using these codes:

1 - Patient Accounting
2 - Accounts Receivable
3 - Bad Debt

The following is an example of the Charge Overflow Report.

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Figure 2.47 FCRCHG - Charge Overflow Report

```
Date: 11/27/89                           General Hospital                       Page  : 1
Time: 12:19am                        Charge Overflow for 11/26/89               Report: FCRCHG
                                             Facility A

Patient Name              Account Number    Location    Order Date   Service Date      Qty    Charge Amount

ANDERSEN,WILLIAM C        8925200009        1           11/25/89     11/26/89          1          100.00

ATKINS,MELINDA F          8917156271        1           11/25/89     11/26/89          1          350.00

BOLLINGER,LAWRENCE V      8917236181        1           11/25/89     11/26/89          1            9.00

CLARKE,STEVEN G           8991000019        1           11/25/89     11/26/89          2          250.00

DONALDSON,KIMBERLEY L     8935171911        1           11/25/89     11/26/89          1          400.00

EDWARDS,ROBERT G          8944265171        1           11/25/89     11/26/89          1           11.00
_____


Date: 11/27/89                           General Hospital                       Page  : 2
Time: 12:19am                        Charge Overflow for 11/26/89               Report: FCRCHG



                                        Today           Yesterday                 Net

                     PA        :        370.00            750.00              1,120.00
                     AR        :          0.00              0.00                  0.00
                     BD        :          0.00              0.00                  0.00
                     Facility Total :    370.00            750.00              1,120.00

                                      End of Report
```

PURGE ARCHIVED ACCOUNT CHARGES REPORT - FARBD

Description/Purpose

The Purge Archived Account Charges Report provides a listing of bad debt accounts selected for the archiving of charge detail, based on the parameter setting of the facility's data retention parameter. The detail charge archive is initiated by running the Bad Debt Charge Deletion Optional Batch Job. There is an online Purge Process to actually delete the detail charges once they are archived. Refer to the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide* for additional information on the purge process.

Generating and Printing this Report

The Purge Archived Account Charges report is generated during midnight processing when the Bad Debt Charge Selection Optional Batch Job is run. The report is sorted by patient name. The report spooler definition is referenced during batch to print the report immediately or on demand.

The following is an example of the Purge Archived Account Charge Report.

Figure 2.48 FARBD - Purge Archived Account Charges Report

```
Date: 11/09/90                              PROVIDENCE MED CENTER                         Page  : 1
Time: 00:51                         Purge Archived Account Charges for 11/08/90           Report: FARBDPP
                                        Facility PROVIDENCE MEDICAL CENTER

Patient Name                 Account Number   Pat Type   Fin Cls    Account Bal   BD Xfer Date   Charge Amt Purged
BARKER,BOB                   90278-00002        E/R        80           117.35     10/19/90            117.35
BROYLES,CORBIN JAMES         90263-00023        E/R        80         1,326.82     10/05/90          1,326.82
CARLIN,ANITA                 90261-00009        OBV        80           638.00     10/05/90            638.00
CHASTAIN,PARKER              90260-00011        I/P        13         2,398.50     10/05/90          2,498.50
CHASTAIN,RENE                90260-00008        OBV        13         2,257.20     10/12/90          2,257.20
CURNICK,ANNE                 90290-00002        E/R        80           463.71     10/26/90            563.71
CURNICK,DONALD               90261-00016        E/R        66           262.45     10/05/90            262.45
CURNICK,JC                   90263-00022        I/P        80         1,289.10     10/05/90          1,289.10
CURNICK,JOSEPHINE            90290-00003        E/R        80           974.40     10/26/90            974.40
CURNICK,ROGER                90267-00011        I/P        13         2,604.55     10/05/90          2,574.65
CURNICK,TED                  90254-00038        E/R        91         1,042.25     11/01/90          1,042.25
CURNICK,TRISHA               90290-00004        E/R        80           775.25     10/19/90            775.25
CZERNY,CYNTHIA               90272-00002        E/R        80           325.35     10/12/90            325.35
FALLECKER,CHRIS              90250-00001        I/P        13           350.00     10/19/90            400.00
FALLECKER,ELIZABETH          90260-00031        E/R        80            42.20     10/19/90             42.20
FAUCETT,BARBARA              90263-00013        LA         11         1,007.80     10/05/90          1,007.80
FAUCETT,ROGER                90263-00014        PSY        11           354.60     10/05/90            354.60
FAUCETT,DAVID                90263-00018        I/P        11         1,355.30     10/05/90          1,355.30
FAUCETT,JENNIE               90263-00012        I/P        11         1,276.10     10/05/90          1,276.10
FRYE,RITA C                  90260-00042        O/P        85           272.89     10/19/90            997.89
HALL,BILLY                   90254-00040        I/P        80         2,037.12     10/19/90          2,037.12
KEELER,EDITH                 90251-00011        I/P        80         4,846.45     10/26/90          4,846.45
KEELER,JAMES                 90278-00003        SER        80           117.35     10/19/90            117.35
LEONARD,MARCELITE            90270-00004        O/P        80           340.28     10/12/90              0.00
NASH,JOHN                    90271-00002        I/P        80           344.45     10/19/90            444.45
NASH,RAYMOND                 90271-00001        I/P        80           525.81     10/19/90            525.81
NEWNAN,CAROL                 90250-00005        ADM        13           148.64     10/19/90            148.64
PAULK,JIMMY                  90261-00033        I/P        91         4,773.00     10/12/90          4,773.00
PAULK,MARILYN                90262-00003        E/R        13         2,634.05     10/05/90          2,634.05
PAULK,MISSY                  90262-00004        E/R        13         1,005.50     10/05/90          1,005.50
PETERS,IRMA                  90262-00015        PSY        80           171.72     10/05/90            171.72
PETERSON,LARRY               90278-00004        O/P        80           117.35     10/19/90            117.35
POLAZNECK,COLLEEN            90254-00001        ERT        13         2,448.56     10/19/90          2,448.56
RANCK,BRIAN C                90269-00003        E/R        80           570.80     10/12/90            570.80
RESZEL,ANGELA                90256-00020        I/P        80           100.00     10/26/90            100.00
RESZEL,BOB                   90255-00003        OBV        80           356.50     10/05/90            356.50
RESZEL,MICHAEL               90260-00017        I/P        80           831.01     10/26/90            831.01
RESZEL,PATRICK               90255-00011        I/P        80           710.52     10/26/90            710.52
RESZEL,RICHARD               90260-00019        O/P        80           269.45     10/05/90            269.45
SMITH,JOHN                   90274-00002        OBV        80           246.00     10/19/90              0.00
                                   Number of accounts affected: 00040
                                   Number of charges purged: 00293
                             Total amount of charges purged:    $51,497.64
                             Balance of affected accounts:      $46,531.22
                                          End of Report
```

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Each report contains a header that includes the date and time the report is generated, the facility name, the report title, the page number, and the report name.

PATIENT NAME
This field contains the patient name.

ACCOUNT #
This field contains the patient account number.

PAT TYPE
This field contains the patient type code used to categorize the patient. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, and series patients.

FIN CLS
This field contains the hospital-defined financial class code assigned to this patient's account.

ACCOUNT BAL
This field contains the dollar amount of the account balance.

BD XFER DATE
This field indicates the date the account was transferred to bad debt.

CHARGE AMOUNT PURGED
This field contains the total of detail charges for the account. This does not equal the account balance if payments or adjustments have been posted to the account since this number reflects the sum of the actual charges on the account.

NUMBER OF ACCOUNTS AFFECTED
This field contains the total number of accounts selected to have detail charges archived.

NUMBER OF CHARGES PURGED
This field contains the total number of detail charges archived for the accounts selected.

TOTAL AMOUNT OF CHARGES PURGED
This field contains the total amount of detail charges archived for the accounts selected.

BALANCE OF AFFECTED ACCOUNTS
This field indicates the total balance of the accounts selected to have detail charges archived. This number is often less than the Total Amount of Charges Purged since it includes payments and adjustments posted to these accounts.

FEE SCHEDULE REPORT BY DEPARTMENT - FBR260

Description/Purpose

The Fee Schedule Report by Department provides a list of SIM items actually charged for accounts that have been final or adjustment billed during midnight processing. The report includes details of charge amount, contract amount, contractual amount and number of charges.

Totals are provided for each department, reimbursement type, and payor.

Generating and Printing this Report

The Fee Schedule Report by Department is generated during midnight processing as an Optional Batch Job and printed on demand. The report is sorted by payor, reimbursement type, and department.

The following is an example of a Fee Schedule Report by Department Report.

Figure 2.49 FBR260 - Fee Schedule Report by Department

```
Date: 09/25/90                  General Hospital              Page  : 1
Time: 10:16am       Fee Schedule Report by Department 09/25/90   Report: FBR260


Payor:  CO COMMERCIAL
Reimbursement Type: Medical Service
Table: 01  From: 04/11/88  Thru: 12/31/99

Sim                    Charge     Contract  Contractual   # of
Item#                     amt          amt          amt   charges


Department:  CSR Central Supply

1039                   173.75        86.88        86.88   1
1094                    83.00        75.00         8.00   1
All Others:             46.00         0.00        46.00   2
Dept Totals:           302.75       161.88       140.88   4


Department:  SGY Surgery

All Others:              0.00         0.00         0.00   0
Dept Totals:             0.00         0.00         0.00   0
Reimb Type Totals:     302.75       161.88       140.88   4
Payor Totals:          302.75       161.88       140.88   4

                       End of Report
```

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Each report contains a header that includes the date and time the report is generated, the facility name, the report title, the page number, and the report name.

PAYOR
This field contains the payor code and description.

REIMBURSEMENT TYPE
This field contains the reimbursement type.

TABLE
This field contains the table number for this payor, as defined in the Payor Table. Refer to the Payor Table Definition function in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide* for more details.

FROM
This field contains the effective from date as defined in the Payor Table for this payor. Refer to the Payor Table Definition function in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide* for more details.

THRU
This field contains the effective from date as defined in the Payor Table for this payor. Refer to the Payor Table Definition function in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide* for more details.

SIM ITEM
This field contains the item's SIM code.

CHARGE AMT
This field contains the total dollar amount charged for the SIM item during the report period.

CONTRACT AMT
This field contains the total contract dollar amount specified for the SIM item in the Fee Schedule Exception list during the report period.

CONTRACTUAL AMT
This field contains the total contractual dollar amount for the SIM item during the report period.

 # OF CHARGES
This field contains the number of charges for this SIM item during the report period.

DEPARTMENT
This field contains the department code and description.

ALL OTHERS:
This line shows a total of all items in the department that are not on the Fee Schedule Exceptions list.

DEPT TOTALS:
This line displays the total of all exception items and items reported under *All Others*.

PATIENT-SPECIFIC FEE SCHEDULE REIMBURSEMENT - FBR270

Description/Purpose

The Patient-Specific Fee Schedule Reimbursement report provides a list of contractual reimbursement billing information, specific for Fee Schedule and summary for non-included SIM items for accounts that have been final or adjustment billed during midnight processing. The report includes the SIM item number, actual charge amount, contract amount, contractual adjustment amount, and number of units.

Totals are provided for each department.

Generating and Printing this Report

The Patient-Specific Fee Schedule Reimbursement report is generated during midnight processing as an Optional Batch Job. The report is sorted by patient account, department, and item number.

The following is an example of a Patient-Specific Fee Schedule Reimbursement Report.

Figure 2.50 FBR270-Patient-Specific Fee Schedule Reimbursement Report

```
Date: 01/24/92                    GENERAL HOSPITAL                   Page  : 1
Time: 08:30am           Patient Specific Fee Sch Reimb 01/23/92     Report: FBR270A

Sim                       Charge     Contract   Contractual    # of
Item#                        amt         amt           amt    units

Patient:      SMITH,MITCH                  Account: 92024-29101
Payor:        Commercial
Date:         01/23/92


Department:   PT Physical Therapy

6044                         21.90       30.00         8.10-       1
6060                         31.35       40.00         8.65-       1
All Others:                  27.00        0.00        27.00        1
Dept Totals:                 80.25       70.00        10.25        3

Department:   RAD Radiology

1813                         66.00       25.00        41.00        1
All Others:                 260.00      208.00        52.00        1
Dept Totals:                326.00      233.00        93.00        2

Department:   RT Respiratory Therapy

5002                          2.00       15.00        13.00-       1
All Others:                   7.45        0.00         7.45        1
Dept Totals:                  9.45       15.00         5.55-       2

Patient Totals:             415.70      318.00        97.70        7
```

Each page of the report contains a header that includes the date and time the report is generated, the facility name, the report title, the page number, and the report name.

For each patient the report displays the payor, charge date, and the account number.

SIM ITEM#
This field displays the number of the item on the Service Item Master that is on the exception list.

CHARGE AMT
This field displays the actual charge amount.

CONTRACT AMT
This field displays the contract amount.

CONTRACTUAL AMT
This field displays the contractual adjustment amount.

 # OF UNITS
This field displays the number of units.

ALL OTHERS:
This line displays a total of all SIM items charged for the fee scheduled department that are not specifically defined on the exception. These are reported as a lump sum under the *All Others* category.

DEPT TOTALS:
This line displays the totals for the department, combining the specific SIM items and the items reported under the *All Others* category.

PA DAILY BALANCING REPORT - FARDBL

Description/Purpose

The PA Daily Balancing Report provides a list of all patients in Patient Accounting, displaying their total charge and transaction amounts as well as account balance information, patient length of stay, financial class, patient type, patient account number, and admit and discharge dates. The end of the report displays totals by patient indicator and financial class.

Generating and Printing this Report

The PA Balancing Report is a daily batch report, printed using the Demand Print function. The system sorts the report by facility, patient indicator, and account number.

The following is an example of a PA Balancing Report. Following the explanation of the fields of this report is an example of the totals page for this report and explanations for the fields on this page of the report.

Figure 2.51 FARDBL - PA Balancing Report

```
Date: 03/20/92                                 GENERAL HOSPITAL                            Page  : 1
Time: 00:51                                PA Daily Balancing Report                        Report: FARDBL
                                                for 03/19/92

Acct #          Patient Name      FC LOS Admit    Dischg    Unbilled Chg   Billed Chg    Payments  Adj/Refunds  Account Balance PT
-----------------------------------------------------------------------------------------------------------------------------------

80251-00004 KARATCHKA,OLAF S      80      01/12/91 01/12/91        0.00     5,128.12    4,820.88        0.00          307.24  E/R
80260-00001 PORTER,MILTON         80      01/27/91 01/27/91    1,046.71         0.00        0.00        0.00        1,046.71  E/R
80278-00001 THOMAS,LISA J         85      02/02/91 02/02/91      846.12       200.00        0.00       35.00-       1,011.12  E/R
80301-00002 SMITH,RONALD A        80    5 02/16/91 02/21/91      460.25    15,626.55   12,281.14      857.41-       2,948.25  I/P
80318-00003 HARGRAVE,WM K         85   21 02/18/91            6,841.82    31,903.82   22,552.03      297.79       16,491.40  I/P
80360-00001 BROMER,JULIA          85    1 02/24/91 02/24/91        0.00       669.23      204.10        2.32          467.45  I/P
80422-00003 TIMMONS,J E           90    2 02/27/91 02/28/91      622.03         0.00        0.00        0.00          622.03  I/P
80451-00004 CARUTHERS,LEON        80    2 03/02/91 03/03/91      893.22       416.12        0.00        5.10        1,314.44  I/P
80518-00001 ROBERTS,ALAN R        85    1 03/04/91 03/04/91      625.10         0.00        0.00        0.00          625.10  I/P
80570-00004 JOHNSON,MICHELLE      80    2 03/06/91 03/06/91    1,049.23         0.00        0.00        0.00        1,049.23  I/P
80612-00002 WALKER,REBECCA        75    3 03/10/91            2,058.31     1,039.55    1,039.55        0.00        2,058.31  I/P
80670-00001 CHARLES,EDGAR         80    2 03/11/91            1,038.72         0.00        0.00        0.00        1,038.72  I/P
80103-00003 TREVOR,DIANNE         91      01/05/91 01/05/91      475.90         0.00        0.00       48.98          524.88  O/P
80272-00001 ARRONSON,QUENTIN      91      01/12/91 01/12/91        0.00       122.45      100.00        2.16           24.61  O/P
80341-00001 ROBINSON,VERA T       85      02/19/91 02/19/91        0.00       938.43        0.00       12.45          950.88  O/P
80360-00004 MORGAN,BERTHA         91      02/22/91 02/22/91      340.12         0.00        0.00        0.00          340.12  O/P
80480-00002 MCRAE,A               85      02/27/91 02/27/91      121.56       204.80      204.80       25.00-          96.56  O/P
80522-00003 EDMUNDS,FRANCIS       91      03/04/91 03/04/91      839.83         0.00        0.00        0.00          839.83  O/P
80568-00001 NORMANSON,ALEX        80      03/06/91 03/06/91      209.80         0.00        0.00        0.00          209.80  O/P
```

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Each page of the report contains a header that includes the date and time the report is generated, the facility name, the report title, the page number, and the report name.

ACCT #
This field contains the account number.

PATIENT NAME
This field contains the patient name.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self-pay, commercial insurance, Medicare, etc.

LOS
This field contains the patient's length of stay (LOS). This field is blank for pre-admitted and outpatient accounts. The LOS equals the discharge date less the admission date. If this is a one-day stay, the LOS is 1.

ADMIT
This field contains the date the patient was admitted.

DISCHG
This field contains the date the patient was discharged.

UNBILLED CHG
This field displays the total amount of unbilled charges for this patient account.

BILLED CHG
This field displays the total amount of billed charges for this patient account.

PAYMENTS
This field displays the total amount of payments made on this patient account.

ADJ/REFUNDS
This field displays the total amount of adjustments and refunds made on this patient account.

ACCOUNT BALANCE
This field displays the current account balance.

PT
This field displays the patient type code used to categorize a specific portion of the patient community. This hospital-defined code categorizes such patient groups as regular admission, emergency room, outpatient, same-day surgery, series patients, and others.

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Figure 2.52 FARDBLPA - Balancing Report - Totals

```
Date: 03/13/91                            GENERAL HOSPITAL                          Page  : 2
Time: 00:51                          PA Daily Balancing Report                      Report: FARDBL
                                           for 03/12/91

Fin    Not         Not                Total          Unbilled      Billed                              Account
Cls    Disch    Discharge  Disch  Discharged  Accts  LOS  Charges      Charges      Payments   Adj/Refunds    Balance

Emergency:
 80     0         0.00       2     1,353.95     2         1,046.71     5,128.12     4,820.88       0.00      1,353.95
 85     0         0.00       1     1,011.12     1           846.12       200.00         0.00      35.00-     1,011.12
Tot:    0         0.00       3     2,365.07     3         1,892.83     5,328.12     4,820.88      35.00-     2,365.07

Inpatient:
 75     1      2,058.31      0         0.00     1    3    2,058.31     1,039.55     1,039.55       0.00      2,058.31
 80     1      1,038.72      3     5,311.92     4   11    3,441.42    16,042.67    12,281.14     852.31-     6,350.64
 85     1     16,491.40      2     1,092.55     3   23    7,466.92    32,573.05    22,756.13     300.11     17,583.95
 90     0         0.00       1       622.03     1    2      622.03         0.00         0.00       0.00        622.03
Tot:    3     19,588.43      6     7,026.50     9   39   13,588.68    49,655.27    36,076.82     552.20-    26,614.93

Outpatient:
 80     0         0.00       1       209.80     1           209.80         0.00         0.00       0.00        209.80
 85     0         0.00       2     1,047.44     2           121.56     1,143.23       204.80      12.55-     1,047.44
 91     0         0.00       4     1,729.44     4         1,655.85       122.45       100.00      51.14      1,729.44
Tot:    0         0.00       7     2,986.68     7         1,987.21     1,265.68       304.80      38.59      2,986.68

Financial Class Totals:
 75     1      2,058.31      0         0.00     1    3    2,058.31     1,039.55     1,039.55       0.00      2,058.31
 80     1      1,038.72      6     6,875.67     7   11    4,697.93    21,170.79    17,102.02     852.31-     7,914.39
 85     1     16,491.40      5     3,151.11     6   23    8,434.60    33,916.28    22,960.93     252.56     19,642.51
 90     0         0.00       1       622.03     1    2      622.03         0.00         0.00       0.00        622.03
 91     0         0.00       4     1,729.44     4    0    1,655.85       122.45       100.00      51.14      1,729.44

Facility Totals:

        3     19,588.43     16    12,378.25    19   39   17,468.72    56,249.07    41,202.50     548.61-    31,966.68

                                          End of Report
```

The top of the page contains a header that includes the date and time the report is generated, the facility name, the report title, the page number, and the report name as used in the system. The report displays the following information for each patient type, then summarizes this information by financial class and for the facility.

FIN CLS
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self-pay, commercial insurance, Medicare, etc.

NOT DISCH
This field displays the number of accounts not discharged.

NOT DISCHARGED
This field displays the total account balance of the patients who have not been discharged.

DISCH
This field displays the number of accounts discharged.

DISCHARGED
This field displays the total account balance of the patients who have been discharged.

TOTAL ACCTS
This field displays the total number of accounts for patients who have been discharged and who have not been discharged.

LOS
This field contains the patient's length of stay (LOS). This field is blank for outpatient accounts. The LOS equals the discharge date less the admission date. If this is a one-day stay, the LOS is 1.

UNBILLED CHARGES
This field displays the total unbilled portion of those accounts that have not been final billed.

BILLED CHARGES
This field displays the total billed portion of those accounts that have not been final billed.

PAYMENTS
This field displays the amount of payments on accounts.

ADJ/REFUNDS
This field displays the amount of adjustments and refunds to accounts.

ACCOUNT BALANCE
This field displays the account balance total. This figure can be used to balance to the Subsidiary Balance on the PA Daily Balance screen.

NOTE: If the patient's financial class is missing but the patient indicator exists, the account balance is subtotaled under the appropriate patient indicator with an asterisk (*) in the Fin Cls column. If the patient indicator is missing but the financial class exists, the patient's account balance is subtotaled under the heading Missing PI Accounts and is listed with the appropriate financial class. If both the patient indicator and financial class are missing on a patient account, the account is totaled under the heading Missing PI Accounts with the financial class listed as an asterisk (*).

All of these totals are included in the Final Account Balance Total on final page of the report. This total balances to the Subsidiary Balance on the PA Daily Balancing screen.

GL MAPPING REPORT - FTSPGM

Description/Purpose

The GL Mapping Table report provides an audit trail for checking and verifying the PA to general ledger mapping.

This report allows the hospital to print a certain key department or subaccount in order to evaluate the set up of a particular general ledger account or key.

Generating and Printing This Report

This report is generated from the GL Mapping Table Reports option under GL Mapping Maintenance. You complete a report selection screen to generate the desired report. Refer to the GL Mapping Maintenance section in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide* for instructions on completing the report selection screen.

The following are two sample GL Mapping reports. The selection always prints on the first page of the report.

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Figure 2.53 FTSPGM - GL Mapping Table Report - Page 1

```
Date: 04/29/91                       GENERAL HOSPITAL                          Page  : 1
Time: 16:31                          GL Mapping Report                         Report:  FTSPGMP
                                       Option Summary


ENTITY: PM      TABLE NO: 01-GENERAL HOSPITAL


Sort by Key Type (K) or Dept-Subaccount (D)?: K

           Key Type:    AR:BDAL:PA

    Patient Indicator:  E:I:O

     Financial Class:   ALL

       Patient Type:    ALL

     Medical Service:   ALL

      Revenue Center:   ALL
```

Figure 2.54 FTSPGM - GL Mapping Table Report - Page 2

```
Date: 04/29/91                           GENERAL HOSPITAL                              Page  : 2
Time: 16:31                              GL Mapping Report                             Report:  FTSPGMP

ENTITY: PM      TABLE NO: 01-GENERAL HOSPITAL

KEY TYPE    PAT IND    FIN CL    PAT TYP    MED SER    REV CNTR    TRAN CODE       DEPT        SUBACCT

AR          E                                                                     1121        021.01
AR          I                                                                     1121        021.01
AR          O                                                                     1121        021.01

                            End of Report
```

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Figure 2.55 FTSPGM - GL Mapping Table Report - Page 3

```
Date: 04/29/91                          GENERAL HOSPITAL                      Page  : 1
Time: 16:32                             GL Mapping Report                     Report: FTSPGMP
                                          Option Summary


ENTITY: PM      TABLE NO: 01-GENERAL HOSPITAL



Sort by Key Type (K) or Dept-Subaccount (D)?: D

Print by (D)epartment or (A)ccount: D

       Department Code:    1121 TO 1125
```

Figure 2.56 FTSPGMGL - Mapping Table Report - Page 4

```
Date: 04/29/91                          GENERAL HOSPITAL                      Page  : 2
Time: 16:31                             GL Mapping Report                     Report:  FTSPGMP

ENTITY: PM      TABLE NO: 01-GENERAL HOSPITAL

KEY TYPE    PAT IND   FIN CL   PAT TYP   MED SER   REV CNTR   TRAN CODE       DEPT      SUBACCT

AR            E                                                              1121      021.01
AR            I                                                              1121      021.01
AR            O                                                              1121      021.01
BD            E                                                              1121
BD            I                                                              1121
BD            O                                                              1121

                        End of Report
```

Each report contains a header which includes the name of the report, date and time generated, report title, page number, and the report name as used in the system.

KEY TYPE
This field lists the key type from the mapping table.

PATIENT INDICATOR
FINANCIAL CLASS
PATIENT TYPE
MEDICAL SERVICE
REVENUE CENTER
TRAN CODE

If any of these components have been used in the mapping, the values for each are printed on the report.

DEPT
This field indicates the department to which the mapping key has been directed.

SUBACCOUNT
This field indicates the subaccount to which the mapping key has been directed.

DAILY GL DEFAULT REPORT - FARDAP

Description/Purpose

The Daily GL Default Report provides you with a list of revenue-generating Patient Accounting events that are posted to the default accounts due to errors in mapping or missing information from the event or the patient's account. The report lists all the existing information about the event based on what is required in the PA/GL Mapping Table. You can use the information on the report to verify that the mapping combination is valid. If the mapping is correct but information needed in the Mapping Table is not on the report, you should log a case with McKesson. This means that either the patient's account or the event is missing information.

Unapplied charges appear on this report on the day they go into unapplied charge. After the system takes them out of unapplied charges and posts them to the correct accounts, they do not appear on this report.

Generating and Printing This Report

This report is produced automatically by facility as a daily batch report. The following is an example of the Daily GL Default Report.

Figure 2.57 FARDAP - Daily GL Default Report

```
Date: 05/29/98                          General Hospital                            Page  : 1
Time: 12:51am                           Daily GL Default                            Report: FARDAPA
                                        Account Posting


                            Trans  Pat  Fin  Pat  Med  Rev              [* = Invalid Key / r = Reclass]
  Patient name              Account #   Code   Ind  Cls  Type  Serv  Code   Trans Amount    Debit  -  Credit     Date
--------------------------------------------------------------------------------------------------------------------

MARKUM,TAYLOR              9728300002  0001   O    PK                        500.00Db   *TRANA   AR      05/28/98

MARKUM,TAYLOR              9814800006              S    OP         7041        50.00Cr   PA       *DPRV   05/28/98

MARKUM,TAYLOR              9806100013              S    OPO                     0.00Cr   PA       *DPRV   05/28/98

YOUNG,TERESA              9813900005              O    MH         6020         0.00Cr   PA       *DPRV   05/28/98

SMITH,MARGERY L           9811000003              B    ALL        6020         0.00Cr   PA       *DPRV   05/28/98

PARKER,AMANDA             9719800019              S    LIR        6190       190.00Cr   PA       *DPRV   05/28/98

PERRY,LOUISE              9811300004              O    ALL        6190       190.00Cr   PA       *DPRV   05/28/98

OSBOURNE,MARTIN A         9813000001              S    ALL        6060       305.00Cr   PA       *DPRV   05/28/98

AVERY,MARCUS R            9807500008                   I/P        6060       290.00Cr   PA       *DPRV   05/28/98

WATSON,APRIL              9812000014                   ALL        6020       210.00Cr   PA       *DPRV   05/28/98

OVERBY,TONYA              9811700004              S    OPO        6020         0.00Cr   PA       *DPRV   05/28/98

PALMER,MARIA A            9806500021              PK   I/P        6020         0.00Cr   PA       *DPRV   05/28/98

CHRISTIANSON,PAUL         9800700001              44   I/P        6020         0.00Cr   PA       *DPRV   05/28/98



                                            Facility Totals


Key           Debit           Credit                   Debit           Credit


DPRV           0.00          1,064.00                                 4,935.00
TRANA        500.00              0.00                  500.00

Total                                                                 4,484.65


                                            End of Report
```

The top of the page contains a header that includes the date and time the report is generated, the facility name, the report title, the page number, and the report name as used in the system.

PATIENT NAME
This field contains the name of the patient.

ACCOUNT #
This field contains the patient's account number.

TRANS CODE
This field contains the transaction code of the event.

PAT IND
This field contains the patient's indicator. Valid codes are I (inpatient), O (outpatient), and E (emergency).

FIN CLS
This field contains the account's financial class.

PAT TYPE
This field contains the account's patient type.

MED SERV
This field contains the account's medical service.

REV CODE
This field contains the account's revenue code.

TRANS AMOUNT
This field contains the dollar amount of the event.

DEBIT
This field contains the GL key for the debit side of the account.

CREDIT
This field contains the GL key for the credit side of the account.

DATE
This field contains the posting date.

DAILY GL SUSPENSE REPORT - FARSAP

Description/Purpose

The Daily GL Suspense Report provides you with a list of any revenue-generating Patient Accounting events that could not be mapped to a default GL account due to errors in mapping. The report lists all the existing information about the event based on what is required in the PA/GL Mapping Table. If any accounts appear on this report, you should notify McKesson.

Generating and Printing This Report

This report is produced automatically by facility as a daily batch report. The following is an example of the Daily GL Suspense Report.

Figure 2.58 FARSAP - Daily GL Suspense Report

```
Date: 05/13/98                              Atlanta City Hope                            Page  : 2
Time: 01:21am                               Daily GL Suspense                            Report: FARSAPA
                                            Account Posting

                                Trans  Pat  Fin  Pat  Med   Rev              [* = Invalid Key / r = Reclass]
  Patient name        Account # Code   Ind  Cls  Type Serv  Code  Trans Amount   Debit  -  Credit    Date
-----------------------------------------------------------------------------------------------------------
 MARSH,JONATHAN        9807700003              V    I/P        7031        259.88Cr   PA      *DFDPRV   05/10/98



                                            Facility Totals


 Key          Debit         Credit               Debit         Credit

 DPRV         0.00          259.88                             259.88


 Total                                                         259.88


                                            End of Report
```

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The top of the page contains a header that includes the date and time the report is generated, the facility name, the report title, the page number, and the report name as used in the system.

PATIENT NAME
This field contains the name of the patient.

ACCOUNT #
This field contains the patient's account number.

TRANS CODE
This field contains the transaction code of the event.

PAT IND
This field contains the patient's indicator. Valid codes are I (inpatient), O (outpatient), and E (emergency).

FIN CLS
This field contains the account's financial class.

PAT TYPE
This field contains the account's patient type.

MED SERV
This field contains the account's medical service.

REV CODE
This field contains the account's revenue code.

TRANS AMOUNT
This field contains the dollar amount of the event.

DEBIT
This field contains the GL key for the debit side of the account.

CREDIT
This field contains the GL key for the credit side of the account.

DATE
This field contains the posting date.

DAILY GL STATISTIC DEFAULT REPORT - FARDSAP

Description/Purpose

The Daily GL Statistic Default Report provides you with a list of Patient Accounting statistical events that are posted to GL statistic default accounts due to errors in mapping or missing information from the event or the patient's account. The report lists all the information about the event based on what is required in the PA/GL Mapping Table. You can use the information on the report to verify that the mapping combination is valid. If the mapping is correct but information needed in the Mapping Table is not on the report, you should log a case with McKesson. This means that either the patient's account or the event is missing information.

Generating and Printing This Report

This report is produced automatically by facility as a daily batch report. The following is an example of the Daily GL Statistic Default Report.

Figure 2.59 FARDSAP - Daily GL Statistic Default Report

```
Date: 05/11/98                        General Hospital                       Page  : 1
Time: 01:36am                      Daily G/L Statistic Default                Report: FARDSAPA
                                       Account Posting


                              Trans  Pat  Fin Pat  Med  Rev           [* = Invalid Key / r = Reclass]
     Patient name     Account #  Code  Ind  Cls Type Serv Code  Trans Amount   Debit  -  Credit    Date
  ------------------------------------------------------------------------------------------------------

  SLEDD,ERIN           9807700003          V   I/P       7031      1.00Cr        *CHQ      05/10/98

  RICE,HUNTER L        9720900001          V   NII       7070      0.00Cr        *RVL      05/10/98

  ROLLINS,DENISE       9806400016          V   I/P       6020      0.00Cr        *RVL      05/10/98

  RALSTON,VIRGINIA M   9805500001          V   I/P       6190      1.00Cr        CHQr      05/10/98

  JACKSON,MICHELLE     9805500001          V   I/P       6190      1.00Cr        *UOS      05/10/98

  HURLEY,JEFF          9805500001          V   I/P       6190      1.00Cr        *UOS      05/10/98

  ROGERS,STEPHANIE     9805500001          V   I/P       6190      0.00Cr        *RVL      05/10/98

  WOOD,KIMBERLY E      9720900001          V   NII       6060      1.00Cr        *CHQ      05/10/98

  HARRISON,AUTUMN      9720900001          V   NII       6060      1.00Cr        *UOS      05/10/98

  ORLET,GEHARDT        9720900001          V   NII       6060      0.00Cr        *RVL      05/10/98

                                        Facility Totals


  Key          Debit        Credit                   Debit        Credit


  CHQ          0.00          3.00                                  3.00
  RVL          0.00          0.00
  UOS          0.00          3.00                                  3.00

  Total



                                        End of Report
```

The top of the page contains a header that includes the date and time the report is generated, the facility name, the report title, the page number, and the report name as used in the system.

PATIENT NAME
This field contains the name of the patient.

ACCOUNT #
This field contains the patient's account number.

TRANS CODE
This field contains the transaction code of the event.

PAT IND
This field contains the patient's indicator. Valid codes are I (inpatient), O (outpatient), and E (emergency).

FIN CLS
This field contains the account's financial class.

PAT TYPE
This field contains the account's patient type.

MED SERV
This field contains the account's medical service.

REV CODE
This field contains the account's revenue code.

TRANS AMOUNT
This field contains the dollar amount of the event.

DEBIT
This field contains the GL key for the debit side of the account.

CREDIT
This field contains the GL key for the credit side of the account.

DATE
This field contains the posting date.

DAILY GL STATISTICS SUSPENSE REPORT - FARSSAP

Description/Purpose

The Daily GL Statistics Suspense Report provides you with a list of Patient Accounting statistical events that could not be posted to GL statistic default accounts due to errors in mapping. The report lists all the information about the event based on what is required in the PA/GL Mapping Table. If anything appears on this report, you should notify McKesson.

Generating and Printing This Report

This report is produced automatically as a daily batch report. The following is an example of the Daily GL Statistics Suspense Report.

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Figure 2.60 FARSSAP - Daily GL Statistics Suspense Report

```
Date: 05/13/98                              General Hospital                              Page  : 1
Time: 01:22am                           Daily GL Statistics Suspense                      Report: FARSSAPA
                                             Account Posting


                          Trans  Pat  Fin  Pat  Med   Rev              [* = Invalid Key / r = Reclass]
    Patient name          Account #   Code  Ind  Cls  Type  Serv  Code   Trans Amount    Debit  -  Credit    Date
  ---------------------------------------------------------------------------------------------------------------
  SLEDD,ERIN              9807700003          V    I/P            7031        1.00Cr             *CHQ     05/10/98



                                             Facility Totals


  Key              Debit         Credit                 Debit         Credit

  CHG                            1.00                                  1.00


  Total                                                               1.00


                                             End of Report
```

The top of the page contains a header that includes the date and time the report is generated, the facility name, the report title, the page number, and the report name as used in the system.

PATIENT NAME
This field contains the name of the patient.

ACCOUNT #
This field contains the patient's account number.

TRANS CODE
This field contains the transaction code of the event.

PAT IND
This field contains the patient's indicator. Valid codes are I (inpatient), O (outpatient), and E (emergency).

FIN CLS
This field contains the account's financial class.

PAT TYPE
This field contains the account's patient type.

MED SERV
This field contains the account's medical service.

REV CODE
This field contains the account's revenue code.

TRANS AMOUNT
This field contains the dollar amount of the event.

DEBIT
This field contains the GL key for the debit side of the account.

CREDIT
This field contains the GL key for the credit side of the account.

DATE
This field contains the posting date.

OPTIONAL BATCH JOBS REPORT - FAROPT

Description/Purpose

The Optional Batch Jobs Report provides a list of all, scheduled, or non-scheduled optional batch jobs. It is used as a planning and scheduling tool by the business office and information systems. The type of report produced is determined by the criteria entered using the Optional Batch Jobs Report menu option.

The Scheduled report provides a listing of all optional batch jobs, aged trial balances (ATBs), and contract ATBs that are scheduled to run within the date range specified. Either a summary or detail Scheduled report may be requested. The primary sort for the Scheduled report is next run date. Within run date, the optional batch jobs may be listed by optional batch job code or description. The 80-column summary Scheduled report includes the run date, optional batch job code/description, frequency, and interval. The detail Scheduled report is a 132-column report that includes the information from the summary report as well as the reporting period for statistical reports and the sort/type, the monthly indicator, the suppress zero balance indicator, and the period end date for ATB and contract ATB reports.

The Non-Scheduled report lists all optional batch jobs, in optional batch job code or description order, that have not been scheduled to run. This includes optional batch jobs whose next run date is in the past.

The All report lists both non-scheduled optional batch jobs and scheduled optional batch jobs and ATBs. The report may be produced in either optional batch job code or description order. In addition to the optional batch job code and description, the report lists the next run date for scheduled optional batch jobs and ATBs.

Generating and Printing This Report

The Optional Batch Jobs Report is requested through the Optional Batch Jobs Report option in Optional Batch Jobs. It is printed through the demand print feature. The format and the sort are determined by the selection criteria entered.

For more information about requesting an Optional Batch Jobs report, refer to the Optional Batch Jobs section in the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide.*

The following pages provide samples of the summary and detail Scheduled, the Non-Scheduled, and the All versions of the Optional Batch Jobs Report.

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Figure 2.61 FAROPT - Optional Batch Jobs Report - Summary Scheduled

```
Date: 03/13/96                  General Hospital A             Page  : 1
Time: 07:55A                    Optional Batch Jobs           Report: FAROPTA
                          Scheduled:03/13/96 through 03/31/96


Run Date  Optional Batch Job Code/Description        Frequency Interval

03/13/96  51  - Claim Reload                         Interval  Every  day
          81  - Collector Statistics Summary Rpt      Interval  Every  day
          43  - Receivable Analysis Report            Interval  Every  day
03/15/96  8   - Bad Debt Pre-List Selection           Day of Mo 15th of mo
03/20/96  3   - AR to Bad Debt Transfer               Interval  Every 30th day
03/22/96  27  - Active Patient Workfile               Day of Mo 22th of mo
03/31/96  5   - Coll Agency Analysis Report           Day of Mo Lst of mo
          *98  - COLLECTOR CONTRACT AGING-MONTH
          *555 - CONTRACT AGING
          41  - Financial Class Revenue Stat Summary  Day of Mo Lst of mo
          *123 - MONTHLY ATB
          *55  - MONTHLY CONTRACT AGING REPORT
          *99  - MONTHLY-CON CODE BY BILL DATE


                          End of Report
```

Figure 2.62 FAROPT - Optional Batch Jobs Report - Detail Scheduled

```
Date: 03/13/96                          General Hospital A                                    Page  : 1
Time: 07:56A                            Optional Batch Jobs                                  Report: FAROPTA
                                  Scheduled:03/13/96 through 03/31/96


Run Date  Optional Batch Job Code/Description        Frequency Interval        Period    Sort/Type Monthly Suppress PE Date

03/13/96  51  - Claim Reload                         Interval  Every  day
          81  - Collector Statistics Summary Rpt      Interval  Every  day
          43  - Receivable Analysis Report            Interval  Every  day
03/15/96  8   - Bad Debt Pre-List Selection           Day of Mo 15th of mo
03/20/96  3   - AR to Bad Debt Transfer               Interval  Every 30th day
03/22/96  27  - Active Patient Workfile               Day of Mo 22th of mo
03/31/96  5   - Coll Agency Analysis Report           Day of Mo Lst of mo
          *98  - COLLECTOR CONTRACT AGING-MONTH                                            F/        Yes     Yes
          *555 - CONTRACT AGING                                                            D/        Yes     No
          41  - Financial Class Revenue Stat Summary  Day of Mo Lst of mo
          *123 - MONTHLY ATB                                                               N/DSC     No      Yes
          *55  - MONTHLY CONTRACT AGING REPORT                                             B/        Yes     Yes
          *99  - MONTHLY-CON CODE BY BILL DATE                                             C/        Yes     Yes


                                  End of Report
```

Figure 2.63 FAROPT - Optional Batch Jobs Report - Non-Scheduled

```
Date: 03/13/96                  General Hospital A            Page  : 1
Time: 07:56A                   Optional Batch Jobs           Report: FAROPTA
                         Non-Scheduled Optional Batch Jobs


      Optional Batch Job Code/Description

      18   -  Agency Cash and Adjustment Report
      31   -  AP Daily Distribution Register
      10   -  AP Refund Invoice
      11   -  AP PO Distr. Invoice Report
      32   -  AP Recurring Invoice Request
      37   -  Bad Debt Charge Deletion
      13   -  Bad Debt to Archive Pre-List Report
      2    -  Bad Debt to Archive Pre-List Selection
      54   -  Biller Statistics
      80   -  Biller Statistics Summary Rpt
      14   -  CCA/RUA/CPA Interface
      44   -  Charge Summary Interface
      47   -  Claim Audit Report
      35   -  Claims Generated but Not Submitted Report
      6    -  Claims Submitted but Unpaid Report
      21   -  Coll Agency Analysis - Detail
      22   -  Coll Agency Analysis - Summary
      79   -  Collection Agency Stat Summary
      53   -  Collection Agency Statistics
      55   -  Collector Statistics
      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
      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
      85   -  Doctor Revenue Ordering Stat Summary
      59   -  Doctor Revenue Ordering Statistics
```

Figure 2.64 FAROPT - Optional Batch Jobs Report - All

```
Date: 03/13/96                  General Hospital A              Page  : 1
Time: 07:56A                    Optional Batch Jobs             Report: FAROPTA
                                All Optional Batch Jobs

      Optional Batch Job Code/Description                  Next Run Date

      20   -  15.1 CCA Interface                            04/08/96
      27   -  Active Patient Workfile                       03/22/96
      18   -  Agency Cash and Adjustment Report
      31   -  AP Daily Distribution Register
      10   -  AP Refund Invoice
      11   -  AP PO Distr. Invoice Report
      32   -  AP Recurring Invoice Request
      3    -  AR to Bad Debt Transfer                       03/20/96
      12   -  Archive Selection                             04/11/96
      37   -  Bad Debt Charge Deletion
      4    -  Bad Debt Pre-List Report                      04/07/96
      8    -  Bad Debt Pre-List Selection                   03/15/96
      13   -  Bad Debt to Archive Pre-List Report
      2    -  Bad Debt to Archive Pre-List Selection
      54   -  Biller Statistics
      80   -  Biller Statistics Summary Rpt
      14   -  CCA/RUA/CPA Interface
      44   -  Charge Summary Interface
      47   -  Claim Audit Report
      51   -  Claim Reload                                  03/13/96
      35   -  Claims Generated but Not Submitted Report
      6    -  Claims Submitted but Unpaid Report
      21   -  Coll Agency Analysis - Detail
      22   -  Coll Agency Analysis - Summary
      5    -  Coll Agency Analysis Report                   03/31/96
      79   -  Collection Agency Stat Summary
      53   -  Collection Agency Statistics
     *98   -  COLLECTOR CONTRACT AGING-MONTH                03/31/96
      55   -  Collector Statistics
      81   -  Collector Statistics Summary Rpt              03/13/96
      42   -  Contract Accounts Report
     *555  -  CONTRACT AGING                                03/31/96
      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
      15   -  Department Logs Report
      33   -  Discharge Statistic Report
      77   -  Discharge Statistic Summary Rpt
      82   -  Doctor Census Admitting Stat Summary
```

Each page of the Optional Batch Jobs Report contains a header that includes the date and time the report was generated, the hospital's name, the report title, the page number, and the report name. On the summary and detail Scheduled reports, the scheduled date range selected also appears in the report header.

The following fields appear on the summary and detail Scheduled reports:

RUN DATE
This field contains the next scheduled run date.

OPTIONAL BATCH JOB CODE/DESCRIPTION
This field contains the optional batch job code and description. The code for ATBs and Contract ATBs is preceded by an asterisk (*) to identify ATB jobs.

FREQUENCY
This field contains the frequency type that has been assigned to the job (Interval, Day of Mo, Day-Wk/Mo). This field is blank for ATB and Contract ATB reports.

INTERVAL
This field contains either the daily interval, the day of the month, or the day-week of the month that this job is scheduled to run. This field is blank for ATB and Contract ATB reports.

In addition to the preceding fields, the following fields appear on the Detail Scheduled report:

PERIOD
This field contains the fiscal year and period to process for statistical reports. If this field is blank, the system defaults to the current fiscal year and period.

SORT/TYPE
This field contains the sort and report type for ATB reports and the sort for Contract ATB reports.

MONTHLY
This field indicates whether the ATB or Contract ATB is scheduled to run monthly.

SUPPRESS
This field indicates whether zero balance accounts are suppressed from printing on the ATB or Contract ATB report.

PE DATE
This field contains the period end date for ATB reports.

NOTE: If the summary or detail Scheduled report is run for a range of dates, the optional batch job appears only under the next date for which the job is scheduled. For example, the Claim Reload is scheduled to run every day and its next run date is 3/13/96. For the date range of 3/13 through 3/31, the Claim Reload runs every day within this range. On the report, it appears under 3/13/96.

The Non-Scheduled and All reports include the following fields:

OPTIONAL BATCH JOB CODE/DESCRIPTION
This field contains the optional batch job code and description.

NEXT RUN DATE
This field contains the next scheduled run date for the job.

MISCELLANEOUS CASH CODES REPORT - FTFMSC

Description/Purpose

The Miscellaneous Cash Codes Report lists the miscellaneous cash codes and provides a means of verifying general ledger mapping information. The report includes the general ledger department and sub-account, the entity, and the transaction code used.

Generating and Printing This Report

This is a demand report that can be generated when exiting from the Miscellaneous Cash Codes table. It can be sorted in alphabetic or miscellaneous cash code sequence.

The following is an example of a Miscellaneous Cash Codes Report:

Figure 2.65 FTFMSC - Miscellaneous Cash Codes Report

```
Date: 03/21/96                          General Hospital                     Page  : 1
Time: 03:45pm                        MISCELLANEOUS CASH CODES                 Report: FTFMSCA

CODE   DESCRIPTION                 DEPARTMENT  SUB ACCOUNT  ENTITY    TRAN CODE

 1     CAFETERIA RECEIPTS             5061       50.10        01      F0001-CAFETERIA RECEIPTS

 6     COMMUNITY EDUCATION REVENUES   5000       50.30        01      F0006-COMMUNITY EDUCATION REVENUE

41     EMPLOYEE HOUSING               5152       50.10        01      F0041-EMPLOYEE HOUSING

 2     GIFT SHOP RECEIPTS             5000       50.20        01      F0002-GIFT SHOP RECEIPTS

44     JENN'S MISC CASH CODE          0000       00.01        01      F4444-JENN'S MISC CASH TRANS

 4     MEDICAL RECORDS ABSTRACT FEES  5085       50.10        01      F0004-MEDICAL RECORDS ABSTRACT FEES

 7     PARKING RECEIPTS               5075       50.10        01      F0007-PARKING RECEIPTS

 3     POSTAGE STAMP SALES            5000       50.40        01      F0003-POSTAGE STAMPS SALES

20     RENTAL INCOME                  5155       50.10        01      F0020-RENTAL INCOME

 8     TELEPHONE COMMISSIONS          5071       50.10        01      F0008-TELEPHONE COMMISSIONS

 5     TELEVISION RENTALS             5081       50.10        01      F0005-TELEVISION RENTALS

 9     VENDING MACHINE COMMISSIONS    5095       50.10        01      F0009-VENDING MACHINE COMMISSIONS


                                  12 active entries


                    End of Report
```

Each report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

CODE
This field contains the miscellaneous cash code.

DESCRIPTION
This field contains the miscellaneous cash code description.

DEPARTMENT
This field contains the General Ledger department number.

SUBACCOUNT
This field contains the General Ledger sub-account number.

ENTITY
This field contains the General Ledger entity code.

TRAN CODE
This field contains the system transaction code.

CREDIT BALANCE BY FINANCIAL CLASS REPORT - FARCBFC

Description/Purpose

The Credit Balance by Financial Class Report reflects all accounts with a credit balance.

Generating and Printing This Report

This report is sorted, totaled, and divided by page in Financial Class order. It requires that the account have a credit balance in one of the buckets for insurance or patient. Refer to "Optional Batch Jobs" in Chapter 2: Financial System Management of the *General Information Volume* in the *STAR Financials Patient Accounting Reference Guide* for more information.

The following is an example of the Credit Balance by Financial Class Report.

Figure 2.66 FARCBFC - Credit Balance by Financial Class Report

```
Date: 07/14/07                          General Hospital                          Page  : 1
Time: 12:55P                       Credit Balance Financial Class                 Report: FARCBFC


Financial Class C

Account No.    FC  PT   Patient Name          Type    Account Balance      Credit Balance     Loc
-------------------------------------------------------------------------------------------------
----
A0711300003    L   I/P  SHORE,BOB             I          1,029.30-           1,535.25-         AR
A0711300004    L   OPO  SHORE,MARK            I          4,212.94-           4,555.75-         AR
A0711300005    L   I/P  SHORE,NANCY           I            434.40               25.00-         AR
                                                                          ----------------
                                                                            $6,116.00-


CARRIER PLAN TOTALS: 017100


                 INPATIENT               2                                  1,560.25-
                 OUTPATIENT              1                                  4,555.75-
                 EMERGENCY ROOM          0                                      0.00
                                     ----------                         ----------------
                                         3                                 $6,116.00-
```

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Each report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ACCOUNT NO
This field contains the account number for the patient. Accounts sort by account number within financial class.

FC
This field contains the account's financial class.

PT
This field contains the account patient type.

PATIENT NAME
This field contains the patient's last name and first name.column, up to 26 characters.

TYPE
This field prints **P** for patient credit or **I** for Insurance credit.

NOTE: For accounts where multiple buckets contain a credit balance, each bucket lists appropriately.

ACCOUNT BALANCE
This field contains the current account balance.

CREDIT BALANCE
This field reflects the credit balance for the bucket being displayed.

CR/PLAN
This field displays the carrier/plan code if the credit type is an **I**.

FINANCIAL CLASS TOTALS
This field totals by patient indicator. Dollar amounts totaled are from the Credit Balance column.

CREDIT BALANCE BY CARRIER/PLAN REPORT - FARCBCP

Description/Purpose

The Credit Balance by Carrier/Plan Report reflects insurance credits.

Generating and Printing This Report

This report is sorted, totaled, and divided by page in Carrier/Plan order. It requires that the account have a credit balance in one of the insurance buckets. Refer to "Optional Batch Jobs" in Chapter 2: Financial System Management of the *General Information Volume* in the *STAR Financials Patient Accounting Reference Guide* for more information.

The following is an example of the Credit Balance by Financial Class Report.

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Figure 2.67 FARCBCP - Credit Balance by Carrier/Plan Report

```
Date: 07/14/97                            General Hospital                          Page  : 1
Time: 12:55P                           Credit Balance Carrier/Plan                  Report: FARCBCP


100 Medicare    500 Part B Plan


ACCOUNT NO.    FC  PT      PATIENT NAME          Cr/Plan      Account Balance      Credit Balance

9722255555     C   I/P     Thomas, Lessie        100/500          125.30              -97.25
9725699882     C   OP      Spencer, Sam          100/500          155.99             -352.11
9725699975     C   ER      Allen, Jason          100/500           25.56             -400.00


Carrier Plan Totals :   100/500


                  INPATIENT            1                 -97.25
                  OUTPATIENT           1                -352.11
                  EMERGENCY ROOM       1                -400.00


           Carrier/Plan TOTAL:        2                -849.36
```

Each report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ACCOUNT NO
This field contains the account number for the patient. Accounts sort by account number within the Carrier/Plan.

FC
This field contains the account's financial class.

PT
This field contains the account patient type.

PATIENT NAME
This field contains the patient's last name and first name.

CR/PLAN
This field displays the carrier/plan code.

ACCOUNT BALANCE
This field displays the current account balance.

CREDIT BALANCE
This field reflects the credit balance for the bucket being displayed.

CARRIER PLAN TOTALS
This field totals by patient indicator. Dollar amounts totaled are from the Credit Balance column.

CHANGE FINANCIAL CLASS REPORT - FAFCRPT (CN Only)

Description/Purpose

The Change Financial Class Report lists accounts whose charges were evaluated to determine if prices needed to be automatically adjusted as a result of a change in financial class. The report provides an important audit trail for users who price by financial class and have implemented the automatic repricing feature.

The report lists the patient name, account number, admit and discharge date, account location, old financial class, and new financial class. For each account, the report also lists each charge that qualified for repricing, the offsetting charge, and the new charge issued. Manually priced and inactive items are also reported for hospital review. Subtotals are provided at the patient level for original charges, adjustments, new charges, manually priced charges, and inactive charges.

Generating and Printing This Report

The Change Financial Class Report is generated during midnight processing for facilities that have implemented the automatic repricing feature. It can be printed through the Demand Print function.

The following is an example of the Change Financial Class Report:

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Figure 2.68 (CN Only) FAFCRPTA - Change Financial Class Report

```
Date: 03/21/96                              General Hospital                          Page  : 1
Time: 01:52pm                             Change Financial Class                      Report: FAFCRPTA

Patient Name                     Account #     Admit    Disch    Loc Old F/C                    New F/C
Seq     Srv Dt    Post Date  Dept SIM  Description             FIM       Physician         Qty   Amount  Ind LC MP

MOORE,REPRICE                    9603000002    01/30/96 02/15/96 AR  O-OTHER COMMERCIAL      KE-KRIS' FINANCIAL CLASS
     Reprice Seq#:   17      Started: 03/21/96 01:45pm   Completed:  03/21/96 01:46pm
         02/15/96  03/21/96  CVC  3000  ABD AORTOGRAM BILATERAL FEMORAL*  72403000   105 BAUER,RICHARD    1    201.00  O   L
         02/15/96  03/21/96  CVC  3000  ABD AORTOGRAM BILATERAL FEMORAL*  72403000   105 BAUER,RICHARD   -1    201.00- A   L
         02/15/96  03/21/96  CVC  3000  ABD AORTOGRAM BILATERAL FEMORAL*  72403000   105 BAUER,RICHARD    1    442.24  N   L
         02/15/96  03/20/96  CVC  3000  ABD AORTOGRAM BILATERAL FEMORAL*  72403000   105 BAUER,RICHARD    1     99.00  O   L
         02/15/96  03/21/96  CVC  3000  ABD AORTOGRAM BILATERAL FEMORAL*  72403000   105 BAUER,RICHARD   -1     99.00- A   L
         02/15/96  03/21/96  CVC  3000  ABD AORTOGRAM BILATERAL FEMORAL*  72403000   105 BAUER,RICHARD    1    442.24  N   L
         02/15/96  03/20/96  CVC  3000  ABD AORTOGRAM BILATERAL FEMORAL*  72403000   105 BAUER,RICHARD    1     99.00  O   L
         02/15/96  03/21/96  CVC  3000  ABD AORTOGRAM BILATERAL FEMORAL*  72403000   105 BAUER,RICHARD   -1     99.00- A   L
         02/15/96  03/21/96  CVC  3000  ABD AORTOGRAM BILATERAL FEMORAL*  72403000   105 BAUER,RICHARD    1    442.24  N   L
         02/15/96  03/20/96  CVC  3000  ABD AORTOGRAM BILATERAL FEMORAL*  72403000   105 BAUER,RICHARD    1     99.00  O   L
         02/15/96  03/21/96  CVC  3000  ABD AORTOGRAM BILATERAL FEMORAL*  72403000   105 BAUER,RICHARD   -1     99.00- A   L
         02/15/96  03/21/96  CVC  3000  ABD AORTOGRAM BILATERAL FEMORAL*  72403000   105 BAUER,RICHARD    1    442.24  N   L
Original Charges:       $498.00  Adjustments:     $498.00-  New Charges:      $1768.96  Manually Priced:       $0.00
                                                                                       Inactive:              $0.00


Facility A Totals:
Original Charges:       $498.00  Adjustments:     $498.00-  New Charges:      $1768.96  Manually Priced:          $0
                                                                                       Inactive:                 $0

                                            End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

PATIENT NAME
This field contains the patient name.

ACCOUNT #
This field contains the patient account number.

ADMIT
This field contains the date the patient was admitted.

DISCH
This field contains the date the patient was discharged.

LOC
This field contains the account location (PA, AR, BD).

OLD F/C
This field contains the old hospital-defined financial class code and description assigned to this patient's account.

NEW F/C
This field contains the new hospital-defined financial class code and description assigned to this patient's account.

SEQ
This field contains the external order number of the charge. For late charges and credits, this field is blank.

SRV DT
This field contains the service date of the charge.

POST DATE
This field contains the posting date of the charge.

DEPT
This field contains the charge department.

SIM
This field contains the SIM item number.

DESCRIPTION
This field contains the description of the charge.

FIM
This field contains the FIM item number.

PHYSICIAN
This field contains the physician code and name.

QTY
This field contains the charge quantity.

AMOUNT
This field contains the charge amount.

IND
This field contains an indicator that identifies the charge. Possible entries include:

- O Original charge
- A Adjusted charge
- N New charge
- I Inactive charge (SIM is currently inactive)
- U Unreconciled charge (Quantity times New Price exceeds total charge amount allowable)

Inactive and unreconciled charges are not automatically adjusted but may need to be reviewed by the hospital for pricing consideration.

LC
This field contains an L if the charge is a late charge.

MP
This field contains an M if the charge is a manually priced item. These charges are not automatically adjusted, but may need to be reviewed by the hospital for pricing consideration.

ORIGINAL CHARGES
This field contains the total of the original charges for the patient that may qualify for repricing.

ADJUSTMENTS
This field contains the total of the adjusted charges issued for the patient.

NEW CHARGES
This field contains the total amount of the new charges issued for the patient.

MANUALLY PRICED
This field contains the total of the manually priced items for the patient.

INACTIVE
This field contains the total amount of the patient charges whose SIM items are now inactive.

CLAIM DISPOSITION ANALYSIS REPORT - FAR126

Description/Purpose

This report allows hospitals to view the disposition of claims in a cash batch after a Claim Disposition rule has been applied. Note, an option on the Claim Disposition Rules table allows users to apply a claim disposition rule code and view the results on the FAR126 report, but the account cannot be updated with the results of the rule. The report also allows you to view which claims were identified as under- and over-payments.

If the system determines there is an error while evaluating the payment information, the error is reported with the transaction on the report. If an error is found, the corresponding error message is displayed, and the claim disposition is not updated. The following are possible error messages that may occur due to the evaluation of the claim and payment based upon the user-defined rules:

- OPPS Information Unavailable

- PCONJ Information Unavailable

- Negative Payment

- Does Not Qualify for PCONI Rules

- Does not Qualify for Star Reim Rules

- Does not Qualify for Ins Bal

- PCONB Information Unavailable

- Claim No Longer Exists

- Subsequent Payment Exists

- Does not Qualify for Act Bal

Generating and Printing the Report

The report can be requested in the following ways:

- From the Cash Posting Exit Batch Processor Screen via the Analyze (B)atch option.

- From the Process Electronic RA function at the time an ERA file is processed via the function. The report is produced automatically for each ERA batch if there are

Claim Disposition Rules defined in the ERA Payment File Definition used for uploading the ERA file.

- The report is also produced when exiting the Unmatched Payments Worklist for associated Cash Batches that have a Claim Disposition Rules code, since a cash batch is reanalyzed after exiting the Unmatched Payments Worklist.

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Figure 2.69 FAR126 - Claim Disposition Analysis Report

```
Date: 07/30/08                              General Hospital                            Page  : 1
Time: 8:03                       Cash Batch Analysis - Batch 253 Facility A            Report: FAR126A
                                            PK3 - ACCT BALANCE

Account #      Account Name                    Trans Amount  Claim Amount   CS      Insurance Bal Adjust Amount ERA Other Adj
Name for Rule                  Formula                                      Cr/Plan COB  Reim Meth STAR Rmb Cal Analysis Value
Rpt Only    Evl for Den  Old CDsp    New CDsp    Over/Und                   Copay        Coinsurance Deductible        Pt Resp
Error Message
-------------------------------------------------------------------------------------------------------------------------
A0820500004   SMITH,DAN                          10.00        630.24       3             673.85
TEST FOR MESSAGE             Act Bal - (Pmt - Adj)                         917/002  2   H                              663.85
No          No           Final       Partial     Underpayment              5.00         5.00        5.00              5.00


                                            End of Report
```

Field Explanations

ACCOUNT #
This column contains the patient's account number.

ACCOUNT NAME
This column contains the patient's name.

TRANS AMOUNT
This column contains the dollar amount of the transaction posted for the account and the COB.

CLAIM AMOUNT
This column contains the amount of the claim for the transaction.

CS
For insurance cash, this column indicates the sequence in which the claim was paid.

INSURANCE BALANCE
The column displays the insurance balance for the selected carrier/plan when the rule is applied.

ADJUSTMENT AMOUNT
This column indicates the contractual adjustment amount posted for insurance cash.

ERA OTHER ADJ
This column indicates the contractual adjustment amount posted when the CAS Reason codes are setup as an ERA Other Adjustment type.

NAME FOR RULE
This column displays the name of the rule which was used to determine the disposition for the claim.

FORMULA
This column displays the name of the formula which was used to determine the new claim disposition.

CR/PLAN
This column indicates the carrier/plan code for the claim to which the payment was applied.

COB
This column indicates the COB for the carrier/plan to which the payment was applied.

REIMBURSEMENT METHOD
This column indicates the type of reimbursement used for posting a will display for OPPS reimbursement type, I, J or B will display for the corresponding PCON reimbursement type, A, C, D or O will display for a STAR reimbursement type, etc.

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STAR RMB CAL
This column displays the reimbursement amount for a J reimbursement type that is sent to PCON.

ANALYSIS VALUE
This column displays the result of the formula.

RPT ONLY
This column indicates if the claim disposition is shown on the report or updated in the cash batch. If this field displays Yes, then the new claim disposition will only appear on the report and will not update the disposition. If the field displays No, the disposition in the cash batch is updated to that which displays in the New CDisp field.

EVL FOR DEN
This column determines if the account has been evaluated for denial tracking. A value of Yes indicates the account has qualified for denial tracking. A value of No indicates the account has not qualified for denial tracking.

OLD CDSP
This column displays the old claim disposition that was entered into the cash batch manually or assigned via a default of the ERA process before the rules have been applied.

If the rule encountered an error, the Old Dsp field is blank and the New Dsp field has the value that is currently in the batch for the disposition. If the rule was applied and the disposition wasn't changed, the report shows the new disposition. If the rule indicated that the new disposition was supposed to be changed even if it is the same disposition, the values in the field are calculated and could be the same.

NEW CDSP
This column displays the new claim disposition that is assigned to the claim after the rules have been applied.

If the rule encountered an error, the Old Dsp field is blank and the New Dsp field has the value that is currently in the batch for the disposition. If the rule was applied and the disposition wasn't changed, the report shows the new disposition. If the rule indicated that the new disposition was supposed to be changed even if it is the same disposition, the values in the field are calculated and could be the same.

OVER/UND
This column indicates if the payment is an underpayment or overpayment based upon the result of the rule.

COPAY
This column displays the amount identified as a copay for this visit. The copay may be entered into the cash batch manually or may come from the ERA file via a CAS Reason code.

COINSURANCE

This column displays the amount identified as coinsurance for this visit. The coinsurance may be entered into the cash batch manually or may come from the ERA file via a CAS Reason code.

DEDUCTIBLE

This column displays the amount identified as the deductible for this visit. The deductible may be entered into the cash batch manually or may come from the ERA file via a CAS Reason code.

PT RESP

This column displays the amount identified as patient responsibility for this visit. The patient responsibility amount may be entered into the cash batch manually or may come from the ERA file via a CAS Reason code.

ERROR MESSAGE

This column displays an error message when the system is unable to apply a rule to a payment. If an error is found, the corresponding error message display   The following are potential error messages that may appear when applicable:

OPPS Information Unavailable

This error occurs when the reimbursement type is not H, COB is not 1, no OPPS information exists, or no estimated OPPS reimbursement exists.

PCONJ Information Unavailable

This error occurs when the reimbursement type is not J, COB is not 1, no PCONJ reimbursement information exists, or no estimated PCONJ reimbursement exists because the claim still has a reimbursement error.

Negative Payment

This error occurs when the payment amount is negative. An example of this is a takeback payment and this is not a transaction where a final disposition would typically be applied. The rationale is that you want to wait for the payment which should appear after the takeback so the system doesn't apply a disposition according to the rule but generates an error to identify the condition. This error message is not valid for the Insurance or Account balance formulas because for insurance and account balance formulas, the system takes the net of all payments for the insurance subtracted from the insurance or account balance.

Does Not Qualify For Pcon1 Rules

This error occurs when the reimbursement type is not I, the COB is not 1, there is a subsequent claim or the current reimbursement information is not for this COB. This edit only appears if the bill is not an adjustment, final or late and if this is not the last final/adj claim.

Does not Qualify for Star Reim Rules

This error occurs when the bill is not an adjustment, final or late bill, if this is not the last final/adj/late claim, or the current reimbursement information is not for this COB.

Does not Qualify for Ins Bal

This error occurs when the claim type is not final, adjustment or late.

PCONB Information Unavailable

This error occurs when the claim type is not B, COB is not for PCON1500, PCON 1500 information does not exist, PCON 1500 reimbursement is not calculated yet as indicated by the presence of an edit.

Claim No Longer Exists

This error occurs when a payment exists, but the claim has been deleted.

Subsequent Payment Exists

This error occurs when there is another payment for the same claim in the cash batch. This error is valid for the Insurance or Account balance formulas because for insurance and account balance formulas, the system takes the net of all payments for the insurance subtracted from the insurance or account balance. This error is not valid for the claim amount and reimbursement type formulas.

Does Not Qualify For Act Bal

This error occurs when the claim type is not final, adjustment or late.

ACCOUNT RETIREMENT ESTIMATES BY YEAR OF DISCHARGE (FARETCT)

Description/Purpose

This report displays counts, by year of discharge, of accounts qualifying and not qualifying for retirement. For BD accounts, the number of accounts qualifying the small balance write-off are counted also. These accounts do not qualify to be retired until the write off is taken.

Optional batch job 134 reads AR and/or BD counts to estimate the number of accounts eligible for retirement and the number of accounts ineligible for retirement. Once complete, the report is produced, and the data are presented by the year of discharge, meaning many accounts in the current year would not be eligible. The following criteria are used to select accounts for retirement.

- Discharge date does not follow 12/31 of the preceding year

- Number of days beyond the Zero Balance Date is greater than 180

The numbers provided for accounts in AR are as follows:

- Number of AR Accounts

- Number of Qualifying AR Accounts

- Number of AR Accounts with Exceptions

The numbers provided for accounts in BD are as follows:

- Number of BD Accounts

- Number of Qualifying BD Accounts

- Number of BD Accounts with Exceptions

- Number of BD Accounts Qualifying for SMB W/O

This Optional Batch Job may be used for discussion with the customer to help determine what they are trying to "fix". This report shows the customer where zero balance accounts are within the database. If the percentage of accounts is greater within AR, the facility may wish to focus first on retiring these older accounts in AR and then move on to BD.

Generating and Printing This Report

This report is generated by optional batch job 134.

Following is a sample of the report.

Figure 2.70 FARETCT - Account Retirement Estimates by
Year of Discharge

```
10/29/10                              General Hospital                         Page  : 1
Time: 08:49am              Account Retirement Estimates by Year of Discharge         Report: FARETCTA


               AR Accounts                        BD Accounts
Year      Total    Qualifying   Exceptions    Total    Qualifying     SMB W/O   Exceptions
1999                                             1                                     1
2001       120         64          56           41                       9            32
2002       479        322         157          115                      12           103
2003     1,801      1,175         626          100          1           13            86
2004       518        341         177           27                                    27
2005       610        401         209           44                                    44
2006       818        656         162           30                       1            29
2007       614        386         228            1                                     1
2008       242        152          90


Total    5,202      3,497       1,705          359          1           35           323
```

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Field Explanations

YEAR
This column contains the year of discharge.

TOTAL (AR ACCOUNTS)
This column contains the total of AR accounts counted on the report.

QUALIFYING (AR ACCOUNTS)
This column contains the number of AR accounts that qualify for retirement.

EXCEPTIONS (AR ACCOUNTS)
This column contains the number of AR accounts that do not qualify for retirement.

TOTAL (BD ACCOUNTS)
This column contains the total of AR accounts counted on the report.

QUALIFYING (BD ACCOUNTS)
This column contains the number of AR accounts that qualify for retirement.

SMB W/O (BD ACCOUNTS)
This column contains the number of BD accounts that qualify for small balance write-off.

SMALL BALANCE WRITE-OFF REVERSAL FOR ACCOUNT RETIREMENT FOR BD ACCOUNTS (FBRRTVX)

Description/Purpose

This report lists accounts processed by optional batch job 132. These are accounts being reported because they qualify for the small balance write-off to be reversed or accounts being reported because the small balance w/o was reversed. If an account is being reported only, it is marked with an *r* preceding the account number. Accounts are reported per the date the selection was made or the account was processed. They are not reported per the run date for the job because the job can run multiple days.

Generating and Printing this Report

This report is generated by optional batch job 132.

Following is a sample of the report.

Figure 2.71 FBRRTVX - Small Balance W/O Reversal for Account
Retirement for BD Accounts

```
Date: 11/15/10                          General Hospital              ge : 1    Time: 13:28
Report: FBRRT
            Small Balance W/O Reversal for Account Retirement for BD Accounts on 11/15/10


            If r Precedes Accnt, Qualifying Account is Being Reported Only


                                                            Zero      Ret Zero
Name                      Accnt          Disch Dt  PT  FC    BD W/O Rev Bal Dt   Bal Dt
MERRITT,TEST              rA0820400001   07/22/08  I/P S     $10.00  11/10/10
SHW-PCONSTD,BABY BOY      rA0928200001   10/09/09  O/P S2    $20.00  11/10/10
                                              End of Report
```

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Field Explanations

NAME
This field contains the patient's name.

ACCOUNT #
This field contains the patient's account number.

DISCH DATE
This column contains the date the patient was discharged.

F/C
This is the financial class of the selected account.

P/T
This is the patient type of the selected account.

BD W/O REV
This is the amount of the bad debt write off that was reversed.

ZERO BAL DATE
This is the date the account had a zero balance.

RET ZERO BAL DT
This is the date the account with a zero balance was reversed.

SMALL BALANCE W/O BEFORE ACCOUNT RETIREMENT (FBRRTB)

Description/Purpose

This report lists accounts processed by optional batch job 131. These are accounts being reported because they qualify for the small balance w/o or accounts being reported because the small balance w/o was made. If an account is being reported only, it is marked with an "r" preceding the account number. Accounts are reported per the date the selection was made or the account was processed. They are not reported per the run date for the job because the job can run multiple days.

Generating and Printing this Report

This report is generated by optional batch job 131.

Following is an example of the report.

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Figure 2.72 FBRRTB - Small Balance W/O Before Account Retirement

```
Date: 11/10/10                         General Hospital                        Page : 1
Time: 13:47                           Retire Accounts Module
Report: FBRRTBA
                      Small Balance W/O Before Account Retirement on 11/10/10
                      If r Precedes Accnt, Qualifying Account is Being Reported Only

                                                                    Zero        Ret Zero
Name                        Accnt         Disch Dt  PT  FC    BD W/O Bal Dt      Bal Dt
MERRITT,RELATIVE TWO        rA0823300002  08/20/08  I/P S2    $11.17
MERRITT,SELFPAY INS         rA0825200001  09/08/08  I/P S     $18.31
MERRITT,TEST                rA0820400001  07/22/08  I/P S     $10.00
SHW-PCONSTD,BABY BOY        rA0928200001  10/09/09  O/P S2    $20.00

                                          End of Report
```

Field Explanations

NAME
This field contains the patient's name.

ACCOUNT #
This field contains the patient's account number.

DISCH DATE
This column contains the date the patient was discharged.

F/C
This is the financial class of the selected account.

P/T
This is the patient type of the selected account.

BD W/O
This is the amount of the bad debt write off for the account.

ZERO BAL DATE
This is the date the account had a zero balance.

RET ZERO BAL DT
This is the date the account with a zero balance was retired.

RETIRED ACCNT EXCEPTIONS (FBRRTEx)

Description/Purpose

This report lists accounts evaluated for retirement in OBJ 130 or due to a user request. The exception is reported. If the exception is specific to an insurance plan, the insurance plan is reported. If the exception is specific to a claim, then the claim is identified. This information would appear in transaction history also. Accounts are reported per the date that the attempt was made. They are not reported per the run date for the job because the job can run multiple days.

Generating and Printing this Report

This report is generated by optional batch job 130.

The following is an example of the report.

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Figure 2.73 Retired Account Exceptions

```
Date: 10/26/10                          General Hospital                          Page  : 1
Time: 9:03                          Retired Accnt Exceptions                      Report: FBRRTEA
                                         for 10/26/10


Patient No. Loc Patient Name               Disch Dt  Zero Bal   Exception                                  Carr/Pln    Clm Seq
-----------------------------------------------------------------------------------------------------------------------------

A1026000001 AR  BRADLEY,MEDICARE           09/17/10  N/A        Balance=0 but No Zero Bal Date
A1026200001 AR  SOMOLIK,DPW                09/14/10  N/A        Balance=0 but No Zero Bal Date
A1025600001 AR  TEST,ANOTHER WORKLIST      09/13/10  N/A        Balance=0 but No Zero Bal Date
A1025800002 AR  WELLSTAR,MITCH TEST        09/15/10  N/A        Balance=0 but No Zero Bal Date
A1025800003 AR  WELLSTAR,TEST CB           09/15/10  N/A        Balance=0 but No Zero Bal Date
A1012400001 AR  ANDERSON,SERIES            05/04/10  08/03/10   Account Excluded
A0900700010 AR  BILL,EIGHT                 01/08/09  07/19/10   Account Excluded
A0900700013 AR  BILL,ELEVEN                01/08/09  07/19/10   Account Excluded
A0900700017 AR  BILL,FIFTEEN               01/08/09  07/19/10   Account Excluded
A0900700016 AR  BILL,FOURTEEN              01/08/09  07/19/10   Account Excluded
A0900700003 AR  BILL,ONE                   01/08/09  07/19/10   Account Excluded
A0900700009 AR  BILL,SEVEN                 01/08/09  07/19/10   Account Excluded
A0900700008 AR  BILL,SIX                   01/08/09  07/21/10   Account Excluded
A0934300004 AR  OPPY,ANOTHER SERIES        12/09/09  08/03/10   Account Excluded
A0934400002 AR  OPPY,ANOTHER SERIES        01/09/10  08/03/10   Account Excluded
A0934300003 AR  OPPY,SERIES                12/09/09  08/03/10   Account Excluded
A0934400001 AR  OPPY,SERIES                01/09/10  08/03/10   Account Excluded
A0900600004 AR  SHORE,NINE                 01/06/09  08/03/10   Account Excluded
A0900600001 AR  SHORE,SIX                  01/06/09  07/24/10   Account Excluded
A0900600005 AR  SHORE,TEN                  01/06/09  07/24/10   Account Excluded
A0900600007 AR  SHORE,TWELVE               01/06/09  08/03/10   Account Excluded
A0905200003 AR  SHW-EAPG,CYCLE-G           02/22/09  08/03/10   Account Excluded
A0905400003 AR  SHW-EAPG,CYCLE-G           02/24/09  08/03/10   Account Excluded
A0905600003 AR  SHW-EAPG,CYCLE-G           02/26/09  08/03/10   Account Excluded
A0905800003 AR  SHW-EAPG,CYCLE-G           02/28/09  08/03/10   Account Excluded
A0906000003 AR  SHW-EAPG,CYCLE-G           03/02/09  08/03/10   Account Excluded
A0906200003 AR  SHW-EAPG,CYCLE-G           03/04/09  08/03/10   Account Excluded
A0906400003 AR  SHW-EAPG,CYCLE-G           03/06/09  08/03/10   Account Excluded
A1025300001 AR  SOMOLIK,FATHER             09/10/10  09/14/10   Patient Balance Exists

                                          End of Report


<Page Break>
```

Field Explanations

NAME
This field contains the patient's name.

ACCOUNT #
This field contains the patient's account number.

LOC
This column contains the account location.

DISCH DATE
This column contains the date the patient was discharged.

ZERO BAL
This column contains the date the account had a zero balance.

EXCEPTION
This column displays the exception for retirement.

CARR/PLAN
This column displays the carrier and plan for an account that has an exception specific to an insurance plan.

ACCOUNT LOCATION CHANGED TO ARR (FBRRTTX)

Description/Purpose

This report lists accounts which have been retired by OBJ 130 or an online transfer. Also, it lists accounts only reported by OBJ 130 and those accounts are marked with an "r" preceding the account number. Accounts are reported per the date that the selection was made or the account was processed. They are not reported per the run date for the job because the job can run multiple days. If the account is being reported due to an online function, *User Req* appears in the Reason column.

Generating and Printing this Report

This report is generated by optional batch job 130 and also nightly, if accounts were manually transferred.

.The following is a sample of the report.

Figure 2.74 FBRRTT - Account Location Changed to ARR

```
Date: 10/26/10                          General Hospital                            Page  : 1
Time: 10:36                          Retire Accounts Module                         Report: FBRRTTA
                             Account Location Changed to ARR on 10/26/10
                        If r Precedes Accnt, Qualifying Account is Being Reported Only


                                                              Zero      Ret Zero  New
Name                    Accnt         Disch Dt  PT  FC   Accnt Bal  Bal Dt    Bal Dt    Loc Reason
ANDERSON,CATHOLIC       rA1012600002  05/14/10  JGH S       $0.00  07/08/10  10/26/10  ARR
ANDERSON,DAWN           rA1015900002  06/08/10  PER S       $0.00  08/03/10  10/26/10  ARR
ANDERSON,OUTPATIENT     rA1013300003  05/14/10  PER S       $0.00  08/03/10  10/26/10  ARR
ANDERSON,SERIES         rA1012400001  05/04/10  SER O       $0.00  08/03/10  10/26/10  ARR
BILL,FIVE               rA0900700007  01/06/09  LIC S       $0.00  07/19/10  10/26/10  ARR
BRADLEY,AFTERMMB        rA1018000005  06/30/10  MMB S       $0.00  08/03/10  10/26/10  ARR
BRADLEY,AFTERMMB        rA1018200004  07/31/10  MMB S       $0.00  08/30/10  10/26/10  ARR
BRADLEY,AFTERMMB        rA1021300004  08/31/10  MMB S       $0.00  09/30/10  10/26/10  ARR
BRADLEY,AFTERMMB        rA1021600005  08/04/10  ERB S       $0.00  09/03/10  10/26/10  ARR
BRADLEY,AFTERMMB        rA1024500002  09/02/10  ALL S       $0.00  10/02/10  10/26/10  ARR
BRADLEY,ER              rA1021800008  08/06/10  POI S       $0.00  09/05/10  10/26/10  ARR
BRADLEY,ER              rA1024500003  09/19/10  POB O       $0.00  09/19/10  10/26/10  ARR
BRADLEY,MARY            rA1018000001  06/30/10  MMB S       $0.00  08/03/10  10/26/10  ARR
BRADLEY,MARY            rA1018200001  07/31/10  MMB S       $0.00  08/30/10  10/26/10  ARR
BRADLEY,MARY            rA1021300001  08/31/10  MMB S       $0.00  09/30/10  10/26/10  ARR
BRADLEY,MMBSERVICE      rA1018000003  06/30/10  MMB S       $0.00  08/03/10  10/26/10  ARR
BRADLEY,MMBSERVICE      rA1018200003  07/31/10  MMB S       $0.00  08/30/10  10/26/10  ARR
BRADLEY,MMBSERVICE      rA1021300003  08/31/10  MMB S       $0.00  09/30/10  10/26/10  ARR
BRADLEY,NAOMI BRUCE     rA1020400004  07/23/10  CNA S       $0.00  08/22/10  10/26/10  ARR
BRADLEY,NAOMI BRUCE     rA1021600006  08/04/10  OPR S       $0.00  09/03/10  10/26/10  ARR
BRADLEY,NOMMB           rA1018000002  06/30/10  MMB S       $0.00  08/03/10  10/26/10  ARR
BRADLEY,NOMMB           rA1018200002  07/31/10  MMB S       $0.00  08/30/10  10/26/10  ARR
B
```

Field Explanations

NAME
This field contains the patient's name.

ACCOUNT #
This field contains the patient's account number.

DISCH DATE
This column contains the date the patient was discharged.

F/C
This is the financial class of the selected account.

P/T
This is the patient type of the selected account.

ACCNT BAL
This column contains the account balance.

RET ZERO BAL DT
This column contains the date the account was retired.

NEW LOCATION
This column contains the account's new location to ARR.

REASON
If the account is being reported due to an online function, *User Req* appears in the Reason column.

ACCNTS CHG FROM RETIRED (FBRRTF)

Description/Purpose

This report lists accounts which have been un-retired by optional batch job 131, an automatic process, or an online transfer. Also, it lists accounts only reported by OBJ 131 and those accounts are marked with an "r" preceding the account number. Accounts are reported per the date that the selection was made or the account was processed. They are not reported per the run date for the job because the job can run multiple days. If   the account is being reported due to an online function, *User Req* appears in the Reason column. If the account is being reported due to an automatic return, the reason for the automatic return is reported in the column Reason column.

Generating and Printing this Report

This report is generated by optional batch job 131 and also nightly, if accounts were manually transferred.

The following is a sample of the report.

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Figure 2.75 FBRRTF - Account Location Changed to AR

```
Date: 11/23/10                          General Hospital                          Page  : 1
Time: 9:55                           Retire Accounts Module                    Report: FBRRTFA
                           Account Location Changed to AR on 11/23/10
                       If r Precedes Accnt, Qualifying Account is Being Reported Only


                                                                Zero     Ret Zero New
Name                       Accnt        Disch Dt PT  FC   Accnt Bal  Bal Dt   Bal Dt   Loc Reason
ACCOUNT,FIRST              A1009600002  04/06/10 LOR S      $0.00  10/01/10 11/23/10  AR
ANDERSON,SERIES           A1012400001  05/04/10 SER O      $0.00  08/03/10 11/23/10  AR
BRADY,PETER               A1004800001  02/17/10 OPS S      $0.00  08/03/10 11/23/10  AR
CONTRACT,LAB A            A1011700004  04/27/10 CBP        $0.00  08/03/10 11/23/10  AR
DONER,MOM                 A0823700001  08/23/08 LOR S      $0.00  07/19/10 11/23/10  AR
DONER,MOMTHREE            A0823700003  08/23/08 I/P S      $0.00  08/03/10 11/23/10  AR
DONER,PRR                 A1001100003  01/11/10 LOC S      $0.00  08/03/10 11/23/10  AR
DURBIN,NEWIP              A0913500004  05/22/09 OPT S      $0.00  08/03/10 11/23/10  AR
EMERGENCY,EMMA E          A0817500001  06/23/08 I/P O      $0.00  07/20/10 11/23/10  AR
EVERY,FIELD               A0917600003  06/25/09 I/P M      $0.00  07/20/10 11/23/10  AR
EVERY,FIELD               A0919500001  07/14/09 I/P M      $0.00  07/20/10 11/23/10  AR
FEW,USERDEFINED           A0908400003  03/25/09 I/P S      $0.00  07/19/10 11/23/10  AR
FIELDS,FEW                A0821000001  07/28/08 OPS S      $0.00  07/19/10 11/23/10  AR
HARDERSEN,JUMPING JIMMINY A0817900001  07/02/08 I/P S      $0.00  08/03/10 11/23/10  AR
HARDERSEN,OHNO AK         A0817900002  07/02/08 I/P S      $0.00  08/03/10 11/23/10  AR
MERRITT,ED ADMITTYPE      A0912600006  05/06/09 ER  S      $0.00  06/07/09 11/23/10  AR
MERRITT,MEDICAL OP        A1011700006  04/27/10 CBP        $0.00  08/03/10 11/23/10  AR
MERRITT,OC CHG            A0912600005  05/06/09 OPO O      $0.00  06/07/09 11/23/10  AR
MERRITT,OC MEDREC         A0912600004  05/06/09 OPO O      $0.00  06/07/09 11/23/10  AR
OPPY,ANOTHER SERIES       A0934300004  12/09/09 SER O      $0.00  08/03/10 11/23/10  AR
OPPY,ANOTHER SERIES       A0934400002  01/09/10 SER O      $0.00  08/03/10 11/23/10  AR
OPPY,BECKY                A0911900002  06/05/09 PAT S      $0.00  08/03/10 11/23/10  AR
OPPY,ONE M22794           A0915600001  06/05/09 OPS S      $0.00  08/03/10 11/23/10  AR
OPPY,ONE M22794           A0916200001  06/11/09 OPS S      $0.00  08/03/10 11/23/10  AR
OPPY,ONE M22794           A0916900001  06/18/09 OPS S      $0.00  08/03/10 11/23/10  AR
```

Field Explanations

NAME
This field contains the patient's name.

ACCOUNT #
This field contains the patient's account number.

DISCH DATE
This column contains the date the patient was discharged.

P/T
This is the patient type of the selected account.

ACCNT BAL
This column contains the account balance.

F/C
This is the financial class of the selected account.

RET ZERO BAL DT
This column contains the date the account was retired.

NEW LOCATION
This column contains the account's new location to ARR.

REASON
If the account is being reported due to an online function, *User Req* appears in the Reason column.

ACCOUNT RETIREMENT STATISTICS - FBRRTS

Description/Purpose

FBRRTS provides the following statistics for the past 50 days. The statistics are for the number of qualifying accounts. An account is counted per the date of the transaction and not the run date for the MNP or online job. If an * follows the number, for at least some of the accounts, the account was reported but not processed. When the optional batch jobs are not used in report mode only, these statistics represent the number of accounts processed, as follows:

- Transfers to ARR

- Transfers to BDR

- Transfers to AR

- Transfers to BD

- Exceptions for Retirement to ARR

- Exceptions for Retirement to BDR

- BD W/O

Generating and Printing this Report

This report is generated by optional batch job 131.

Figure 2.76 FBRRTS - Account Retirement Statistics

```
Date: 11/22/10                General Hospital              Page  : 1
Time: 2:06                Account Retirement Statistics     Report: FBRRTSA


          Transfers                            Exceptions Reported
Date        To ARR     To BDR     To AR      To BD      AR       BD     BD W/O
  10/02/10      0          0          0          0       0        0
  10/03/10      0          0          0          0       0        0
  10/04/10      8          2          3          3       3        0
  10/05/10      4          4          4          4       0        0
  10/06/10      2          2          1          1       0        0
  10/07/10      3          3          3          3       0        0
  10/08/10      0          0          0          0       0        0
  10/09/10      0          0          0          0       0        0
  10/10/10      0          0          0          0       0        0
  10/11/10      5          0          1          0       3        0
  10/12/10      0          0          0          0       0        0
  10/13/10      0          0          0          0       0        0
```

Chapter 3 - ACCOUNT FOLLOW-UP REPORTS

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Illustrations

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This chapter contains screens, field explanations, and other documentation for Canadian usage of this product. Generally, the documentation reflects the base (US) product. Documentation for the Canadian version appears in the online version with blue highlighting. Canadian documentation is further identified by (CN) or by (CN Only).

AGED TRIAL BALANCE REPORT - FARATB

Description/Purpose

The Aged Trial Balance Report displays the aged financial status of all accounts in Accounts Receivable. Up to thirteen aging categories are set up in the Report Aging Code table. Accounts can be aged from discharge date, final bill date, or last payment date.

The detail report includes the patient account number, patient name, financial class, patient type, discharge date, final bill date, last payment date, insurance balance, patient balance, account balance, and aging categories.

NOTE: You can use the STAR Audit Service to audit user requests for this report. The Audit Service collects and stores information such as report request date and time, the name of the user requesting the report and the criteria selected for the report. For more information, see the STAR Audit Service Reference Guide.

Generating and Printing This Report

The Aged Trial Balance Report can be generated monthly during midnight processing, on demand, or requested to print during midnight processing.

There are two methods that the system uses for fiscal balances. These are to use month-end balances or to use balances as of midnight.

To use the month-end balances, the system displays the following prompt seven days past month-end:

   Use XX/XX/XX fiscal period balances? (Y/N)

The XX/XX/XX indicates the month-end fiscal period date.

Enter **Y** to use the month-end fiscal balances. Enter **N** to not use the month-end fiscal balances.

To use the balances as of midnight, choose the tonight option. The system uses balances as of midnight, even if the Aged Trial Balance report is still running the next morning.

The report is set up using the Define ATB Report function and generated using the Request ATB Report function. Zero balance accounts may be suppressed by setting the indicator in the Define ATB Report function.

The Aged Trial Balance Report can be sorted by account name, account number, financial class and name, or financial class and dollars. When sorted by financial class,

each new financial class prints on a new page. For each financial class, the report provides subtotals of the number of accounts and the account balances by patient indicator and a total for the financial class.

NOTE: The number of accounts and the account balances are subtotaled for each financial class if the report is sorted by financial class name or financial class dollars.

The last page of the ATB report provides an aging summary with the number of accounts and account balances.

The following is an example of the Aged Trial Balance Report.

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Figure 3.1 FARATB - Aged Trial Balance Report - Page 1

```
Date: 01/16/06                        Model Hospital A                        Page  : 54
Time: 12:50                      Detail Aged Trial Balance Rpt                 Report: FARATBA
                                    AGED BY DISCHARGE DATE


                               FBIL   DSCH   LAST          INS       PAT       ACCT  AGING CATEGORIES
ACCOUNT NO.   ACCOUNT NAME     FC PT  DATE   DATE   PYMT    BAL       BAL        BAL  123456789012+
0536300005    JAMES,JIMMY      O  I/P 01/01/06 12/29/05    1189.98   900.00   2089.98 X
0536300006    NORRIS,NANCY     O  O/P 01/01/06 12/29/05       0.00  1051.40   1051.40  X
0536300008    RANDOLPH,RANDY   O  O/P 01/01/06 12/29/05       0.00     0.00      0.00   X
0536300011    BOOK-BOROFSKY,BABY GIRL O O/P 01/01/06 12/29/05  0.00 1011.42   1011.42   X
0536300012    SMALL,SALLY S    O  O/P 01/01/06 12/29/05       0.00    46.74     46.74   X
0536400002    EVANS,EDITH      O  O/P 12/31/05 12/30/05     106.42     5.00    111.42    X
0600400002    RUTHERFORD,SPLITONE O PWR 01/05/06 01/05/06 10389.30   576.20  10965.50     X
0600400006    VAUGHN,VON V     O  O/P 01/08/06 01/01/06       0.00     0.00      0.00      X
0600500001    ULMAN,URSULA U   O  O/P 01/07/06 01/03/06       0.00     0.00      0.00       X
0600500003    WESSON,WES W     O  O/P 01/11/06 01/03/06       0.00     0.00      0.00        X
0600900002    KESLER,BLAISE    O  O/P 01/09/06 01/09/06     400.00   315.45    715.45         X
0601000002    STEWART,KAREN    O  I/P 01/14/06 01/11/06    1477.11   295.10   1772.21          X

                                                        2461635.68 16262944.96 18724580.64


STATISTICAL GROUP TOTALS: 5 OTHER
              INPATIENT         455            10,719,961.46
              OUTPATIENT        936             6,840,144.33
              EMERGENCY ROOM    307             1,164,474.85

GRAND TOTAL:                   1698           $18,724,580.64
```

Figure 3.2 FARATB - Aged Trial Balance Report - Page 2

```
Date: 01/16/06                            Model Hospital A                      Page  : 55
Time: 12:50                          Detail Aged Trial Balance Rpt            Report: FARATBA
                                        AGED BY DISCHARGE DATE



AGING TOTALS:
   Category 1       0- 30 DAYS       42                1,766,172.95
   Category 2      31- 60 DAYS       54                  766,535.37
   Category 3      61- 90 DAYS      159                1,802,900.72
   Category 4      91-120 DAYS      249                2,327,461.59
   Category 5     121-150 DATS
   Category 6     151-180 DATS
   Category 7     181-210 DAYS
   Category 8     211-240 DAYS
   Category 9     241-270 DAYS
   Category 10    271-300 DAYS
   Category 11    301-330 DATY
   Category 12    331-360 DAYS
   Category 13    OVER 360  DAYS    1881               16,678,772.59


        PATIENT ACCOUNTS TOTAL     2385               $23,341,843.22

PATIENT INDICATOR TOTALS:
             INPATIENT             618                14,682,549.39
             OUTPATIENT          1,393                 7,472,403.48
             EMERGENCY ROOM        374                 1,186,890.35


                                    End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ACCOUNT NO.
This field contains the account number.

ACCOUNT NAME
This field contains the patient or guarantor name.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc.

PT
This field contains the patient type code and is used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

FBIL DATE
This field contains the final billing date for this patient's account.

DSCH DATE
This field contains the patient's discharge date.

LAST PYMT
This field contains the date of the last payment made to this patient's account.

INS BAL
This field contains the insurance balance.

PAT BAL
This field contains the patient balance.

ACCT BAL
This field contains the account balance.

AGING CATEGORIES
This field contains an X under the appropriate aging category as defined by the selection made on the Define ATB Report screen. Thirteen aging categories are displayed on this report. A single number in each column heading coincides with a category number: 1=1, 2=2, 3=3, 4=4, 5=5, 6=6, 7=7, 8=8, 9=9, 10=0, 11=1, 12=2, and 13=3.

AGING TOTALS
This field contains the number of accounts and account balances for each of the aging categories and totaled for all accounts according to the report aging category selected.

PATIENT ACCOUNTS TOTAL
The field contains the sum of all the account balances included on the Aged Trial
Balance.

COLLECTOR AGED TRIAL BALANCE REPORT - FARCATB

Description/Purpose

The collector version of the Aged Trial Balance provides a detail listing of accounts by the guarantor's collector. The Collector Aged Trial Balance report displays the aged financial status of all accounts in accounts receivable. Up to thirteen aging categories are set up in the Report Aging Code table. Accounts can be aged from discharge date, final bill date, or last payment date.

There are two versions of this report:

- Standard - The standard report lists the patient account number, patient name, financial class, patient type, discharge date, final bill date, last payment date, insurance balance, patient balance, account balance, and aging categories.

- Insurance - The insurance version of the report lists the patient account number, patient name, financial class, patient type, carrier/plan, subscriber/HIC #, discharge date, insurance balance, account balance, and aging categories.

Generating and Printing This Report

The Collector Aged Trial Balance Report can be generated monthly during Midnight Processing, on demand, or requested to print during Nidnight Processing.

To use the month-end balances, the system displays the following prompt seven days past month-end on the Define ATB Report screen :

Use XX/XX/XX fiscal period balances? (Y/N)

The XX/XX/XX indicates the month-end fiscal period date.

Enter **Y** to use the month-end fiscal balances. Enter **N** to not use the month-end fiscal balances.

To use the balances as of midnight choose the tonight option. The system uses balances as of midnight, even if the Collector Aged Trial Balance report is still running the next morning.

The report is set up using the Define ATB Report function and generated using the Request ATB Report function. Zero balance accounts may be suppressed by setting the indicator in the Define ATB Report function.

The Collector Aged Trial Balance Report is sorted by the guarantor's collector. Subtotals are provided for each collector.

The following are examples of the Collector Aged Trial Balance Report, standard and insurance versions.

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Figure 3.3 FARCATB - Collector Aged Trial Balance Report (Standard Version)

```
Date: 07/05/06                         Model Hospital A                           Page  : 2
Time: 9:50                        Collector Aged Trial Balance                    Report: FARCATBA
                                    AGED BY FINAL BILL DATE
                                  COLLECTOR: 13 Barron,Johnny L


                                   FBIL   DSCH   LAST       INS       PAT       ACCT   AGING CATEGORIES
ACCOUNT NO.   ACCOUNT NAME      FC PT  DATE   DATE   PYMT       BAL       BAL       BAL  12345678901+
0610300001    OSBORN,GZ ONE     S2 ER  04/27/06 04/13/06 05/22/06  0.00    140.71    140.71   3
0610300003    OSBORN,GZ TWO     M  O/P 04/27/06 04/13/06 05/22/06  0.00     54.98     54.98   3
0610900001    MERRITT,ICD A     S  O/P 05/19/06 04/19/06           0.00     53.02     53.02   3
0610900002    MERRITT,ICD B     S  O/P 05/19/06 04/19/06           0.00     81.94     81.94   3
0613600018    SMITH,BOB         S  ER  06/15/06 05/16/06           0.00   2824.65   2824.65   2
0613600023    ROD,OP ONE        S  O/P 06/15/06 05/16/06           0.00    208.44    208.44   2
0613600024    ROD,OP TWO        S  O/P 06/15/06 05/16/06           0.00    260.50    260.50   2
0613700012    TESTTEST,TEST     S  ER  06/16/06 05/17/06           0.00    189.77    189.77   2
0613900002    ROD,DAY SIX       S  ERB 06/18/06 05/19/06           0.00    450.96    450.96   2
0614300002    ANTOP,TEST        S  OP  06/22/06 05/23/06           0.00    254.65    254.65   2
0614600003    DONER,ER          S  ER  06/25/06 05/26/06           0.00    591.26    591.26   1
0614600005    DONER,EMERGENCY   S  ERN 06/25/06 05/26/06           0.00    652.26    652.26   1

                                                                   0.00   5763.14   5763.14


AGING TOTALS:
        1      0 -   10 DAYS        2                  1,243.52
        2     11 -   30 DAYS        6                  4,188.97
        3     31 -   90 DAYS        4                    330.65
        4     91 -  120 DAYS                               0.00
        5    121 -  180 DAYS                               0.00
        6    181 -  360 DAYS                               0.00
        7    361 -  400 DAYS                               0.00
        8    401 -  500 DAYS                               0.00
        9    501 -  600 DAYS                               0.00
       10    601 -  700 DAYS                               0.00
       11    701 -  720 DAYS                               0.00
       12       OVER 720 DAYS                              0.00

       PATIENT ACCOUNTS TOTAL       12                $5,763.14
```

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Figure 3.4 FARCATB - Collector Aged Trial Balance Report (Insurance Version)

```
Date: 04/01/03                              General Hospital                              Page  : 1
Time: 13:40                            Collector Aged Trial Balance                       Report: FARCATBA
                                         AGED BY FINAL BILL DATE
                                         COLLECTOR: 2 SMITH, DAVE


                                                             DSCH        INS        ACCT  AGING CATEGORIES
ACCOUNT NO.   ACCOUNT NAME          CR/PL  SUBSCRIBER/HIC #   FC PT  DATE       BAL         BAL  1 2 3 4 +
0229000002    KARP, BILL            100/100 12345678901234567890  M  ER  10/17/02 121199.65 125018.44 X
0229400004    KASH, MIKE            100/100 98765432109876543210  C  I/P 10/21/02 121706.60 454134.13 X

                                                                    242906.25  579152.57

AGING TOTALS:
                     30 DAYS       2                 9,152.57
                     60 DAYS                             0.00
                     90 DAYS                             0.00
                    120 DAYS                             0.00
                OVER 120 DAYS                            0.00

           PATIENT ACCOUNTS TOTAL   2                $9,152.57
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ACCOUNT NO.
This field contains the account number.

ACCOUNT NAME
This field contains the patient or guarantor name.

CR/PL
This field contains the carrier and plan. This field is only displayed on the insurance version of the report.

SUBSCRIBER/HIC #
This field contains the subscriber ID number or the health insurance claim number. The field is displayed only on the Insurance version of the report.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc.

PT
This field contains the patient type code and is used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

FBIL DATE
This field contains the final billing date for this patient's account. This field is displayed only on the standard version of the report.

DSCH DATE
This field contains the patient's discharge date.

LAST PYMT
This field contains the date of the last payment made to this patient's account. This field is displayed only on the standard version of the report.

INS BAL
This field contains the insurance balance.

PAT BAL
This field contains the patient balance. This field is displayed only on the standard version of the report.

ACCT BAL
This field contains the account balance.

AGING CATEGORIES
This field contains an X under the appropriate aging category as defined by the selection made on the Define ATB Report screen. Thirteen aging categories are displayed on this report. A single number in each column heading coincides with a category number: 1=1, 2=2, 3=3, 4=4, 5=5, 6=6, 7=7, 8=8, 9=9, 10=0, 11=1, 12=2, and 13=3.

AGING TOTALS
This field contains the number of accounts and account balances for each of the aging categories for the collector.

PATIENT ACCOUNTS TOTAL
The field contains the total number of accounts and the sum of the account balances for the collector.

SUMMARY AGED TRIAL BALANCE REPORT - FARSATB

Description/Purpose

A summary report can also be requested which includes totals by patient indicator within aging category.

The Summary Aged Trial Balance Report is a two-part report. The first part of the report is the Summary Aged Trial Balance, which provides facility totals by patient indicator and financial class within aging category.

The second part of the report is the Aged Trial Balance Reserve Recap Report. The Aged Trial Balance Reserve Recap Report places account balances in an accumulator based on aging category, patient indicator and financial class. The Report Aging Code table enables the hospital to specify a reserve percentage for each accumulator. The accumulated account balance is multiplied by the reserve percentage to determine the reserve dollars which print for the accumulated category.

This report can be used to study receivables and to estimate the dollar amount of receivables that may become uncollectible. It prints if the Summary ATB Report is requested.

Generating and Printing This Report

The Summary Aged Trial Balance Report can be generated monthly during midnight processing, on demand, or requested to print during midnight processing.

To use the month-end balances, the system displays the following prompt seven days past month-end:

Use XX/XX/XX fiscal period balances? (Y/N)

The XX/XX/XX indicates the month-end fiscal period date.

Enter **Y** to use the month-end fiscal balances. Enter **N** to not use the month-end fiscal balances.

To use the balances as of midnight choose the tonight option. The system uses balances as of midnight, even if the Summary Aged Trial Balance report is still running the next morning.

The report is set up using the Define ATB Report function and printed using the Request ATB Report function.

The following is an example of the Summary Aged Trial Balance Report.

Figure 3.5 FARSATB - Summary Aged Trial Balance Report - Inpatient Summary

```
Date: 01/16/06                          Model Hospital A                          Page  : 1
Time: 12:50                        Summary Aged Trial Balance                   Report: FARSATBA
                                     AGED BY FINAL BILL DATE
                                       Inpatient Summary


          Fin Class 09        Fin Class B          Fin Class H         Fin Class K         Fin Class L
Aging   #Acct      Amount   #Acct      Amount    #Acct      Amount   #Acct      Amount   #Acct      Amount

 0- 30    0         0.00      1     92,699.39      0         0.00      0         0.00      0         0.00
31- 60    0         0.00      0         0.00       1      2,050.00     5     31,984.28     1    100,000.00
61- 90    1      4,369.34     0         0.00       0         0.00      0         0.00      0         0.00
91-120    0         0.00      2      1,290.00      0         0.00      2      5,179.14     0         0.00
121-150
151-180
181-210
211-240
241-270
271-300
301-330
331-360
361-999   1       746.00     12  1,527,960.56     2      4,519.69     6     38,832.00     1     31,199.56
TOTAL     2      5,115.34     15  1,621,949.95     3      6,569.69    13     75,995.42     2    131,199.56




          Fin Class S2        Fin Class SP        ******TOTALS******
Aging   #Acct      Amount   #Acct      Amount    #Acct      Amount

 1- 30    0         0.00      0         0.00      24   2,146,788.49
31- 60    0         0.00      0         0.00      29     401,791.51
61- 90    1     16,986.43     0         0.00      24     204,648.74
91-120    0         0.00      0         0.00      78   1,475,022.34
121-150
151-180
181-210
211-240
241-270
271-300
301-330
331-360
121-999   9     95,292.71     1    290,310.84    224  10,454,298.31
TOTAL    10    112,279.14     1    290,310.84    379  14,682,549.39
```

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Figure 3.6 FARSATB - Summary Aged Trial Balance Report - Combined Summary

```
Date: 07/05/06                          Model Hospital A                          Page  : 1
Time: 9:57                         Summary Aged Trial Balance                     Report: FARSATBA
                                    AGED BY FINAL BILL DATE
                                      Inpatient Summary

           Fin Class B            Fin Class C            Fin Class JA           Fin Class K            Fin Class L
Aging      #Acct     Amount       #Acct     Amount       #Acct     Amount       #Acct     Amount       #Acct     Amount

  0-  10     1     1,014.01         1     1,035.52         0        0.00          0        0.00          0        0.00
 11-  30     1       315.59         1       554.62         0        0.00          0        0.00          0        0.00
 31-  90     2     5,846.94         0        0.00          0        0.00          0        0.00          0        0.00
 91- 120     0        0.00          0        0.00          0        0.00          0        0.00          1      501.06
121- 180     1       967.50         0        0.00          0        0.00          1      645.00          0        0.00
181- 360     0        0.00          1       810.60         1      810.60         0        0.00          0        0.00
361- 400     0        0.00          0        0.00          0        0.00          0        0.00          0        0.00
401- 500     0        0.00          0        0.00          0        0.00          0        0.00          0        0.00
501- 600     0        0.00          0        0.00          0        0.00          0        0.00          0        0.00
601- 700     0        0.00          0        0.00          0        0.00          0        0.00          0        0.00
701- 720     0        0.00          0        0.00          0        0.00          0        0.00          0        0.00
721-9999     0        0.00          0        0.00          0        0.00          0        0.00          0        0.00
TOTAL        5     8,144.04         3     2,400.74         1      810.60          1      645.00          1      501.06


           Fin Class M            Fin Class O            Fin Class S            Fin Class S2           ******TOTALS******
Aging      #Acct     Amount       #Acct     Amount       #Acct     Amount       #Acct     Amount       #Acct     Amount

  0-  10     0        0.00          4    37,495.39         2     1,932.04         0        0.00          8    41,476.96
 11-  30     1     1,503.54         3    31,736.85         3     6,159.04         0        0.00          9    40,269.64
 31-  90     3  -107,399.25         4    57,915.53        25   107,726.99         3    12,008.58        37    76,098.79
 91- 120     0        0.00          0        0.00          0        0.00          0        0.00          1      501.06
121- 180     0        0.00          2     7,186.92         2     1,692.39         2    10,287.97         8    20,779.78
181- 360     0        0.00          1       711.83         0        0.00          0        0.00          3     2,333.03
361- 400     0        0.00          0        0.00          0        0.00          0        0.00          0        0.00
401- 500     0        0.00          0        0.00          0        0.00          0        0.00          0        0.00
501- 600     0        0.00          0        0.00          0        0.00          0        0.00          0        0.00
601- 700     0        0.00          0        0.00          0        0.00          0        0.00          0        0.00
701- 720     0        0.00          0        0.00          0        0.00          0        0.00          0        0.00
721-9999     0        0.00          0        0.00          0        0.00          0        0.00          0        0.00
TOTAL        4  -105,895.71        14   135,046.52        32   117,510.46         5    22,296.55        66   181,459.26
```

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Figure 3.7 FARSATB - Summary Aged Trial Balance Report - Reserve Recap

```
Date: 03/02/06                             Model Hospital A                          Page  : 8
Time: 2:05                            Summary Aged Trial Balance                      Report: FARSATBA
                                        AGED BY FINAL BILL DATE
                                           RESERVE RECAP


             1-30         31-60         61-90         91-120        121-150       151-180       181-210       211-240       241-270
                 271-300       301-330       331-360       361 =         TOTAL
             DAYS          DAYS          DAYS          DAYS          DAYS          DAYS          DAYS          DAYS          DAYS
                 DAYS          DAYS          DAYS          DAYS


KB-KARINA'S SELF  PAY

I-$          0.00          0.00          0.00          0.00          0.00          0.00          0.00          0.00          0.00
                 0.00          0.00          0.00          0.00          0.00
RES %        0.00          0.00          0.00          0.00          0.00          0.00          0.00          0.00          0.00
                 0.00          0.00          0.00          0.00          0.00
RES $        0.00          0.00          0.00          0.00          0.00          0.00          0.00          0.00          0.00
                 0.00          0.00          0.00          0.00          0.00


*TOT $       0.00          0.00          0.00          0.00          0.00          0.00          0.00          0.00          0.00
                 0.00          0.00          0.00          0.00          0.00
*RES $       0.00          0.00          0.00          0.00          0.00          0.00          0.00          0.00          0.000
                 0.00          0.00          0.00          0.00          0.00
```

Figure 3.8 FARSATB - Summary Aged Trial Balance Report - Reserve Recap

```
Date: 01/16/06                              Model Hospital A                                Page  : 12
Time: 12:50                            Summary Aged Trial Balance                           Report: FARSATBA
                                        AGED BY FINAL BILL DATE
                                           RESERVE RECAP


                Category          I - $    Res %            Res $          Total $         Reserve $
SP - Dale's Self Pay
    Cat 1        0 -  30    999,999,999.99  25.00    999,999,999.99   999,999,999.99   999,999,999.99
    Cat 2       31 -  60    999,999,999.99  25.00    999,999,999.99   999,999,999.99   999,999,999.99
    Cat 3       61 -  90    999,999,999.99  25.00    999,999,999.99   999,999,999.99   999,999,999.99
    Cat 4       91 - 120    999,999,999.99  25.00    999,999,999.99   999,999,999.99   999,999,999.99
    Cat 5      121 - 150    999,999,999.99  25.00    999,999,999.99   999,999,999.99   999,999,999.99
    Cat 6      151 - 180    999,999,999.99  25.00    999,999,999.99   999,999,999.99   999,999,999.99
    Cat 7      181 - 210    999,999,999.99  25.00    999,999,999.99   999,999,999.99   999,999,999.99
    Cat 8      211 - 240    999,999,999.99  25.00    999,999,999.99   999,999,999.99   999,999,999.99
    Cat 9      241 - 270    999,999,999.99  25.00    999,999,999.99   999,999,999.99   999,999,999.99
    Cat 10     271 - 300    999,999,999.99  25.00    999,999,999.99   999,999,999.99   999,999,999.99
    Cat 11     301 - 360    999,999,999.99  25.00    999,999,999.99   999,999,999.99   999,999,999.99
    Cat 12     361 - 999    999,999,999.99  25.00    999,999,999.99   999,999,999.99   999,999,999.99
          Totals            999,999,999.99          999,999,999.99   999,999,999.99   999,999,999.99

Grand Total $              999,999,999.99          999,999,999.99   999,999,999.99   999,999,999.99

Grand Total Reserves $     999,999,999.99          999,999,999.99   999,999,999.99   999,999,999.99
```

Each report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

Summary Aged Trial Balance Report Description

For each patient indicator, the following totals are accumulated by financial class within each aging category.

 # ACCT
This field contains the total number of accounts. Zero balance accounts may be excluded by choosing to suppress them on the *Define ATB Report* screen.

AMOUNT
This field contains the accumulated account balance.

FIN CLASS
This field contains the hospital defined financial classification code.

AGING
This field contains the aging category originally defined in the Report Aging Code Table and is selected on the *Define ATB Report* screen.

Aged Trial Balance Reserve Recap Report Description

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc.

RESERVE %
This field contains the hospital-defined, historical reserve percentage assigned to this specific patient indicator under this financial class. The reserve percentage is defined in the Report Aging Code table. Exceptions may be defined by financial class.

RESERVE DOLLARS
This field contains the total reserve dollars for a specific patient indicator under a specific financial class aged according to the report aging categories selected.

*TOTAL DOLLARS
This field contains the total dollars for AR accounts for all patient indicators under a specific financial class aged according to the report aging categories selected.

**RESERVE DOLLARS
This field contains the total reserve dollars for a all patient indicators under a specific financial class aged according to the report aging categories selected.

**TOTAL DOLLARS
This field contains the facility's total dollars for all AR accounts for all financial classes and patient indicator aged according to the report aging categories selected.

**RESERVE DOLLARS
This field contains the total reserve dollars for all financial classes and patient indicators aged according to the report aging categories selected.

ACCOUNTS RECEIVABLE TO BAD DEBT TRANSFER REPORT - FFR210

Description/Purpose

The Accounts Receivable to Bad Debt Transfer Report lists accounts transferred from AR to BD. It is generated when an account is transferred from accounts receivable to bad debt.

The report lists patient name, account number, discharge date, patient indicator, financial class, patient type, last payment date, number of payments, collector number, follow-up schedule code, and account balance. It also reflects, by patient indicator, the number of accounts that transferred from AR to BD, including grand totals for all agencies. It features a separate summary report page which reports subtotals by collection agency and facility totals by patient indicator. This report can be used as a detail audit trail of accounts transferred from Accounts Receivable to Bad Debt.

Generating and Printing This Report

The AR to BD Transfer Report is generated when an account is transferred from accounts receivable to bad debt. Bad Debt Transfer is an Optional Batch Job scheduled at the hospital's discretion. Refer to "Optional Batch Jobs" in Chapter 2: Financial System Management of the *General Information Volume* in the *STAR Financials Patient Accounting Reference Guide* for more information.

The report can be set up as a demand report and printed through the Demand Print function. Primary sort sequence is by Collection Agency and subsorted by patient name.

The following is an example of the Accounts Receivable to Bad Debt Transfer Report.

Figure 3.9 FFR210 - AR to BD Transfer Report

```
Date: 04/15/99                               Model Hospital A                          Page  : 1
Time: 8:43                                 AR to BD Transfer Report                     Report: FFR210A


                                 COL      MODEL HOSPITAL AGENCY            X


Guarantor Name                   Patient Name               Account #   Atnd Dr #   No Stmts  Last Stmt    Acct Balance
                                 Dsch Date  Ind  F/C  P/T              Last Pymt   No Pymt  Coll #  CS    Internal

SHORE,ARNOTE                     SHORE,ARNOTE               9905700001    100         2      02/28/99           450.24
                                 02/26/99   O    S    LOR               03/06/99     2      4      5        Yes
SHORE,DAD                        SHORE,DAD                  9905700007    2000        2      03/12/99            85.22
                                 02/26/99   O    M    LOR               03/31/99     9      31     5        Yes

                                             Collection Agency Totals:   Outpatient            2          535.46
                                                                         Total                 2          535.46
```

```
Date: 04/15/99                               Model Hospital A                          Page  : 2
Time: 8:43                                 AR to BD Transfer Report                     Report: FFR210A


                                             Summary Totals


                        Collection Agency Totals
                          COL MODEL HOSPITAL AGENCY      X        2          535.46
                          Total                                   2          535.46


                        Facility Totals
                                Outpatient                        2          535.46
                                Total                             2          535.46




                                             End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

PATIENT NAME
This field contains the patient's name.

ACCOUNT #
This field contains the patient's account number.

DSCH DATE
This field contains the date the patient was discharged.

IND
This field contains the patient indicator. Classes for this field include I-inpatient, O-outpatient, and E-emergency.

F/C
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc.

P/T
This field contains the patient type code used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

ATND DR #
This field contains the patient's attending physician's code number.

NO STMT
This field contains the total number of statements mailed to the account.

LAST STMT
This field contains the date of the last statement mailed.

LAST PAYMENT
This field contains the amount of the last payment received for the account.

NO PYMTS
This field contains the total number of payments received for the account.

COLL #
This field contains the collector assigned to this account.

CS
This field contains the follow-up schedule assigned to this patient's account.

INTERNAL
This field indicates whether the account transferred to an Internal Collection or External Bad Debt Collection agency. Y for Yes indicates that this is an Internal Bad Debt Collection agency. N for No indicates that this is an External Bad Debt Collection agency.

ACCOUNT BALANCE
This field contains the account balance.

BAD DEBT TO ACCOUNTS RECEIVABLE TRANSFER REPORT - FFR220

Description/Purpose

The Bad Debt to Accounts Receivable Transfer Report lists accounts selected for transfer from Bad Debt back to Accounts Receivable. This report lists the original account balance transferred to Bad Debt and the current account balance transferred back to Accounts Receivable. It also lists the patient name, patient number, financial class, patient type, next follow-up sequence number, next follow-up date, collector code, follow-up schedule, collection agency, date transferred to bad debt, and date transferred back to Accounts Receivable.

Facility totals are provided by patient indicator for the number of accounts transferred, amount of the original transfer to Bad Debt, and the amount of the transfer back to Accounts Receivable. Next follow-up information is provided so the hospital collector can reset follow-up as necessary.

This report serves as a detail audit trail of accounts transferred from Bad Debt to Accounts Receivable.

Generating and Printing This Report

The Bad Debt to Accounts Receivable Transfer Report is produced as a result of midnight processing and is sorted by patient name. Page breaks occur at the end of a page.

The following is an example of the Bad Debt to Accounts Receivable/Transfer Report.

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Figure 3.10 FFR220 - Bad Debt to Accounts Receivable/Transfer Report

```
Date: 11/29/89                            General Hospital                          Page  : 1
Time: 12:21am                          BD to AR Transfer Report                     Report: FFR220


                                       Next F/U    Coll      Coll  Old Transfer To B/D    Transfer to A/R
Account Name                Account #  F/C P/T  No   Date   Code  CS Agency  Date      Amount Date    Act Balance

SANDY ANDERSON              05002-91828 25 E/R   1 11/28/89  1    1  HSI     11/25/89    314.20 11/28/89     210.00
ERIN MASTERS               24432-37306 11 E/R   1 11/28/89  1    1  HSI     11/20/89     79.00 11/28/89      24.00
JAY NORTON                 35559-08205 11 ADM   1 11/28/89  1    1  HSI     11/25/89     15.00 11/28/89       5.00

                                               Old Transfer      Transfer To A/R
                    Facility Totals    # Accts    To BD          Account Balance
                           Emergency      2       393.20             210.00
                           Inpatient      1        15.00              24.00
                           Total          3       408.20               5.00



                                       End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ACCOUNT NAME
This field contains the patient account name.

ACCOUNT #
This field contains the patient account number.

F/C
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc.

P/T
This field contains the patient type code is used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

NEXT F/U NO
This field contains the next follow-up sequence number scheduled for this patient's account.

NEXT F/U DATE
This field contains the date when the next follow-up is scheduled for this patient's account.

COLL CODE
This field contains the collector assigned to this account.

CS
This field contains the follow-up schedule assigned to this patient's account.

COLL AGENCY
This field contains the collection agency assigned to this account.

OLD TRANSFER TO B/D DATE
This field contains the date the account was transferred to BD.

OLD TRANSFER TO B/D AMOUNT
This field contains the dollar amount originally transferred to BD.

TRANSFER TO A/R DATE
This field contains the date the account was transferred to AR.

TRANSFER TO A/R AMOUNT
This field contains the dollar amount transferred to AR.

CHANGE GUARANTORS WITH REFUNDS - FRB100

Description/Purpose

The Change Guarantor With Refunds Report lists accounts in the refund file that have had a change of guarantor. This report can be used to verify that the correct guarantor receives a refund check when the check is produced.

Generating and Printing This Report

This report, which is sorted by account number, is generated daily as a result of midnight processing and can be printed using the demand print process.

The following is an example of the Change Guarantors With Refunds Report.

Figure 3.11 FRB100 - Change Guarantors With Refunds Report

```
Date: 07/19/90                              GENERAL HOSPITAL                              Page  : 1
Time: 05:18                            Change Guarantor With Refunds                      Report:  FRB100P


Account  Nbr   Patient Name              New Guarantor                     STS  Refund Amount  Account Balance
Vendor Nbr                               Old Guarantor

02354-52       WILLIAMS,HAROLD B         WILLIAMS,SHARON C
  560                                    WILLIAMS,MICHAEL C


               Facility Totals      Number Changes: 1                                     55.67          -55.67



                                             End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital name, as used by the system, the report title, the page number, and the report name as used by the system.

ACCT NBR
This field contains the patient account number.

VENDOR NBR
This field contains the vendor number for the refund. For carrier refunds, this number is the carrier/plan number; for guarantor refunds, this number is the guarantor's internal system number.

PATIENT NAME
This field contains the patient name.

NEW GUARANTOR
This field contains the name of the new guarantor.

OLD GUARANTOR
This field contains the name of the guarantor before the guarantor was changed.

STS
This field contains the status of the refund record. Only refunds that have a status of H (hold) or A (approved) are included on this report.

REFUND AMOUNT
This field contains the amount to be refunded to the patient or carrier. The system prints the refund amount existing at the time the guarantor name change was processed. A change made to the refund amount after the refund record is updated is not reflected on this report.

ACCOUNT BALANCE
This field contains the balance of the account at the time the account was selected for a refund.

FACILITY TOTALS
This field contains the total number of refund records that were updated with new guarantor information. The system also prints the total refund amount and account balance affected.

COLLECTION AGENCY ANALYSIS - FFR250

Description/Purpose

The Collection Agency Analysis Report provides an audit of accounts assigned to a collection agency and any recoveries made. It lists, by collection agency, the patient's name, account number, financial class, patient type, final bill date, date the account was transferred to the agency, amount transferred, last payment amount, number of payments, current account balance, and the amount recovered.

The second portion of this report provides an aging recap of all accounts placed with a collection agency. This portion of the report lists, by collection agency, the number of accounts, original balance, recovery amount, and percentage of recovery by days by aging category (0-30, 31-60, 61-90, 91-120, 121-150, 151-180, 181-210, 211-240, 241-999).

NOTE: This report contains detail and summary information found individually on the Collection Agency Analysis - Detail report (FFR251) and Collection Agency Analysis - Summary report (FFR252). If you typically run these two reports during midnight processing, you can save system time by running only the Collection Agency Analysis report (FFR250).

This report is used to monitor the status and collection efficiency of collection agencies.

Generating and Printing This Report

The Collection Agency Analysis Report is generated as an optional batch job and can be printed as a demand report through the Demand Print function. The system sorts the first part of the report by collection agency, subsorting by patient account name. The system sorts the second part of the report by collection agency code, subsorting by days in collection.

The following is an example of the Collection Agency Analysis Report.

Figure 3.12 FFR250 - Collection Agency Analysis Report - Page 1

```
Date: 11/15/89                          General Hospital                        Page  : 1
Time: 12:40am                        Collection Agency Analysis                 Report: FFR250

                                         HSI COLLECTIONS

                                               Transfer To Coll    Last     No      Current
Account Name              Acct Number F/C P/T FB Date   Date      Amount  Payment Pymts  Balance   Recovery

DORIS WOTTEN              89180-50444 01 ADM 08/04/89  08/31/89    225.00 08/23/89   1     200.00     25.00
JOE WHEELER              03002-15381 11 O/P 10/31/89  11/03/89    850.00            0     850.00      0.00
JIM STENNETT            89180-08888 01 ADM 08/30/89  11/03/89    135.00 10/29/89   1     135.00    135.00
JANE ROMINES            01001-75157 50 ADM 10/28/89  11/09/89  2,724.00            0   2,724.00      0.00

                    Collection Agency Totals Inpatient    3        2,859.00            3,889.00     20.00
                                             Outpatient   1          850.00              850.00      0.00
                                             Total        4        3,709.00            4,739.00     20.00
```

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COLLECTION AGENCY ANALYSIS - FFR250

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Figure 3.13 FFR250 - Collection Agency Analysis Report - Page 2

```
Date: 11/15/89                            General Hospital                        Page  : 2
Time: 12:40am                          Collection Agency Analysis                 Report: FFR250

                                         Collection Agency Summary

Days In Coll        0-30      31-60      61-90      91-120     121-150    151-180    181-210    211-240    241-999      Total

Coll Agency: HCC HEALTH CARE COLLECTIONS
# Acct               14         20         11                    4                                                        49
Orig Bal         5450.00    2000.00    1000.00       0.00     1000.00       0.00       0.00       0.00       0.00     5450.00
Recovery         1000.00     200.00     500.00       0.00        0.00       0.00       0.00       0.00       0.00     1700.00
Recovery %         18.34      10.00      50.00       0.00        0.00       0.00       0.00       0.00       0.00       31.19

Coll Agency: HSI COLLECTIONS
# Acct                3                     1                                                                              4
Orig Bal         3709.00       0.00    1000.00       0.00        0.00       0.00       0.00       0.00       0.00     4709.00
Recovery          750.00       0.00     100.00       0.00        0.00       0.00       0.00       0.00       0.00      850.00
Recovery %         20.22       0.00      10.00       0.00        0.00       0.00       0.00       0.00       0.00       18.05




                                              End of Report
```

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Each report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

ACCOUNT NAME
This field contains the patient or guarantor name.

ACCT NUMBER
This field contains the account number.

F/C
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc.

P/T
This field contains the patient type code used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

FB DATE
This field contains the final billing date for this account.

TRANSFER TO COLL DATE
This field contains the date the account was transferred to the collection agency.

TRANSFER TO COLL AMOUNT
This field contains the dollar amount transferred to the collection agency.

LAST PAYMENT
This field contains the date of the last payment for the account.

NO PYMTS
This field contains the number of payments received for the account.

CURRENT BALANCE
This field contains the dollar amount currently due on this account.

RECOVERY
This field contains the dollar amount of the debt recovered from the guarantor of this account.

COLLECTION FOLLOW-UP REPORT - FFR260

Description/Purpose

The Collection Follow-up Report provides a listing of accounts selected for collection follow-up (statement, data mailer, letter, or telephone follow-up). It lists the account name, account number, patient/guarantor indicator, financial class, patient type, follow-up type, follow-up number and account balance. The report is divided into four different sections:

1) PA accounts receiving follow-up

2) AR accounts receiving follow-up

3) Bad Debt accounts receiving follow-up.

4) Accounts placed on follow-up hold for the reason of an invalid or blank address on the account.

This report is used to monitor collection follow-up by account.

Generating and Printing This Report

The Collection Follow-Up Report is generated as a product of the follow-up routines in Midnight Processing. It is a demand report and can be set up to print through the Demand Print Function. The report is sorted by patient account name.

The following are examples of the Collection Follow-up Report.

Figure 3.14 FFR260 - Collection Follow-up Report (1)

```
Date: 11/24/07                                                              Page  : 1
Time: 05:15                        Collection Follow Up Report              Report: FFR260


                                Pt/           F/U        Message Account    Patient      BD
         Account Name           Account #  Guar  F/C  P/T  Type  F/U  Number Balance     Balance   Agcy Agcy
Message                                                         Sq #
#
         ANDREWS,JAMES D        89265-00001   G   85   IP   T    6  1   15,270.26  15,270.26
         CAST,CYNTHIA F         89250-00001   G   13   OP   D    2  1       40.50      40.50
         DOE,JOHN F             89365-00002   G   01   IP   T    1  1    7,660.00   7,660.00  INSTP
         EVANS,DONALD S         89345-00004   G   01   IP   T    3  1   27,576.00  27,576.00  INSTP
         TURNER,LESTER W        89235-00006   G   13   ER   D    1  1      109.00     109.00  INSTP

              Facility Totals
                   Emergency   1                      109.00
                   Inpatient   3                   50,506.26
                   Outpatient  1                       40.50

                   Total       5                   50,655.76

              Detail Statement  2
                   Total       5


                               End of Report
```

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Figure 3.15 FFR260 - Collection Follow-up Report (2)

```
Date: 02/25/07                          Model Hospital A                       Page : 3
Time: 16:18                          Collection Follow Up Report               Report: FFR260A
                  AR Accounts- No Follow-up, Blank Alternate Address, On F/U Hold, Invalid Address

@G under Pt/Guar indicates account moved from guarantor to account level f/u schedule


                        Pt/              F/U   F/U  Message     Account     Patient   Int/Ext      BD
Account Name         Account #  Guar  F/C  P/T  Type  Seq #    #        Balance     Balance   Agcy        Agcy

FANNY FARMER         0427300005   P    M   RES   D     1       1        5,334.15      78.18


                               AR Totals- No Follow-up, Blank Alternate Address
                                      Inpatient          1        5,334.15
                                      Total              1        5,334.15

                                      Detail Statement   1        5,334.15
                                      Total              1        5,334.15


                        Pt/              F/U   F/U  Message     Account     Patient   PC     BD
Account Name         Account #  Guar  F/C  P/T  Type  Seq #    #        Balance     Balance  Agcy   Agcy

Bob Smith            0437500004   P    M   RES   D     1       1        5,334.15      78.18


                               AR Totals- No Follow-up, Invalid Address
                                      Inpatient          1        5,334.15
                                      Total              1        5,334.15

                                      Detail Statement   1        5,334.15
                                      Total              1        5,334.15
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ACCOUNT NAME
This field contains the account name.

ACCOUNT NUMBER
This field contains the account number.

PT/GUAR
This field displays either P or G to indicate whether the recipient was the patient or the guarantor.

F/C
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc.

P/T
This field contains the patient type code used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

F/U TYPE
This field contains the follow-up type. Valid types include L-letter, T-telephone call, or D-detail statement.

F/U #
This field contains the step number of the scheduled follow-up.

MESSAGE #
This field contains the follow-up message number that corresponds to the F/U sequence number.

PATIENT BALANCE
This field contains the patient balance.

ACCOUNT BALANCE
This field contains the dollar amount due on the account.

INT/EXT AGCY
This field contains the agency processing code associated with an account that is in AR location and has an agency processing status.

BD AGCY
This field contains the Bad Debt Collection agency code if the account is in a Bad Debt location.

COLLECTOR WORKFILE REPORT - FFR270

Description/Purpose

The Collector Workfile Report lists accounts contained in the collector's workfile. The report is sorted by collector and lists the date(s) the account was placed in the workfile, number of times the account has been selected for the workfile, number of days in the workfile, the workfile type, guarantor name, corporate number, patient name, last payment date, patient balance, account balance, financial class, last follow-up date, account location/sub location, and collection agency. The total guarantor balance is printed. Totals are provided by collector for the number of accounts selected, total days in workfile, average days in workfile, number of payment plan accounts, and number of delinquent accounts.

Generating and Printing This Report

The Collector Workfile is generated automatically as a result of midnight processing (follow-up function). This report is set up as a demand report and printed through the Demand Print function. It is sorted by collector and subsorted by descending account balance and date selected. Page breaks occur by collector.

The following is an example of the Collector Workfile Report.

Figure 3.16 FFR270 - Collector Workfile Report

```
Date: 06/09/06                              General Hospital                              Page  : 1
Time: 0115am                             Collector's Workfile Report                      Report: FFR270

                                          3 Collier,David A.

Orig Sel Last Sel  #  W/F  WF   Guarantor Name                          Last      Patient    Account FC  Last    ST LC       Agcy
   Date     Date  Sel Days Ty   Guarantor Phone      Corp #  Patient Name    Payment   Balance    Balance     Follow Up

07/10/05 07/14/05  5   4  B  CARTER,HENRY         00000517                                                        07/14/05    AR/FCRV

                                              CARTER,VIRGINIA              2,485.00   2,880.00 T        S

                                           Guarantor Total:      $2,880.00

07/11/05 07/11/05  1   3  C  MEYERS,TANYA         00000528                                                        AR/FCRV
                             (404)987-6543
                                              MEYERS,JEFF                    0.00      386.83 G        S        INSTP
                                              MEYERS,JEFF                    0.00      868.83 G        S

                                           Guarantor Total:      $1,255.66




Total Number of Workfile Entries:     2
Total Days in Workfile:      7   Average Days in Workfile:     4

Payment Plan Accounts:          Delinquent Accounts:

Legend: W/F Type - A=Active, D=Delinquent, P=Partial Payment, B=Business Office, R=Promise To Pay, S=Standard, C=Agency, W=Internal Bad Debt
        ST (Schedule Type) - S=Standard, G=Guarantor Custom, P=Guarantor Payment Plan
                        A=Account Custom, R=Account Payment Plan, T=Account Separate

                                           End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, the report name as used in the system, and the collector's name and number.

ORIG SEL DATE
This field contains the date the account was *first* selected for guarantor follow-up.

LAST SEL DATE
This field contains the date the account was *last* selected for guarantor follow-up.

 # SEL
This field displays the number of times this account has been selected for guarantor follow-up.

W/F DAYS
This field contains the number of days this patient's account has been in the collector's workfile. The system calculates this value using the original selection date.

W/F TY
This field contains the workfile type. Workfile types are: D - Delinquent Phone, P - Partial Payment Phone, B - Business Office Phone, R - Promise to Pay, S - Standard, C - Agency, W - Internal Bad Debt.

GUARANTOR NAME
This field contains the guarantor name.

GUARANTOR PHONE
This field contains the guarantor phone number.

CORP #
This field contains the corporate id number.

PATIENT NAME
This field displays the patient name in the format of last name, first name, and middle name. If the patient name exceeds twenty characters, it is truncated from the right.

LAST PAYMENT
This field contains the date the last payment was made.

PATIENT BALANCE
This field contains the balance due from the patient.

ACCOUNT BALANCE
This field displays the balance due for the account.

FC
This field displays the patient financial class.

LAST FOLLOW UP

This field contains the date of last follow up.

ST

This field indicates the schedule type. Valid types are: S - Standard, G - Guarantor Custom, P - Guarantor Payment Plan, A - Account Custom, R - Account Payment Plan, T - Account Separate.

LC

This field contains the current account location/sub location.

AG

This field contains the Collection Agency code of the account. The collection agency can only be an AR Collection Agency if the account is in an AR location. The collection agency can only be an Internal or External Bad Debt agency if the account is in a Bad Debt location.

GUARANTOR TOTAL

This field displays the total account balance for the guarantor.

TOTAL NUMBER OF WORKFILE ENTRIES

This field displays the total number of workfile entries on this report.

TOTAL DAYS IN WORKFILE

This field displays the total number of days workfile entries. This total is determined by adding workfile days for each account by collector.

AVERAGE DAYS IN WORKFILE

This field displays the average days in the workfile. This field is calculated by dividing the total days in the workfile by the total number of workfile entries.

PAYMENT PLAN ACCOUNTS

This field contains the payment plan accounts. The payment plan accounts field contains the total of all accounts with R (promise to pay) and P (partial payment) workfile types.

DELINQUENT ACCOUNTS

This field contains the delinquent accounts. The delinquent accounts field contains the total number of D (delinquent) workfile types.

COLLECTION AGENCY TRANSFER REPORT - FFR340

Description/Purpose

The Collection Agency Transfer Report, FFR340, lists accounts that have been transferred from one collection agency to another collection agency. Specifically, the report lists accounts that have transferred from Internal Collection, Internal Bad Debt, and External Bad Debt Collection agencies to Internal Collection, CCI Collection, Internal Bad Debt, and External Bad Debt Collections agencies. The Collection Agency Transfer can be initiated through the online Collection Agency Transfer function or through the Agency Follow-Up Schedules.

Generating and Printing This Report

The Collection Agency Transfer Report is generated automatically as a result of Midnight Processing. The primary sort is New Collection Agency by Collection Agency type. The CCI collection agencies are displayed first, followed by Internal agencies, External Bad Debt agencies, and Internal Bad Debt agencies. The subsequent sorts are collector and account name. This report provides totals by agency and by facility.

The following is an example of the Collection Agency Transfer Report.

Figure 3.17 FFR340 -Collection Agency Transfer Report

```
Date: 05/30/98                              General Hospital                          Page  : 1
Time: 2:10                       Collection Agency To Collection Agency Transfer Report           Report: FFR340A


                                        PMKBD - EXTERNAL Bad Debt Agency

                                              ----- Old ------            ----- New ------
                                              Coll    Ag   Coll           Coll    Ag   Coll
Account
Account Name       Acct Number  F/C  P/T  FB Date   Agency  Type Code Sch  Agency  Type Code Sch  Balance      Requested by

CHRISTINE FRANKLIN 9712700001   PK   O/P  05/07/97  PMKBD   IB   13   99   PMK     EB   13   444  2,887.50     KRK
FRANCINE FRANKLIN  9709000002   PK   O/P  03/31/97  PMKBD   IB   13   926  PMK     EB   13   444  5,144.00     SYSTEM
JERRY FRANKLIN     9712700003   PK   O/P  05/07/97  PMKBD   IB   13   926  PMK     EB   13   444  5,775.00     SYSTEM

                                                           Collection Agency Totals  O/P     3         13,806.50
                                                                                     Total   3         13,806.50

                                                           Facility Totals           O/P     3         13,806.50
                                                                                     Total   3         13,806.50
```

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COLLECTION AGENCY TRANSFER REPORT - FFR340   Chapter 3 - ACCOUNT FOLLOW-UP REPORTS

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, the report name as used in the system, and the collection agency's type code and name.

ACCOUNT NAME
This field contains the patient's name.

ACCT NUMBER
This field contains the patient's account number.

F/C
This field contains the account's financial class.

P/T
This field contains the account's patient type.

FB DATE
This field contains the final bill date of the account.

AGENCY
This field contains the old collection agency code for the account. Valid values are IB for Internal Bad Debt, EB for External Bad Debt, IP for Internal Agency, and CP for CCI

AG TYPE
This field contains the agency type of the old collection agency.

COLL CODE
This field contains the old collector code for the account.

SCH
This field contains the old follow-up schedule for the account. If the account is in bad debt, it is an agency follow-up schedule. If the account is in accounts receivable, it is a agency collection follow-up schedule.

TRANSFER AGENCY
This field contains the new collection agency code.

AG TYPE
This field contains the agency type of the new collection agency. Valid values are IB for Internal Bad Debt, EM for External Bad Debt, IP for Internal Agency, and CP for CCI.

COLL CODE
This field contains the new collector code for the account.

SCH
This field contains the new follow-up schedule of the account. If the account is in bad debt, it is an agency follow-up schedule. If the account is in accounts receivable, it is an agency collection follow-up schedule.

ACCOUNT BALANCE
This field contains the account balance.

REQUESTED BY
This field indicates who initiated the collection agency transfer. If the transfer was initiated through the online collection agency transfer process, this field contains the initials of the user who requested the transfer. If the transfer was initiated through an agency follow-up schedule, the field indicates SYSTEM.

INSURANCE COLLECTOR WORKFILE REPORT - FFR400

Description/Purpose

The Insurance Collector Workfile Report provides a cumulative listing of the accounts scheduled for insurance follow-up in the collector workfiles. Two lines of detail information are printed per account.

Generating and Printing This Report

This report is generated during nightly batch processing. The report is sorted by and page breaks occur by collector. The detail information per collector is sorted based on the date the account was placed in the workfile, beginning with the oldest work first.

The following is an example of the Insurance Collector's Workfile Report.

Figure 3.18 FFR400 -Insurance Collector Workfile Report

```
Date: 06/29/92                            General Hospital                         Page  : 1
Time: 0100am                          Insurance Collector Workfile                 Report: FFR400

                                          45 Myerson,Allen

Patient Name              Account #    Carrier                 Policy #       CS       Ins Phone #      Claim Amount
  Insured Name            Claim Date   Group Name              Group #        *      Confinement Dates  Carrier Bal

HARDISON,JEFF             92127-00220  MEDICARE PART A                        1       (404)698-5512           220.10
  HARDISON,JEFF           06/22/92     MEDICARE GROUP          12366          *1    05/06/92-05/07/92       8,195.22
SMITH,BILL                92114-00131  MEDICARE PART A                        4       (404)698-5512         2,447.77
  SMITH,MARY              06/23/92     MEDICARE GROUP          12123          *1    05/06/92-05/07/92       3,951.09
TUCKER,RON                92116-00142  MEDICARE PART A                        7       (404)698-5512         4,940.44
  TUCKER,RON              06/24/92     MEDICARE GROUP          12366          *1    05/06/92-05/07/92       5,475.30

                     * - # of times claim has been selected for followup      Total Carrier Bal          17,621.61


                                          End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

PATIENT NAME
This field contains the patient name.

ACCOUNT #
This field contains the patient account number.

CARRIER
This field contains the insurance plan name.

POLICY #
This field contains the insurance policy number from the patient's insurance plan demographic information.

CS
This field displays the claim sequence.

INS PHONE #
This field contains the insurance phone number from the patient's insurance plan demographic information.

TOTAL AMOUNT
This field contains the total claim amount.

INSURED NAME
This field contains the name of the insured person for this claim.

CLAIM DATE
This field contains the date on which the claim was submitted to the insurance company.

GROUP NAME
This field, if applicable, contains the insurance group name from the patient's insurance plan demographic information. For Champus plans, the Branch of Service Code is listed.

GROUP #
This field, if applicable, contains the insurance group number from the patient's insurance plan demographic information. For Champus plans, the Military Status and Pay Grade codes are listed.

*
This field displays the number of times this claim has been selected for the workfile.

CONFINEMENT DATES
This field contains the patient's admission and discharge dates.

TOTAL DUE
This field contains the total of all claim amounts listed for the specified collector.

TOTAL CARRIER BALANCE
This field displays the total balance currently due from the carrier.

COLLECTOR WORKFILE EXCEPTION REPORT - FFR320

Description/Purpose

The Collector Workfile Exception Report lists those accounts whose follow-up varies from the selected follow-up established for the account. An exception occurs if within the telephone follow-up processor and the reschedule telephone follow-up processor, the next follow-up type and/or step is changed from the original schedule.

The report lists the collector number, guarantor name, guarantor balance, last payment date, last follow-up date, delinquency date, account number, patient name, the follow-up type and sequence and number, and the actual follow-up type, and number used in place of the scheduled follow-up. The report features the total number of accounts and total account balances for the facility.

Generating and Printing This Report

This daily batch report is automatically generated when guarantor follow-up is run and exceptions occur. This report is printed through the Demand Print function and sorted by collector code in descending order. If the collector for the account is a supervisor or manager, the collector code prints in front of the supervisor or manager name.

The following is a copy of the Collector Workfile Exception Report.

Figure 3.19 FFR320 - Collector Workfile Exception Report

```
Date: 12/13/89                          General Hospital                        Page  : 1
Time: 08:33am                       Collector Workfile Except Rpt                Report: FFR320A

                                        45 Myerson,Allen

                                                                         Selected    Actual
                       Combined   Last    Last F/U  Delq                   F/U        F/U     Agcy
Coll #  Guarantor Name  Acct Bal  Payment   Date    Date   Account #   Patient Name  LC  Sq  T #   Sq T #

11      ROMINES,JANE   2   500.00  10/12/89 10/10/89        89265-0004  ROMINE,JANE      1  D 102   T 1000  INSTP
11      CLARK,JEFFREY  2   200.00  11/23/89 10/10/89        89266-0003  CLARKE,ROBERT    1  D 102   T 2000
11      WALTERS,TED    2   400.00  10/27/89 11/10/89        89219-0005  WALTERS,SUSAN    1  D 103   T 1000

        Facility Total     1100.00


                                        End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

COLL #
This field contains the number of the collector assigned to this account.

GUARANTOR NAME
This field contains the guarantor name.

COMBINED ACCT BAL
This field contains the combined account balanced remaining on the guarantor's accounts.

LAST PAYMENT
This field contains the date of the last payment.

LAST F/U DATE
This field contains the date of the last scheduled follow-up.

DELQ DATE
This field contains the date the account became delinquent.

ACCOUNT #
This field contains the patient's account number.

PATIENT NAME
his field contains the patient name.

LC
This field contains the current account location.

SELECTED F/U
This field contains the selected follow-up listed by sequence, type, and number according to the account's established collection schedule. The entry in this field indicates the normal step in the schedule.

ACTUAL F/U
This field contains the actual follow-up listed by type and number as it differs from the account's established collection schedule. The entry in this field indicates what follow-up was done.

AGCY
This field contains the Collection Agency code of the account. The collection agency can only be an agency collection if the account is in an AR location. The collection agency can only be an Internal or External Bad Debt agency if the account is in a Bad Debt location.

INSURANCE TIME OUT REPORT - FFR360

Description/Purpose

The Insurance Time Out Report provides a list of patients who have reached the time out set up in their insurance follow-up schedule and have had their carrier liability transferred to the next carrier or patient's liability as defined by the insurance time out parameter.

This report lists the account number, patient name, carrier/plan, financial class, new financial, transaction type, new carrier/plan assigned, transfer amount, remaining carrier balance, patient balance, and account balance by collector.

This report provides a list of accounts having insurance but whose insurance is no longer responsible for the balance.

Generating and Printing This Report

The Insurance Time Out Report part of midnight processing for insurance follow-up and is sorted by collector and subsorted by patient name. This report can be printed through the Demand Print function.

The following is an example of the Insurance Time Out Report.

Figure 3.20 FFR360 - Insurance Time Out Report

```
Date: 12/25/89                              General Hospital                          Page  : 1
Time: 12:26am                          Insurance Time Out Report                      Report: FFR360

                                           10 SMITH,MARY A

                         Carrier        New  Trans   New     Transfer    Remaining    Patient    Account
Account     Patient Name Plan      FC   FC   Type    CR/PL     Amount   Carrier Bal   Balance    Balance

01001-73798 FREIDA HARRALSON  04-1804  22   44    P            285.00       0.00       285.00     285.00
05002-91828 SANDY WINTERS     01-1010  03   25    P            314.20       0.00       314.20     314.20



                                           End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

ACCOUNT
This field contains the patient's account number.

PATIENT NAME
This field contains the patient name.

CARRIER PLAN
This field contains the carrier/plan code.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc.

NEW FC
If the Insurance Time Out parameters indicate a financial class change, this field contains the new financial class.

TRANS TYPE
This field contains the transfer type. Valid type include P-patient or C-carrier (C indicates a transfer to a secondary carrier).

NEW CR/PL
If responsibility for the account is transferred to a new carrier/plan, this field contains the new carrier/plan code.

TRANSFER AMOUNT
This field contains the dollar amount transferred to the patient's liability or the carrier/plan when time out is reached for the carrier/plan.

REMAINING CARRIER BAL
This field contains the balance due on the account from the carrier.

PATIENT BALANCE
This field contains the balance due on the account from the patient.

ACCOUNT BALANCE
This field contains the total balance due on the account.

INSURANCE TIME OUT EXCEPTION REPORT - FFR365

Description/Purpose

The Insurance Time Out Exception Report provides a list of patients who have reached the time out criteria defined in their insurance follow-up schedule but do not time out due to exceptions. Exceptions can include accounts whose financial class does not allow transfer of liability to the patient or carrier, or the carrier has other unmailed claims.

This report lists the account number, patient name, carrier name, claim date, carrier liability, account balance and the exception notice by insurance collector.

Generating and Printing This Report

The Insurance Time Out Exception report is generated during midnight processing for insurance follow-up and is sorted by collector and subsorted by patient name. This report can be printed through the Demand Print function.

The following is an example of the Insurance Time Out Exception Report.

Figure 3.21 FFR365 - Insurance Time Out Exception Report

```
Date: 10/14/89                              General Hospital                          Page  : 1
Time: 12:21am                          Insurance Time Out Exceptions                  Report: FFR365

                                            10 SMITH,MARY A


                                   Carrier    Claim       Carrier      Account
Account           Patient Name     Plan       Date        Liability    Balance    Exception

05002-92073       CARY DELMONICO   07-9836    10/11/88       104.00      309.00    Financial class disallows timeout
01001-74556       PATRICIA JASON   04-1650    10/11/88       208.00    1,208.00    Primary carrier not timed out
05002-92032       SARAH ANN SMITH  07-9836    10/11/88       118.80    2,276.00    Primary carrier balance not zero
05002-92032       SAMUEL DAVIDOFF  04-1577    10/11/88        93.00      456.00    Financial class disallows timeout
05002-92032       WILLIAM STARNES  04-1500    10/11/88        25.80    9,278.00    Financial class disallows timeout
05002-92057       KATHARINE ANDERSON 04-1667  10/11/88       100.00      673.00    Account balance less than zero
05002-92057       LEONARD RUBIN    07-9836    10/11/88       118.80    2,144.00    Unmailed claims




                                          End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

ACCOUNT
This field contains the patient's account number.

PATIENT NAME
This field contains the patient's name.

CARRIER PLAN
This field contains the carrier code number and the plan associated with this patient's claim.

CLAIM DATE
This field contains the date of the claim.

CARRIER LIABILITY
This field contains the carrier's liability.

ACCOUNT BALANCE
This field contains the total account balance.

EXCEPTION
This field contains the exception notice describing why the insurance time-out was disallowed. The following provides the exception messages for this report.

- Financial class disallows time out
  This message displays if the accounts assigned to financial class does not allow insurance time out.

- Primary carrier not timed out
  This message displays when the secondary carriers do not time out if the carrier has outstanding claims for the primary carrier.

- Unmailed claim
  This message displays if the carrier has additional claims which have not been submitted.

- Primary carrier balance not zero
  This message displays if the secondary carriers do not time out while a balance remains on the primary carrier.

- Account balance less than zero
  This message displays if the overall balance of the account is a credit.

NOTE: Only accounts with the message *Financial class disallows time out* repeat the last step of the insurance follow up schedule until some action is taken on the account. All other accounts remain on the report but do not repeat the last step. In either of these cases, the accounts on this report require manual intervention by the user.

GUARANTOR FOLLOW-UP EXCEPTION REPORT - FFR420

Description/Purpose

The Guarantor Follow-Up Exception Report lists those patients who are ready for follow up but do not have a follow up schedule.

Generating and Printing the Report

This report, which is sorted by collector and then descending balance, is generated daily as a result of midnight processing and can be printed using the demand print process.

The following is an example of the Guarantor Follow-Up Exception Report.

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Figure 3.22 FFR420 - Guarantor Follow Up Exception Report

```
Date: 11/16/90                              PROVIDENCE MED CENTER                          Page  : 1
Time: 00:51                          Guarantor Follow Up Exception Report                  Report: FFR420P

                             B26


                            Combined                  Last   Last F/U
Guarantor Name              Acct Bal     Schedule    Payment   Date    Account #     Patient Name

KENNETH RAWLINGS              304.05    Payment Plan          09/06/90 90310-00002   CHARLES A BISHOP

         Facility Total     1    304.05


-----------------------------------------------------------FFR420----------------------------------------------------------

End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

GUARANTOR NAME
This field contains the name of the guarantor who is responsible for the exception patient account.

COMBINED ACCT BAL
This field contains the account balance total of all patients assigned to this guarantor.

SCHEDULE
This field identifies the guarantor's follow up schedule.

LAST PAYMENT
This field contains the date of the last payment.

LAST F/U DATE
This field contains the date of the last follow up.

ACCOUNT #
This field contains the patient's account number who has been assigned to the guarantor.

PATIENT NAME
This is the name of the patient who has been assigned to the guarantor.

FACILITY TOTAL
This field contains the total number of patient exceptions and the total amount of the account exception balances for the facility.

GUARANTOR FOLLOW-UP ADDITIONS REPORT - FFR430

Description/Purpose

The Guarantor Follow-Up Additions Report lists the new patients who have been assigned to an existing guarantor. The guarantors are also listed on the report. Information such as the guarantor's schedule and current sequence, next follow up date, the guarantor's balance and the account balance is included. The report also displays a message detailing why the system transferred the account back to guarantor follow-up. Transfer reasons include:

- Final Bill Time - Self Pay
- Insurance Time-out
- Balance Transfer
- Adjustments
- Cash Posting
- Manual Deletion from Internal Agency
- Manual Deletion from CCI Agency
- Friday Night Follow-up (Updates for Missing Schedule, Collector, or Follow-up Request)

Generating and Printing This Report

This report, which is sorted by collector and then descending balance, is generated daily as a result of midnight processing and can be printed using the demand print process.

The following is an example of the Guarantor Follow-Up Additions Report.

Figure 3.23 FFR430 - Guarantor Follow Up Additions Report

```
Date: 07/20/00                              Model Hospital A                          Page  : 1
Time: 0:11                          Guarantor Follow Up Additions Report              Report: FFR430A


                                    1 MANAGER,PA

                                    Next F/U      Guarantor    Account                        Sch Pat
Corp #     Guarantor Name     Schedule  Date   SEQ  Balance    Balance  Acct Nbr    Patient Name        PC FC  FC

00001503   DAD ADAMS              50    07/17/00  1    521.44    121.44  0005400006  PEYTON ADAMS        PK  S *
                                        Balance Transfer



           Facility Total     1                                 121.44



------------------------------------------------------------FFR430-------------------------------------------------------------

End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

CORP #
This field contains the guarantor's corporate number.

GUARANTOR NAME
This field contains the name of the guarantor who is responsible for the new patient account.

SCHEDULE
This field identifies whether the guarantor is on a Custom or Payment schedule, or it displays the CSM Schedule Code. If no follow-up has been scheduled for the guarantor, this field displays zero (0).

NEXT F/U DATE
This field contains the date of the guarantor's next follow-up. Beneath the date the transaction description that caused the patient to be added to the follow up prints.

SEQ
This field identifies the current sequence number indicating which step of the follow-up schedule.

GUARANTOR BALANCE
This field contains the total of the patient account balances for which the guarantor is responsible.

ACCOUNT BALANCE
This field contains the account balance of the new patient.

ACCT NBR
This field contains the patient's account number who has just been assigned to the guarantor.

PATIENT NAME
This is the name of the patient who has been assigned to the guarantor.

PC
This field contains the collection maintenance or status code.

FACILITY TOTAL
This field contains the total number of patient additions and the total amount of the account balances for the facility.

SCH FC
The Sch FC field contains the financial class that assigns the guarantor schedule.

FC
The FC field contains the financial class that is currently assigned to the account.

GUARANTOR FOLLOW-UP SUPPRESSION REPORT - FFR440

Description/Purpose

The Guarantor Follow-Up Suppression Report lists the accounts that are suppressed due to pending insurance liability. These accounts also have been scheduled to give follow-up during midnight processing.

Generating and Printing This Report

This report, which is sorted by guarantor corporate number, is generated as a result of midnight processing.

The following is an example of the Guarantor Follow-Up Suppression Report.

Figure 3.24 FFR440 - Guarantor Follow Up Suppression Report

```
Date: 03/31/94                          General Hospital                          Page  : 1
Time: 00:52AM                   Guarantor Follow Up Suppression Report             Report: FFR440


                                        Coll   Final Bill   Account       Patient      Insurance
Guarantor                   Patient     Sch    Date         Balance       Balance      Balance

00000333 Richard West    A9405600001 Rich West      30   03/24/94    $5,548.27   -$4,315.00   $9,863.27
00000335 Bill Green      A9403500003 William Green  30   02/04/94      $537.13     $323.00     $214.13
00000335 Bill Green      A9403500001 William Green  30   02/08/94      $840.60     $365.00     $475.60
00000370 John Smith      A9403500010 Bill Smith     30   03/23/94      $723.70       $0.00     $723.70
00000374 Mary Jones      A9405900001 Jimmy Smith    30   03/23/94    $4,680.00       $0.00   $4,680.00
00000378 Bobby Moore     A9406100001 Jill Moore     30   03/02/94      $649.35     $544.67     $104.68
00000384 Marv Kinddy     A9406200001 Bob Kinddy     30   03/07/94      $780.00       $0.00     $780.00
00000394 Kate Perry      A9403600001 Mike Perry     30   03/07/94       $68.25       $0.00      $68.25


                              Facility Totals       8   $13,827.30   -$3,082.33  $16,909.63
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

GUARANTOR
This field contains the guarantor's corporate number. This field also contains the name of the guarantor who is responsible for the new patient account.

PATIENT
This contains the patient's account number who has been assigned to the guarantor. This field also contains the name of the patient who has been assigned to the guarantor.

COLL SCH
This field identifies the guarantor follow-up schedule for the patient.

FINAL BILL DATE
This field contains the final billing date for this patient's account.

ACCOUNT BALANCE
This field contains the account balance of the patient.

PATIENT BALANCE
This field contains the patient's balance

INSURANCE BALANCE
This field contains the insurance balance.

FACILITY TOTALS
This field identifies the totals associated with the number of accounts being suppressed and their corresponding dollar amounts.

BAD DEBT PRE-LIST REPORT - FFR300

Description/Purpose

The Bad Debt Pre-List Report lists accounts meeting the criteria for transfer to Bad Debt. These accounts have reached the final step of guarantor follow-up and their balance is greater than the small balance write-off threshold yet less than the maximum automatic transfer limit. These accounts are selected for transfer by the system or the hospital.

This report lists the guarantor name, collector code, financial class, patient type, patient name, final billing date, pre-list date, number of statements, number of payments, last payment date, account balance, collection agency, selection flag, carrier/plan, insurance balance, collector, and patient account number. Subtotals are provided by collection agency. Summary totals are provided by selection flag and patient indicator by collector.

This report is useful in removing accounts selected for bad debt transfer or placing accounts on hold prior to running the AR to BD Transfer report. It is also used to monitor the agency to which the account is sent.

Generating and Printing This Report

The Bad Debt Pre-List Report is generated as a Optional Batch Job (see Optional Batch Jobs for additional information on running this report). The report is automatically generated when the Optional Batch Job Bad Debt Pre-list Selection is requested. This process flags new accounts, existing accounts, and accounts on hold. Refer to "Optional Batch Jobs" in Chapter 2: Financial System Management of the *General Information Volume* in the *STAR Financials Patient Accounting Reference Guide* for more information.

Generating the report only is also an Optional Batch Job that prints only those existing or on-hold accounts flagged for prelist.

The following is an example of a Bad Debt Pre-List Report.

Figure 3.25 FFR300 - Bad Debt Pre-List Report - Page 1

```
Date: 07/10/99                          GENERAL HOSPITAL                       Page  : 1
Time: 01:21am                         Bad Debt Pre-List Report                 Report: FFR300A


                                        1 -- Myers,Naomi


Corp #     Guarantor Name            Pt Name            Patient Number     Diagnosis              Employer
   Pt Cls  F/C  P/T  P/L Date   FB Date    Stmt   Pymt Last Pymt Acct Balance  PT Balance  Atd Dr  CL Agy  Sel  Carr/Pl      Ins Bal  P
--------------------------------------------------------------------------------------------------------------------------------
00003620   DANNY SMITH               DANNY SMITH        92164-00003   M48.50xA Collapsed vertebra NOS
           S  OPO 07/09/99   06/12/99    1                  385.00      385.00     998  COL     M
00003617   CARSON JEANNE SMITH       CARSON JEANNE SMITH  92163-00001
           M  **SER**        07/02/99                       79.00       79.00     998  A             850001       0.00  D
                                                                                                     850003       0.00


                                        Collector Totals


                       Selection Flag           # Accts          Amount
                       M Manually Selected          1            385.00
                       S System Selected            1             79.00
                       H System Hold                               0.00
                       U User Hold                                 0.00


                       Patient Indicator
                             Outpatient             2            464.00


                       Agency
                                                                   0.00
                         Bonded Collection Agency    2            464.00


                       Collector Total               2            464.00
```

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BAD DEBT PRE-LIST REPORT - FFR300   Chapter 3 - ACCOUNT FOLLOW-UP REPORTS

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Figure 3.26 FFR300 - Bad Debt Pre-List Report - Page 2

```
Date: 07/10/92                          GENERAL HOSPITAL                          Page  : 2
Time: 01:21am                        Bad Debt Pre-List Report                     Report: FFR300A


                                        Facility Totals


                        Selection Flag          # Accts              Amount
                        M Manually Selected         1                385.00
                        S System Selected           1                 79.00
                        H System Hold               0                  0.00
                        U User Hold                 0                  0.00


                        Patient Indicator
                                Outpatient          2                464.00

                        Agency
                                                                       0.00
                          Bonded Collection Agency  2                464.00

                        Facility Total              2                464.00



                                        End of Report
```

Each page of the report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

The first part of the report contains account-specific information by payor. After the account specific information, the report displays totals for the collector.

CORP #
This field contains the guarantor corporate number.

GUARANTOR NAME
This field contains the name of the guarantor.

PT NAME
This field contains the name of the patient.

PATIENT NUMBER
This field contains the patient account number.

DIAGNOSIS
This field displays the discharge diagnosis of the patient. If there is an ICD-10 Principal Diagnosis Code in Medical Records, this code and description prints. If there is no ICD-10 Principal Diagnosis Code in Medical Records, but there is an ICD-9 Principal Diagnosis Code in Medical Records, this code and description prints.

PT CLS
This field contains the patient classification code assigned to this patient's account. If the Patient Class is an alerted patient class, this field contains two asterisks (**). If the alerted patient class is a cleared patient class, the asterisks (**) are followed by a lowercase "c." If the alerted patient class also has a follow-up suppression indicator, the asterisks (**) are followed by a lowercase "s."

F/C
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc.

P/T
This field contains the patient type code used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

P/L DATE
This field contains the date when the account was placed on the pre-list report.

FB DATE
This field contains the final billing date for this patient's account.

STMT
This field contains the total number of statements mailed for the account.

PYMT
This field contains the total number of payments for the account.

LAST PYMT
This field contains the date of the last payment made to this patient's account.

ACCT BALANCE
This field contains the total dollar balance owed on this account.

PT BALANCE
This field contains the patient's liability for this account.

ATD DR
This field contains the patient's attending physician's code number.

CL AGY
This field contains the collection agency this account is transferred to.

SEL
This field contains the selection flag indicating how the accounts were placed on the pre-list report. Valid selection flags include M-manually selected, S-system selected, H-system hold, and U-user hold.

EMPLOYER CARR/PL
This field contains the carrier plan code.

INS BAL
This field contains the balance due from insurance for this claim.

P
This field contains the Pre-Collection maintenance or status code.

Following the account-specific portion, the report displays totals for the collector. The system prints the number and amount of accounts for each bad debt prelist selection method (manually selected, system selected, system hold, and user hold), totals by patient indicator, totals by collection agency, and total number of accounts and dollar amounts for the collector.

The last page of the report displays totals for the facility. The system prints the number and amount of accounts for each bad debt prelist selection method (manually selected, system selected, system hold, and user hold), totals by patient indicator, totals by collection agency, and total number of accounts and dollar amounts for the facility.

BAD DEBT PRELIST EXCEPTION REPORT - FFR385

Description/Purpose

The Bad Debt Prelist Exception Report lists all accounts that are eligible for transfer to Bad Debt, but that cannot advance because they have not met the established criteria for turnover. The system checks accounts in the following order:

- Credit balance
- Zero balance
- Account balance too large for automatic flagging
- Insurance pending

If an account meets one of these criteria, the system includes the account on the report and lists the appropriate criteria in the Exception Message column of the report. If the account meets more than one criterion, the system displays the first exception on the report. For example, if an account has both insurance pending and the balance exceeds the allowable balance for automatic prelisting, the system displays the account on the report with the message *Account Balance Too Large for Automatic Flagging* since this was the first criteria the system found. As such, this report provides an audit trail of accounts requiring follow-up activity and the necessary action.

Accounts qualifying on this report appear each time the report is produced until the excepted condition is corrected.

Accounts also qualify through Optional Batch Processing and through daily Guarantor Follow-Up in Midnight Processing.

Generating and Printing This Report

The report, which is sorted by patient name within collector, is generated through Optional Batch Job and accompanies the Bad Debt Prelist Report. Refer to "Optional Batch Jobs" in Chapter 2: Financial System Management of the *General Information Volume* in the *STAR Financials Patient Accounting Reference Guide* for more information.

The following is an example of a Bad Debt Prelist Exception Report.

Figure 3.27 FFR385 - Bad Debt Prelist Exception Report

```
Date: 07/10/99                         General Hospital                      Page  : 1
Time: 12:21am                    Bad Debt Prelist Exception Report           Report: FFR385

                                      17 - MORRIS,TODD


Guar Corp#   Guarantor Name         Patient Name            Patient Number   Exception Message
   Pt Cls  F/C  P/T      FB Date     Stmt  Pymt   Last Pymt    Acct Balance      Pt Balance            Carr/Pl      Ins Bal  P
--------------------------------------------------------------------------------------------------------------------------
00003610    CLAIRE LITTLE          PAT BLOCK               92160-00019     Can't Transfer with pending insurance
   PHL      S   I/P      06/11/99      1     1    07/06/99         535.80          503.80               383030        32.00  D
00001920    SIMMONS,HOMER          TRACY PARKINSON         92159-02354     Can't Transfer with pending insurance
**PHY**s    E   O/P      06/11/99      1     1    07/04/99         231.05          121.76               383030       109.29

                                      End of Report
```

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BAD DEBT PRELIST EXCEPTION REPORT - FFR385

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

GUAR CORP #
This field contains the guarantor corporate number.

GUARANTOR NAME
This field contains the name of the guarantor.

PT NAME
This field contains the name of the patient.

PATIENT NUMBER
This field contains the patient account number.

EXCEPTION MESSAGE
This field displays the reason this account could not prelist. Error messages are:

• Accounts With Credit Balance
  This indicates an account has a credit balance and requires a balance transfer, refund or adjustment. This guarantor's accounts do not prelist with a credit balance.

• Can't Transfer With Pending Insurance
  An account has outstanding insurance that needs to be confirmed or denied prior to turnover.

• Account Balance Too Large For Automatic Flagging
  An account balance is greater than the automatic transfer limit set up in the Bad Debt transfer parameter. This requires the account to be viewed individually and manually prelisted.

• Alerted Pt Cls Set to Suppress
  This account is assigned a patient class which has an alert status and a follow-up suppression indicator. This requires the account be viewed individually, and manually prelisted.

PT CLS
This field contains the patient classification code assigned to this patient's account. If the Patient Class is and alerted patient class, this field contains two asterisks (**). If the alerted patient class is a cleared patient class, the asterisks (**) are followed by a lowercase "c." If the alerted patient class also has a follow-up suppression indicator, the asterisks (**) are followed by a lowercase "s."

F/C
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc.

P/T
This field contains the patient type code used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

FB DATE
This field contains the final billing date for this patient's account.

STMT
This field contains the total number of statements mailed for the account.

PYMT
This field contains the total number of payments for the account.

LAST PYMT
This field contains the date of the last patient payment made to this patient's account.

ACCT BALANCE
This field contains the total dollar balance owed on this account.

PT BALANCE
This field contains the patient's liability for this account.

CARR/PL
This field contains the carrier plan code.

INS BAL
This field contains the balance due from insurance for this account.

P
This field contains the Pre-Collection maintenance or status code.

SMALL BALANCE WRITE-OFF EXCEPTION REPORT - FFR370

Description/Purpose

The Small Balance Write Off Exception Report lists accounts with balances less than the user-defined threshold for small balance write-off but that can not be written off because other qualifying criteria have not been met. For example, an account may list on this report if it has met other write-off criteria, but the minimum number of follow-ups have not been sent. This report provides you with a tool you can use to help you control the number of active accounts on the system.

The report contains the patient name, account number, account balance, collector name, guarantor balance and exception message. The exception message explains the reason the account has not been written off.

Generating and Printing This Report

This report is generated during midnight processing. It is set up as a demand report, printed through the Demand Print function and sorted by patient account number.

The following is an example of a Small Balance Write Off Exception Report.

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Figure 3.28 FFR370 - Small Balance Write-Off Exception Report

```
Date: 10/12/89                          General Hospital                      Page  : 1
Time: 08:38am                   Small Balance Write Off Exception Report      Report: FFR370


Patient    Patient                          Account  Collector         Exception
  Nmbr     Name                             Balance  Name              Message

9220600308  HALL,MARY                         25.00  JOHNSON,KELLIE     Minimum follow-ups not sent
9220500250  DOWNS,CARL                        48.50  TERRANOVA,THERESA  Minimum follow-ups not sent
9219900062  SMITH,LINDA                       15.00  WESTCOTT,MARVIN    Minimum follow-ups not sent
9221000155  DAVIS,CYNTHIA                    -15.00  EDWARDS,CHARLES    Minimum follow-ups not sent
9220100172  LEDBETTER,EUGENE                 -20.00  ROMAINE,ELISE      Minimum follow-ups not sent
9220700014  CASE,THOMAS                        6.00  CARTER,BENNET      Minimum follow-ups not sent



                                        End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

PATIENT NMBR
This field contains the patient account number.

PATIENT NAME
This field contains the patient name.

ACCOUNT BALANCE
This field contains the balance owed by the guarantor for this account.

COLLECTOR NAME
This field contains the name of the collector assigned to this account.

EXCEPTION MESSAGE
This field contains the system-supplied exception message. This message explains the reason the system has not written off the balance of this account.

The following error messages may be displayed:

- Guarantor has accounts in AR (or PA or BD)
  The collective amount of the guarantor's balances is greater than the automatic write-off amount, even though individual account balances may be less than the limit. PA and BD are referenced only if the PAAR Control Screen is set up to review these areas. Also, only one error message prints, even if accounts appear in multiple locations.

- Minimum follow-ups not done
  The minimum number of follow-up attempts per the follow-up schedule has not been met.

- Pending Insurance
  The account meets the write-off criteria, but has an insurance balance greater than zero.

INSURANCE SMALL BALANCE WRITE-OFF DAILY EXCEPTION REPORT - FFR375

Description/Purpose

The Insurance Small Balance Write-Off (ISBWO) Daily Exception Report lists all carrier/plans with accounts in AR that meet an ISBWO exception when their scheduled insurance follow-up is processed. It lists accounts that meet the insurance small balance write-off amount but for which the write-off has not occurred due one of the following exceptions:

- Outstanding claims
  This exception occurs if an insurance carrier/plan qualifies for an ISBWO but has the ISBWO Claims parameter set to No and has a claim that is not submitted and not final dispositioned.

- Claims in Awaiting Payment Work Status
  This exception occurs if the insurance carrier/plan qualifies for an ISBWO but has a claim with a Claim Work Status of Awaiting Payment.

- Insurance Small Balance Write-off not allowed
  This exception occurs if the insurance follow-up schedule is set not to allow insurance small balance write-offs. The ISBWO? field controls whether an insurance is reviewed for a write-off.

- Days from Submit Date not met
  This exception occurs if the insurance qualifies for a write-off but the claim has not met the days set in the Days from Submit Date field. This exception can occur only if the ISBWO Claims field is set to No.

The report contains the COB indicator, the carrier/plan number, the insured name, the patient name, the account number, the insurance balance, the account balance, the claim sequence number, the claim amount, the claim date, the claim disposition, the claim status, the submit date, and exception messages. The exception message explains the reason the account has not been written off.

Generating and Printing This Report

This report is generated during midnight processing. It is sorted by insurance carrier/plan, insurance collector, insured name, and account name.

The following is an example of a Insurance Small Balance Write-off Exception Report.

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Figure 3.29 FFR375 - Insurance Small Balance Write-Off Daily Exception Report

```
Date: 04/03/98                                  General Hospital A                              Page  : 1
Time: 01:10am                      Insurance Small Balance Writeoff Daily Exception Report      Report: FFR380A


COB Insurance             Carrier/Plan   Insured Name           Patient Name            Account #    Ins Balance   Acct Balance
 CS Clm Amount   Clm Dt   Clm Dsp  Clm Wk St  Submit Dt  Nxt F/U Dt  Sch#  #F/U  Col  Exception Msg(s)

1   BLUE CROSS COMMERCIAL  917001         FRANK ALBERTS          FRANK ALBERTS           9805100002      5.00-         5.00-
 1      440.00  02/20/98   R       F                                926   0          Outstanding Claims

 3      940.00  02/25/98   P       F                    04/05/98    926   0      929  Outstanding Claims

1   BLUE CROSS COMMERCIAL  917001         ALICIA SOULES          ALICIA SOULES           9805100001    500.00      8,025.00
 1    8,000.00  02/20/98   R       F                                926   0          Outstanding Claims

 2    8,050.00  02/20/98   R       F                                926   0          Outstanding Claims

1   MEDICARE               917001         PATRICK ALGER          PATRICK ALGER           9728300002     12.82         12.82
 2      322.82  02/16/98           F                                926   0          Outstanding Claims

    Insurance Totals
    Outstanding Writeoffs for 917001:      3          507.82
    Number of Claim Exceptions    :        5


    Facility Totals
    Outstanding Writeoffs         :        4          707.82
    Number of Claim Exceptions    :        6




                                               End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

COB INSURANCE
This field displays the coordinate of benefits indicator for this claim.

CARRIER/PLAN
This field contains the insurance description and code.

INSURED NAME
This field contains the name of the insured.

PATIENT NAME
This field contains the patient's name.

ACCT NBR
This field contains the patient's account number.

SCH #
This field contains the insurance follow-up schedule number associated with this claim sequence.

 # FU
This field contains the number of follow-ups produced for the claim sequence. It is a total of the insurance collection letters, tracer claims, and the insurance telephone workfile entries that are processed for this claim sequence.

NEXT F/U DATE
This field contains the next scheduled insurance follow-up date for the associated claim sequence.

INS BALANCE
This field contains the balance currently due from the carrier.

ACCT BALANCE
This field displays the balance due for the account.

COLL
This field contains the insurance collector code associated with the claim.

CS
This field contains the system generated claim sequence number assigned to this claim.

CLM AMT
This field contains the amount of the claim.

CLM DT
This field contains the date the claim was generated.

CLM DSP
This field displays the disposition code for this claim. The valid claim disposition values are P for Partial Payment, C for Clear Disposition, T for Transferred, F for Final Payment, A for Adjusted to Zero, D for Denied, R for Replaced, or blank for No Disposition.

CLM WK ST
This field contains the claim status associated with the claim record.

SUBMIT DT
This field contains the submission (mailing) date of the claim.

EXCEPTION MSG(S)
This field contains the exception messages that are applicable for the insurance.

INSURANCE SMALL BALANCE WRITE-OFF EXCEPTION REPORT - FFR380

Description/Purpose

The Insurance Small Balance Write-Off (ISBWO) Exception Report lists all carrier/ plans with accounts in AR that meet an ISBWO exception regardless of the carrier/ plans' scheduled insurance follow-up date. It lists accounts that meet the insurance small balance write-off amount but for which the write-off has not occurred due one of the following exceptions:

- Outstanding claims
  This exception occurs if an insurance carrier/plan qualifies for an ISBWO but has the ISBWO Claims parameter set to No and has a claim that is not submitted and not final dispositioned.

- Claims in Awaiting Payment Work Status
  This exception occurs if the insurance carrier/plan qualifies for an ISBWO but has a claim with a Claim Work Status of Awaiting Payment.

- Insurance Small Balance Write-off not allowed
  This exception occurs if the insurance follow-up schedule is set not to allow insurance small balance write-offs. The ISBWO? field controls whether an insurance is reviewed for a write-off.

- Days from Submit Date not met
  This exception occurs if the insurance qualifies for a write-off but the claim has not met the days set in the Days from Submit Date field. This exception can occur only if the ISBWO Claims field is set to No.

The report contains the COB indicator, the carrier/plan number, the insured name, the patient name, the account number, the insurance balance, the account balance, the claim sequence number, the claim amount, the claim date, the claim disposition, the claim status, the submit date, and exception messages. The exception message explains the reason the account has not been written off.

Generating and Printing This Report

This report is an optional batch job. It is sorted by insurance carrier/plan, insurance collector, insured name, and account name. Refer to "Optional Batch Jobs" in Chapter 2: Financial System Management of the *General Information Volume* in the *STAR Financials Patient Accounting Reference Guide* for more information.

The following is an example of a Insurance Small Balance Write-off Exception Report.

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Figure 3.30 FFR380 - Insurance Small Balance Write-Off Exception
Report

```
Date: 04/03/98                                  General Hospital A                                    Page  : 1
Time: 01:10am                       Insurance Small Balance Writeoff Exception Report                 Report: FFR380A


COB Insurance            Carrier/Plan   Insured Name              Patient Name            Account #   Ins Balance   Acct Balance
 CS Clm Amount    Clm Dt  Clm Dsp  Clm Wk St  Submit Dt  Nxt F/U Dt  Sch#  #F/U  Col  Exception Msg(s)

1   BLUE CROSS COMMERCIAL  917001         FRANK ALBERTS             FRANK ALBERTS           9805100002      5.00-        5.00-
 1      440.00  02/20/98  R       F                                  926   0         Outstanding Claims

 3      940.00  02/25/98  P       F                     04/05/98    926   0    929  Outstanding Claims

1   BLUE CROSS COMMERCIAL  917001         ALICIA SOULES             ALICIA SOULES           9805100001     500.00     8,025.00
 1    8,000.00  02/20/98  R       F                                  926   0         Outstanding Claims

 2    8,050.00  02/20/98  R       F                                  926   0         Outstanding Claims

1   MEDICARE               917001         PATRICK ALGER             PATRICK ALGER           9728300002      12.82        12.82
 2      322.82  02/16/98           F                                  926   0         Outstanding Claims

    Insurance Totals
    Outstanding Writeoffs for 917001:       3          507.82
    Number of Claim Exceptions      :       5


    Facility Totals
    Outstanding Writeoffs           :       4          707.82
    Number of Claim Exceptions      :       6




                                              End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

COB INSURANCE
This field displays the coordinate of benefits indicator for this claim.

CARRIER/PLAN
This field contains the insurance description and code.

INSURED NAME
This field contains the name of the insured.

PATIENT NAME
This field contains the patient's name.

ACCT NBR
This field contains the patient's account number.

SCH #
This field contains the insurance follow-up schedule number associated with this claim sequence.

 # FU
This field contains the number of follow-ups produced for the claim sequence. It is a total of the insurance collection letters, tracer claims, and the insurance telephone workfile entries that are processed for this claim sequence.

NEXT F/U DATE
This field contains the next scheduled insurance follow-up date for the associated claim sequence.

INS BALANCE
This field contains the balance currently due from the carrier.

ACCT BALANCE
This field displays the balance due for the account.

COLL
This field contains the insurance collector code associated with the claim.

CS
This field contains the system generated claim sequence number assigned to this claim.

CLM AMT
This field contains the amount of the claim.

CLM DT
This field contains the date the claim was generated.

CLM DSP
This field displays the disposition code for this claim. The valid claim disposition values are P for Partial Payment, C for Clear Disposition, T for Transferred, F for Final Payment, A for Adjusted to Zero, D for Denied, R for Replaced, or blank for No Disposition.

CLM WK ST
This field contains the claim status associated with the claim record.

SUBMIT DT
This field contains the submission (mailing) date of the claim.

EXCEPTION MSG(S)
This field contains the exception messages that are applicable for the insurance.

COLLECTION AGENCY REPORT - FXPCAT4

Description/Purpose

The Collection Agency Report lists all accounts transferred to a selected collection agency. It is used by the collection agency to verify accounts added to their files for collections.

Generating and Producing This Report

NOTE: If you want more information on producing a collection agency file, see Chapter 3 of the *Account Transactions Volume* of the *STAR Financials Patient Accounting Reference Guide.*

This report can be generated in conjunction with a collection agency file or alone.

To produce this report, select Collection Agency Functions from the Account Management menu. Next, select Collection Agency File/Report and the agency or agencies for which you want to generate the report. At this point, the system prompts you to determine whether you want to produce only a Collection Agency Report, FXCAT4, or a file. If you produce a collection agency file, two reports are produced in conjunction with the file, the Collection Agency Report, FXCAT4, and the Collection Agency Interface Report, FXPCAT5.

Separate reports are produced for each collection agency selected.

The following is an example of the Collection Agency Report.

Figure 3.31 FXPCAT4 - Collection Agency Report

```
Date: 04/05/00                              General Hospital                          Page  : 1
Time: 9:23                            Collection Agcy Interface Rept                  Report: FXPCAT4A
                                           JOHN'S INTERNAL BD


                                   Dsch                Atnd  No   Last    Last    No  Coll          Account
Patient Name             Account #  Date   Ind F/C P/T Dr # Stmt  Stmt   Payment Pymts Nmbr  CS      Balance
-----------------------------------------------------------------------------------------------------------

ADAMS,JOHN               A0006800004 03/10/00  I  JA I/P  2234    3 03/22/00 03/21/00 2    55   50    $3,000.95
ADAMS,JODIE              A0006800003 03/08/00  O  S2 OP   2234               03/23/00 2    13   96    $3,650.00



                         Facility Totals
                             # of Accts                     2
                             Amount                   $6,650.95




                         Collection Agency Totals
                             # of Accts                     2
                             Amount                   $6,650.95

                                         End of Report
```

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Chapter 3 - ACCOUNT FOLLOW-UP REPORTS

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The report contains a header that includes the date and time the report is generated, your hospital's name, the collection agency name, the report title, the page number, and the report name as used in the system.

PATIENT NAME
This field contains the patient's name.

ACCOUNT #
This field contains the patient's account number.

DSCH DATE
This field contains the date on which the patient was discharged.

IND
This field contains the account patient indicator. Valid indicators are I-inpatient, O-outpatient, and E-emergency room account.

F/C
This field contains the account financial class.

P/T
This field contains the account patient type.

ATND DR #
This field contains the ID number of the attending doctor.

NO STMT
This field contains the number of follow up statements generated for the selected account.

LAST STMT
This field contains the date of the last follow up for the selected account.

LAST PAYMENT
This field contains the most recent date on which a payment was posted to the account. The last payment date could be either a patient or insurance payment.

NO PYMTS
This field contains the total number of payments (insurance and patient) posted to this account.

COLL NMBR
This field contains the code of the collector assigned to the selected account.

CS
This field contains the code of the collection schedule assigned to the selected account.

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ACCOUNT BALANCE
This field contains the account balance.

COLLECTION AGENCY TOTAL
This field contains the collection agency code and description and the total amount of all accounts transferred to the agency.

COLLECTION AGENCY INTERFACE REPORT - FXPCAT5

Description/Purpose

The Collection Agency Interface Report lists demographic information of accounts transferred to a selected collection agency. It is used by the business office to validate account data transferred to a collection agency.

Generating and Producing This Report

This report is generated in conjunction with a collection agency file. It is a verification of the data copied onto the file to be processed by the collection agency. Since the report verifies data on the file, the report cannot be produced alone. If a collection agency is unable to read a file the report could be used to manually key the data transmitted.

To produce this report and the accompanying file select Collection Agency Functions from the Account Management menu. Next, select Collection Agency File/Report and select the agency or agencies for which you want to generate a file. The FXPCAT5 report is automatically generated after the collection agency file is produced.

Separate reports are produced for each collection agency selected.

The following is an example of the Collection Agency Interface Report.

Figure 3.32 FXPCAT5 - Collection Agency Interface Report

```
Date: 06/19/02                                General Hospital                              Page  : 1
Time: 9:24                                Collection Agcy Interface Rpt                      Report: FXPCAT5A
                                              JOHN'SINTERNAL BD


Patient Information:               Address            City            St Zip      Phone      Age Sx Mar  Account #
Guarantor Information:                                                                       Disch Dt   Acct Balance


----------------------------------------------------------------------------------------------------------------


ADAMS,JOHN                         300 TREE RD        ATLANTA         GA 30336                40  M  M   A0006800004
SELF                                                                                         01/01/02      1000.00
ADAMS,JODI                         191 RED OAK        ALPHARETTA      GA 30336                30  F  M   A0006800003
SELF


Facility Totals
Total Records =                     1
Total Amount =            1,000.00


Agency Totals
Total Records =                     1
Total Amount =            1,000.00

                                               End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the collection agency name, the report title, the page number, and the report name as used in the system.

PATIENT INFORMATION
The following patient information is printed and processed onto the collection agency transfer tape.

PATIENT NAME
This field contains the patient's name.

PATIENT ADDRESS
This field contains the patient's address.

NOTE: The confidential address is used when the Mail To Address field on the Patient Additional Information Page for the patient is completed with a Yes and an alternate address is defined.

PATIENT CITY, STATE AND ZIP CODE
These fields contain the city, state, and ZIP code portions of the patient's address.

NOTE: The confidential address is used when the Mail To Address field on the Patient Additional Information Page for the patient is completed with a Yes and an alternate address is defined.

PATIENT TELEPHONE NUMBER
This field contains the patient's telephone number.

NOTE: The confidential phone number is used when the Confidential Add/Ph field field on the Patient Additional Information Page for the patient is completed with a Yes and an alternate phone number is defined.

PATIENT AGE
This field contains the age of the patient, displayed in years. A **0** is displayed in this field for children under 12 months old; a **1** is displayed in this field for children from 12 to 24 months less one day old.

PATIENT SEX
This field contains the sex of the patient. Patients under the age of one year will display an age of **0**.

PATIENT MARITAL STATUS
This field contains the marital status of the patient.

PATIENT ACCOUNT NUMBER
This field contains the patient's account number.

GUARANTOR INFORMATION:
The following guarantor information is printed and processed onto the collection agency transfer tape.

GUARANTOR NAME
This field contains the guarantor for the patient.

GUARANTOR ADDRESS
This field contains the guarantor's address.

NOTE: The confidential address is used when the Mail To Address field on the Patient Additional Information Page for the patient is completed with a Yes and an alternate address is defined.

GUARANTOR 2nd ADDRESS
This field contains the guarantor's second address.

NOTE: The confidential address is used when the Mail To Address field on the Patient Additional Information Page for the patient is completed with a Yes and an alternate address is defined.

GUARANTOR CITY, STATE ZIP CODE
These fields contains the city, state, and ZIP code portions of the guarantor's address.

GUARANTOR TELEPHONE NUMBER
This field contains the guarantor's telephone number.

DISCH DT
This field contains the patient's discharge date.

ACCT BALANCE
This field contains the patient's account balance.

COLLECTION AGENCY TAPE ERRORS REPORT - FXPCPTE

Description/Purpose

The Collection Agency Tape Errors Report lists all payments transmitted from a collection agency that the system was unable to post.

This report, which is sorted by patient account number, includes the account number, patient name, payment date, payment amount, patient corporate number and an error message.

Generating and Printing This Report

This report is automatically generated when a payment tape from a collection agency is processed. It is generated in conjunction with the Collection Agency Tape Payments report (FXPCPTP).

The following is an example of the Collection Agency Tape Errors Report.

Figure 3.33 FXPCPTE - Collection Agency Tape Errors Report

```
Date: 04/10/90                              GENERAL MEDICAL CENTER - A                    Page  : 3
Time: 03:47                                   COLL AGY TAPE ERRORS                        Report: FXPCPTEP
                                            999 - PAYMENTS TAPE - HCC


Patient #          Patient Name         Date Paid     Payment Amount   Corp. #   Error Message
-----------------------------------------------------------------------------------------------------------
C008628637         HARBEN, MELVIN       03/28/89      146.11                     ACCOUNT NUMBER IS IN HS
C008708448         FORTNIS,MELONY       03/08/89       12.50                     ACCOUNT NUMBER DOES NOT EXIST
C008718734         ALGORE,KRIS          03/24/89       97.41                     ACCOUNT NUMBER DOES NOT EXIST
C003720641         ALGORE,KRIS          03/24/89      256.29                     ACCOUNT NUMBER DOES NOT EXIST
C008733354         DOLLAR,SONNY         03/23/89      123.34                     ACCOUNT NUMBER IS IN HS
C008766560         FORTNIS, JANE        03/08/89        9.74                     ACCOUNT NUMBER DOES NOT EXIST
C008940512         FORTNIS, JANE        03/08/89       12.50                     ACCOUNT NUMBER DOES NOT EXIST
C100015058         COTTER,TRUDY         03/28/89       10.00                     ACCOUNT NUMBER IS IN HS
C100142132         BOWDER,FELICITY      03/21/89        9.13                     ACCOUNT NUMBER IS IN AR
C100142818         DUNKIRK,JOE          03/22/89      300.00                     ACCOUNT NUMBER IS IN AR
C100186733         JONES,LIZA C         03/01/89      115.05                     ACCOUNT NUMBER IS IN AR
C500065776         CORDERO,JOEY         03/03/89      346.59                     ACCOUNT NUMBER IS IN AR
C500166643         LAWRY,JOY            03/17/89       97.86                     ACCOUNT NUMBER IS IN AR
C500198999         BORNE,INDIA          03/21/89       15.16                     ACCOUNT NUMBER NOT ASSIGNED TO THIS AGY
C701962671         PLANTER,HILLARY      03/28/90       44.45                     ACCOUNT NUMBER IS IN AR
C800149865         GRIFFIS,ANDREW       03/08/89       66.04                     ACCOUNT NUMBER IS IN AR
C800153785         BAXLEY,MARYANN       03/14/89      118.68                     ACCOUNT NUMBER IS IN AR
C800190001         FICKLER,MORTON       03/23/89       29.85                     ACCOUNT NUMBER IS IN AR
D ACCOUNT0         MCGINTY,FRANCIS      03/06/89       25.00                     ACCOUNT NUMBER DOES NOT EXIST

TOTAL ACCOUNTS IN ERROR:  71         TOTAL AMOUNT:  12349.75

END OF REPORT
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the page number, and the report name as used in the system. The batch number and description for the collection agency tape being processed are printed below the hospital and report names.

PATIENT #
This field contains the patient account number.

PATIENT NAME
This field contains the patient's name.

DATE PAID
This field contains the date on which the collection agency posted the payment to the account.

PAYMENT AMOUNT
This field contains the amount paid on this account for the date specified.

CORP #
This field contains the guarantor's corporate number.

ERROR MESSAGE
This field contains the reason that the payment was not processed. Several messages are possible:

- Account number is in HS
  The account is in the MPI, but has been previously archived and purged, or was never active in STAR Financials.

- Account number is in ARC
  The account has been archived.

- Account number is in PA
  The account has not been final billed.

- Account number is in AR
  The account is in Accounts Receivable and is not assigned to a collection agency.

- Account number not assigned to this agency
  The account is in Bad Debt, but assigned to a different agency than the one for which this tape is being processed.

- Account number does not exist
  The account is not in the MPI.

COLLECTION AGENCY TAPE PAYMENTS - FXPCPTP

Description/Purpose

The Collection Agency Tape Payments Report lists all payments transmitted from a collection agency that the system processed and posted to the patient account.

This report, which is sorted by patient account number, includes the account number, patient name, payment date, payment amount, and patient corporate number.

Generating and Printing This Report

This report is automatically generated when a payment tape from a collection agency is processed. It is generated in conjunction with the Collection Agency Tape Errors report (FXPCPTE).

The following is an example of the Collection Agency Tape Payments Report.

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Figure 3.34 FXPCPTP - Collection Agency Tape Payments Report

```
Date: 04/10/90                        GENERAL MEDICAL CENTER                  Page  : 1
Time: 03:47                             COLL AGCY PAYMENTS                     Report: FXPCPTP
                                      999 - PAYMENTS TAPE - HCC


Patient #         Patient Name           Date Paid   Payment Amount   Corp. #
------------------------------------------------------------------------------------------------
8833600150        BROOKING,ALVIN         03/28/90              8.50   00136850
8833800060        KEMP,WILL              03/08/90             65.00   00090232
8833800060        ECKHART,DIANE          03/24/90              5.00   00023995
8833800176        TAGORE,EMMANUEL        03/24/90            130.00   00140611
8834000246        MILLER,GREGORY         03/23/90             47.46   00142699
8834100033        DUNN,BABY BOY          03/08/90             70.00   00024110
8834100408        MEJEUR,ADRIANNE        03/08/90             14.90   00157314
8834800034        DEHAAN,TRUDY           03/28/90              8.50   00253327
8835700079        PETERSON,ANNE          03/21/90             95.05   00090232
8900200090        DUNKIRK,COLIN          03/22/90            129.89
8900300454        JONES,PAULINE          03/01/90            580.25   00079584
8900400085        CORDERO,XAVIER         03/03/90            109.78   00079590
8900500195        JOHNSON,BEN            03/17/90             24.97   00211259
8901100175        SAND,GEORGE            03/21/90             48.69   00204983
8901900217        PLANTER,HILLARY        03/28/90              8.50   00047851
8901900271        GRIFFIN,ANDREW         03/08/90             35.50   00234443
8902100013        BAXTER,MARIAN          03/14/90             63.75
8905200107        DEAN,CHERYL            03/23/90              9.35   00079584


TOTAL ACCOUNTS PAID : 538         TOTAL AMOUNT :        41991.98

                                      END OF REPORT
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the page number, and the report name as used in the system. The batch number and description for the collection agency tape that is being processed are printed below the hospital and report names.

PATIENT #
This field contains the patient account number.

PATIENT NAME
This field contains the patient's name.

DATE PAID
This field contains the date on which the collection agency posted the payment to the account.

PAYMENT AMOUNT
This field contains the amount paid on this account for the date specified.

CORP #
This field contains the guarantor's corporate number.

TOTALS
These fields contain the total number of accounts and payments included on this report.

PATIENT COMPASS INTERFACE RECAP - FARPC

Description/Purpose

The Patient Compass Interface Recap Report shows the number of accounts and the account balances for locations PA, AR, and BD and provides the total number of accounts and the combined account balance.

Generating and Printing This Report

The Patient Compass Interface Recap report is generated from the Patient Compass Detail File Optional Batch Job.

The following is an example of the Patient Compass Interface Recap Report.

Figure 3.35 FARPC - Patient Compass Interface Recap Report

```
Date: 05/02/08                Windward Medical University       Page  : 1
Time: 02:08am                 Patient Compass Interface Recap   Report: FARPCA


File: 05022008_OrgNameID9_test_A_patinfo.dat

        Location                    Accounts              Account Balance
    ------------------------------------------------------------------------------

          PA                           0                      $0.00

          AR                          17                  $3,956,584.13

          BD                           0                      $0.00

                                  ==========            ===================

                                      17                  $3,956,584.13
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the page number, and the report name as used in the system.

LOCATION
This column identifies the location as PA, AR, or BD.

ACCOUNTS
This column contains the number of accounts for each location. The total number of accounts is also shown.

ACCOUNT BALANCE
This column shows the account balance for each location. The combined account balance is also shown.

PATIENT COMPASS AUDIT REPORT - FARPC2

Description/Purpose

The Patient Compass Interface Audit report contains a detail list of accounts downloaded to Patient Compass. Y% is the facility associated with the hospital. This report is a tool to assist the facility in monitoring and tracking accounts sent to Patient Compass. The information on the report is reflective of the data that is contained in the Patient Summary record/Patinfo.dat file.

The primary sort of the report is location. Next are stop code, guarantor name and account name.

A trigger reason code/description is also associated with each account on the report if an Incremental file is processed. An account can meet various conditions for being triggered to Patient Compass but only one displays. If an Incremental Update run is processed the trigger reason is Update Run. If a Full file is processed with an Account Index the report generates and has a trigger reason of Full.

The name of the patient summary file that is associated with the Patient Compass Interface run is included on the top of the report. The patient summary file is written out to the Unix directory that is defined in the Unix Directory Path on the Patient Compass Interface Parameters.

Example:

File: 11112008_OrgNameID173_test_A_patinfo.dat

11112008 is the date the file was created.

OrgNameID173 is the organization name that is contained on the Patient Compass Interface Parameters.

The word test is included if the Test Mode field on the Patient Compass Interface parameters is set to Yes.

A is the hospital facility associated with the Patient Compass Interface run.

Patinfo.dat is the name of the Patient Compass Patient Summary file.

Generating and Printing this Report

The Patient Compass Interface Audit report is generated when the Patient Compass Interface is run for Patient Compass 2.0 where an Incremental, Incremental Update or a Full Interface run with an Account Index is processed. It is not generated when a Patient Compass Classic (Version 1.0) interface run is processed.

Figure 3.36 Patient Compass Interface Audit Report - FARPC2

```
Date: 08/22/09                              General Hospital                              Page  : 1
Time: 08:54                              Patient Compass Audit Report                     Report: FARPC2A


File: 01222009_Providenceor_test_V_patinfo.dat

Patient Name                    Pat Acct#       Adm Dt    DC Dt    FC  PT  Stop Cd  Sch Type Last FU Type Last FU Dt Last FU Seq# Loc
  Guar Name                     Pt Amt Due  Dunn Cd   Agy Cd  Due Dt   Pymt  Plan Level  Trigger1 Dt  Trigger2 Dt      Acct Chgs
  Pymt Plan Delinq/Pre-paid Amt Total Pymt Plan Amt     Pt Pymts        Pt Adjs    Pt Refunds     Ins Pymts     Ins Adjs
     Ins Refs                   Acct Bal            Ins Bal Final Bill Dt    Rebill Dt   Rebill Ind  Dmd Bill Dt Dmd Bill Ind
  Trigger Reason


CAMPBELL,TWO                    A0815900095    09/15/08            01  I/P NO                                                    PA
  CAMPBELL,TWO                    $1,245.00                                                                           $1,245.00
         $0.00                         $0.00      $0.00        $0.00       $0.00       $0.00       $0.00
         $0.00                    $1,245.00      $0.00
Charges

ITPTEST,FOUR,PATIENT            A0847500010    06/23/08  06/24/08 01  E/R NO             D             01/21/09  1              AR
  ITPTEST,FOUR,PATIENT           $3,454.85  DM200                                 01/21/09  12/22/08                $4,038.85
         $0.00                         $0.00      $0.00        $0.00       $0.00       $0.00       $0.00
         $0.00                    $4,038.85    $584.00 06/25/08
Follow-up Information

JJJTEST,SEPT,TST                A0810800001    04/17/08  04/17/08 01  O/P NO             L             07/23/08  4              AR
  TEST,GUARANTOR                  $243.15  L775                                   07/23/08  07/08/08                 $243.15
         $0.00                         $0.00      $0.00        $0.00       $0.00       $0.00       $0.00
         $0.00                      $243.15      $0.00 04/21/08         07/23/08    A
Guarantor Info

JJJTEST,SEPT,TST                A0818500022    07/03/08  07/03/08 09  SNO NO             L             07/23/08  4              AR
  TEST,GUARANTOR                    $0.00  LM200                                  07/23/08  07/08/08                 $127.00
         $0.00                         $0.00      $0.00        $0.00       $0.00       $0.00       $0.00
         $0.00                      $127.00    $127.00 07/07/08         07/15/08    A
Guarantor Info

JJJTEST,SEPT,NINEXXX            A0816000034    06/12/08  06/14/08 BC  RON NO             D             12/30/08  2              AR
  JEJTEST,SEPT,NINEXX           -$1,778.00  D1300                                 12/30/08  11/30/08                 $889.00
         $0.00                         $0.00  -$2,667.00        $0.00       $0.00       $0.00       $0.00
         $0.00                   -$1,778.00      $0.00 06/18/08
Payment
                                                    End of Report
```

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FIELD EXPLANATIONS

All fields included on the report are from the patient summary record with a few exceptions, which are noted in the field descriptions.

PATIENT NAME
This field contains the patient name and entitle/suffix associated with the Patient. The field contains the information as follows: last entitle,first, middle initial or name Smith JR,Tom,M Pat Acct#.

This field contains the account number.

ADM DT
This field contains the patient's admission date.

DC DT
This field contains the patient's discharge date.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc.

PT
This field contains the patient type code and is used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

LOC
This field contains the location associated with the account when it was processed by the Patient Compass Interface. Valid location values are PA, AR, BD and ARC.

STOP CODE
This field indicates if an account is valid for Patient Compass. If an account is valid for processing on Patient Compass it will contain a value of No for don't stop processing it on Patient Compass and if an account is not valid for processing on Patient Compass it will contain a value of Yes for stop processing on Patient Compass.

If an account was previously sent to Patient Compass and then meets a condition so that it no longer qualifies for Patient Compass, a stop code of Yes is generated.

If an account wasn't sent to Patient Compass but now meets criteria to be sent to Patient Compass, the account is added to the next interface run and the stop code value would be No.

Various conditions impact the Stop Code such as:

1. If an account is put on Account/Guarantor Follow-Up Hold then a Stop Code of Yes is generated to indicate that the account should be stopped on Patient Compass. If an account is removed from Account/Guarantor Follow-Up Hold then a Stop Code of No is generated to indicate that the account should not be stopped on Patient Compass.

2. Agency

If an account is transferred to an agency that is not defined as a valid agency for Patient Compass then a Stop Code of Yes is generated to indicate that the account should be stopped on Patient Compass. If an account is transferred to an agency that is valid for Patient Compass, a Stop Code of No is generated to indicate that the account should not be stopped on Patient Compass.

3. Location

If an account's location doesn't meet the valid locations for sending to Patient Compass, a Stop Code of Yes is generated to indicate that the account should be stopped on Patient Compass. If an account meets the valid locations for sending to Patient Compass. a Stop Code of No is generated to indicate that the account should not be stopped on Patient Compass.

4. Zero Balance

If a zero balance account meets the days defined in the Zero Balance field on the Patient Compass Interface Parameters. a Stop Code of Yes is generated to indicate that the account should be stopped on Patient Compass. If a zero balance account doesn't meet the days defined in the Zero Balance field on the Patient Compass Interface Parameters. a Stop Code of No is generated to indicate that the account should not be stopped on Patient Compass.

5. Archived accounts

If an account is archived either from an AR or Bad Debt location. a Stop Code of Yes is generated to indicate that the account should be stopped on Patient Compass. If an account is un-archived then a Stop Code of No is generated to indicate that the account should not be stopped on Patient Compass.

SCHEDULE TYPE
This field contains the type associated with a schedule. Valid values for account level schedules are separate, custom and pymt pl. Valid values for guarantor level schedules are standard, G custom and G Pmt Pl.

GUAR NAME
This field contains the guarantor name and entitle/suffix associated with the guarantor. The field contains the information as follows: last entitle,first, middle initial or name Smith JR,Tom,M.

LAST F/U TYPE
This field contains the last type of follow-up done on the account.

The valid values are D - Detail statement, L - Collection Letter, T - Telephone   and W-Wait.

LAST F/U DATE
This field contains the date of the last follow-up event.

LAST F/U SEQ#
This field contains the sequence number associated with the last follow-up step.

PATIENT AMT DUE
This field contains the balance that is associated with the patient.

DUNNING CD
This field contains the follow-up type concatenated with the Message Code associated with Trigger Date 1. For example if the follow-up type was a detail statement and the associated message code was a 1, the dunning code would be D1.

If Trigger Date 1 is Final Bill Date, there will be no Dunning Code.

AGY CD
This field contains the agency code that is associated with an account. This field is for accounts at AR and Bad Debt agencies that are at either Internal or External agencies.

PYMT PLAN AMT
This field contains the amount due for the payment plan.

DUE DT
This field contains the payment plan due date which is the date the account becomes delinquent on STAR.

ACCT/GUAR QUESTIONS
This field indicates a patient is on a guarantor level or account level payment plan.

PYMT PLAN DELINQ AMT
A delinquent amount will be a positive amount while the pre-paid amount will be a negative number.

This field contains the delinquent amount if it exists and if not, the field contains the pre-paid amount if it exists.

TRIGGER DATE 1
This field contains the date of the most recent Final Bill/Detailed Statement/Collection Letter.

TRIGGER DATE 2
This field contains the date of the previous (the one before the last) Final Bill/Detailed Statement/Collection Letter Date. For example if an account had a Final bill on Jan 1, a detail statement on Jan 15 and another detail statement on Jan 30th then Trigger Date 1 would be Jan 30th for the detail statement and Trigger Date 2 would be Jan 15th for the other detail statement.

TOTAL PYMT PLAN AMT
This field contains the total payment plan amount due which is calculated as: Current Amount Due + Delinquent Amount - Pre-paid amount

PATIENT PYMTS
This field contains the total amount of patient payments associated with the account.

PATIENT ADJS
This field contains the total amount of patient adjustments associated with the account.

PATIENT REFUNDS
This field contains the total amount of patient refunds associated with the account.

INS PYMTS
This field contains the total amount of insurance payments associated with the account.

INS ADJ
This field contains the total amount of insurance adjustments associated with the account.

INS REF
This field contains the total amount of insurance refunds associated with the account.

ACCT CHGS
This field contains the total amount of charges associated with the account.

ACCT BAL
This field contains the current balance for all charges owed (patient and Insurance) on account.

INS BAL
This field contains the current insurance carrier balance associated with the account. This field corresponds to the Insurance Charges Pending field in the Patient Summary record/Patinfo.dat file.

FINAL BILL DATE
This field contains the initial final billing date for this patient's account.

REBILL DT
This field contains the date of the last adjustment or late bill for this patient's account.

REBILL IND
This field contains the Rebill indicator associated with last adjustment or late bill. Valid indicators are A for Adjustment Bill and L for Late Bill.

DEMAND BILL DT
This field contains the date of the last demand bill for this patient's account.

DEMAND BILL INDICATOR
This field contains the Demand Bill indicator associated with last Demand bill. Valid indicator value is D for Demand Bill.

TRIGGER REASON
This field contains the first reason an account was triggered to go to Patient Compass. An account could meet various conditions for being triggered to Patient Compass but only one displays. Valid Trigger Reasons for an Incremental file Include:

Zero Balance

This trigger reason indicates the account met the Zero Balance Days.

Charges

This trigger reason indicates that a charge was posted to the account.

Payment

This trigger reason indicates that a payment was posted to the account.

Adjustment

This trigger reason indicates that an adjustment was posted to the account.

Refund

This trigger reason indicates that a refund was posted to the account.

Balance Transfer

This trigger reason indicates that a balance transfer was posted to the account.

Financial Class Change

This trigger reason indicates that a financial class change was posted to the account.

Change in Balances

This trigger reason indicates that either the Delete Financial Activity process or the Insurance Timeout process occurred on the account.

Change in Insurance CarriersThis trigger reason indicates that an insurance carrier/ plan was added, resequenced or deleted.

Archive

This trigger reason indicates that the account was archived and no longer valid for Patient Compass.

Un-archive Account

This trigger reason indicates that the account was archived b   been unarchived and is now valid for Patient Compass.

Adjustment Bill

This trigger reason indicates that an adjustment bill was generated for the account.

Late Bill

This trigger reason indicates that a late bill was generated for the account.

Demand Bill

This trigger reason indicates that a demand bill was generated for the account.

Agency Criteria

This trigger reason indicates that an agency change resulted in the account being triggered.   For example, if an account qualified for Patient Compass while in an AR location and then it transferred to a bad debt location and didn't qualify because of the agency then it will get the trigger for agency criteria.

Transfer to BD

This trigger reason indicates that an account was transferred payment was posted to the account.

Transfer from BD

This trigger reason indicates that an account was transferred from a bad debt location and now qualifies for Patient Compass.

Change in Accnt Location

This trigger reason indicates that the account changed account location.

BD Transfer Date

This trigger reason indicates that the bad debt transfer date caused the account to be included in the interface.

Follow-up Information

This trigger reason indicates that a change in follow-up information caused the account to be included in the index.

Guarantor Info

This trigger reason indicates that a change in guarantor information caused the account to be included in the index.

Patient Info

This trigger reason indicates that a change in patient information caused the account to be included in the index.

Account Info

This trigger reason indicates that a change in account information caused the account to be included in the index.

Manual Trigger

This reason displays if the user goes to the Patient Compass Status screen and manually requests that the account be sent to Patient Compass.

Update Run

This trigger reason displays if the user requests an Incremental Update run.

The following trigger reason is not an Incremental trigger: Full Run. This trigger reason displays if the user requests a Full run and is retaining the Account Index.

PATIENT COMPASS INTERFACE RECAP - FARPC1

Description/Purpose

The Patient Compass Interface Recap Report shows the number of accounts and the account balances for locations PA, AR, and BD and provides the total number of accounts and the combined account balance. The report also displays totals by the stop code associated with the accounts sent to Patient Compass and totals by the stop code associated with the accounts in the STAR Account Index.

This report is generated only for Patient Compass Version 2.

Generating and Printing This Report

The Patient Compass Interface Recap report is generated from the Patient Compass Detail File Optional Batch Job.

The following is an example of the Patient Compass Interface Recap Report.

Figure 3.37 Patient Compass Interface Recap - FARPC1

```
Date: 01/30/09                               General Hospital                          Page  : 1
Time: 05:08                          Patient Compass Version 2 Interface Recap                        Report: FARPC1P


File: 01302009_Hospitaltest_test_P_patinfo.dat

Summary of Accounts Sent to Patient Compass

        Location                 Accounts              Account Balance                    Stop Code
--------------------------------------------------------------------------------------------------------------------

           PA                      262                 $25,650,542.66                  Yes=; No=262

           AR                       17                    $296,885.71                  Yes=1; No=16

           BD                        0                          $0.00                  Yes=; No=

           ARC                       0                              0                  Yes=; No=

                                ==========            ===================
                                   279                 $25,947,428.37

Summary of Accounts in STAR Account Index

        Location                 Accounts                 Stop Code
--------------------------------------------------------------------------------------------------------------------

           PA                      690                 Yes=; No=690

           AR                     1164                 Yes=8; No=1156

           BD                      799                 Yes=769; No=30

           ARC                       0                 Yes=; No=

                                ==========            ===================

                                  2653                 Yes=777; No=1876

                                          End of Report
```

Field Explanations

The report contains a header that includes the date and time the report is generated, your hospital's name, the page number, and the report name as used in the system.

Summary of Accounts Sent to Patient Compass

This section contains totals for accounts in a PA, AR, BD and ARC location. It also displays totals by the Stop Code value associated with the accounts. Note accounts that have a stop code of Yes reflect that the accounts went to Patient Compass on this run and now have a Stop Code of Yes.

Summary of Accounts in STAR Account Index

This section contains totals for accounts in a PA, AR, BD and ARC location. It also displays totals by the Stop Code value associatedwith the accounts. Note accounts that have a stop code of Yes reflect that the accounts went to Patient Compass at some point and now have a Stop Code of Yes. STAR doesn't delete an account out of the account index once it has a stop code of Yes. It remains in the index so that it can display the value of the stop code on the Patient Compass Status screen.

Field Explanations

LOCATION

This column identifies the location as PA, AR, or BD.

ACCOUNTS

This column contains the number of accounts for each location. The total number of accounts is also shown.

ACCOUNT BALANCE

This column shows the account balance for each location. The combined account balance is also shown.

STOP CODE

This column shows the stop code associated with the account.

ACCOUNT SELECTION REPORTS

The Account Selection Reports are facility-specific demand reports enabling you to create and generate Patient Accounting Management reports using a wide range of account selection criteria. These reports can be printed in a detail or summary form.

This report function is used to generate the following group of reports:

- Account Selection Criteria report - FARASC
- Account Selection Report/One-Line ATB (standard or insurance version)- FARASA
- Account Selection Financial Class Summary report - FARASF
- Summary Recap report - FARASP
- Account Selection report - FARASR

NOTE: You can use the STAR Audit Service to audit user requests for this report. The Audit Service collects and stores information such as report request date and time, the name of the user requesting the report and the criteria selected for the report. For more information, see the STAR Audit Service Reference Guide.

- The Account Selection Report function enables you to determine how the report is to be aged and whether detail transactions, guarantor information, a one-line (ATB) Aged Trial Balance (standard or insurance version), and summary information print. Each report can be identified by a user-defined, 20-character report definition. Information can be selected based on date ranges for accounting events such as admission dates, discharge dates, last bill dates, last/next insurance F/U dates, next/last patient F/U dates, insurance claim release and submission dates, last patient/insurance and account payment dates, last patient/account and insurance adjustment dates. All date ranges can be selected on a specific date or on a default response of Earliest and Latest. The discharge date and all last payment date fields also allow you to select accounts based on the date field being blank.

This function also enables you to define report selection criteria based on next F/U sequences, patient F/U hold flags, insurance hold flags, patient types, patient indicators, patient last name ranges, guarantor last name ranges, account locations, financial classes, patient classification, insurance carriers, insurance plans,collector codes, guarantors on payment plans, accounts on payment plans, biller codes, F/U schedules, number of patient F/Us, insurance F/U schedules, prelisted accounts, prelist indicators, converted accounts, collection agency accounts, patient balance ranges, insurance balance ranges, and account balance ranges.

Selected criteria are cumulative in nature. Accounts must meet all defined criteria to be included on the report.

NOTE: Keep in mind while using the Account Selection Report function that many of the fields are used to determine what information the system should check in

order to determine an account's inclusion on the report. If you do not want the system to consider a criteria in determining whether or not to include accounts on the report, make sure that you either make no entry to the appropriate field or select all available options from the appropriate table.

You can define a set of selection criteria for an Account Selection report, then create the report as needed at later dates. You can edit the selection criteria for these predefined Account Selection reports.

You can queue the Account Selection report to print after you finish defining or editing the selection criteria using the current account balance or have the system print the report during the batch run using the pre-batch balance. During the first seven days of each fiscal period you can request the report to use the previous period end balances.

For more information on how to define an Account Selection Report, refer to the *Account Transactions Volume* of the *STAR Financials Patient Accounting Reference Guide.*

The following outlines the differences in each of the Account Selection Reports. Examples of each report are provided.

ACCOUNT SELECTION CRITERIA REPORT - FARASC

DESCRIPTION/PURPOSE

This report prints a detailed listing of the user-defined selections used for the Account Selection Reports.

GENERATING AND PRINTING THIS REPORT

This report is generated by selecting the Account Selection Reports option from the Account Management Reports menu. It is also available as a demand report.

The following is an example of the Account Selection Criteria Report.

Figure 3.38 FARASC - Account Selection Criteria Report

```
Date: 05/04/05                           Model Hospital A                              Page  : 1
Time: 12:55                        Account Selection Criteria Rpt                      Report: FARASCA
                                        EVT - FOLLOW-UP HOLD
--------------------------------------------------------------------------------------------------------
AGING BY                       : LAST PATIENT F/U DATE    AGE CATEGORY                 : SUSAN'S REPORT AGING
PRINT SUMMARY RPTS-FARASF,FARASP: Exclude                 PRINT DETAIL REPORT-FARASR   : No
PRINT ATB REPORT-FARASA        : Ins Version              PRINT GUARANTOR INFO.        : Include
                                 Final Bill, Discharge Date / Insurance, Account
SUPPRESS ZERO BALANCE ACCTS    : Yes                      PRINT DETAIL TRANSACTIONS    : No
INSURANCE SELECTION            : Primary Only                 REPORTED BALANCES            : Current as of 02/04/99 at 12:02 PM
PAGE BREAK ON PRIMARY SORT     : Yes
                                 13- DESCENDING BAL ACCT (Guar)
ADMISSION DATES                : Earliest thru Latest     DISCHARGE DATES              : Earliest thru Latest
LAST BILL DATES                : Earliest thru Latest     LAST PATIENT PAYMENT DATES   : Earliest thru Latest
LAST ACCOUNT PAYMENT DATES     : Earliest thru Latest     LAST INSURANCE PAYMENT DATES : Earliest thru Latest
LAST INSURANCE F/U DATES       : Earliest thru Latest     LAST PATIENT F/U DATES       : Earliest thru Latest
NEXT INSURANCE F/U DATES       : Earliest thru Latest     NEXT PATIENT F/U DATES       : Earliest thru Latest
INSURANCE CLAIM RELEASE DATES  : Earliest thru Latest     INSURANCE CLAIM SUBMIT DATES : Earliest thru Latest
LAST ACCOUNT ADJUSTMENT DATES  : Earliest thru Latest     LAST PATIENT ADJUSTMENT DATES: Earliest thru Latest
LAST INSURANCE ADJUSTMENT DATES: Earliest thru Latest     BAD DEBT TRANSFER DATES      : Earliest thru Latest
PAYMENT PLAN DELINQUENT DATES  : Earliest thru Latest
ACCOUNT LOCATIONS              : AR                       PATIENT INDICATORS           : I
PATIENT TYPES                  : ER,ERT,ERN
HOSPITAL SERVICES              : ERS,MED,OBS,ORT,SUR
FINANCIAL CLASSES              : B,C,K,M,O,P,S,W
BILLER CODES                   : 5,4,1,3,2
ACCOUNT BALANCE                : -999999 to  1000000      PATIENT LAST NAME RANGE      : to
GUARANTOR BALANCE              : to                       GUARANTOR LAST NAME RANGE    : AAA to ZZZ
PATIENT BALANCE                : to                       CONVERTED INDICATOR          : All
INSURANCE BALANCE              : to                       INCLUDE CONVERTED ACCOUNTS   : Include
COLLECTOR CODES                :  ()
PATIENT CLASSIFICATIONS        :
PT CLASS ALERT/SUPPRESS        :
COLLECTIONS AGENCY CODES       :
INVALID ADDRESS/PHONE          :  Both - AB,CD,EF,X1,X3
```

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ACCOUNT SELECTION REPORT/ONE-LINE - FARASA

DESCRIPTION/PURPOSE

The Account Selection Report/One-Line provides a one-line, ATB-type report using hospital-defined selection criteria. There are two versions of this report:

- Standard - The standard report lists the account name, account number, financial class, patient type, discharge date, final bill date, last payment date, account balance and aging category (an X identifies the age of each account).

- Insurance - The insurance version of the report lists the account name, account number,subscriber/HIC #, financial class, patient type, discharge date, insurance balance, patient balance, account balance and aging category (an X identifies the age of each account).

Accounts are included on this report based on the setting of the Insurance Selection field on the first page of the Account Selection Report request. If the Insurance Selection field is set to Primary Only, then accounts qualify based on the primary insurance plan and the account appears on the report only one time. If the Insurance Selection field is set to All Insurance plans, then accounts may appear on the report more than one time based on each insurance plan.

This report is only available when the user selects the one-line print option. It is printed as a by-product of the Account Selection Report with totals provided by aging category. Subtotals by the primary sort key are provided when the Page Break field is set to Yes. Grand totals are provided when the Insurance Selection field is set to Primary Only.

GENERATING AND PRINTING THIS REPORT

The Account Selection Report/One-Line is available as a demand report. It is printed as a by-product of selecting reports using the Account Selection function. The report is printed from the Accounts Management Reports option while the sort is selected using the Account Selection screen.

To use the fiscal period end balances, the system displays the following prompt in the Account Selection Report request function seven days past fiscal period end:

Use XX/XX/XX fiscal period balances? (Y/N)

The XX/XX/XX indicates the fiscal period end date.

Enter **Y** to use the fiscal period end balances. Enter **N** to not use the fiscal period end balances.

To use the balances as of midnight choose the tonight option. The system uses balances as of midnight, even if the Account Selection Report/One-Line report is still running the next morning.

The following are examples of an Account Selection Report/One-Line, both standard and insurance versions.

Figure 3.39 FARASA - Account Selection Report/One-Line Report (Standard Version)

```
Date: 01/17/06                          Model Hospital A                       Page  : 1
Time: 8:34                              Account Selection                      Report: FARASAA
                                     MLK - HIGH DOLLAR ACCOUNTS


                                   FBIL   DSCH    LAST      INS        PATIENT      ACCOUNT AGING CATEGORIES
ACCOUNT NO.   ACCOUNT NAME        FC PT   DATE   DATE   PYMT  BALANCE      BALANCE      BALANCE  1234567890123
0409000018    JONES,IIR           S  LIC 12/23/04 11/23/04     0.00     200148.70     200148.70  X
0409100015    ALT,TEN             S  LTC 12/23/04 11/23/04     0.00     222841.67     222841.67  X
0409200001    HIPAA,ONE           S  I/P 12/29/04 11/29/04     0.00     169552.92     169552.92    X
0410300006    JONES,IOR           S  LOB 06/11/05 05/12/05     0.00     228433.59     228433.59          X
0411000001    ALT,NEW             S  I/P 05/07/05 04/07/05     0.00     865962.15     865962.15   X
0411400004    MOTHERTWO,BABY GIRL SP NEW 08/24/05 07/25/05     0.00     290310.84     290310.84         X
0412500001    THRASHER,ALICE      S  MH  05/15/04 05/05/04     0.00     200000.00     200000.00       X
0414000015    SAKOWSKI,CHANGEDNAME O  I/P 01/14/06 01/11/06 349562.60   121877.75     471440.35           X
PATIENT ACCOUNTS TOTAL:                                    $705,309.55            $10,762,152.82
                                                              $10,056,843.27              # ACCTS:       35


AGING CATEGORY TOTALS:
        Cat  1     0 -   30 DAYS              0.00
        Cat  2    31 -   60 DAYS              0.00
        Cat  3    61 -   90 DAYS        109,748.31              1
        Cat  4    91 -  120 DAYS              0.00
        Cat  5   121 -  150 DAYS              0.00
        Cat  6   151 -  180 DAYS
        Cat  7   181 -  210 DAYS
        Cat  8   210 -  240 DAYS
        Cat  9   241 -  270 DAYS
        Cat 10   171 -  300 DAYS
        Cat 11   301 -  330 DAYS
        Cat 12   331 -  360 DAYS
        Cat 13      151> DAYS       10,652,404.51             34
PATIENT ACCOUNTS TOTAL:            $10,762,152.82             35

                                    End of Report
```

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Figure 3.40 FARASA - Account Selection Report/One-Line Report
(Insurance Version)

```
Date: 07/05/06                          Model Hospital A                                    Page  : 1
Time: 9:53                              Account Selection                                  Report: FARASAA
                                   MLK - PA ACCOUNTS-INS VER


                                                          DSCH      INS      PATIENT    ACCOUNT AGING CATEGORIES
ACCOUNT NO  ACCOUNT NAME        CRPL  SUBSCRIBER/HIC #   FC PT  DATE    BALANCE    BALANCE    BALANCE  123456789012
0532600001  RAD,TEST                                     S  I/P            0.00   84960.95   84960.95       6
0532600002  RAD,ANOTHER                                  S  I/P            0.00  228072.00  228072.00       6
0532600003  RAD,OPB             500100 10293842          O  OPB       145183.00  177683.00  322866.00       6
0533200001  OPPY,BECKY          100100 6767676767        M  ER  11/28/05    0.00       0.00       0.00       6
0534900002  CREDIBLE,JUSTIN                              S  OPO            0.00  113192.41  113192.41       6
0535300001  HARDERSEN,CHESTER                            S  I/P            0.00  159695.83  159695.83       6
0535400003  HARDERSEN,HOOFER H                           S  ALL            0.00  158444.46  158444.46       6
0536300001  OPPY,BECKY                                   S  JGH            0.00  150446.25  150446.25       6
0600900001  OPPY,BECKY          100100 92379879837       M  ER  01/09/06    0.00       0.00       0.00       5
0601200004  CMS,TEST            100100                   M  OPS 01/12/06  154.53       0.00     154.53       5
0602600003  MILLER,MEG          500400                   O  O/P 01/26/06  158.16       0.00     158.16       5
0602600004  CARR,CARRIE C       500400                   O  I/P 01/26/06 1327.72      20.42    1348.14       5
0602900003  MILLER,MEG          500400 912577            O  O/P 01/29/06  319.00      77.00     396.00       5
0603700001  MERRITT,ADMIT DX    500100                   O  I/P       96815.36    -436.74   96378.62       5
0604800002  ALBERS,ALBERT A     500400                   O  OPS 02/17/06 101244.03    70.28  101314.31       5
0605300001  KING,KIMWITHDATA                             S  ALL            0.00  106908.75  106908.75       5
0605500001  REYANT,RENEE        200100 00640333          K  SN1 06/30/06    0.00       0.00       0.00       5
0605800003  GUI,BED DISPLAY                              S  I/P            0.00  105783.11  105783.11       5
0605900001  TEST,JOHN 161                                S  IPC            0.00  104734.60  104734.60       5
0606500001  HELMS,JEAN          100100 CLAIM NUMBER      M  O/P 03/06/06    0.00       0.00       0.00       5
0606500002  TEST,JOHN 161       100100 123               M  ER  03/06/06    0.00       0.00       0.00       5
0606500003  OPPY,BECKY          100100 92379879837       M  O/P 03/06/06    0.00       0.00       0.00       5
0606600001  TEST,PCA STAR       100100 123               M  ER  03/07/06    0.00       0.00       0.00       4
0606800001  TEST,PCA STAR       100100 123               M  ER  03/09/06    0.00       0.00       0.00       4
0607000001  TEST,PCA STAR       100100 123               M  ER  03/11/06    0.00       0.00       0.00       4
0607100001  TEST,PCA STAR       100100 123               M  ER  03/12/06    0.00       0.00       0.00       4
0607200001  PCATEST,MONDAY ONE  100100 CLAIMNUMBER       M  O/P 03/13/06    0.00       0.00       0.00       4
0607200002  PCATEST,THREE       100100 CLAIMNUMBER       M  O/P 03/13/06    0.00       0.00       0.00       4
0607200003  TEST,CHARPCA 161    100100 789               M  OP  03/13/06   74.44     105.10     179.54       4
0607200004  OPPY,BECKY          100100 92379879837       M  O/P 03/13/06    0.00       0.00       0.00       4
0607300001  MERRITT,ABIGAIL     998300                   B  I/P       145926.93  -59818.17   86108.76       4
0607300002  TEST,PCA STAR       100100 123               M  ER  03/14/06    0.00       0.00       0.00       4
0607300003  TEST,JOHN 161       100100 123               M  ER  03/14/06  659.64      95.10     754.74       4
0607300004  TEST,JOHN 161       100100 123               M  ER  03/14/06   89.33      95.10     184.43       4
0608000001  DONER,OSF TESTING                            S  I/P            0.00   90249.44   90249.44       4
0608000002  DONER,OSF OPB       100100 021938479A        M  OPB 06/26/06 62415.61   10223.10   72638.71       4
0608300001  CMS,TEST            100100                   M  O/P 03/24/06  521.21      95.10     616.31       4
0608800001  PCA,ATLANTA         100100 CLAIMNUMBER       M  O/P 03/29/06    0.00       0.00       0.00       4
0609400006  LORENTZ,JUDITH                               S  SN1 06/30/06    0.00    1812.72    1812.72       4
0609400007  DILLOW,RALEIGH                               S  SN1 06/30/06    0.00     265.21     265.21       4
0609400008  COOPER,JOYCELYN S                            S  SN1 06/30/06    0.00      14.89      14.89       4
0609400009  STOLI,PATRICK I                              S  SN1 06/30/06    0.00       0.00       0.00       4
0609400010  BAIN,CYNTHIA DIANE                           S  SN1 06/30/06    0.00       0.00       0.00       4
0609400011  SMITH,CAROLINE LEIGH                         S  SN1 06/30/06    0.00       0.00       0.00       4
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

HEADINGS
If a page break is indicated for the primary sort key, a heading containing the code and the description of the primary sort key prints at the top of each page of data.

ACCOUNT NO.
This field contains the account number.

ACCOUNT NAME
This field contains the patient or guarantor name.

SUBSCRIBER/HIC #
This field contains the subscriber ID number or the health insurance claim number. The field is displayed only on the Insurance Version of the report.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc.

PT
This field contains the patient type code and is used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

INSURANCE BALANCE
This field contains the patient's insurance balance. This field is displayed only on the Insurance Version of the report.

FBIL DATE
This field contains the final billing date for this patient's account. This field is not displayed on the Insurance Version of the report.

DSCH DATE
This field contains the patient's discharge date.

LAST PYMT
This field contains the date of the last payment made to this patient's account.

INS BAL
This field contains the insurance balance.

PAT BAL
This field contains the patient balance.

ACCT BAL
This field contains the account balance.

AGING CATEGORIES
This field contains an X under the appropriate aging category as defined by the selection made on the Request Account Selection Report screen. Thirteen aging categories are displayed on this report. A single number in each column heading coincides with a category number: 1=1, 2=2, 3=3, 4=4, 5=5, 6=6, 7=7, 8=8, 9=9, 10=0, 11=1, 12=2, and 13=3.

SUBTOTALS
If a page break is requested for the primary sort key, subtotals for the insurance balance, patient balance, account balance and number of accounts are provided immediately following the detail data within the primary sort key.

- Insurance Balance - The total insurance balance for all accounts within the primary sort key.

- Patient Balance - The total patient balance for all of the accounts within the primary sort key.

- Account Balance - The total account balance for all of the accounts within the primary sort key.

- # Accts - The total number of accounts included within the primary sort key.

AGING CATEGORY SUBTOTALS
If a page break is requested for the primary sort key, subtotals for account balance and number of accounts are provided for each aging category. If a page break is not requested for the primary sort key, subtotals and aging subtotals are not be provided.

AGING TOTALS
This field contains the number of accounts and account balances for each of the aging categories and totaled for all accounts according to the report aging category selected. Aging totals are provided when the Insurance Selection field is set to Primary Only.

PATIENT ACCOUNTS TOTAL
This field contains the sum of all account balances and number of accounts included on the One Line ATB Report. Patient Accounts Totals are provided for all sort options when the Insurance Selection field is set to Primary Only.

NOTE: Totals are for accounts included in the Account Selection Report according to the user-defined criteria.

ACCOUNT SELECTION FINANCIAL CLASS SUMMARY - FARASF

DESCRIPTION/PURPOSE

The Financial Class Summary Reports (inpatient, outpatient, emergency room, and total) provide a synopsis of the number of accounts and total balances aged by user-defined categories and reported by financial class. Only financial classes with accounts/balances print on the report. Separate reports are printed by inpatient, outpatient, emergency room, and total.

Within each financial class on each of the four above reports, if Suppress Zero Balance Accounts is set to Yes in the Request Account Selection Report function, then the # Acct totals excludes zero balance accounts within each aging category.

NOTE: This report, run for patients in PA and AR, equals the FSR910 report, except that FARASF does not include accounts with blank financial classes.

GENERATING AND PRINTING THIS REPORT

This report is available as the result of selecting and requesting Summary Reports from the Account Selection Report menu. The Account Selection Financial Summary Reports are demand reports generated from the Account Management Reports menu.

To use the fiscal period balances, the system displays the following prompt seven days past fiscal period end:

Use XX/XX/XX fiscal period balances? (Y/N)

The XX/XX/XX indicates the fiscal period end date.

Enter **Y** to use the fiscal period end balances. Enter **N** to not use the fiscal period end balances.

To use the balances as of midnight choose the tonight option. The system uses balances as of midnight, even if the Account Selection Financial Class Summary report is still running the next morning.

The following is an example of Account Selection Financial Class Summary Report.

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Figure 3.41 FARASF - Account Selection Financial Class Summary Report

```
Date: 01/17/06                               Model Hospital A                                   Page  : 1
Time: 8:34                              Account Selection Report                                Report: FARASFA
                             Inpatient Financial Class Summary (MLK - HIGH DOLLAR ACCOUNTS)

                 Financial Class B       Financial Class O      Financial Class S      Financial Class SP    --------TOTAL---------
 Aging Category   # Acct      Amount    # Acct      Amount    # Acct      Amount    # Acct      Amount    # Acct        Amount

  000-030 Days               0.00                   0.00                   0.00                   0.00                   0.00
  % of FC         0.00       0.00       0.00        0.00      0.00        0.00      0.00        0.00      0.00          0.00

  031-060 Days               0.00                   0.00                   0.00                   0.00                   0.00
  % of FC         0.00       0.00       0.00        0.00      0.00        0.00      0.00        0.00      0.00          0.00

  061-090 Days               0.00                   0.00                   0.00                   0.00                   0.00
  % of FC         0.00       0.00       0.00        0.00      0.00        0.00      0.00        0.00      0.00          0.00

  091-120 Days               0.00                   0.00                   0.00                   0.00                   0.00
  % of FC         0.00       0.00       0.00        0.00      0.00        0.00      0.00        0.00      0.00          0.00

  121-150 Days               0.00                   0.00                   0.00                   0.00                   0.00
  % of FC         0.00       0.00       0.00        0.00      0.00        0.00      0.00        0.00      0.00          0.00

  151+ 180 DAYS      1   442956.98      1    471440.35     20   6135931.49      1   290310.84     23   7340639.66
  % of FC       100.00     100.00    100.00      100.00   100.00      100.00   100.00      100.00   100.00        100.00

  181-210 DAYS       1   442956.98      1    471440.35     20   6135931.49      1   290310.84     23   7340639.66
  % of FC       100.00     100.00    100.00      100.00   100.00      100.00   100.00      100.00   100.00        100.00

  211-240 DAYS       1   442956.98      1    471440.35     20   6135931.49      1   290310.84     23   7340639.66
  % of FC       100.00     100.00    100.00      100.00   100.00      100.00   100.00      100.00   100.00        100.00


  Total             1   442956.98      1    471440.35     20   6135931.49      1   290310.84     23   7340639.66
```

ACCOUNT SELECTION SUMMARY RECAP REPORT - FARASP

DESCRIPTION/PURPOSE

The Account Selection Account Summary Recap Report is a synopsis of the number of accounts, insurance balance, patient balance, and total account balances aged by user-defined categories and reported by patient indicator (inpatient, outpatient and emergency room).

For each patient indicator within each aging category, if Suppress Zero Balance Accounts is set to Yes in the Request Account Selection Report function, then the #Acct totals exclude zero balance accounts.

GENERATING AND PRINTING THIS REPORT

This report is available by selecting and requesting Summary Reports from the Account Selection Report menu option. This is a demand report generated from the Account Management Reports menu.

To use the fiscal period balances, the system displays the following prompt seven days past fiscal period end:

Use XX/XX/XX fiscal period balances? (Y/N)

The XX/XX/XX indicates the fiscal period end date.

Enter **Y** to use the fiscal period end balances. Enter **N** to not use the fiscal period end balances.

To use the balances as of midnight choose the tonight option. The system uses balances as of midnight, even if the Account Selection Summary Recap report is still running the next morning.

The following is an example of an Account Selection Summary Recap Report.

Figure 3.42 FARASP - Account Selection Summary Recap Report

```
Date: 04/10/08                          Windward Medical University                    Page  : 1
Time: 02:51pm                            Account Selection Report                       Report: FARASPA
                                      Summary Recap (FUH - F/UP HOLD ACCTS)

   Aging Category      Accounts      %       Ins Balance       %        Pt Balance        %          Total          %
------------------------------------------------------------------------------------------------------------------------


IP    0 -   30 Days                 0.00          0.00       0.00           0.00        0.00          0.00        0.00
OP                                  0.00          0.00       0.00           0.00        0.00          0.00        0.00
ER                                  0.00          0.00       0.00           0.00        0.00          0.00        0.00

IP   31 -   60 Days                 0.00          0.00       0.00           0.00        0.00          0.00        0.00
OP                                  0.00          0.00       0.00           0.00        0.00          0.00        0.00
ER                                  0.00          0.00       0.00           0.00        0.00          0.00        0.00

IP   61 -   90 Days                 0.00          0.00       0.00           0.00        0.00          0.00        0.00
OP                                  0.00          0.00       0.00           0.00        0.00          0.00        0.00
ER                                  0.00          0.00       0.00           0.00        0.00          0.00        0.00

IP   91 -  120 Days                 0.00          0.00       0.00           0.00        0.00          0.00        0.00
OP                                  0.00          0.00       0.00           0.00        0.00          0.00        0.00
ER                                  0.00          0.00       0.00           0.00        0.00          0.00        0.00

IP        121+ Days      15       100.00    1021091.84     100.00      785328.22      100.00    1806420.06      100.00
OP                       10       100.00     978293.38     100.00    19029578.37      100.00   20007871.75      100.00
ER                                  0.00          0.00       0.00           0.00        0.00          0.00        0.00


IP    Total             15         60.00    1021091.84      51.07      785328.22        3.96    1806420.06        8.28
OP    Total             10         40.00     978293.38      48.93    19029578.37       96.04   20007871.75       91.72
ER    Total                         0.00          0.00       0.00           0.00        0.00          0.00        0.00

      Total             25                  1999385.22              19814906.59                21814291.81

                                            End of Report
```

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ACCOUNT SELECTION REPORT - FARASR

DESCRIPTION/PURPOSE

The Account Selection Report is a facility-specific, user-defined demand report. This report allows the user to create and generate Patient Account Management reports using a wide range of account selection criteria.

All Account Selection reports enable you to define selection criteria. Examples are the following:

- Account Balance Ranges
- Account Locations
- Accounts on Payment Plans
- Admission Dates
- Biller Codes
- Collection Agency Accounts
- Collector Codes
- Converted Indicator
- Discharges Dates
- F/U Schedules
- Financial Classes
- Guarantor Last Name Ranges
- Guarantors on Payment Plans
- Include Converted Accounts
- Insurance Account Balance Ranges
- Insurance Carriers
- Insurance Claim Release/Submission Dates
- Insurance F/U Schedules
- Insurance F/U Hold Flags
- Insurance Plans
- Last Account Payment Dates
- Last Bill Dates
- Last Insurance Payment Dates
- Last/Next F/U Insurance Dates
- Last/Next Patient F/U Dates
- Last Pat/Ins/Acct Adjustment Dates
- Last Patient Payment Dates
- Next F/U Sequences
- Number of Patient F/Us
- Patient Account Balance Ranges
- Patient Classification
- Patient F/U Hold Flags
- Patient Indicators
- Patient Last Name Ranges
- Patient Types
- Prelist Accounts
- Prelist Indicators

This option enables you to select guarantor information, detail transactions, aging and sort criteria.

GENERATING AND PRINTING THIS REPORT

This report, which is a demand report, is available by selecting and requesting the Account Selection Report menu option within the Account Management function. You may also select the sort of the report from can extensive list of system defined sort options. The age of each account is based on the user-defined aging categories.

The following is an example of an Account Selection Report that includes guarantor and detail transactions.

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Figure 3.43 FARASR - Account Selection Report - Guarantor and Detail Transactions

```
Date: 06/19/06                              Model Hospital A                              Page  : 1
Time: 12:39                              Account Selection Report                         Report: FARASRA
                                      ARF - AR BY FINANCIAL CLASS
           - PATIENT INFORMATION -                        - FOLLOW UP INFORMATION -
Name  : KING,ELIZABETH             Carrier             Bl  Bill  Last     Amount   Cl     No  Last   F/U   Next H
Number: A9722300001                Plan       Balance  Cd  Date  Pd Dt    Paid     Cd  Sh F/U  Date  Ty Sq F/U  I
Admitted  : 02/11/05    Loc: AR/FCRV  400100  149587.40           02/26/05 1250.00
Discharged: 06/01/05    Fc : B                    0.00
Conv-Ind  :             Typ: I/P                  0.00
Prelist   : N           Age: 20                   0.00
Sched Type: Standard             Excess           0.00
Agency    :                      Patient      2 120.10  02/11/05 02/11/05 100.00     5      0              02/26/05 N
Pat Class :                      Account    151707.50   3
Pymt Plan Amt:     0.00   Prepaid Amt:       0.00
Delinq Amt   :     0.00   Delinq Date:
        - GUARANTOR INFORMATION -                      - GUARANTOR ACCOUNTS -
Name  : KING,ELIZABETH                           No        Ins         Patient        Account
Corp No: 00001056                                Accts     Balance     Balance        Balance
Address: LAKE STREET
                                       PA    002      0.00          577.50          577.50
        General Hospital, GA 30346     AR    006  149587.40       10020.30        159607.70
                                       BD    000      0.00            0.00            0.00

Home Phone                             Total  008  149587.40       10597.80        160185.20
Work Phone
Pymt Plan Amt:     0.00   Prepaid Amt   :    0.00
Delinq Amt   :     0.00   Delinq Date   :
Pr to Pay Amt:     0.00   Pr to Pay Date:
                                   - DETAIL TRANSACTIONS -
    Tran-Type
      Code       Description                  Amount      Date      Batch     User
    Y 0001       CYCLE BILL                   10625.00    03/05/05            0
    Y 0001       CYCLE BILL                   11900.00    04/05/05            0
    Y 0001       CYCLE BILL                   17125.10    05/05/05            0
    Y 0001       CYCLE BILL                   12750.00    06/05/05            0
    Y 0001       CYCLE BILL                   13175.00    07/05/05            0
    Y 0001       CYCLE BILL                   13477.01    08/05/05            0
    Y 0001       CYCLE BILL                   12055.54    09/05/05            0
    Y 0001       CYCLE BILL                   13559.78    10/05/05            0
    Y 0001       CYCLE BILL                   12750.00    11/05/05            0
    Y 0001       CYCLE BILL                   13600.00    12/05/05            0
    Y 0001       CYCLE BILL                   12750.00    01/05/06            0
    S 0004       Account Transfer PA to AR    152857.50   02/27/06
    Y 0002       FINAL BILL                    9090.07    03/27/06            0
    M 0013       Workfile Telephone Entry     152857.50   04/28/06            SYSTEM
    M 0013       Workfile Telephone Entry     152857.50   05/29/06            SYSTEM
```

General information lines are printed for all accounts selected. Guarantor and account detail is printed if selected in the parameter report.

NOTE: A Detail report is not created if you choose to use fiscal period balances because the information is not saved at that level of detail. Guarantor information is not included if the report is run using the "tonight" option.

The first line of the report header contains the date the report is generated, the facility name, and page number of the report. The second line contains the time the report is generated, the label *Account Selection Report,* and the system name of the report. The third line contains the three-character, user-defined title of the report.

The following are explanations of selected fields on this report.

Follow-Up Information

NAME
This field displays the account name.

NUMBER
This field displays the account number.

CARRIER PLAN
This field contains the user-defined carrier and plan codes (not to exceed six digits.) The combination is defined by the hospital. Up to nine carrier/plans can be associated with an account.

BALANCE
This field contains the insurance carrier balance, the excess COB amount, the patient and account balance.

BL CD
This field contains the up to three-digit Biller code identifying the biller assigned to the account.

BILL DATE
For the carrier plan line, this field contains the date the most recent claim was mailed. For the patient balance line, this field contains the final bill or most recent bill date.

LAST PD DT
This field contains the date the most recent payment was received from the carrier(s) or patient.

AMOUNT PAID
This field contains the amount of the payments made.

CL CD
This field contains the up to three-digit code identifying the collector handling the follow-up for the carrier plan and for the guarantor.

SH

This field contains the code identifying the follow-up schedule used for insurance and guarantor follow-up and agency follow-up.

NO F/U

This field contains the number of follow-ups (letters and statements) sent to each carrier and the guarantor.

LAST DATE

This field contains the last date for follow-up for each carrier and guarantor.

F/U TY SQ

This field identifies the most recent follow-up type and sequence used for the carriers and the guarantor. Follow-up types include L (follow-up letter), D (detail statement) or T (telephone call).

NEXT F/U

This field contains the next scheduled follow-up date for each carrier and guarantor.

HI

This field displays whether the account is on hold from follow-up. If the account is on hold, the system displays Y in this field. If the account is not on hold, the system displays N or leaves this field blank.

ADMITTED

This field contains the date the patient was admitted.

DISCHARGED

This field contains the date the patient was discharged.

PRELIST

This field displays whether this account is prelisted for transfer to bad debt. If this account is prelisted for transfer to bad debt, this field displays Y. If this account is not prelisted for transfer to bad debt, this field displays N.

LOC

This field contains the accounting location/sub location of this account.

FC

This field contains the user-defined financial class code assigned to this patient.

TYP

This field contains the user-defined patient type code assigned to this patient.

AGE

This field contains the aging category specified in the Account Selection Parameter report.

SCHED TYPE
This field displays the type of schedule on which this account has been placed.

AGENCY
This field contains the user-defined code identifying the collection agency to which this account has been assigned, if applicable. The collection agency codes selected can have an agency type of Internal, CCI, External Bad Debt, or Internal Bad Debt.

PAT CLASS
This field combines the patient classification and the patient classification suppress/ alert indicator into one field. The information displays in a format similar to the display on the Account Inquiry and Account Revision Flash Card screen, where leading and trailing asterisks (**) denote the alert status for the patient classification. Patient Classifications that are not alert statuses do not have the asterisks. Following are examples of this information.

Pt Class: **DLQ** Alert only

Pt Class: **BRD** Suppressed

Pt Class: **BRD** Cleared

Pt Class: DNR

PYMT PLAN AMT
This field contains the payment plan amount.

DELINQ AMT
This field contains the amount delinquent on the account.

PREPAID AMT
This field contains the prepaid amount on the account.

DELINQ DATE
This field contains the date the account is delinquent based on the payment plan.

Guarantor Accounts

NAME
This field displays the guarantor name.

CORP NO
This field displays the guarantor corporate number.

ADDRESS
This field displays the guarantor address.

NO ACCTS
This field displays the number of accounts that this guarantor has in Patient
Accounting, Accounts Receivable, and Bad Debt.

INS BALANCE
This field displays the balance due from the insurance company for accounts that this
guarantor has in Patient Accounting, Accounts Receivable, and Bad Debt.

PATIENT BALANCE
This field displays the balance due from the patient for accounts that this guarantor has
in Patient Accounting, Accounts Receivable, and Bad Debt.

ACCOUNT BALANCE
This field displays the total account balance for this guarantor for Patient Accounting,
Accounts Receivable, and Bad Debt.

HOME PHONE
This field displays the home phone number for the guarantor.

WORK PHONE
This field displays the work phone number for the guarantor.

PYMT PLAN AMT
This field displays the payment plan amount for this guarantor.

PYMT PLAN AMT
This field displays the payment plan amount for this guarantor.

DELINQ AMT
This field displays the delinquent amount for this guarantor.

PR TO PAY AMT
This field displays the promise to pay amount for this guarantor.

PREPAID AMT
This field displays the prepaid amount for this guarantor.

DELINQ DATE
This field displays the date this guarantor became delinquent.

PR TO PAY DATE
This field displays the promise to pay date for this guarantor.

NOTES UPLOAD SUMMARY REPORT - FFRNU

DESCRIPTION/PURPOSE

This report is generated when note files are uploaded manually by accessing Financial System Management, Interface Functions, Agency Processing Interfaces, and selecting Manual Notes Upload. The report provides a concise audit trail of the note recipient, the agency, and the applicable notes file name. The entries posted are based on the prior day's activities.

GENERATING/PRINTING THIS REPORT

After using the Manual Notes Upload Process, this report is generated during Midnight Processing when all of the applicable files are updated. The selection of accounts is a by-product of the upload process. This report is facility-specific.

Following is a sample of the Notes Upload Summary Report.

Figure 3.44 FFRNU - Notes Upload Summary Report

```
Date: 03/29/06              General Hospital              Page  : 1
Time: 08:50am                Notes Upload Summary         Report: FFRNUA

AGENCY (/hbo/tmp/F9196.NTE)


Note Type  Tran Cd  Date/Time       Recipient      Name
-------------------------------------------------------------------------------
Standard   T0001    03/29/06 08:49  A9912300123    SMITH,CREDIT;CHECK
Freeform   T0004    03/29/06 08:49  A9912300123    SMITH,CREDIT;CHECK
Freeform   T0004    03/29/06 08:49  A9912300123    SMITH,CREDIT;CHECK
Standard   T0001    03/29/06 08:49  A9912300123    SMITH,CREDIT;CHECK
Freeform   T0004    03/29/06 08:49  A9912300123    SMITH,CREDIT;CHECK


                         End of Report
```

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Field Explanations

AGENCY
This field contains the agency code included in the manually uploaded notes file. The description is filled from the Collection Agency Code table.

FILE NAME
This field contains the file name included in the manually uploaded notes file.

NOTE TYPE
This field contains Standard for S note types, Freeform for F note types and Contract for C note types, as defined in the manually uploaded notes file.

TRAN CD
This field contains the transaction code used in the creation of Transaction History, as defined in the manually uploaded notes file. The default code comes from the PAAR Control, Free Form Notes Transaction Code field.

DATE/TIME
This field contains the date and time the transaction history entry was created.

RECIPIENT
This field contains the patient account number having a note applied. Guarantor level notes may result in multiple notes being generated from a single input file entry. The Recipient for guarantor type notes is the Corporate number for the guarantor. The contract code is displayed for contract notes.

NAME
This field contains the patient/guarantor/contract name.

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NOTES UPLOAD EXCEPTIONS REPORT - FFRNUE

DESCRIPTION/PURPOSE

This report provides a concise audit trail of accounts that have a note to be posted (from the Manual Notes Upload Process) but do not exist on the STAR Patient Accounting system or in a non-PA, AR, or BD location.

Exceptions included on the report are:

- Invalid Recipient (account number/corporate/vendor)

- Invalid facility code - any error of this nature is displayed in the facility listed first in ~CF (list of active facilities).

- Account not in PA, AR, or BD location

- Invalid Record Type

- Invalid Transaction Code

- Invalid Description

- Too Many Note Text Records

- Invalid Note Type (S/F)

- N2 without matching N1

- Invalid Agency Code

The entries selected to be printed are a by-product of the upload process.

GENERATING/PRINTING THIS REPORT

After using the Manual Notes Upload Process, this report is generated during Midnight Processing when all of the applicable files are updated. The report is cumulative from the prior day's activity. It is facility-specific. The report is spooled to FFRNUE.

Following is a sample of the Notes Upload Exceptions Report.

Figure 3.45 FFRNUE - Notes Upload Exceptions Report

```
Date: 03/29/06                              General Hospital                                Page  : 2
Time: 08:50am                             Notes Upload Summary                           Report: FFRNUEA

JOHNNY - JOHNNY'S TEST AGENCY (/home/emp/patnotes.dat)

Excess Note Text Records
JOHNNYN2P A 0518100003                                          021420061440F0004123456789012345678901234567890
TEST NOTE LINE 1 -----------------------------------------------------------8

Excess Note Text Records
JOHNNYN2P A 0518100003                                          021420061440F0004123456789012345678901234567890
TEST NOTE LINE 1 -----------------------------------------------------------9

Excess Note Text Records
JOHNNYN2P A 0518100003                                          021420061440F0004123456789012345678901234567890
TEST NOTE LINE 1 -----------------------------------------------------------10

Excess Note Text Records
JOHNNYN2P A 0518100003                                          021420061440F0004123456789012345678901234567890
TEST NOTE LINE 1 -----------------------------------------------------------11

Excess Note Text Records
JOHNNYN2P A 0518100003                                          021420061440F0004123456789012345678901234567890
TEST NOTE LINE 1 -----------------------------------------------------------12

Excess Note Text Records
JOHNNYN2P A 0518100003                                          021420061440F0004123456789012345678901234567890
TEST NOTE LINE 1 -----------------------------------------------------------13
```

COLLECTOR WORKFILE PURGE DETAIL REPORT - FFRRWSP

DESCRIPTION/PURPOSE

This report is generated when detail or summary collector statistics are purged in Receivables Workstation. The system generates a report of information that was purged, by facility.

GENERATING/PRINTING THIS REPORT

This report is generated auomatically as part of the statistics purge process in the Receivables Workstation. The report is spooled to FFRRWSP.

Following is a sample of the Collector Workfile Purge Detail Report.

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Figure 3.46 FFRRWSP - Collector Workfile Purge Detail Report

```
Date:  05/07/02                           General Hospital                          Page:      1
Time:  10:13                          Collector Workfile Purge Detail
Report:  FFRRWSP                      RWS Detail Statistics Purged on 05/07/02
Seq  Worked Info        For/By CC Work Type    Description                         ID        Name
    F/U amount     T Code   Fac          F/U Date  Begin Time    End Time
  1 Process Assigned       For 2        Insurance char = 23xxxxxxxxxxxxxxx          A0112300035 Doe,John
     111,234.50  T0012   A          xx/xx/xx     09:36    10:04
  2  Resched Switched   BY            98 AR Acct Pay Plan                           B0213400123 Smith,Bob
      574.34  T9013   B          xx/xx/xx  :42        17:51
```

Field Explanations

SEQUENCE
This field contains the number in the counter of workfiles processed or rescheduled.

WORKED INFO
This field contains information on how the workfile was dispositioned. The options are 1) Process Switched; 2) Process Assigned; 3) Resched Switched; and 4) Resched Assigned.

FOR/BY CC
This field contains the code of the collector who was assigned to the workfile entry (FOR) and the code of the collector who processed or rescheduled the workfiles and was not assigned to the workfile entry (BY).

WORK TYPE
This field contains the type of workfile processed or rescheduled. The options are Insurance, Standard, Focus Ins, Focus Pat, Agency, Bad Debt, Prom Pay, Part Pay, Delinquent, Active, and Contract.

DESCRIPTION
This field contains the type of workfile entry defined within Work Type. The options are as follows:

- Insurance

- Standard

- Focus Insurance

- Focus Patient

- AR Agency

- Bad Debt

- Promise Pay

- Part Pay

- Active

- Contract

ID
This field contains the ID to which the workfile was applicable. The options are listed below:

1) Insurance

a. Patient account number

2) Standard

a. Guarantor corporate number if account is on a guarantor level follow up logic

b. Patient account number if the account is on a patient level follow up logic.

3) Focus Insurance

a. Patient account number

4) Focus Patient

a. Guarantor corporate number if account is on a guarantor level follow up logic

b. Patient account number if the account is on a patient level follow up logic.

5) AR Agency

a. Patient account number

6) Internal Bad Debt

a. Patient Account Number

7) Promise to Pay

a. Guarantor Corporate number

8) Partial Pay

a. Guarantor corporate number if account is on a guarantor level follow up logic

b. Patient account number if the account is on a patient level follow up logic.

9) Delinquent

a. Guarantor corporate number if account is on a guarantor level follow up logic

b. Patient account number if the account is on a patient level follow up logic.

10) Active

a. Patient Account Number

11) Contract

a. Contract Description

NAME
This field contains the appropriate information as defined in the ID column of information.

F/U AMOUNT
This field contains the dollar amount being collected when the workfile entry is processed or rescheduled.

T CODE
This field contains the last transaction code applicable to notes added or the default transaction code.

FAC
This field contains the number of the facility for which the workfile applied.

F/U DATE
The field contains the follow-up date on which the workfile was processed or rescheduled.

BEGIN TIME
This field contains the time the collector accessed the workfile entry.

END TIME
This field contains the time the workfile was processed or rescheduled.   The minimum time allowed is one minute.

RECEIVABLES WORKSTATION VOLUME STATS PROM PAY INFORMATION - FFRRWSR

Description/Purpose

This report lists collectors establishing the promise to pay for an account. The promise to pay is linked to the collector establishing the promise to pay. This person may be different than the collector assigned to the account/guarantor for follow-up. The promise to pay information is maintained for each time a promise was made and the last promise to pay date is not in the past. Updates to the promise amount or date are reflected in the current information as long as the promise to pay date is the current date or a future date.

Generating/Printing This Report

This report is generated from Receivables Workstation (RWS) when the Print button is clicked on the Volume Workfile Statistics - Promise to Pay Detail for Collector window. Receivables Workstation generates a report spooled to FFRRWSP.

For information on the Receivables Workstation, refer to the online help.

Following is a sample of the report.

Figure 3.47 RWS Volume Stats Prom Pay Info Report - FFRRWSR

```
Date: 06/10/02                              STAR Development System                              Page  : 1
Time:10:15                                RWS Volume Stats Prom Pay Info                          Report: FFRRWSR
Facility: All Facilities      Collector Group: ALL GROUPS        Collector:  98 New, Steve      Dates: 04/17/02 - 06/10/02
Fac Corp ID  Name                 Created  Promised Original Amt  Current Amt  Promise Amt Dt Paid   Amount Paid  Outstanding
A  00002091 BARR, MARK            04/23/02 04/23/02  $500.00       $500.00      $500.00                $0.00       $500.00
A  00002091 BAO,NANCY             05/01/02 05/17/02  $500.00       $400.00      $565.00 05/07/02       $165.00     $400.00
A  00002238 ADAMS,JASON           06/04/02 06/05/02  $1,000.00     $1,000.00    $1,000.00 06/04/02     $8.00       $992.00
A  00002619 KANE, MIKE            04/18/02 04/18/02  $1,000.00     $1,000.00    $1,000.00              $0.00       $1,000.00
A  00002741 TIMMS, MARGE          04/23/02 04/23/02  $1,000.00     $1,000.00    $1,000.00              $0.00       $1,000.00
A  00002915 SMITH, BOB            05/22/02 05/23/02  $500.00       $500.00      $500.00                $0.00       $500.00
                                                                  End of Report
```

Field Explanations

FACILITY
This field contains the name of the facility(ies) selected to review.

COLLECTOR GROUP
This field contains the name of the collector group selected to review information.

COLLECTOR
This field contains the name and number of the collector establishing the promise to pay.

DATES (START AND ENDING)
This field contains the starting and ending dates for the promise to pay activity which is reported.

FACILITY
This field contains the facility code of the guarantor's account for which the promise to pay was made.

CORP ID
This field contains the corporate number of the guarantor in which a promise to pay was established by the collector.

NAME
This field contains the name of the guarantor for which a promise to pay was established.

CREATED
This field contains the date the promise to pay was made.

PROMISED
This field contains the date the promise to pay was agreed to.

ORIGINAL AMT
This field contains the amount of a promise to pay as originally defined.

CURRENT AMT
This field contains the amount of the total promise made.

PROMISE AMT
This field contains the promised amount.

DT PAID
This field contains the last date a guarantor or patient payment was posted. This applies only to accounts in location AR. Bad Debt accounts linked to an internal or external collection agency are not reflected in payments made to the promise to pay amount and as a result do not update the last Date Paid information.

AMOUNT PAID

This field contains the cumulative dollar amount of payments made on PA, AR, and Internal BD location accounts. This amount is updated only if the Promise to Pay date is not a past date. The dollar amount does not accumulate patient adjustments as an amount paid.

OUTSTANDING

This field contains the outstanding amount of money not received on the promise.This field represents the total amount promised less payments received on AR location accounts.

RECEIVABLES ANALYSIS REPORT - FSR910

Description/Purpose

The Receivables Analysis Report provides a daily analysis of the hospital's receivables. The average daily revenue and AR days are updated by financial class and patient indicator.

This report assists the hospital in concentrating its collection efforts on areas of greatest need.

Generating and Printing This Report

The Receivables Analysis Report is an optional batch job, scheduled to run at a user-specified time. It is sorted by financial class and subsorted by patient indicator with page breaks at the end of every page. Refer to "Optional Batch Jobs" in Chapter 2: Financial System Management of the *General Information Volume* in the *STAR Financials Patient Accounting Reference Guide* for more information.

The following is an example of a Receivables Analysis Report.

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Figure 3.48 FSR910 - Receivables Analysis Report

```
Date:  03/05/92                              GENERAL HOSPITAL                              Page  :  1
Time:  02:02 pm                         Receivables Analysis Report                        Report:  FSR910

        Average   % Tot  PA Pre  Unbilled PA  PA    Unbilled PA                AR                    Total                   AR
        Daily Rev  Rev   Disch   Pre-Discharg Disch  Discharged   Billed PA   Accts    Billed AR    Accts     Total AR      Days

13 MEDICARE HOSPICE
    E      11.70   0.15%    0        0.00      0        0.00          0.00       2     $1,160.12       2     $1,160.12      99.2
    I   $3,*577.31 45.28%  14    $41,313.00    6     $2,404.00   $133,541.04     17   $171,543.27      37   $348,801.31      97.5
    O    $383.26   4.85%    0        0.00      1       $455.00      $20.00-       1    $72,753.40       2    $73,188.40     191.0
  Tot  $3,972.27  50.28%   14    $41,313.00    7     $2,859.00   $133,521.04     20   $245,456.79      41   $423,149.83     106.8

28 WELFARE-OUT OF S
    E    $127.66   1.62%    0        0.00      0        0.00          0.00       2       $762.10       2       $762.10      48.1
    I   $3,596.16  45.52%  20     $9,750.00    3        0.00    $315,612.75       2    $14,217.25      25   $339,580.00      94.4
    O    $203.52   2.58%    0        0.00      0        0.00          0.00       1    $10,909.35       1    $10,909.35      53.6
  Tot  $3,927.34  49.72%   20     $9,750.00    3        0.00    $315,612.75       5    $25,888.70      28   $351,251.45      92.4

Facility Totals
       $7,899.61 100.00%   34    $51,063.00   10     $2,859.00   $449,133.79     25   $271,345.49      69   $774,401.28      98.0

*Number of days used for Average Daily Revenue Calculation: 72


                                          End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

The report displays the code and description of the financial class. For each patient indicator (E-emergency room, I-inpatient, O-outpatient) for the financial class, the following fields of information display:

AVERAGE DAILY REVENUE
This field displays the average daily revenue for the facility. The hospital uses the PAAR Control Table to define the number of months the system should use for the calculation of Average Daily Revenue. For more information, refer to the discussion of the PAAR Control Table in Financial System Management section in the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide*.

The system displays the number of days used in this calculation at the end of the report.

% TOT REV
This field contains the percentage of the average daily revenue of total revenue by reported category.

PA PRE DISCH
This field contains the number of accounts in PA that have not been discharged, for the reported category. This value includes zero balance accounts.

UNBILLED PA PRE-DISCHARG
This field contains the amount of unbilled charges for non-discharged patients.

PA DISCH
This field contains the number of accounts in PA that have been discharged, for the reported category. This value includes zero balance accounts.

UNBILLED PA DISCHARGED
This field contains the amount of unbilled charges for discharged patients.

BILLED PA
This field contains the amount of billed charges, including payments and adjustments, for patients who have not been final-billed. These patients may or may not have been discharged.

AR ACCTS
This field contains the number of accounts in AR for the reported category. This value does not include zero balance accounts.

BILLED AR
This field contains the amount of billed charges, including payments and adjustments, for patients who have been final-billed.

TOTAL ACCTS

This field contains the total number of accounts in PA and AR. This value includes zero balance accounts that are in PA but does not include zero balance accounts that are in AR.

TOTAL AR

This field contains the total of all Accounts Receivable (the amounts in the preceding balance fields).

AR DAYS

This field contains the number of total days outstanding in Accounts Receivable. The system calculates this value by dividing the value in the Total AR column by the value in the Average Daily Rev column.

FACILITY TOTALS

This field contains the total of the amounts in the preceding fields for the facility.

AGENCY PROCESSING TRANSFER REPORT - FFR610

Description/Purpose

The Agency Processing Transfer Report, FFR610, lists all of the accounts that are transferred to a status of agency processing.There are two versions of this report. One version reports on the guarantor collector's accounts, and the other version reports on the insurance collector's accounts.

Generating and Printing This Report

The Agency Processing Report report is generated from the Agency Processing Optional Batch Job. This report is sorted by guarantor name within the collector name. This report is totaled by collector and by AR agency.

This report contains a header that includes the date and time the report is generated, your hospital name, the report title, the page number, and the report name as used in the system.

Figure 3.49 FFR610 - Agency Processing Transfer Report (Guarantor
Version)

```
Date: 03/04/07                               Model Hospital A                               Page : 1
Time: 2:04                        Agency Processing Transfer Report for ABC                 Report: FFR610A


Guarantor Collector: 12   Bob Henderson


Corp #    Guarantor Name            Patient Name            Account #   Schedule
D/C Date   Ind   F/C   P/T    Paper F/U     Acct Balance    Pat Balance   Last Patient Payment   Last Insurance Payment     M/S
-----------------------------------------------------------------------------------------------------------------------------
14234523  *-KART, MIKD           INV-KART, MIKE
Total Collector 12                0 accounts        $0.00


Report Total                      0 accounts        $0.00


 ** - Incomplete Address,  ## - Invalid Address/Phone
                                              End of Report
```

Figure 3.50   FFR610 - Agency Processing Transfer Report (Insurance
Version)

```
Date: 05/19/06                               Model Hospital A                               Page : 2
Time: 7:36                        Agency Processing Transfer Report for ABC                 Report: FFR610A


Insurance Collector: 222 Brewer,Bobbie R.


Corp #    Guarantor Name            Patient Name            Account #   Schedule
D/C Date   Ind   F/C   P/T    Paper F/U     Acct Balance    Car Balance   Last Carrier Payment   Car/Plan   Seq            M/S
-----------------------------------------------------------------------------------------------------------------------------
00004903  STEWART,KAREN          STEWART,KAREN             0601000001
01/11/06   I     O     I/P                    1,541.11       1,436.11          0.00             500/100    3              L


Total Collector 222               1 accounts    $1541.11

Report Total                      2 accounts    $3082.22


        ##-Invalid Address

                                              End of Report
```

Field Explanations

CORP #
This field contains the corporate number.

GUARANTOR NAME
This field contains the guarantor name.

PATIENT NAME
This field contains the patient's name.

ACCOUNT #
This field contains the patient's account number.

SCHEDULE
This field contains the Follow-up schedule of the account.

D/C DATE
This field contains the date the patient was discharged.

IND
This field contains the patient indicator. Values for this field are: I-inpatient, O-outpatient, and E-emergency.

F/C
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc.

P/T
This field contains the patient type code used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

PAPER F/U
This field contains the total number of statements and letters and the date the last statement or letter was generated. This field does not include memo statements or letters.

ACCT BALANCE
This field contains the account balance.

PAT BALANCE
This field contains the patient's balance. This field is displayed only on the guarantor version of the report.

CAR BALANCE
This field contains the carrier's balance. This field is displayed only on the insurance version of the report.

LAST PATIENT PAYMENT
This field contains the amount of the last patient payment and the date of the last patient payment. This field is displayed only on the guarantor version of the report.

LAST CARRIER PAYMENT
This field contains the amount of the last carrier payment and the date of the last payment. This field is displayed only on the insurance version of the report.

LAST INSURANCE PAYMENT
This field contains the amount of the last insurance payment and the date of the last insurance payment. This field is displayed only on the guarantor version of the report.

CAR/PLAN
This field contains the carrier and plan numbers. This field is displayed only on the insurance version of the report.

SEQ
This field identifies the current sequence number indicating the step of the follow-up schedule for the account. This field is displayed only on the insurance version of the report.

M/S
This field contains the maintenance or status code of the account.

AGENCY PROCESSING REJECTION REPORT - FFR620

Description/Purpose

The Agency Processing Rejection Report, FFR620, includes accounts that did not transfer to agency collection because they did not meet the agency collection information criteria. Accounts only appear on the report if their rejection reasons have a prioritization assigned in the agency collection information.

Generating and Printing This Report

The Agency Processing Rejection report is generated from the Agency Processing Optional Batch Job. This report sorts by collector and then by either, primary rejection reason, or guarantor last name. The Primary Sort for Rejection Reports field in the Pre-Collection Information Parameters controls if the report sorts by primary rejection reason or guarantor last name. If this report sorts by guarantor name, the Primary Reject Reason field on the report is blank but all of the rejection reasons are still displayed in the Rejection Reasons field. This report totals by rejection reason within collector.

The following is an example of the Agency Processing Rejection Report.

Figure 3.51 FFR620 - Agency Processing Rejection Report

```
Date: 05/06/07                              General Hospital A                              Page  : 1
Time: 09:31am                          Agency Processing Report for INTSP                   Report: FFR620A
Collector: 12 KESER,NANCY                               Primary Reject Reason: 64 AR/BD STATUS BLOCK       (*)
Corp #     Guarantor Name               Patient Name            Account #   Schedule   Reject Reason(s)
D/C Date   Ind  F/C  P/T     Paper F/U    Acct Balance   Pat Balance  Last Patient Payment  Last Insurance Payment   M/S
---------------------------------------------------------------------------------------------------------------------
00001621   RESLER,FRANCINE              RESLER,FRANCINE          9701600026            64
01/16/97   O    S1   O/P                   1,130.00     1,130.00     20.00 02/03/97          0.00                T
Total Rejection Reason 64          1 accounts      $1,130.00
Total Collector 12                 1 accounts      $1,130.00
Report Total                       1 accounts      $1,130.00


12=Pat Bal Low   23=Act Bal Low    30=Reselet Days 35=Days Fnl Bill 42=Pat Payment   57=Ins Carrier    62=Fin Class      87=Zip Code
16=Wait Cycle    25=Act Bal High   33*Ins Balance  39=Days Ins Pay  46=Church        58=Ins Car/Plan  64*AR/BD Status 88=Pat Indicator
22=Pat Bal High  29*Step/Sch Chg   34=Days Dischg  40=Pat F/U Cnt   48=Pat Type      59=Occupation     78*F/U Hold
90=Inv Addr/Ph

            ** - Incomplete Address,  ## - Invalid Address/Phone


                                        End of Report
```

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This report contains a header that includes the date and time the report is generated, your hospital name, the report title, the page number, and the report name as used in the system.

CORP #
This field contains the corporate number.

GUARANTOR NAME
This field contains the guarantor name.

PATIENT NAME
This field contains the patient's name.

ACCOUNT #
This field contains the patient's account number.

SCHEDULE
This field contains the Follow-up schedule that the account uses if it transfers to agency collection.

REJECTION REASON
This field contains the rejection reason code. Please refer to the legend at the bottom of the page. Rejection reason codes with an asterisk (*) are fatal rejection reason codes. For more information about rejection reason codes, refer to Appendix A in the *Follow-Up Functions Volume* in the *STAR Financials Patient Accounting Reference Guide*.

D/C DATE
This field contains the date the patient was discharged.

IND
This field contains the patient indicator. Values for this field are: I-inpatient, O-outpatient, and E-emergency.

F/C
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc.

P/T
This field contains the patient type code used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

PAPER F/U
This field contains the total number of statements and letters and the date the last statement or letter was generated. This field does not include memo statements or letters.

ACCT BALANCE
This field contains the account balance.

PAT BALANCE
This field contains the patient's balance.

LAST PATIENT PAYMENT
This field contains the amount of the last patient payment and the date of the last patient payment.

LAST INSURANCE PAYMENT
This field contains the amount of the last insurance payment and the date of the last insurance payment.

M/S
This field displays the maintenance or status code of the account. If the account is unselected for agency processing due to a fatal rejection reason, an asterisk (*) displays in this field. The account does not have a maintenance code to display and is removed from the report. Refer to Appendix A in the *Follow-Up Functions Volume* in the *STAR Financials Patient Accounting Reference Guide* for an explanation of the maintenance and status codes.

PENDING/CANDIDATE TRANSFER REPORT - FFR630

Description/Purpose

The Pending/Candidate Transfer Report, FFR630, lists all accounts that have transferred to Pending/Candidate.

Generating and Printing This Report

The Pending/Candidate Transfer Report is generated from the Agency Processing Optional Batch Job. This report is sorted by guarantor name within collector. This report totals by collector.

The following is an example of the Pending/Candidate Transfer Report.

Figure 3.52 FFR630 - Pending/Candidate Transfer Report

```
Date: 05/06/05                              General Hospital A                                  Page  : 1
Time: 09:31am                    Pending/Candidate Transfer Report for INTSP                    Report: FFR630A
Collector: 12 KESER,NANCY
Corp #    Guarantor Name              Patient Name                  Account #    Schedule
D/C Date   Ind  F/C  P/T    Paper F/U      Acct Balance    Pat Balance   Last Patient Payment   Last Insurance Payment    M/S
------------------------------------------------------------------------------------------------------------------------
00001557  ALBERTS,JERRY               ALBERTS,JERRY                 9701600075   776
01/16/05   I    S    I/P    1 01/31/97      1,279.10      1,279.10          10.00  02/04/05        0.00                    F
00001948  WARD,SEAN                   WARD,SEAN                     9626000014   776
09/20/04   I    S1   PMK                    1,100.25      1,100.25           0.00                  0.00                    F
14234523  *-KRANE, MIKE               INV-KRANE, MIKE


Total Collector 12            2 accounts      $2379.35
Report Total                  2 accounts      $2379.35

** - Incomplete Address,  ## - Invalid Address/Phone


                                          End of Report
```

This report contains a header that includes the date and time the report is generated, your hospital name, the report title, the page number, and the report name as used in the system.

CORP #
This field contains the corporate number.

GUARANTOR NAME
This field contains the guarantor name.

PATIENT NAME
This field contains the patient's name.

ACCOUNT #
This field contains the patient's account number.

SCHEDULE
This field contains the Follow-up schedule that the account uses if it transfers to agency collection.

D/C DATE
This field contains the date the patient was discharged.

IND
This field contains the patient indicator. Values for this field are: I-inpatient, O-outpatient, and E-emergency.

F/C
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc.

P/T
This field contains the patient type code used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

PAPER F/U
This field contains the total number of statements and letters generated for the patient and the date of the last statement or letter. This number does not include memo statements or letters.

ACCT BALANCE
This field contains the account balance.

PAT BALANCE
This field contains the patient's balance.

LAST PATIENT PAYMENT
This field contains the amount and the date of the last patient payment.

LAST INSURANCE PAYMENT
This field contains the amount and the date of the last insurance payment.

M/S
This field displays the maintenance or status code of the account. Refer to Appendix A in the *Follow-Up Functions Volume* in the *STAR Financials Patient Accounting Reference Guide* for an explanation of the maintenance and status codes.

PENDING/CANDIDATE REJECTION REPORT - FFR640

Description/Purpose

The Pending/Candidate Rejection Report, FFR640, includes accounts that are flagged but did not transfer to pending or candidate because they did not meet the collection information criteria. Accounts only appear on this report if their rejection reasons have a priority.

Generating and Printing This Report

The Pending/Candidate Rejection Report is generated from the Agency Collection optional batch job. This report is sorted by collector, and then by either primary rejection reason, or guarantor last name. The Primary Sort by Rejection reports field in the Pre-Collection Information Parameters controls if the report sorts by primary rejection reason or guarantor last name. If this report sorts by guarantor name, the Primary Reject Reason field on the report is blank, but all of the rejection reasons are still displayed in the Rejection Reasons field. This report totals by rejection reason within collector.

The following is an example of the Pending/Candidate Rejection Report.

Figure 3.53 FR640 - Pending/Candidate Rejection Report

```
        Model Hospital A                                          Page  : 1
Time: 09:31am                             Pending/Candidate Rejection Report for INTSP                        Report: FFR640A
Collector:                                                 Primary Reject Reason:
Corp #    Guarantor Name              Patient Name              Account #   Schedule   Reject Reason(s)
D/C Date   Ind  F/C  P/T    Paper F/U     Acct Balance     Pat Balance   Last Patient Payment   Last Insurance Payment      M/S
-----------------------------------------------------------------------------------------------------------------------------
00001023   SMITH,ANNE               SMITH,ANNE                971270002   976                              0.00
05/07/05    0   PK   O/P    2 06/03/97      761.25        161.25        0.00                 0.00                          F


Total Rejection Reason 62        1 accounts      $761.25
Total Collector                  1 accounts      $761.25
Report Total                     1 accounts      $761.25


12=Pat Bal Low   23=Act Bal Low    30=Reselet Days 35=Days Fnl Bill 42=Pat Payment   57=Ins Carrier    62=Fin Class    87=Zip Code
16=Wait Cycle    25=Act Bal High   33*Ins Balance  39=Days Ins Pay  46=Church        58=Ins Car/Plan 64*AR/BD Status 88=Pat Indicator
22=Pat Bal High 29*Step/Sch Chg    34=Days Dischg  40=Pat F/U Cnt   48=Pat Type      59=Occupation     78*F/U Hold
90=Inv Addr/Ph

            ** - Incomplete Address,   ## - Invalid Address/Phone


                                End of Report
```

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PENDING/CANDIDATE REJECTION REPORT - FFR640
Chapter 3 - ACCOUNT FOLLOW-UP REPORTS

This report contains a header that includes the date and time the report is generated, your hospital name, the report title, the page number, and the report name as used in the system.

CORP #
This field contains the corporate number.

GUARANTOR NAME
This field contains the guarantor name.

PATIENT NAME
This field contains the patient's name.

ACCOUNT #
This field contains the patient's account number.

SCHEDULE
This field contains the Follow-up schedule that the account uses if it transfers to agency processing.

REJECTION REASON
This field contains the rejection reason code. Please refer to the legend at the bottom of the page. Rejection reason codes with an asterisk (*) are fatal rejection reason codes. For more information about rejection reason codes, refer to Appendix A in the *Follow-Up Functions Volume* of the *STAR Financials Patient Accounting Reference Guide.*

D/C DATE
This field contains the date the patient was discharged.

IND
This field contains the patient indicator. Values for this field are I-inpatient, O-outpatient, and E-emergency.

F/C
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc.

P/T
This field contains the patient type code used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

PAPER F/U
This field contains the total number of statements and letters and the date the last statement or letter was generated. This field does not include memo statements or letters.

ACCT BALANCE
This field contains the account balance.

PAT BALANCE
This field contains the patient's balance.

LAST PATIENT PAYMENT
This field contains the amount of the last patient payment and the date of the last patient payment.

LAST INSURANCE PAYMENT
This field contains the amount of the last insurance payment and the date of the last insurance payment.

M/S
This field displays the maintenance or status code of the account. If the account is unselected for collection due to a fatal rejection reason, an asterisk (*) displays in this field. The account does not have a maintenance code to display and is removed from the report. Refer to Appendix A in the *Follow-Up Functions Volume* in the *STAR Financials Patient Accounting Reference Guide* for an explanation of the maintenance and status codes.

PENDING/CANDIDATE WORKFILE REPORT FOR CCI - FFR650

Description/Purpose

The Pending/Candidate Workfile Report for CCI, FFR650, includes all of the accounts that are in the Pending/Candidate Workfile.

Generating and Printing This Report

The Pending/Candidate Workfile Report can be requested online and can be scheduled as an Optional Batch Job. This report generated by the optional batch job lists all of the accounts that are in the workfile. The online report is requested by collector for selected agencies. To request an online report go to Financial System Management, Account Management, Account Reports, and select Pending/Candidate Workfile report.

This report sorts by collector, collection agency, and guarantor last name. The report page breaks and totals by collector.

The following is an example of the Pending/Candidate Workfile Report for CCI.

Figure 3.54 FFR650 - Pending/Candidate Workfile Report

```
Date: 03/06/05                                  General Hospital                               Page  : 1
Time: 01:15pm                          Pending/Candidate Workfile Report for CCI               Report: FFR650

Collector: 12 KESER,NANCY                               Agency: HOSP B INTSP


Corp #    Guarantor Name             Patient Name          Account #   Schedule                          Rzn
D/C Date    Ind   F/C   P/T    Paper F/U     Acct Balance  Pat Balance  Last Patient Payment  Last Insurance Payment  M/S  Rev
-------------------------------------------------------------------------------------------------------------------
00001621  FOSTER,FRANCINE            FOSTER,FRANCINE       B9704100003  926
02/10/97    O     O     O/P                  999,999.99    999,999.99   999,999.99- 02/11/97       0.00               T    ***


Total Agency CCIC             1 accounts    $999,999.99

Total Collector 12            1 accounts    $999,999.99

Report Total                  1 accounts    $999,999.99

12=Pat Bal Low   23=Act Bal Low   30=Reselet Days 35=Days Fnl Bill 42=Pat Payment   57=Ins Carrier    62=Fin Class    87=Zip Code
16=Wait Cycle    25=Act Bal High  33*Ins Balance  39=Days Ins Pay  46=Church        58=Ins Car/Plan   64*AR/BD Status 88=Pat Indicator
22=Pat Bal High  29*Step/Sch Chg  34=Days Dischg  40=Pat F/U Cnt   48=Pat Type      59=Occupation     78*F/U Hold
90=Inv Addr/Ph
                    ** - Incomplete Address,   ## - Invalid Address/Phone


                      End of Report
```

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This report contains a header that includes the date and time the report is generated, your hospital name, the report title, the page number, and the report name as used in the system.

CORP #
This field contains the corporate number.

GUARANTOR NAME
This field contains the guarantor name.

PATIENT NAME
This field contains the patient's name.

ACCOUNT #
This field contains the patient's account number.

SCHEDULE
This field contains the Follow-up schedule of the account.

RZN
This field contains the rejection reason code. Please refer to the legend at the bottom of the page. Rejection reason codes with an asterisk (*) are fatal rejection reason codes. For more information about rejection reason codes, refer to Appendix A in the *Follow-Up Functions Volume* in the *STAR Financials Patient Accounting Reference Guide.*

D/C DATE
This field contains the date the patient was discharged.

IND
This field contains the patient indicator. Values for this field are I-inpatient, O-outpatient, and E-emergency.

F/C
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc.

P/T
This field contains the patient type code used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

PAPER F/U
This field contains the total number of statements and letters and the date the last statement or letter was generated. This field does not include memo statements or letters.

ACCT BALANCE
This field contains the account balance.

PAT BALANCE
This field contains the patient's balance.

LAST PATIENT PAYMENT
This field contains the amount of the last patient payment and the date of the last patient payment.

LAST INSURANCE PAYMENT
This field contains the amount of the last insurance payment and the date of the last insurance payment.

M/S
This field displays the maintenance or status code of the account. Refer to Appendix A in the *Follow-Up Functions Volume* in the *STAR Financials Patient Accounting Reference Guide* for an explanation of the maintenance and status codes.

REV
This field contains the reviewed workfile entry indicator. This field contains three asterisks (***) if the workfile entry has been marked as reviewed.

PATIENT CLASSIFICATION SUPPRESSED ACCOUNTS REPORT - FFR280

Description/Purpose

The Patient Classification Suppressed Accounts Report, FFR280, provides a listing of all or selected accounts that are suppressed for follow-up as determined by the suppression indicator for the account. For more information, refer to the Financial Patient Classification table in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

Accounts with a Patient Classification Suppression indicator of suppress are available for inclusion on the Patient Classification Suppressed Accounts report. Selection criteria for the report is defined in the Define Patient Classification Suppressed Accounts Report screen. For example, users may choose to only include accounts with no insurance liability to produce a worklist of special accounts needing evaluation for possible write-offs.

The frequency of the report may be defined in the Optional Batch Job for the report. If the optional batch job is established without completing the Define Patient Classification Suppressed Accounts Report screen, the report is produced with the following message as data rather than accounts:

> *Define Patient Classification Suppressed Accounts Reports Screen not completed.*

The report may also be produced on demand in the Define Patient Classification Suppressed Accounts Report functions. The report may be requested to run immediately or during midnight processing.

The sort of the report is defined in the Define Patient Classification Suppressed Accounts Report screen. The options are account name, account number, account balance/name, insurance balance/name, patient class/account name, and patient class/insurance balance. The user may indicate to insert a page break for each change in the patient classification when it is the primary sort.

Generating and Printing This Report

The report may be generated in three different ways:

- immediately on demand

- during midnight processing on demand

- during midnight processing as a regularly scheduled optional batch job.

In all three methods, the Request Patient Class Suppressed Accounts Report screen is referenced to determine the sort and selection criteria for the report.

To obtain the report immediately, you must complete the Request Patient Class Suppressed Accounts Report screen and respond (N)ow to the run prompt upon exiting the function.

To obtain the report on demand during the next midnight processing run, you must complete the Request Patient Class Suppressed Accounts Report screen and respond (T)onight to the run prompt upon exiting the function.

To obtain the report on a regularly scheduled frequency during midnight processing, you must complete the Optional Batch Job for the Patient Class Suppressed Accounts Report. An optional batch job for the new report must be added to the system.

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Figure 3.55 FFR280 - Patient Classification Suppressed Accounts
Report

```
Date: 03/04/99                               Model Hospital A                          Page  : 1
Time: 15:14                        Patient Classification Suppressed Accounts           Report: FFR280A
                                          BRD - BOARD MEMBER

                              F  PAT PAT LAST CYC   FBIL     DSCH     LAST     LAST      INS      PATIENT    ACCOUNT
ACCOUNT NO.   ACCOUNT NAME    C  TYP CLS  DATE      DATE     DATE     PYMT   INS PYMT  BALANCE    BALANCE    BALANCE

9900100040    ANDERSON,KATE   O  ER  BRD                    01/01/99                    95.00       5.00     100.00
9900100042    COOPER,ANN      O  ER  BRD           01/01/99 01/01/99                    50.00     100.00     150.00
9900100039    PAIGE, MAUREEN  O  ER  BRD           01/01/99 01/01/99          03/04/99   0.00       0.00       0.00
9900100038    SUMMERS, JOE    N  ER  BRD           01/01/99 01/01/99 02/10/99            0.00      90.00      90.00
9836400001    HUNTER, ED      O  ER  BRD                    12/30/98          03/04/99 425.00-    375.00      50.00-

Totals for BRD - BOARD MEMBER                                                          280.00-    570.00     290.00

                                          PHY - PHYSICIAN

9829600002    RESLER,KURT     PK O/P PHY                    10/23/98                   5000.00      0.00    5000.00
9829600001    JOHNSON, SAM    PK O/P PHY 01/21/99           10/23/98                   1000.00      0.00    1000.00
9822900001    LARSON, SCOTT   PK OP  PHY                    08/17/98                    782.98      0.00     782.98
9900100041    MCDONALD, JIM   C  ER  PHY           01/01/99 01/01/99 02/10/99           75.00      15.00      90.00
9828600001    WINTERS, CYNTHIA PK I/P PHY          10/13/98 10/13/98                     0.00       0.00       0.00
9822900002    RAILEY, ERIC    S2 OP  PHY                    08/17/98                      0.00     782.98     782.98

Totals for PHY - PHYSICIAN                                                             6857.98    797.98    7655.96


GRAND TOTALS                                                                           6577.98   1367.98    7945.96

                                          End of Report
```

If the primary sort of this report is by patient classification, then the patient classification code and description print as a header.

Field Explanations

ACCOUNT NO.
This field contains the account number.

ACCOUNT NAME
This field contains the patient's name.

FC
This field contains the hospital-defined financial class code assigned to this patient's account.

PAT TYP
This field contains the patient type code and is used to categorize a specific portion of the patient community.

PAT CLS
This field contains the financial patient classification code assigned to the account. The patient classification is typically assigned to the patient during the admission process and may be updated in Revise Admission, Account Revision or Revise MPI.

LAST CYC DATE
This field contains the last cycle billing date for this patient's account.

FBIL DATE
This field contains the final billing date for this patient's account. This field is blank if the account's location is PA.

DSCH DATE
This field contains the patient's discharge date.

LAST PYMT
This field contains the date of the last payment made to this patient's account. This may be an insurance or a patient payment.

INS BALANCE
This field contains the insurance balance. The insurance balance is calculated as the account balance minus the patient balance.

PATIENT BALANCE
This field contains the patient balance.

ACCOUNT BALANCE
This field contains the account balance.

SUBTOTALS BY PATIENT CLASSIFICATION
Subtotals are provided if the primary sort is by patient classification.

Insurance Balance - This field contains the sum of all insurance balances included on the report for this patient classification.

Patient Balance - This field contains the sum of all patient balances included on the report for this patient classification.

Account Balance - This field contains the sum of all account balances included on the report for this patient classification.

GRAND TOTALS
Grand totals are provided on the last page of the report.

Insurance Balance - This field contains the sum of all insurance balances included on the report.

Patient Balance - This field contains the sum of all patient's balances included on the report.

Account Balance - This field contains the sum of all account balances included on the report.

PA ACTIVITY REPORT - FFPARA

Description/Purpose

This report alerts users about activities in PA follow-up that relate to being added, deleted, or assigned to a default schedule.

Generating and Printing This Report

The report is generated as a function of midnight processing. The information in this report is grouped by activity and sorted numerically.

The following is an example of the PA Activity report.

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Figure 3.56 FFPARA - PA Activity Report

```
Date: 07/14/99                          General Hospital                          Page  : 10
Time: 12:48am                       PA Follow Up Activity Report                   Report: FFRPARA
                                        6 BASKER,TODD D
Account Name            Account #    FC    PT    Schedule Description       F/U Date  Activity
Guarantor Name
KATHERYN TERTHOUR       A9804700008  B     I/P   TEST 1                     07/14/99  PA Addition
KATHERYN TERTHOUR
                        Add Reason : Not in Follow Up - Added by System
JONATION MATE           A9832200003  B     0/P   TEST 1                     07/14/99  PA Addition
CINDY MATE
                        Add Reason : Not in Follow Up - Added by System
JONNIE M MEYERS         A9832300004  B     ER    TEST 1                     07/14/99  PA Addition
JONNIE M MEYERS
                        Add Reason : Not in Follow Up - Added by System
SUSANNA MEYERS          A9834400002  B     I/P   TEST 1                     07/14/99  PA Addition
SUSANNA MEYERS
                        Add Reason : Not in Follow Up - Added by System
SUEANN MEYERS           A9834500001  B     I/P   TEST 1                     07/14/99  PA Addition
SUSANNA MEYERS
                        Add Reason : Not in Follow Up - Added by System
              Total PA Additions to Follow Up : 5
STEVE DEAL              A9808200007  KE    I/P   HBO DEFAULT SCHEDULE       07/31/99  PA Default
STEVE DEAL
DIANA TOVE              A9812100002  L     I/P   HBO DEFAULT SCHEDULE       07/31/99  PA Default
DIANA TOVE
KENNETH RAIL            A9834200005  KE    I/P   HBO DEFAULT SCHEDULE       07/31/99  PA Default
KENNETH RAIL
EDWARD MURRALOVICH      A9714000018  KE    OB    HBO DEFAULT SCHEDULE       07/31/99  PA Default
EDWARD MURRALOVICH
KEN KART                A9900600004  A     I/P   HBO DEFAULT SCHEDULE       07/31/99  PA Default
KEN KART
DIANA TOVE              A9902600007  L     I/P   HBO DEFAULT SCHEDULE       07/31/99  PA Default
DIANA TOVE

              Total PA Default Accounts in Follow Up : 6


-------------------------------------------------FFRPAR-------------------------------------------------
                                        End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, the collector's name and number, and the report name as used in the system.

ACCOUNT NAME
This field contains the patient name.

GUARANTOR NAME
This field contains the guarantor name.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc.

PT
This field contains the patient type code and is used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

SCHEDULE DESCRIPTION
This field contains the schedule description associated with the account. If an account is added to PA follow-up, the reason for the addition is added to this field as well.

F/U DATE
This field contains the next scheduled insurance follow-up date for the associated claim sequence.

ACTIVITY
Activity that took place to put account on the report. Reasons would include accounts added to the schedule or accounts on the PA default schedule.

PA ACCOUNTS TRANSFERRED TO AR - WITH PA DEFINED AR SCHEDULE - FF450A

Description/Purpose

This report informs the Business Office of what has happened to follow-up once the PA account has gone to AR. Accounts that appear on this report were in PA follow-up, were either on a payment plan schedule or a custom schedule, and the *Transfer Schedule Type to AR?* (custom, advanced payment plan, or balance payment plan) flag on the PA follow-up schedule was set to **Y** for yes.

Generating and Printing This Report

The report is generated as a function of midnight processing. The information contained in this report is sorted by collector.

The following is an example of the PA Accounts Transferred to AR - With PA Defined AR Schedule report.

Figure 3.57 FFR450A - PA Accounts Transferred to AR - With PA
Defined AR Schedule

```
Date: 07/14/99                           General Hospital                            Page  : 1
Time: 12:46am              PA Accounts Transferred to AR - With PA Defined AR Schedule         Report: FFR450A
                                      30 COLLIER,HECTOR C
Account Name           Account #  FC  PT  PA Schedule PA on Hold? AR Schedule        F/U Type    F/U Date Account Bal
Guarantor Name                            PA Schedule Description AR Schedule Description         F/U Step Patient Bal
BETTYANN CASARVA       A9902900001 V  NEW 2         No          22                    Payment Plan 07/14/99    350.00
JAMES DAVID CASARVA                       EXCEPTION SCHEDULE     TEST FOR DUE DAYS SCHED          2          350.00
Collector Totals    Accounts : 1     Account Balance :      350.00   Patient Balance :        350.00
Facility Totals     Accounts : 1     Account Balance :      350.00   Patient Balance :        350.00
--------------------------------------------------------FFR450-------------------------------------------------------
                                      End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, the collector's name and number, and the report name as used in the system.

ACCOUNT NAME
This field contains the patient name.

ACCOUNT #
This field contains the account number for the patient.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc.

PT
This field contains the patient type code and is used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

PA SCHEDULE
The schedule number the account was on prior to going to AR.

PA ON HOLD?
Is the account on follow-up hold?

AR SCHEDULE
The schedule number the account transferred to in AR.

F/U TYPE
The type of schedule the account is on in AR.

F/U DATE
The next schedule follow-up date.

ACCOUNT BAL
This field contains the dollar amount of the account balance.

GUARANTOR NAME
This field contains the guarantor name.

PA SCHEDULE DESCRIPTION
The description of the schedule number the account was on prior to going to AR.

AR SCHEDULE DESCRIPTION
The description of the schedule the account transferred to in AR.

F/U STEP
The next scheduled follow-up step.

PATIENT BAL
The dollar amount owed by the patient.

PA ACCOUNTS TRANSFERRED TO AR - WITHOUT PA DEFINED AR SCHEDULE - FF460A

Description/Purpose

This report informs the Business Office of what has happened to follow-up once the PA account has gone to AR. Accounts on this report were in PA follow-up, were either on a payment plan schedule or a custom schedule, and the *Transfer Schedule Type to AR?* (custom, advanced payment plan, or balance payment plan) flag on the PA follow-up schedule was set to **N** for no, or were on a separate schedule. Separate schedule accounts never transfer based on the PA follow-up schedule.

Generating and Printing This Report

The report is generated as a function of midnight processing. The information in this report is sorted by collector.

The following is an example of the PA Accounts Transferred to AR - Without PA Defined AR Schedule report.

Figure 3.58 FFR460A - PA Accounts Transferred to AR - Without PA
Defined AR Schedule

```
Date: 07/16/99                              General Hospital                              Page  : 1
Time: 02:04pm              PA Accounts Transferred to AR - Without PA Defined AR Schedule       Report: FFR460A
                                            3 CROFT,ALAM S
Account Name          Account #   FC  PT  PA Schedule Number    AR Schedule Number    F/U Type    F/U Date Account Bal
Guarantor Name                            PA Schedule Description AR Schedule Description           F/U Step Patient Bal
BART V COURLICK       A9809600001 B   SER 1                      220                   Custom      07/17/99  6,275.85
BART V COURLICK                           TEST 1                 PATRICE PATIENT                    1             22.00-
Collector Totals    Accounts : 1        Account Balance :      6,275.85      Patient Balance :          22.00-
Facility Totals     Accounts : 1        Account Balance :      6,275.85      Patient Balance :          22.00-
----------------------------------------------------FFR460----------------------------------------------------
                                            End of Report
```

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PA ACCOUNTS TRANSFERRED TO AR - WITHOUT PA DEFINED AR SCHEDULE - FF460A Chapter 3 - ACCOUNT FOLLOW-UP

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, the collector's name and number, and the report name as used in the system.

ACCOUNT NAME
This field contains the patient name.

ACCOUNT #
This field contains the account number for the patient.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc.

PT
This field contains the patient type code and is used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

PA SCHEDULE NUMBER
The schedule number the account was on prior to going to AR.

AR SCHEDULE NUMBER
The schedule number the account transferred to in AR.

F/U TYPE
The type of schedule the account is on in AR.

F/U DATE
The next schedule follow-up date.

ACCOUNT BAL
This field contains the dollar amount of the account balance.

GUARANTOR NAME
This field contains the guarantor name.

PA SCHEDULE DESCRIPTION
The description of the schedule number the account was on prior to going to AR.

AR SCHEDULE DESCRIPTION
The description of the schedule the account transferred to in AR.

F/U STEP
The next scheduled follow-up step.

PATIENT BAL
The dollar amount owed by the patient.

AR F/U UPDATES DUE TO AN FC CHANGE - FFR710

Description/Purpose

This report assists facilities in tracking accounts whose guarantor follow-up information was updated as a result of a financial class change. The parameters that control the updating of guarantor follow-up information are the Ins FC Update of AR F/U field in PAAR Control Maintenance, the Bal FC Update of AR F/U in the Balance Designation Parameters, and the Timeout FC Update of AR F/U in the Insurance Timeout Parameters. The primary sort of this report is the guarantor name. The secondary sort is the account number. This report includes old and new guarantor information.

Generating and Printing This Report

The report is generated as a function of midnight processing.

The following is an example of the AR F/U Updates Due to an FC Change report.

Figure 3.59 FFR710x - AR F/U Updates Due to an FC Change

```
Date: 04/15/00                                Model Hospital A                                   Page  : 1
Time: 1:55                                 AR F/U Updates due to FC Chg                          Report: FFR710A


Guarantor Name          Corp #          Old/New                     ---- Next ----
Account #        Account Name         RS  COB1    FC  P/T  ST  Sch#  Step  F/U Date  WF Types  Col

RESLER,KURT                  00001204
  9931900003    RESLER,KURT           B   917001  S   OP   T   5     2     04/14/00  S         13
                                          917001  S2  OP   T   96    1     05/14/00  S         13


Total Insurance              0
     Balance Designation     1
     Insurance Timeout       0
                          ========
                             1
```

<div style="text-align:center">

ST (Schedule Type) - S=Standard, G=Guarantor Custom, P=Guarantor PaymentPlan
A=Account Custom, R=Account Payment Plan, T=Account Separate

</div>

Legend: WF Type - D=Delinquent, P=Partial Payment, R=Promise To Pay, S=Standard

```
---------------------------------------------------------------FFR710----------------------------------------------------------------



End of Report
```

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AR F/U UPDATES DUE TO AN FC CHANGE - FFR710

Column Explanations

GUARANTOR NAME
This column contains the guarantor name.

ACCOUNT #
This column indicates the account number for the patient.

CORP #
This column contains the corporate number.

OLD/NEW
This column contains data before the update/data after the update.

RS
This column indicates the reason for the change: B-Balance Designation, I-Insurance, T-Ins Timeout

COB1
This column contains the Primary Insurance Carrier/Plan code.

F/C
This column contains the account's financial class.

P/T
This column contains the account's patient type.

ST
This column contains the account's schedule type. Valid types are: S - Standard, G - Guarantor Custom, P - Guarantor Payment Plan, A - Account Custom, R - Account Payment Plan, T - Account Separate.

SCH #
This column contains the follow-up schedule for the account.

NEXT STEP
This column contains the step number for the account's follow-up schedule number.

NEXT F/U DATE
This column indicates the date of next follow-up.

WF TYPES
This column contains the workfile type. Workfile types are: D - Delinquent Phone, P - Partial Payment Phone, B - Business Office Phone, R - Promise to Pay, S - Standard, C - Agency, W - Internal Bad Debt.

COL
This column contains the number of the collector assigned to this account.

RWS VOLUME STATISTICS SUMMARY REPORT - FFRRWSS

Description/Purpose

This report can only be generated if the Receivables Workstation is activated. The report produces a paper copy of an online screen display. The report reflects the summary information of workfile activity for a collector or group of collectors.

Generating and Printing this Report

To create the report, access the Receivables Workstation module, Options, Statistics, Collector Workfile Volume Statistics, Select collector(s), complete the Start Date and End Date, View Details button, and click the Report Button.

Following is an example of this report.

Figure 3.60 FFRRWSS - RWS Volume Statistics Summary Report

```
Date: 08/23/02                          STAR Development System                      Page  : 1
Time: 10:22                            RWS Volume Statistics Summary                 Report: FFRRWSS

        Facility: All Facilities      Collector Group: ALL GROUPS        Dates: 06/26/02 - 08/23/02

Name                     Totals   Ins Stndard Foc Ins Foc Pat Pre Col  Int BD Prm Pay Part PP  Del PP  Active Contrct

SUMMARY        Current      1369     5      72      66    1002      2       0       4       0       0     215       3
               Switched For   28     9       7       0       0      0       2       3       0       0       5       2
               Referrals For   2     2       0       0       0      0       0       0       0       0       0       0
               Reviewed      213    40      49       8      11      0       7      12       0       2      75       9

               Begin Count     0     0       0       0       0      0       0       0       0       0       0       0
               Added        2603     0       5     342    2013      0       0       5       0       0     235       3
               Processed     -17     0      -8       0      -4      0      -2       0       0       0      -2      -1
               Rescheduled    -4     0      -3       0       0      0       0       0       0       0       0      -1
               System Updates 220    4      84       0       0      2       0       0       0       0     127       3
               Transfers       4     1       0       0      -1      0       2       2       0       0       0       0
               Purged      -1425     0       0    -276   -1006      0       0       0       0       0    -143       0
               Switched By    -12     0      -6       0       0      0       0      -3       0       0      -2      -1
               Referrals By     0     0       0       0       0      0       0       0       0       0       0       0
               End Count     1369     5      72      66    1002      2       0       4       0       0     215       3

  6 Bassett,J   Current       26      0      11       1      11      0       0       3       0       0       0       0
               Switched For   10      0       3       0       0      0       0       0       0       0       5       2
               Referrals For   1      1       0       0       0      0       0       0       0       0       0       0
               Reviewed       39      1      20       0       1      0       0       2       0       0      12       3

               Begin Count     0      0       0       0       0      0       0       0       0       0       0       0
               Added          99      0       3      73      21      0       0       2       0       0       0       0
               Processed      -3      0      -2       0      -1      0       0       0       0       0       0       0
```

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Column Explanations

Collector totals are shown for each work type in the system, including: Insurance, Standard, Focus Insurance, Focus Patient, Agency Collection, Internal Bad Debt, Promise to Pay, Active, and Contract.

CURRENT
This column contains a real time synopsis of number of workfiles by workfile type.

SWITCHED FOR
This column contains the number of workfiles the individual collector worked which were not assigned to the collector, during the period of time selected by the user. This reflects the number of workfiles worked when the Collector Switch and Look (Select) process was used. This only applies if the workfile is assigned to another collector.

REFERRALS FOR
This column contains the number of work files that were referred to the collector and subsequently processed/rescheduled.

REVIEWED
This column contains the number of workfile entries reviewed by the collector. A counter keeps track of the number of workfile entries selected by going into the worklist or via the look function.

- This counter is not updated if the collector accesses the Look function and then selects the Review option or if a referral is replied to.

- This counter is used to compare workfile entries reviewed and the number processed/rescheduled, switched for, and referrals for.

- This counter is incremented whenever the detail account folders are displayed. It does not matter if the work file is processed, rescheduled, or referred.

BEGIN COUNT
This information is captured on a daily basis through Midnight Processing. After all workfiles are generated through Midnight Processing, a count of workfiles by type is counted and stored. The information displayed represents the counts based on the first day of the date range selected. Processes such as Active Patient Worklist, Focus Patient, and Focus Insurance (select and purge) are to be suspended if they run into Midnight Processing. This is mandatory so a clean cut-off between days can be accomplished. If a process spans multiple days, part of the entries are reflected in day one and the remaining are reflected in day two.

ADDED
This column contains workfiles created. Most of these are created through Midnight Processing. Examples of exceptions to this rule are focus patient work and focus insurance work requested to run during the day.

PROCESSED
This column contains assigned and transferred workfile entries processed by the collector.

RESCHEDULED
This column applies to assigned and transferred workfile entries rescheduled by the collector.

SYSTEM UPDATES
This column represents the number of workfiles that were removed by the system. Examples are:

- Accounts going to a zero balance and automatically deleting insurance, guarantor workfiles and others. This applies to approved refunds, adjustment, and payment postings.

- Final billings that remove Active patient worklist entries

- Claim final disposition that remove claim related workfiles.

- Accounts placed on follow-up hold

- Caims placed on follow-up hold.

- Bad debt prelisted.

- Approved refunds which take the carrier or account to a zero balance.

- Updates to the account follow-up such as accounts being updated to a guarantor level follow-up or being linked to a guarantor/account payment plan.

- Bad Debt Prelisting

- AR to BD transfers

- BD to AR transfers

- Balance Transfers

- Pre-collect to non pre-collect for AR accounts

- Internal to external BD agencies and vice versa

- Late charges/credits

- Insurance timeout

- Insurance small balance write-off

- Patient small balance write-off

- Archiving (claim and account)

- Follow-up maintenance (guarantor to account level, account level to guarantor level).

- Merges

- Change of guarantors. Workfiles are updated to be linked to the new guarantor for standard, agency, internal BD.

- Collector Reassignment

- Change collector for contracts.

TRANSFERS
This column represents workfiles transferred from one collector to another. The value can be positive or negative depending on whether work is transferred to or from the collector. Reasons for this include:

- Collector Reassignment optional batch job

- Work transferred manually from one collector to another

PURGED
This column only applies to focus patient, focus insurance, and active patient work lists. Because these purge functions are initiated outside of Midnight Processing, they can cross days. For example: a focus work purge was started at 11:00 PM and completed at 8:00 AM the next day. Part of the purged entries (11:00 to midnight) would be reflected in day one statistics, and the remaining would be reflected in day two statistics

SWITCHED BY
This column reflects workfiles worked by another collector. This value has a corresponding value reflected in the Switched For field for the person working the entry.

REFERRALS BY
This column represents workfiles referred to another collector and processed/ rescheduled by the referred to collector. A correlating entry is reflected in the "Referrals For" for the referred to collector.

END COUNT
This column represents the number of workfiles present for the collector, for the specified end dates. It represents a summation of the statistics beginning with Begin Count.

RWS VOLUME STATISTICS DETAIL REPORT - FFRRWSD

Description/Purpose

This report can only be generated if the Receivables Workstation is activated. The report is intended to produce a paper copy of an online screen display. The report reflects the detail of workfiles processed and rescheduled by the collector.

Generating and Printing this Report

To create the report access the Receivables Workstation module, Options, Statistics, Collector Workfile Volume Statistics, select a collector, complete the Start Date and End Date, View Details button, Entries Worked, and click the Report button.

Figure 3.61 FFRRWSD - RWS Volume Statistics Detail Report

```
Date: 08/23/02                          STAR Development System                          Page  : 1
Time: 10:17                           RWS Volume Statistics Detail                       Report: FFRRWSD

     Facility: All Facilities       Collector Group: ALL GROUPS        Collector:  98 Dean,Mike    Dates: 06/26/02 - 08/23/02

Seq Worked Info      For/By CC Work Type   Description         ID          Name        F/U Amount    TCode Fac F/U Date Beg    End

1   PROCESS ASSIGNED           STANDARD    AR GUAR STANDARD    00002415    DONER,MOM      $35,824.75 T0033  A  06/28/02 15:10 15:11
2   PROCESS ASSIGNED           STANDARD    AR GUAR PAY PLAN    00002452    SITH,MIK        $1,868.17 T0033  A  07/01/02 09:16 09:17
3   RESCHED ASSIGNED           STANDARD    AR GUAR STANDARD    00002744    TEST,MERGEC     $1,399.61 T0033  A  07/01/02 09:16 09:17
4   PROCESS ASSIGNED           STANDARD    AR ACCT SEPARATE    C0112100011 KING,WITHLABC $278,294.00 T0033  C  07/01/02 09:19 09:20
5   PROCESS ASSIGNED           STANDARD    AR ACCT SEPARATE    A0115700008 ADAMS,JASON     $3,401.75 T0033  A  07/01/02 09:20 09:21
6   PROCESS ASSIGNED           CONTRACT    MULTIPLE            EPI1        EPIDEMIOLOGY    $1,105.26 T0001  A  07/01/02 10:57 10:58
7   RESCHED ASSIGNED           CONTRACT    BILL SEQ-1 04/23/01 ESC         KARINAS SENCO    $474.08 T0001  A  07/01/02 10:58 10:59
8   PROCESS ASSIGNED           ACTIVE      PA ACCOUNT          A0213600015 ADAMS,JASON        $19.42 N/A    A  07/01/02 11:22 11:23
9   PROCESS ASSIGNED           ACTIVE      PA ACCOUNT          A0115100012 ANDERSON,BABE       $0.00 N/A    A  07/01/02 11:22 11:23
10  PROCESS SWITCHED FOR   55  BAD DEBT    AGENCY-JAIBD        A0100400050 SOMOLIK,ANOTH     -$51.50 T0033  A  07/01/02 11:25 11:34
11  PROCESS SWITCHED FOR   55  INSURANCE   CARRIER-750100 CS-1 A0126800013 ADAMS,BEN        $826.80 T0033  A  07/01/02 13:02 13:03
12  RESCHED SWITCHED FOR   55  BAD DEBT    AGENCY-JAIBD        A0100100001 LU,YUN           $900.00 T0033  A  07/01/02 14:50 14:54
13  PROCESS SWITCHED FOR   55  INSURANCE   CARRIER-100100 CS-3 A0109300015 XREF,PA 3      $3,022.52 T0033  A  07/01/02 14:55 14:56
14  PROCESS SWITCHED FOR   55  INSURANCE   CARRIER-100100 CS-1 A0115200005 MEYER,SEV      $2,475.00 T0033  A  07/01/02 14:56 14:57
15  PROCESS SWITCHED BY    6   CONTRACT    BILL SEQ-3 08/31/01 HOHO        HOHOHO HEALTH    $453.20 T0021  A  07/01/02 17:16 17:17
16  PROCESS REFERRAL FOR   1   INSURANCE   CARRIER-400999 CS-16 A0036600021 CARLA,QAFOUR     $15.95 T0004  A  07/02/02 08:19 08:20
17  PROCESS SWITCHED FOR   4   INSURANCE   CARRIER-888111 CS-1 A0122800002 TEST,JAYBIRD   $62,416.63 T0004  A  07/02/02 08:40 08:48
18  PROCESS SWITCHED FOR   4   INSURANCE   CARRIER-888111 CS-2 A0122800002 TEST,JAYBIRD   $62,416.63 T0004  A  07/02/02 08:40 08:48
19  PROCESS SWITCHED FOR   4   INSURANCE   CARRIER-888111 CS-3 A0122800002 TEST,JAYBIRD   $62,416.63 T0009  A  07/02/02 08:40 08:48
20  PROCESS SWITCHED FOR   4   INSURANCE   CARRIER-888111 CS-4 A0122800002 TEST,JAYBIRD   $62,416.63 T0007  A  07/02/02 08:40 08:49
21  PROCESS SWITCHED FOR   4   INSURANCE   CARRIER-888111 CS-5 A0122800002 TEST,JAYBIRD   $62,416.63 T0019  A  07/02/02 08:40 08:49
22  PROCESS ASSIGNED           STANDARD    AR GUAR STANDARD    00002424    ALICE,RMB       $3,217.37 T0008  A  07/02/02 09:32 09:33
23  PROCESS SWITCHED FOR   6   STANDARD    AR GUAR STANDARD    00003347    KANE,MED         $810.27 T0004  A  07/02/02 09:48 09:49
24  RESCHED SWITCHED FOR   6   STANDARD    AR GUAR CUSTOM      A0114400005 KESLER,CHARLE   $1,592.72 T0004  A  07/02/02 09:48 09:49
25  PROCESS SWITCHED FOR   6   STANDARD    AR GUAR STANDARD    00002576    MERGE,NETWORK
```

Column Explanations

SEQUENCE
This column contains a counter of workfiles processed or rescheduled.

WORKED INFORMATION
This column reflects how the workfile was dispositioned. The options are 1) Process Switched, 2) Process Assigned, 3) Reschedule Switched, and 4) Reschedule Assigned.

FOR/BY CC
This column represents workfiles processed or rescheduled by a collector not assigned to the workfile entry. One entry is listed on the collector's statistics for which the entry was worked. The description is listed as **By ccc**. The same workfile will be reflected as **For ccc**". The value of **ccc** represents the collector code. The entries displayed as **FOR xxx** tie back to the top section of the summary page fields for "Switched For" and "Referrals For."

WORK TYPE
This column contains the type of workfile processed or rescheduled. The options are Insurance, Standard, Focus Ins, Focus Pat, AR Agency, Bad Debt, Prom Pay, Part Pay, Delinquent, Active, and Contract.

The type of workfile entry defined within Work Type.   The options are as follows:

1) Insurance

    a. Carrier - xxxxxx CS - x

2) Standard

    a. AR Guar Custom

    b. AR Guar Pay Plan

    c. AR Guar Standard

    d. AR Acct Separate

    e. AR Acct Custom

    f. AR Acct Pay Plan

3) Focus Ins

    a. Carrier - xxxxxx

4) Focus Pat

      a. AR Guar Custom

      b. AR Guar Pay Plan

      c. AR Guar Standard

      d. AR Acct Separate

      e. AR Acct Custom

      f. AR Acct Pay Plan

5) Agency

      a. Agency - xxxxxx

6) Bad Debt

      a. Agency - xxxxxx

7) Prom Pay

      a. AR Guar Custom

      b. AR Guar Pay Plan

      c. AR Guar Standard

      d. AR Acct Separate

      e. AR Acct Custom

      f. AR Acct Pay Plan

8) Part Pay

      a. AR Guar Custom

      b. AR Guar Pay Plan

      c. AR Guar Standard

      d. AR Acct Separate

      e. AR Acct Custom

      f. AR Acct Pay Plan

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9) Active

    a. PA Account

10) Contract

    a. Multiple

    b. Bill Seq- x xx/xx/xx

ID
This column reflects who the workfile was applicable to. Below is a synopsis:

1) Insurance

    a. Patient account number

2) Standard

    a. Guarantor corporate number if account is on a guarantor level follow up logic

    b. Patient account number if the account is on a patient level follow up logic.

3) Focus Insurance

    a. Patient account number

4) Focus Patient

    a. Guarantor corporate number if account is on a guarantor level follow up logic

    b. Patient account number if the account is on a patient level follow-up logic.

5) AR Pre-Collect

    a. Patient account number

6) Internal Bad Debt

    a. Patient account number

7) Promise to Pay

    a. Guarantor corporate number

8) Partial Pay

    a. Guarantor corporate number if account is on a guarantor level follow up logic

b. Patient account number if the account is on a patient level follow up logic.

9) Delinquent

a. Guarantor corporate number if account is on a guarantor level follow up logic

b. Patient account number if the account is on a patient level follow up logic.

10) Active

a. Patient Account Number

11) Contract

a. Contract code

NAME
This column contains the appropriate information as defined in the ID column of information.

F/U AMOUNT
This column contains the dollar amount being collected when the workfile entry is processed or rescheduled.

T CODE
This column contans the last transaction code applicable to notes added or the default transaction code from the initial screen.

CHANGE PATIENT TYPE AFTER FINAL BILL REPORT - FACPTAFB

Description/Purpose

The Change Patient Type After Final Bill Report (FACPTAFB) is designed to give the biller information on AR accounts that have had a change patient type after final bill. The change patient type information along with other account information is printed on the report. This report is generated by facility.

Generating and Printing This Report

This report is generated if any Change Patient Type After Final Bill transactions are processed by STAR Patient Processing and sent to STAR Financials Patient Accounting. The CPTAFB function can be initiated through the Change Patient Type After Final Bill function on Patient Processing. This report is processed every night during Midnight Processing. The report is produced with zero accounts even if there are not any CPTAFB transactions. Accounts are selected for the report if they are in AR and their associated patient type was updated after final bill. All accounts that had a change patient type after final bill request processed during the day are included on the report. The report is sorted based upon primary biller and by account number. This report page breaks by biller.

The following is an example of the report.

Figure 3.62 FACPTAFB - Change Patient Type After Final Bill Report

```
Date: 05/25/09                          General Hospital                                Page : 1
Time: 0:23                    Change Patient Type after Final Bill Report               Report: FACPTAFBA

                                       3 BILLERTHREE,BILLER
Name              Account   F/C P/I Old-New P/T  Admit   Disch    Pror R/B Chgs  Pror Anc Chgs  Unbilled Chg Amt
   Combine Bill DPW External Agency  CPTAFB Bill Hold    Auto CPTAFB Bill    MR HCPCS-DT     MR DX Code-DT
Acct Bal
     Cycle Bills         Activity       Old-New Bill Parm   Old-New Reimb Type                Abs Complete Dt
          Old-New Clm Load Edit /Ins Carrier Plan      Old-New Ins Doll Def /Ins Carrier Plan
DEARN, BILL      A0410500006 O  E   O/P-ER        04/14/04 04/14/04 No            Yes                   $0.00
   From         No-No            No              No               No            No                  $887.81
   No           Yes            927-11            I-I
     927-99 /918100                             927-PMK /918100
Totals        I/P            $0.00
              O/P            $0.00
              E/R      1     $887.81
Grand Totals  I/P            $0.00
              O/P      1     $500.00
              E/R      1     $887.81

                                       End of Report
```

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Column Explanations

NAME
This field contains the patient name.

ACCOUNT
This column contains the patient account number.

F/C
This column contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes values such as self-pay, commercial insurance, and Medicare.

PI
This field contains the patient indicator. Values for this field are I for inpatient, O for outpatient and E for emergency.

OLD-NEW PT
This field contains the patient type code that was associated with the patient before and after a CPTAFB transaction. The patient type code is used to categorize a specific portion of the patient community. The hospital-defined code represents patient segments such as regular admission, emergency room, outpatient, same day surgery, and series patients

ADMIT
This column contains the date the patient was admitted.

DISCH
This column contains the date the patient was discharged.

PROR R/B CHGS
This column indicates whether prorated room and bed charges are associated with the patient. A value of Yes indicates that prorated room and bed charges are associated with the patient.   A value of No indicates that prorated room and bed charges are not associated with the patient.

PROR ANC CHGS
This column indicates whether prorated ancillary charges are associated with the patient. A value of Yes indicates that prorated ancillary charges are associated with the patient.   A value of No indicates that prorated ancillary charges are not associated with the patient.

UNBILLED CHG AMT
This column contains the amount of unbilled charges for the account.

COMB BILL
This column indicates whether an account is a Combine To account. The column contains either From, To, or blank. A value of To indicates that the account is a

Combine To account. A value of From indicates that the account is a Combine From account.

DPW

This column indicates if an account was a DPW inpatient or outpatient account before or after a CPTAFB transaction. This field contains either a value of I/P (inpatient), O/P (outpatient) or blank. This is a two-character field separated by a dash. A value of I/P in the first character indicates that the account was a DPW inpatient according to the old patient type. A value of O/P in the first character indicates that the account was a DPW outpatient according to the old patient type.   A value of I/P in the second character indicates that the account is a DPW inpatient according to the new patient type. A value of O/P in the second character indicates that the account is a DPW outpatient according to the new patient type A value of blank indicates that the account was not associated with DPW.

EXTERNAL AGENCY

This column indicates if the account was at external agency collection before or after a CPTAFB transaction. This is a two-character field separated by a dash. Valid values are either Yes or No.

- A value of Yes for the first character indicates that the account was either an Internal or CCI collections account according to the old patient type. A value of Yes for the second character indicates that the account is either an Internal or CCI collections account according to the new patient type.

- A value of Yes for the first character indicates that the account was either an Internal or CCI collections account according to the old patient type. A value of No for the second character indicates that the account is not an Internal or CCI collections account according to the new patient type.

- A value of No for the first character indicates that the account was neither an Internal nor CCI collections account according to the old patient type. A value of Yes for the second character indicates that the account is either an Internal or CCI collections account according to the new patient type.

- A value of No for the first character indicates that the account was neither an Internal nor CCI collections account according to the old patient type. A value of No for the second character indicates that the account is neither an Internal or CCI collections account according to the new patient type.

CPTAFB BILL HOLD

This column contains a value of Yes if the account is on CPTAFB Bill Hold. A value of No indicates the account is not on CPTAFB Bill hold. If an account is not on CPTAFB Bill Hold, it is not included in the CPTAFB worklist.

AUTO CPTAFB BILL
This column contains a value of Yes if an automatic CPTAFB adjustment bill has been produced. A value of No indicates that an automatic CPTAFB adjustment bill has not been processed for the account.

MR HCPCS-DT
This column indicates whether Medical Record HCPCS codes exist for the account. A value of Yes indicates that Medical Record HCPCS codes exist and a value of No indicates that Medical Record HCPCS codes don't exist.

MR DX CODE-DT
This column indicates whether Medical Record diagnoses codes exist for the account. If there is an ICD-10 Admitting and/or Principal Diagnosis Code in Medical Records, the report prints a Yes in this field. If there is no ICD-10 Admitting and/or Principal Diagnosis Code in Medical Records, the system looks for an ICD-9 Admitting and/or Principal Diagnosis Code in Medical Records. If one exists, the report prints a Yes in this field. .

ACCT BAL
This column contains the account balance.

CYCLE BILLS
This column indicates whether cycle bills are associated with the account.

ACTIVITY
This column indicates if any activity was associated with the account prior to the CPTAFB transaction. Activity includes any claim payments, claim adjustments or refunds. A value of Yes indicates activity was associated with the account prior to the CPTAFB transaction. A value of No indicates activity wasn't associated with the account prior to the CPTAFB transaction.

OLD-NEW BILL PARM
This column indicates if the Billing Parameters were updated as a result of a CPTAFB transaction. if the Billing Parameters were updated, the field displays the old and new Billing Parameters. A value of blank indicates that the Billing Parameters were not updated as a result of a CPTAFB transaction. This is a two-character field where the first and second characters are separated by a dash.

OLD-NEW REIMB TYPE
This column indicates if the Reimbursement Type was updated as a result of a CPTAFB transaction. If the Reimbursement Type was updated, the field displays the old and new Reimbursement Type. If the reimbursement type has not been updated, then the field will be blank. A value of blank indicates that the Reimbursement Type was not updated as a result of a CPTAFB transaction. This is a two-character field where the first and second characters are separated by a dash.

ABS COMPLETE DT
This column contains the Medical Records Abstract Complete Date. Valid values for this field are a date or blank. If this field contains a date, it indicates that there is

currently an Abstract Complete Date associated with the account. If this field is blank it indicates that there is not an Abstract Complete Date associated with the account.

OLD-NEW CLM LOAD EDIT /INS CARRIER PLAN
This column indicates if the Claim Load and Edit Parameters were updated as a result of a CPTAFB transaction. If the Claim Load and Edit Parameters were updated, the field displays the old and new Claim Load and Edit Parameters and the associated Insurance Carrier/Plan code. A value of blank indicates that the Claim Load and Edit Parameters were not updated as a result of a CPTAFB transaction. This is a three-character field where the first two characters are separated by a dash and the second and third characters are separated by a forward slash.

OLD-NEW INS DOLL DEF /INS CARRIER PLAN
This column indicates if the Insurance Dollar Definition code was updated as a result of a CPTAFB transaction. If the Insurance Dollar Definition code was updated, the field displays the old and new Insurance Dollar Definition code and the associated Insurance Carrier/Plan code. A value of blank indicates that the Insurance Dollar Definition code was not updated as a result of a CPTAFB transaction.This is a three-character field where the first two characters are separated by a dash and the second and third characters are separated by a forward slash. If the Insurance Dollar Definition has been updated for more than one plan, the field only displays one insurance and the associated Old-New Insurance Dollar Definitions. If more than one insurance had its Insurance Dollar Definition value updated, the system selects the one that is the most primary insurance and displays the Old-New values. If there is more than one insurance that had its Insurance Dollar Definition values updated, an asterisk follows the value in the field for the Insurance plan code. An example of this is: Old- New Ins Doll Def/ Ins Plan*.

AR F/U UPDATES DUE TO CPTAFB REPORT - FFR720

Description/Purpose

This report assists facilities in tracking accounts whose guarantor follow-up information was updated as a result of a change patient type after final bill transaction. The primary sort of this report is the guarantor name. The secondary sort is the account number. This report includes old and new guarantor information.

Generating and Printing This Report

The report is generated during Midnight Processing. Even if there are not any entries for the report, the report header is generated.

Following is a sample of the report.

Figure 3.63 FFR720 - AR F/U Updates Due to CPTAFB Report

```
Date: 05/08/07                           General Hospital                      Page  : 1
Time: 20:16                          Follow-Up CPTAFB Change Rpt                Report: FFR720A

                                            --------Old-New----------------  -----Next------
Guarantor Name            Corp #    Final Bill Date    Agency    P/T    PI  ST  Sch #   Col #   Step  F/U Date
KESLERG,CPTAFB            00002662
0411200006  KING, MARK  B           04/22/04  06/08/04           O/P-I/P  I-O     5-92   717-23   1    06/30/04

Total #       1



End of Report
```

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Column Explanations

GUARANTOR NAME
This column contains the guarantor name.

CORP #
This column contains the corporate ID number.

ACCOUNT NO.
This column contains the account number.

ACCOUNT NAME
This column contains the patient or guarantor name.

FINAL BILL DATE
This column contains the final billing date for this patient's account.

AGENCY
This column contains the AR agency code associated with an account that is in AR location and has an agency processing status.

PT
This column contains the patient type code before and after the change patient type after final billing transaction. The hospital-defined code represents patient segments such as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

PI
This column contains the patient indicator code before and after the change patient type after final billing transaction.

ST
This column indicates the schedule type before and after the change patient type after final billing transaction. Valid types are: S - Standard, G - Guarantor Custom, P - Guarantor Payment Plan, A - Account Custom, R - Account Payment Plan, T - Account Separate.

SCH #
This column identifies the schedule number both before and after the change patient type after final bill transaction.

STEP F/U DATE
This column contains the date of the guarantor's next follow-up, before and after the . patient type was changed after final billing.

EXTERNAL AGENCY RECONCILIATION REPORT (FFR671)

Description/Purpose

This report allows a hospital to reconcile with the collection agency to which accounts are assigned. When the report is requested, it is captured to the Audit Server process.

Generating and Printing This Report

This report can be requested only manually through Financial System Management>Interface Functions>Agency Processing Interfaces>External Agency Process>Agency Reconciliation Report/File.

Following is a sample of the report.

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Figure 3.64 FFR671 - External Agency Reconciliation Report

```
Date: 07/29/07                                Model Hospital A                               Page  : 1
Time: 14:36                      External Agency Reconciliation Report for MIKEGA            Report: FFR671A


Account #       Patient Name              F/C   P/T    Guarantor Name            Guar Phone #    Disch Date   Xfer Date
Last Payment Date    Account Balance    Carrier Balance    Car/Plan   Seq
----------------------------------------------------------------------------------------------------------------------
A0533400003    Smith, Bob                 C     I/P    Smith, Bob                                11/30/05
                                   $810.60    300100     4

A0534200002    Saunders, Tom             NY     ER     Mettle, Anne                             12/08/05
                                   $254.87    700150    13

A0601000001    STEWART,KAREN              S     I/P    Smith, Allan             (404)338-2851    01/11/06    05/16/06
                                 $1,341.11    500100     5
```

COLUMN EXPLANATIONS

ACCOUNT NUMBER
This field contains the patient's account number.

PATIENT NAME
This field contains the patient's name.

F/C
This column contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes values such as self-pay, commercial insurance, and Medicare.

PT
This field contains the patient type code and is used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

GUARANTOR NAME
This field contains the guarantor name.

GUARANTOR PHONE
This field contains the guarantor phone number.

DSCH DATE
This field contains the patient's discharge date.

XFER DATE
This field indicates the date the account was transferred to an external collection agency.

LAST PYMT DATE
This field contains the date of the last payment made to this patient's account.

ACCT BALANCE
This field contains the account balance.

CARRIER BALANCE
This field contains the carrier balance.

CAR/PLAN
This field contains the carrier and plan numbers.

SEQ
This field identifies the claim sequence number.

EXTERNAL AGENCY AUDIT REPORT (FFR670)

Description/Purpose

This report is a tool to assist the facility in monitoring and tracking accounts sent to external collection agencies.

The primary sort of the report is by agency. The next sorts are by collector, section, report reason, and guarantor. The accounts are grouped in four different sections: Demographic Updates, Deleted Accounts, Financial Updates, and New Accounts. Accounts are reported in each section that is pertinent to them. For example, if an account had demographic and financial changes, it would be reported in the Demographic Update and the Financial Update sections. A report reason code is also associated with each account. This reason code reflects the reason the account is on the report.

Generating the Report

The External Agency Audit Report (FFR670) is generated when the Agency Processing Interface is run.

The following is an example of the report.

Figure 3.65 FFR670 - External Agency Audit Report

```
Date: 07/29/07                          Model Hospital A                                Page  : 1
Time: 1:34                   External Agency Audit Report for MIKEGA                    Report: FFR670A

Collector: 98 Young, Bonnie                                               Section: DEMOGRAPHIC CHANGES

Corp #    Guarantor Name           Patient Name          Account #     Sched    Car/Plan    Seq
D/C Date    Ind   F/C   P/T  Transfer   Prev Balance   Acct Balance  Pat Balance  Car Balance        Last Payment   Rzn  Sts
-------------------------------------------------------------------------------------------------------------
00004938  Cohn, Bob                 Cohn,Bob              0606500005            400200    73
03/06/06    E     B     ER                0.00       4,806.58                   0.00                                      D

00004938  Smith, Nancy             Stewart, Jim           0606500005            500100    74
03/06/06    E     B     ER                0.00       4,806.58                   0.00                                      D

00004938  Martin, Nell             Martin, Nell           0606500005            500200    75
03/06/06    E     B     ER                0.00       4,806.58                   0.00
```

Column Explanations

COLLECTOR
This field contains the collector's name and number.

GUARANTOR NAME
This field contains the guarantor name.

PATIENT NAME
This field contains the patient's name.

ACCOUNT #
This field contains the patient's account number.

SCHED
This field contains the current follow-up schedule assigned to this patient's account.

D/C DATE
This field contains the date the patient was discharged.

IND
This field contains the patient indicator. Values for this field are: I-inpatient, O-outpatient, and E-emergency.

F/C
This field contains the enterprise-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc.

P/T
This field contains the patient type code used to categorize a specific portion of the patient community. The enterprise-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

TRANSFER
This field contains the Transfer Date.

PREV BALANCE
This field contains the account balance at the time of the last Interface Run.

ACCT BAL
This field contains the account balance.

PAT BAL
This field contains the patient's balance.

CAR BAL
This field contains the carrier balance.

LAST PAYMENT
This field contains the amount of the last payment.

RZN
This field contains the rejection reason code, which identifies why an account fails for agency collection. Refer to Appendix A in the *Follow-Up Functions Volume* of the *STAR Financials Patient Accounting Reference Guide* for an explanation of the rejection reason codes.

STS
This field contains the agency collection status of the account. Refer to Appendix A in the *Follow-Up Functions Volume* of the *STAR Financials Patient Accounting Reference Guide* for an explanation of the status codes.

DENIAL AUDIT REPORT (FFR367)

Description/Purpose

This report includes new denials from all denial tracking input methods, including Insurance Cash, Line Item Cash, Balance Transfer, ERA, and Adjustment.

The Denial Audit report is a Daily Batch Report. If there are no accounts to be included on the report, the system generates a header with no accounts on the report. The sort for the report is account number.

There are two sections on the report. The first section is for denials being tracked, the second section is for denials not being tracked. The information associated with the accounts is at the time the denial instance is tracked or not tracked. Totals are provided by carrier/plan and by denial input.

Generating the Report

The Denial Audit Report (FFR367) is a daily batch report. If there are no accounts to be included on the report the system generates a report with a report header, and no accounts are included on the report. The following is an example of the report.

Figure 3.66 FFR367 - Denial Audit Report)

```
Date: 07/20/07                              General Hospitasl                              Page  : 1
Time: 2:04                                  Denial Audit Report1                           Report: FFR367A
                                            Tracking Denials

Account #        Account Name                     Loc FC PT  Admit DT Discharge DT CR/PL    CS  Clm Disposition  Denial Input
Den-App Ind      Denial Instance #   Total Denied Amount    Est Reimb Amt                Carrier Bal      Account Bal
       Denial Codes   Clm Adj Group    Denial Amt       HCPCS Code          Line item Chg Amt          Line item Pymt Amt
-----------------------------------------------------------------------------------------------------------------------------

A0719200002      KANE,TESTC                       AR  O  O/P  07/11/07 07/11/07   918/100  1                      B
D-Open Appeal              1        200.00              320.00                    348.32          348.32
       18            CO              200.00

A0719200003      KANER,TESTD                      AR  O  O/P  07/11/07 07/11/07   918/100  1  Partial Payment  I
D-Open Appeal              1         75.00              320.00                    328.32          328.32
       18            CO               30.00
       18            CO               10.00
       35            CO               35.00

Report Totals By Carrier/Plan
CR/PL           Count           Total Denial Amount
------------------------------------------------------------
918/100           2                     275.00

Report Totals By Denial Input
Denial Input    Count           Total Denial Amount
------------------------------------------------------------
B                 1                     200.00
```

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Field Explanations:

ACCOUNT #
This field contains the patient account number.

ACCOUNT NAME
This field contains the patient name.

LOC
This field contains the location of the account.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial classes categorize patients based on fiscal responsibilities. Examples of financial classes include C-Commercial and M-Medicare.

PT
This field contains the hospital-defined patient type code which represents such patient segments as regular admission, emergency room, outpatient, same day surgery, and series patients.

ADMIT DT
This field contains the date the patient was admitted.

DISCHARGE DT
This field contains the date the patient was discharged. If this is a cycle bill account, this field will be blank if the patient hasn't been discharged.

CR/PL
This field contains the carrier plan code for the claim

CS
This field contains the system-generated claim sequence number assigned to this patient's claim record.

CLM DISPOSITION
This field contains the disposition associated with the claim.

DENIAL INPUT
This field indicates how the denial was entered into the system, by one of the following:

- I for Insurance Cash

- L for Line Item Cash

- B for Balance Transfer

- E for ERA

- A for Adjustment

- V for Vendor

DEN-APP IND
This field contains the denial/appeal indicator. Values for the Denial-Appeal indicator are:

D-Inactive

D-Open Appeal

D-Pre-Appeal

D-No Appeal

D-Clsed Appeal

Not Valid/2nd Ins

Not Valid

Never Denied

A value of *D* indicates that the claim has been denied at least once and doesn't meet the criteria for Not Valid. The values appended to the right of the *D* indicate the status of the appeal that is associated on the Denial/Appeal Tracking parameters was not set to Live at the time of the denial.

D-Inactive

This indicates that the status of the appeal for the most current denial is inactive/turned off which means the Appeal Status field that is associated with the denial.

NOTE: The Appeal Status field corresponds to ~FAT. If the field is not set to *Live*, the value of tilde FAT is blank.

D-Open Appeal

This indicates that the status of the appeal for the most current denial is Active. This applies to all active appeal types such as:

Active Appeal

Active 1st Attempt

Active 2nd Attempt

Active 3rd Attempt

Active 4th Attempt

Active 5th Attempt

Active Final Payment

D-Pre-Appeal

This indicates that the status of the appeal for the most current denial is Pre-Appeal.

D-No Appeal

This indicates that the status of the appeal for the most current denial is No Appeal.

D-Clsd Appeal

This indicates that the status of the appeal for the most current denial is Closed. This applies to all Closed types such as:

Closed Withdrawn

Closed Manually

Closed Final Payment

Closed Resequenced

Closed Replaced/Submitted

Closed Timeout

Note this also includes closed pre-appeals.

Not Valid/2nd Ins

A value of Not Valid/2nd Ins indicates denial tracking is not valid because the insurance associated with the claim is not associated with COB 1.

Not Valid

A value of Not Valid indicates the claim doesn't qualify for denial tracking. This could be if denial tracking is not turned on for the facility. The Denial/Appeal Parameters, Denial Method field determines if Denial Tracking is turned on for the facility. If a claim has a disposition of R for replaced then the denial-appeal indicator would also display as Not Valid.

Never Denied

A value of Never Denied indicates that claim hasn't been denied, and it also doesn't meet the criteria for a value of Not Valid.

DENIAL INSTANCE #
This field contains the instance number associated with the denial. Every time a new denial instance is associated with a claim, the denial instance number is increased.

TOTAL DENIED AMOUNT
This field contains the sum of all of the denied amounts associated with the denial codes for the claim.

EST REIMB AMT
This field contains the dollar amount expected from this carrier/plan.

CARRIER BAL
This field contains the balance currently due from the carrier.

ACCOUNT BAL
This field contains the outstanding account balance.

DENIAL CODES
This field contains the payor's denial reason.

CLM ADJ GROUP
This field contains the claim adjustment group code which is the general grouping of reasons for the associated CAS Reason Code. This field is valid only for ERA denials. The standard ANSI X12 835 codes are CO for Contractual Obligations, CR- Correction and Reversals, OA- Other Adjustments, PI- Payor Initiated Reductions, Pr-Patient Responsibility.

DENIAL AMT
This field contains the denial amount for this denial reason code. This field contains the denial input code associated with the denials.

COUNT
This field contains the number of denials per denial input code.

HCPCS CODE
This field contains the HCPCS procedure code with any attached HCPCS modifiers for the charge. This field is used only for ERA claims. It comes from the SVC01-2 field in the ERA file.

LINE ITEM CHARGE AMT
This field contains the charge amount that is related to the service line on the claim. This field is used only for ERA claims. It comes from the SVC02 field in the ERA file.

LINE ITEM PTMT AMT
This field contains the payment that is related to the service line on the claim. This field is used only for ERA claims. It comes from the SVC03 field in the ERA file.

Report Totals

CR/PL
This field contains the carrier/plan code associated with the denials.

COUNT
This field contains the number of denials per the carrier/plan code.

TOTAL DENIED AMOUNT
This column contains the total denied amount per denial input code.

ESTIMATES OF ACCOUNTS/CLAIMS TO BE ARCHIVED (FAARCCT)

Description/Purpose

This report provides an estimated number of accounts qualifying for archiving and the number of claims qualifying for archiving. For AR and/or BD accounts four numbers are provided:

- Number of accounts in account location.This is labeled Existing Accounts.

- Number of claims for accounts in account location where the account discharge date precedes or equals the Claim End Disch Dt found on the Data Retention Parameters screen for Maintain Facility Information. This is labeled Existing Claims.

- Number of accounts qualifying for archiving if the archive program was run using the date of the report. This includes accounts selected for archiving already. This is labeled Qualifying Accounts.

- Number of claims qualifying for archiving if the archive program was run using the date of the report. This is labeled Qualifying Claims.

The first section of the report titled By Year, gives the numbers for AR and/or BD accounts by year using the date of discharge. The second section of the report titled By Month for Current and Previous Two Years, gives the numbers for AR and/or BD accounts by year and month using the date of discharge. If there are no accounts for the month and year, that year/month is not reported. You may see this in your test ID.

Generating the Report

This report is produced by running Optional Batch Job 129 (Estimate Accounts/Claims to be Archived). If this optional batch job is selected, it runs for the selected facility. It is started as a background job during up time processing for PA's batch processing. When the optional batch job is selected, you can determine whether to calculate statistics for AR and/or BD accounts.

Following is a sample of the report.

Figure 3.67 FAARCCT - Estimate of Accounts/Claims to be Archived

```
Date: 09/28/11                          Windward Medical University                    Page  : 1
Time: 12:25pm                    Estimate of Accounts/Claims to be Archived          Report: FAARCCTA
                                                By Year


                    Counts for AR Accounts                  *              Counts for BD Accounts
Year            Existing Claims/Accts       Qualifying Claims/Accts *      Existing Claims/Accts         Qualifying
Claims/Accts
                Accounts        Claims      Accounts       Claims *        Accounts       Claims      Accounts        Claims
1999               0              0            0             0 *              1             3            1              3
2001             119              0            0             0 *             41             0            9              0
2002             478              0            0             0 *            114             0           12              0
2003           1,800              0            0             0 *            100             0           13              0
2004             518              0            0             0 *             27             0            0              0
2005             610              0            0             0 *             44             0            0              0
2006             822              0            0             0 *             30             0            2              0
2007             643              0            0             0 *              1             0            0              0
2008             270              0            0             0 *              0             0            0              0
2009             140              0            0             0 *              2             0            0              0
2010              77              0            0             0 *              0             0            0              0
2011             933         17,040          218         6,717 *            146            50            2             25
Total          6,410         17,040          218         6,717 *            506            53           39
```

Field Explanations

EXISTING ACCOUNTS
This column contains the number of accounts in account location.

EXISTING CLAIMS
This column contains the number of claims for accounts in account location where the account discharge date precedes or equals the Claim End Disch Dt found on the Data Retention Parameters screen for Maintain Facility Information.

QUALIFYING ACCOUNTS
This column contains the number of accounts qualifying for archiving if the archive program was run using the date of the report. This includes accounts selected for archiving already.

QUALIFYING CLAIMS
This column contains the number of claims qualifying for archiving if the archive program was run using the date of the report.

Chapter 4 - BILLING AND CLAIMS REPORTS

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BILLED ACCOUNTS REPORT - FBR200

Description/Purpose

The Billed Accounts Report lists all inpatient, outpatient, and emergency room accounts selected for billing. Accounts included are either hospital-selected or system-selected accounts.

The report lists the patient name, account number, bill sequence, discharge date, patient type, patient indicator, financial class, carrier/plan number, insurance balance, cash collected, patient balance, amount billed, bill type, and account balance. Subtotals are summarized and sorted by bill types within the given patient type indicator. Facility totals are provided by patient type indicator, by bill type and bill totals.

This report provides a daily audit trail of all accounts billed and is used in the daily balancing of PA and AR. The account balance of bill type *F* indicates the PA to AR transfer amount.

Generating and Printing This Report

The Billed Accounts Report is a daily batch report and is printed through the Demand Print function. The report is sorted by user-defined bill sort criteria. Sort selections are biller code, carrier code, carrier/plan code, financial class, patient account number, patient indicator, patient name, and patient type.

The following is an example of the Billed Accounts Report.

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Figure 4.1 FBR200 -- Billed Accounts Report

```
Date: 02/06/06                              General Hospital A                              Page  : 1
Time: 17:12                                 Billed Accounts Report                          Report: FBR200A
                                          Accounts Billed on 02/05/06


                      Bill Dsch    PT  I F Carrier/      Plan       Account      Patient      Cash         Amount    B S
Patient Name     Account No  Seq  Date   Type O C Plan   Balance    Balance      Balance      Collected    Billed    T G
-----------------------------------------------------------------------------------------------------------------------
SMITH,KURT       0601800002  6           SER  O O 918 100  6,231.34   11,857.60    5,621.26       0.00         0.00  *Z*
                                                  500 200     5.00
         Bill totals
                      Outpatient :Bill totals
                      Emergency  :
                                    Adjustment      3      488.12
                                    CycA*           1      100.99
                                    Cycle           5    5,790.00        8,
                                    Total           9    6,278.12        8,
                      Inpatient  :
                                    Cycle         315 642,805,360.28 45,769
                                    Total         315 642,805,360.28 45,769
                      Outpatient :
                                    CycA           34 5,488,768.25 17,547,
                                    Cycle           2        0.00
                                    Total          36 5,488,768.25 17,547,


                                    Cycle           1    6,236.34   11,857.60    5,621.26       0.00         0.00
                                    Total           1    6,236.34   11,857.60    5,621.26       0.00         0.00
Bill Type Totals


         Bill type totals       C Cycle           1    6,236.34   11,857.60    5,621.26       0.00         0.00 Z Cycle Adj
1      6,236.34    10,857.60      5,621.26        0.00        0.00
                                 *Z Cycle Adj      1    6,236.34   12,857.60    5,621.26       0.00         0.00
Facility Total for Adj and Cycle Adj            2    6,236.34   33,857.60    5,621.26       0.00         0.00


                                 Z Cycle Adj       1    6,236.34   10,857.60    5,621.26       0.00         0.00
                                 *Z Cycle Adj      1    6,236.34   12,857.60    5,621.26       0.00         0.00

                                 C Cycle           1    6,236.34   33,857.60    5,621.26       0.00         0.00
Facility Total for Final,Late,Cycle             1    6,236.34   33,857.60    5,621.26       0.00         0.00


                      Facility Total           1    3    6,236.34   11,857.60    5,621.26       0.00         0.00
                           End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

PATIENT NAME
This field contains the patient name.

ACCOUNT NO
This field contains the patient account number. The letter P following the account number indicates the account was part of the Pre-bill Edit process.

BILL SEQ
This field contains the bill sequence number of the bill for the account.

DSCH DATE
This field contains the date the patient was discharged.

IO
The entry printed in this field identifies the patient as an inpatient (I) or an outpatient (O).

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities. Examples include S-self pay, C-commercial or M-Medicare.

CARRIER/PLAN
This field displays the patient's carrier and plan codes.

PLAN BALANCE
This field displays the plan balance for each insurance plan as prorated by the system.

ACCOUNT BALANCE
This field displays the current account balance for this patient.

PATIENT BALANCE
This field displays the current patient balance.

CASH COLLECTED
This field displays any cash payment made on the account prior to final or cycle billing.

AMOUNT BILLED
This field displays the total charges from all bills produced (final bill, cycle bill, adjustment bill and late bill) for the patient.

BT
This field contains the bill type assigned to this patient's account. Valid bill types are C-cycle, A-adjustment, F-final, L-late, and Z-cycle adjustment. The bill type of Z is preceded by an asterisk (*) if the bill has been suppressed and therefore not printed.

SG
This field determines that an account's final bill has been system-generated or forced. If a final bill is forced, Y prints in this field indicating the account has reached the maximum suspense days parameter for the bill type indicated.

BILL TYPE TOTALS
This field contains the total dollars sorted by type of bill.

FACILITY TOTALS
This field contains the facility grand totals for all accounts billed. The facility total for the Account Balance column is used to balance to the total amount in the Billed Accounts (A/R) column on the Administrative Operating Summary (FSRAOS) report.

NOTE: If an account displays on this report with all balances as zero, charges from this account may have been combined to another account using the Combine Bills function. For more information on this function, refer to the description of the Combine Bills function in the Patient Billing section in the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide*.

BILLED ACCOUNTS BY FINANCIAL CLASS - FBR211A

Description/Purpose

The Billed Accounts by Financial Class Report lists all inpatient, outpatient, and emergency room accounts selected for billing. Accounts included are either hospital-selected or system-selected accounts.

The report lists the patient name, account number, bill sequence, discharge date, patient type, patient indicator, financial class, carrier/plan number, insurance balance, cash collected, patient balance, amount billed, bill type, and account balance. Subtotals are summarized and sorted by bill types within the given patient type indicator. Facility totals are provided by patient type indicator, by bill type and bill totals.

This report provides a daily audit trail of all accounts billed and is used in the daily balancing of PA and AR. The account balance of bill type *F* indicates the PA to AR transfer amount.

Generating and Printing This Report

The Billed Accounts Report is a daily batch report and is printed through the Demand Print function. The report is sorted by financial class.

The following is an example of the Billed Accounts Report.

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Figure 4.2 FBR211A - Billed Accounts by Financial Class Report

```
Date: 07/20/99                                Model Hospital A                               Page  : 3
Time: 6:01                               Billed Accounts by Fin Class                        Report: FBR211A
                                          Accounts Billed on 07/19/99
                                              O - OTHER COMMERCIAL


                        Bill Dsch     PT   I  Carrier/      Plan         Account       Patient       Cash         Amount    B S
Patient Name      Account No  Seq  Date  Type  O  Plan     Balance       Balance       Balance     Collected      Billed    T G
-------------------------------------------------------------------------------------------------------------------------------
--
HARRISON,CAITLIN 9900100040    3 01/01/99 ER   E  500 100     80.00        100.00       100.00         0.00          0.00 A
HARRISON,CAROLYN 9911700003    1 04/27/99 I/P  I  500 100    370.50        370.50         0.00         0.00        370.50 F
                                                  500 200      0.00
HARRISON,DIANE C 9902500002    6          I/P  I  500 100  77,343.25     77,323.25        20.00-       10.00     13,557.50 C
HARRISON,GARRETT 9911700004    1 04/27/99 I/P  I  500 100    340.25        340.25         0.00         0.00        340.25 F
                                                  500 200      0.00
HARRISON,GREG    9911700005    1 04/27/99 I/P  I  500 100    400.25        400.25         0.00         0.00        400.25 F
                                                  500 200      0.00
HARRISON,MAGGIE  9910900009    3 04/19/99 ER   E  500 100    155.27        155.27         0.00         0.00        206.57 A
                                                  500 200      0.00


        Bill totals
                Emergency  :
                          Adjustment        2       235.27        255.27       100.00         0.00        206.57
                          Total             2       235.27        255.27       100.00         0.00        206.57
                Inpatient  :
                          Cycle             1    77,343.25     77,323.25        20.00-       10.00     13,557.50
                          Final             3     1,111.00      1,111.00         0.00         0.00      1,111.00
                          Total             4    78,454.25     78,434.25        20.00-       10.00     14,668.50


        Bill type totals       A Adjustment 2       235.27        255.27       100.00         0.00        206.57

                               C Cycle      1    77,343.25     77,323.25        20.00-       10.00     13,557.50
                               F Final      3     1,111.00      1,111.00         0.00         0.00      1,111.00
        Fin Class Total for Final,Late,Cycle 4   78,454.25     78,434.25        20.00-       10.00     14,668.50


                Financial Class Total       6    78,689.52     78,689.52        80.00        10.00     14,875.07
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

PATIENT NAME
This field contains the patient name.

ACCOUNT NO
This field contains the patient account number.

BILL SEQ
This field contains the bill sequence number of the bill for the account.

DSCH DATE
This field contains the date the patient was discharged.

IO
The entry printed in this field identifies the patient as an inpatient (I) or an outpatient (O).

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities. Examples include S-self pay, C-commercial or M-Medicare.

CARRIER/PLAN
This field displays the patient's carrier and plan codes.

PLAN BALANCE
This field displays the plan balance for each insurance plan as prorated by the system.

ACCOUNT BALANCE
This field displays the current account balance for this patient.

PATIENT BALANCE
This field displays the current patient balance.

CASH COLLECTED
This field displays any cash payment made on the account prior to final or cycle billing.

AMOUNT BILLED
This field displays the total charges from all bills produced (final bill, cycle bill, adjustment bill and late bill) for the patient.

BT
This field contains the bill type assigned to this patient's account. Valid bill types are C-cycle, A-adjustment, F-final, L-late, and Z-cycle adjustment. The bill type of Z is preceded by an asterisk (*) if the bill has been suppressed and therefore not printed.

SG
This field determines that an account's final bill has been system-generated or forced. If a final bill is forced, Y prints in this field indicating the account has reached the maximum suspense days parameter for the bill type indicated.

BILL TYPE TOTALS
This field contains the total dollars sorted by type of bill.

FACILITY TOTALS
This field contains the facility grand totals for all accounts billed. The facility total for the Account Balance column is used to balance to the total amount in the Billed Accounts (A/R) column on the Administrative Operating Summary (FSRAOS) report.

NOTE: If an account displays on this report with all balances as zero, charges from this account may have been combined to another account using the Combine Bills function. For more information on this function, refer to the description of the Combine Bills function in the Patient Billing section in the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide*.

CLAIM FORM PARAMETERS - FCRCP

Description/Purpose

The Claim Form Parameters report provides a detailed listing of the Claim Form and Edit parameters defined on the STAR Financials Patient Accounting system. There are two versions of the report - one for UB claims and one for 1500 claims (including the state claims). Since the Claim Load and Edit Parameters are not split by facility, the report does not contain a facility indicator. The system defaults to *General Hospital* in place of the facility name. This report is used in the installation process to verify that each Claim Load and Edit Parameter has been defined correctly.

Generating and Printing This Report

This report is requested through the Claim Load and Edit Parameters option. After you access a claim form type and a user-defined code, the system displays the screens used in the table build process. When you exit this function, the system displays the following prompt:

Do you want a printed list (Y/N) [N]?

Enter **Y** if you want to generate the report. The system references the spooler report definition to determine if the report is printed immediately or on demand and what printer is used for output. If the report is spooled for subsequent printing, the report name remains FCRCP since this report is not split by facility.

The following is an example of the Claim Form Parameters Report for a UB claim.

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Figure 4.3 FCRCP - Claim Form Parameter Report - UB Claim

```
Date: 04/15/10                          General Hospital                        Page  : 1
Time: 01:44pm                         CLAIM FORM PARAMETERS                      Report: FCRCP

CLAIM   CLAIM                                                        DETAIL    LAST      GENERATION
TYPE   CODE/FORM   DESCRIPTION          BEGIN DATE  END DATE  MEDIA  START STOP GENERATED PENDING

55     X-UB        UB92 PARM 55         04/15/2009            BOTH PAPER AND ELECTRONIC  19   41   04/02/09 0848  NO

VERSION:  UB04   ICD-10 EFFECTIVE DATE:

       1500 FORMAT                    NY CLAIM TYPE      LOAD $0.0 CLAIM        ELECTRONIC TYPES    TOP LINE BLK
                                      None               A,C,F,L,Z,R,T          A,C,F,L,Z,R,T        NO

       ICD9 ERRONEOUS SURGERY DIAGNOSES      ICD10 ERRONEOUS SURGERY DIAGNOSES
       E8765,E8766,E8767

       COMBINE BILL MED INFO          DPW MED INFO                            USE ADM DX IF NO MR DX
       ALL/TO THEN FROM ACCOUNT       ALL/TO THEN FROM ACCOUNT                YES

       COMBINE BILL OP POA            DPW OP POA                              DPW ICD PROC TIMEFRAME
       Y                              Y                                       ALL CHARGES

       COMBINE BILL EXCLUDE ICD9 PROC  DPW EXCLUDE ICD9 PROC
       2049,2051,2059                 None

       COMBINE BILL EXCLUDE ICD10 PROC  DPW EXCLUDE ICD10 PROC
       00520ZT,00520ZU

       UB LOC 54 PRIOR PYMT CALC      1500 LOC 29 AMOUNT PAID CALC
       PYMT+ADJ


   **CLAIM LOCATOR: 1-PROVIDER INFORMATION

          FIELD #: 1-Provider Name        FLD TYPE: X:Alphanumeric  INTERNAL ELEMENT: UB PROVIDER CLAIM NAME
                                          PRINT   : YES      PRINT ROUTINE   : 1-STANDARD PRINT (NO FORMATTING)
   ***   REQUIRED: YES                    SETUP ROUTINE   :
                                          ONLINE EDIT ROUT:
          ROW     : 2                     BATCH EDIT ROUT :
          COLUMN  : 4                     DISPLAY ROUTINE :
          LENGTH  : 24                    DEFAULT VALUE   :
          VAL ENTR:
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

CLAIM TYPE
This field indicates the user-defined Claim Load and Edit Parameter code.

CLAIM CODE/FORM
This field indicates the claim code and form, for example, X=UB.

DESCRIPTION
This field contains the description of the Claim Load and Edit Parameter code.

BEGIN DATE
This field contains the beginning effective date.

END DATE
This field contains the effective ending date.

MEDIA
This field indicates whether the claims are paper, electronic, or both.

DETAIL START
This field indicates the line at which the detail charge information starts printing.

DETAIL STOP
This field indicates the line at which the detail charge information stops printing.

LAST GENERATED
This field contains the date on which this Claim Load and Edit parameter was generated. Any time changes are made, the parameter must be regenerated to activate the changes.

GENERATION PENDING
This field contains Yes or No. Yes indicates that changes have been made but the parameter has not been regenerated. The report reflects the values as they will be once the parameter is regenerated. No indicates that no changes have been made.

VERSION
If the claim type is a UB (claim type X), Medi-Cal UB (claim type R), 1500 (claim type B), or Non Pro Fee 1500 (claim type Z), the version of the claim type prints. For the UB and the Medi-Cal UB, valid versions are the UB92 and the UB04. For the 1500 and the Non Pro Fee 1500, valid versions are the 1992 and the 08/05.

ICD-10 EFFECTIVE DATE
This field contains the format of the claim followed by the ICD effective date. The ICD effective date prints only for claim types X-UB in the UB04 Format, R-Medi-Cal UB in the UB04 Format, B-1500 in the 08/05 Format, and Z-Non Pro Fee 1500 in the 08/05 Format,

The report prints the ICD-10 Effective Date from the header screen of the Claim Load Edit Parameter, and either Admission Date or Discharge Date, depending on if the effective date is for the Admission Date or the Discharge Date. A blank ICD-10 Effective Date field on the Claim Load Edit Parameter signifies that the insurances attached to this Claim Load Edit Parameter will load either ICD-10 or ICD-9, based on the settings of the ICD-10 Effective Date fields in the Hospital Facility Options on STAR Patient Processing, the Insurance Plan Tables, the Insurance Carrier Tables, and the Financial Class Tables. A date in the ICD-10 Effective Date field on the Claim Load Edit Parameter signifies that the insurances attached to this Claim Load Edit Parameter require ICD-10 codes for patients with an admission date or a discharge date on or following the effective date.

CLAIM LOCATORS
Each form locator for the claim is listed.

Certain form locators are multi-line and are further broken down into multiple fields. For example, form locator 1 on the UB is the Provider information containing four lines of information: the name, address, city, state, ZIP code, and phone number.

The following data is listed for each form locator/field:

FLD TYPE
This field indicates the field type. Valid options are:

X - Alphanumeric
N - Numeric
T - Time
A - Alpha
D - Date
M - Money

PRINT
This field indicates whether the contents of the field should be printed on the claim.

REQUIRED
This field indicates whether the field is required or not required. If Yes is entered, three asterisks are displayed on this report to facilitate verification during the installation process. Required fields that are left blank cause an error condition in the claim edit process.

ROW
This field contains the row number for this item.

COLUMN
This field contains the beginning column number for this item.

LENGTH
This field indicates the maximum length of the field.

VAL ENTR
This field indicates the valid entries for this form locator field.

INTERNAL ELEMENT
This field indicates the internal element that is loaded in this field. A McKesson claim master that contains the standard internal elements for most form locators is predefined for each claim type. The unlabeled form locators, which vary by state, are set up during the installation process.

PRINT ROUTING
This field indicates the format that is used when printing.

SETUP ROUTINE
This field indicates, where applicable, the routing that is used to load the data.

ONLINE EDIT ROUTINE
This field indicates the format that is used in the on-line claim edit process.

BATCH EDIT ROUTINE
This field indicates, if applicable, the format used in batch edit. For example, the patient's ZIP code utilizes a batch edit routine.

DISPLAY ROUTINE
This field indicates the format used for display in claim edit.

DEFAULT VALUE
This field indicates the value that is loaded/printed if no other data is loaded by the system.

ICD9 ERRONEOUS SURGERY DIAGNOSES
This field lists the ICD-9 erroneous surgery diagnosis codes for this Claim Load Edit Parameter.

ICD10 ERRONEOUS SURGERY DIAGNOSES
This field lists the ICD-10 erroneous surgery diagnosis codes for this Claim Load Edit Parameter.

COMBINE BILL MED INFO
This field lists the setting of the Combine Bill Med Info.

DPW MED INFO
This field lists the setting of the DPW Med Info.

COMBINE BILL OP POA
This field contains the Combine Bill outpatient Present on Admission indicator for diagnoses with a blank POA.

DPW OP POA
This field contains the DPW outpatient Present on Admission indicator for diagnoses with a blank POA.

COMBINE BILL EXCLUDE ICD9 PROC
This field contains the excluded ICD-9 procedures for combine billing.

DPW EXCLUDE ICD9 PROC
This field contains the excluded ICD-9 procedures for DPW.

COMBINE BILL EXCLUDE ICD10 PROC
This field contains the excluded ICD-10 procedures for combine billing.

DPW EXCLUDE ICD10 PROC
This field contains the excluded ICD-10 procedures for combine DPW.

RELEASED CLAIMS REPORT (FCR270) AND RELEASED CLAIMS SUMMARY REPORT (FCR270S)

Description/Purpose

The Released Claims Report lists all accounts that passed or bypassed the claim edits and were printed or available for electronic submission during midnight processing. This report provides a listing of the claims released for the patient on the same day that have the same carrier. Included are the carrier/plan, account number, patient name, admit date, discharge date, total charges on the claim, claim sequence, media type, shared claim indicator, and carrier liability.

A summary version of this report is also created (FCR270S). This report is a summary of the claims reported on the Released Claims Report (FCR270). This report is generated with the Released Claims Report but must be viewed and printed separately.

Facility totals for total claims, total claim amount and carrier liability are also provided on the summary report. This summary provides totals, by carrier, for the number of claims, total claim amount and carrier liability.

Generating and Printing This Report

The Released Claims Report and Released Claims Summary Report are daily batch reports and are printed as demand reports through the Demand Print function. The report is sorted by insurance carrier name and subsorted by media type and patient account number. Facility totals are printed on a separate page.

The following are examples of the Released Claims and Released Claims Summary Reports.

Figure 4.4 FCR270 - Released Claims Report

```
Date: 12/21/07                                General Hospital                               Page  : 1
Time: 12:11am                          Released Claims Report for 12/20/07                   Report: FCR270

                                                 04-AETNA

Account #    Patient Name               Plan  Claim  Admit    Discharge  Claim  Media  Shared   Tot Claim       Carrier
                                               Seq    Date      Date     Stat   Type   Plans    Amount          Liability
0718000001   JONES,ERIK                  100   11    1  12/16/07 12/17/07   S    Y,P              $1,182.50        $929.50
             Claim Attachments:  CF-Consent Form
             HP-History and Physical


        Carrier:04     No. Claims:      1            TOTALS:                                      $1,182.50        $929.50
_____
Date: 12/21/07                                General Hospital                               Page  : 2
Time: 12:11am                          Released Claims Report for 12/20/07                   Report: FCR270

                                              90-SELF INSURED

Account #    Patient Name               Plan  Claim  Admit    Discharge  Claim  Media  Shared   Tot Claim       Carrier
                                               Seq    Date      Date     Stat   Type   Plans    Amount          Liability

0500-291-174 TURNER,ELIZABETH W          1901   1   12/16/07 12/16/07     R     N,T               $360.00         $360.00


        Carrier:90     No. Claims:      1            Totals:                                       $360.00         $360.00
_____
Date: 12/21/07                                General Hospital                               Page  : 3
Time: 12:11am                          Released Claims Report for 12/20/07                   Report: FCR270

                                              FACILITY TOTALS

Facility:              P     No. Claims:       2     Total Claim Amt:                            $1,542.50       $1,289.50


                                               End of Report
```

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Figure 4.5 FCR270S - Claims Released Summary Report

```
Date: 12/21/07                                 General Hospital                            Page  : 1
Time: 12:34am                           Released Claims Summary for 12/20/07               Report: FCR270S

         Carrier                          No. Claims        Total Claim $$        Total Carrier $$

         04-AETNA                              1               1,182.50                929.50

         90-SELF-INSURED                       2                 360.00                360.00

                          Facility P Totals:   4              $1,542.50             $1,289.50


                                                End of Report
```

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Each report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

CLAIM SEQ
This field contains the system-generated claim sequence number assigned to this patient's claim record.

ADMIT DATE
This field contains the date the patient was admitted.

DISCHARGE DATE
This field contains the date the patient was discharged. If this is a cycle bill account, this field is blank.

CLAIM STAT
This field contains the claim status associated with this patient's claim record. Valid statuses can be M-manually released, R-system released, and S-system released after suspense days.

MEDIA TYPE
This field displays the setting of the Produce Claim indicator, followed by a comma, followed by the type of media used to transfer this claim to the carrier. The Produce Claim flag is set in the Billing and Claim Parameters within the Insurance Plan Coverage master, and can also be seen on the Claim Status Information screen within Claims Management.   The Produce Claim indicator displays either Y for Yes (claims are spooled to either the paper or electronic file when released) or N for No (claims are not spooled to either the paper or the electronic file when released, but are suppressed instead). Valid types of media are A (Electronic Media A), B (Electronic Media B), C (Electronic Media C), D (Electronic Media D), E (Electronic Media E), T (Electronic Media T), and P (Paper).

SHARED PLANS
This field shows any other insurance carrier being billed on this claim.

TOTAL CLAIM AMOUNT
This field contains the total amount of charges billed on this claim.

CARRIER LIABILITY
This field displays the prorated amount due from the carrier.

CARRIER
This field contains the insurance carrier code and description.

NO. CLAIMS
This field contains the total number of claims released for this carrier.

TOTAL CLAIM $$
This field contains the total amount of the claims released for this carrier.

TOTAL CARRIER $
This field contains the total liability of this carrier.

FACILITY TOTALS
These fields contain the totals for the facility.

CLAIM ATTACHMENTS
This field contains attachments sent with the claim, such as HP-History and Physical and PT-Physical Therapy.,

CLAIMS SUBMITTED-UNPAID REPORT - FCR280

Description/Purpose

The Claims Submitted-Unpaid Report lists all claims that have been submitted but remain unpaid, including those that received partial payment.

To be included in this report, a claim must meet the following criteria:

- The days must be met to qualify for the report, as set in the Days/Sort for Unpaid Report field on the PAAR Control screen.

- The paid in full indicator must be blank or N. This field can be viewed in Claims Management, Carrier Status Information. Dispositions of (F)inal Payment, (A)djusted to Zero, and (D)enied set the Paid in Full indicator to a Yes.

- The claim must have a submit date.

- The claim estimated amount due - payments + or - adjustments must be greater than zero.

- The carrier balance must be greater than zero.

- The claim disposition must be P for Partial Payment, C for Clear Disposition, T for Transfer, or blank.

- The claim disposition can not be Replaced or Denied.

- The claim work status must be manually released, forced, suppressed, system released, or awaiting payment. The work status can not be Failed, Denied, Hold, or Edit.

The report lists the carrier/plan, patient name, claim disposition, claim submission date, claim liability, partial payment amount, claim adjustment amount, amount remaining to be paid on the claim, and the carrier balance. Subtotals are provided by carrier/plan for number and amount of claims outstanding. Facility totals are provided for total number and amount of claims outstanding.

This report can also be sorted by Insurance Collector. If you select this option, the heading displays the insurance collector number and name, and the report displays subtotals by insurance collector. The pages of the report break by insurance collector. If the account is in location Bad Debt, the collector reflects the term Bad Debt. Claims are not in insurance follow-up when the account is in location Bad Debt, which results in not having an insurance collector.

NOTE: Claims with a zero balance or credit balance for the carrier do not print on this report. The system also excludes from this report claims that have a zero balance or credit balance calculated for the amount remaining for the claim.

If the biller index indicates a submitted claim but the claim data indicates otherwise, the claim does not appear in the report, and it is marked to be fixed during midnight processing.

Generating and Printing This Report

The Claims Submitted-Unpaid Report is generated through the Optional Batch Job Processor. Refer to the Financial System Management section in the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide* for information on setting up this report.

You control how claims are selected for this report by setting the number of unpaid days a claim must meet (using PAAR Control) before being included on this report. You must select to sort this report either by insurance collector or carrier/plan.

The following pages contain examples of the Claims Submitted-Unpaid Report.

Figure 4.6 FCR280 - Claims Submitted-Unpaid Report, Sort by Carrier/ Plan

```
Date: 12/21/91                              General Hospital                                 Page  : 1
Time: 12:11am                      UNPAID SUBMITTED CLAIMS AS OF 12/20/91                    Report: FCR280

ACCOUNT #    PATIENT NAME              COB CLM  CLM   SUBMIT         CLAIM      PARTIAL    ADJUSTMENT      AMOUNT       CARRIER
                                           DSP  SEQ    DATE       LIABILITY    PAYMENT      AMOUNT      REMAINING     BALANCE

  ***** 60-0041 MEDICARE/A/HOSP ONLY *****

05002-1166   JOHN,KRISTIN A             1        16  12/20/91    $1,128.56      $0.00       $0.00       $1,128.56    $1,128.56

90017-0007   MARTIN,RONALD S            1   P     5  12/20/91    $1,000.00    $500.00       $0.00         $500.00      $500.00

    PLAN 0041 TOTALS:       NO. CLAIMS   2                       $2,128.56    $500.00       $0.00       $1,628.56    $1,628.56


  ***** 64-1564 W/C ALSTON & BIRD *****

0100-00008   TURNER,NANCY L             2         1  12/20/91      $210.00      $0.00       $0.00         $210.00      $210.00

8918-00921   SMITH,HARRIET V            3   C     2  12/20/91      $500.00      $0.00       $0.00         $500.00      $500.00

8190-52411   JACKSON,JENNIFER R         1         4  12/20/91      $600.00      $0.00       $0.00         $600.00      $600.00

    PLAN 1564 TOTALS:       NO. CLAIMS   3                       $1,310.00      $0.00       $0.00       $1,310.00    $1,310.00

  ***** 90-1901 LOCKHEED GEORGIA *****
100
0500-26156   SOTHEBY,JAMES D            1         3  12/20/91      $360.00      $0.00       $0.00         $360.00      $360.00

    PLAN 1901 TOTALS:       NO. CLAIMS   1                         $360.00      $0.00       $0.00         $360.00      $360.00

    FACILITY P TOTALS:      NO. CLAIMS   6                       $3,798.56    $500.00       $0.00       $3,298.56    $3,298.56

                                             End of Report
```

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Figure 4.7 FCR280 - Claims Submitted-Unpaid Report, Sort by Insurance Collector

```
Date: 12/21/91                              General Hospital                            Page  : 1
Time: 12:11am                     UNPAID SUBMITTED CLAIMS AS OF 12/20/91                Report: FCR280
                                          12  Smith,Tim
ACCOUNT #    PATIENT NAME            COB   CLM  CLM  SUBMIT       CLAIM      PARTIAL     ADJUSTMENT     AMOUNT       CARRIER
                                          DSP  SEQ   DATE      LIABILITY    PAYMENT      AMOUNT      REMAINING     BALANCE

 ***** 60-0041 MEDICARE/A/HOSP ONLY *****
05002-1166   JOHN,KRISTIN A          1     P   16  12/20/91   $1,128.56    $100.00      $0.00      $1,028.56    $1,028.56

90017-0007   MARTIN,RONALD S         1     P    5  12/20/91   $1,000.00    $400.00      $0.00        $600.00      $600.00

0102-00648   HARRISON,MIKE           2     C    1  12/20/91     $210.00      $0.00      $0.00        $210.00      $210.00

8929-00238   JONES,LOUISE            1     P    2  12/20/91     $500.00    $200.00      $0.00        $300.00      $300.00

8130-52515   PARKER,ROBERT           1     P    4  12/20/91     $600.00    $300.00      $0.00        $300.00      $300.00

    PLAN 0041 TOTALS:       NO. CLAIMS    5                   $3,438.56   $1000.00      $0.00      $2,438.56    $2,438.56

    COLLECTOR 12 TOTALS:    NO. CLAIMS    5                   $3,438.56   $1000.00      $0.00      $2,438.56    $2,438.56
                                         End of Report
```

Each of the reports contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system. The report sorted by insurance collector also contains the number and name of the collector.

COB
This field displays the coordinate of benefits indicator for this claim. This field displays COB 1, 2, 3, or 4.

CLM DSP
This field displays the disposition code for this claim. This is P (Partial Payment), C (Clear Disposition), T (Transferred), or blank. Claims with a disposition code of F (Final Payment), A (Adjusted to Zero), D (Denied), or R (Replaced) do not display on this report.

CLAIM SEQ
This field contains the system-generated claim sequence number assigned to this claim.

SUBMIT DATE
This field contains the submission (mailing) date of the claim.

CLAIM LIABILITY
This field contains the system-calculated amount for which the carrier is responsible.

PARTIAL PAYMENT
This field contains any partial payments made on this patient's claim.

ADJUSTMENT AMOUNT
This field contains any adjustments made on this patient's claim.

AMOUNT REMAINING
This field contains the calculated amount remaining for this claim. This amount equals the claim liability less payments and adjustments for the claim.

CARRIER BALANCE
This field contains the balance currently due from the carrier. The system repeats this amount if there are multiple claim sequences for the same account for the same carrier; however, this amount is included in the totals only once.

CLAIM WORK TRANSFER REPORT - FCRCWT

Description/Purpose

The Claim Work Transfer Report reflects claim work types that were transferred from one biller to another. The report shows the original biller to whom the claim was assigned, the biller to whom the claim work type was transferred, the account number for the claim, patient's name, claim sequence number, and transfer type (claims with errors, claims without errors, claims generated (not submitted) or claims submitted).

A summary section on the last page of the report shows the total transfer activity. It lists claims transferred with totals by claim transfer type.

Generating and Printing This Report

The Claim Work Transfer Report is generated when claim work is transferred from one biller to another.

The following page shows an example of the Claim Work Transfer Report.

Figure 4.8 FCRCWTX - Claim Work Transfer Report

```
Date: 06/25/02                    General Hospital                       Page 1
Time: 11:06                       Claim Work Transfer                    FCRCWTA



From Biller                    To Biller                 Acct Number     Name        CS Type
---------------------------------------------------------------------------------------------
5-BILLERFIVE,BILLER            4-BILLERFOUR,BILLER        A0112300012     Fred Brown   1  Submitted



Summary Section:      With Errors       283
                      Without Errors      0
                      Not Submitted      77
                      Submitted          29

                      Total             389
```

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Field Explanations

FROM BILLER
This column contains the biller code and name of the original biller assigned to the claim.

TO BILLER
This column contains the biller code and name of the biller to whom the claim was transferred.

ACCT NUMBER
This column contains the account number for the claim that was transferred.

NAME
This column contains the name of the patient whose claim was transferred.

CS
This column contains the claim sequence number.

TYPE
This column contains the claim transfer type, as follows:

- With Errors

- Without Errors

- Generated (not submitted)

- Submitted

CLAIMS CHARGE DATA AUDIT REPORT - FCR290

Description/Purpose

The Claims Charge Data Audit Report provides an audit trail for claims adjustments made by the biller during claim edit for the business day. Any additions, deletions or changes to the charge dollars are reported. The report lists the account number, patient name, claim sequence, claim type, original claim amount, current claim amount, and adjustment amount. Subtotals for adjustments are reported for each carrier by biller code. A facility grand total is reported for all adjustments.

Generating and Printing This Report

The Claims Charge Data Audit Report is generated as a part of midnight processing. Refer to Chapter 2, Financial System Management (Optional Batch Jobs), of the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide,* for more information.

The report is sorted by biller code and subsorted then by carrier plan, account number, and claim sequence number. Page breaks occur at the end of the page after each biller and after each biller summary.

The following is an example of the Claims Charge Data Audit Report.

Figure 4.9 FCR290 - Claims Charge Data Audit Report

```
Date: 12/29/97                              General Hospital                         Page  : 1
Time: 12:20am                       CLAIM AUDIT REPORT FOR 12/28/97                  Report: FCR290

                                        123 - Dimble,Jeannete R

ACCOUNT #        PATIENT NAME           CLM   CLAIM            ORG CLAIM AMT   CURR CLAIM AMT   ADJ AMOUNT
                                        SEQ   TYPE

89265-00004      CARLSON,JAMES D         2    UB               10,230.60       10,200.00         30.00

86000-20001      PRESLEY,PATRICK F       2    UB               10,600.12       10,540.20         60.00

                                                          TOTAL ADJUSTMENT AMOUNT       $90.00

                                                          HOSPITAL ADJUSTMENT AMOUNT     $0.00

                                        End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

ACCOUNT #
This field contains the patient account number.

PATIENT NAME
This field contains the patient name.

CLM SEQ
This field contains the claim sequence number.

CLAIM TYPE
This field contains the claim type. Valid claim types include U-UB82, X-UB, and B-1500.

ORG CLAIM AMT
This field contains the original claim amount before edits.

CURR CLAIM AMT
This field contains the claim amount after edits.

ADJ AMT
This field contains the adjusted amount.

TOTAL ADJUSTMENT AMOUNT
This field contains the total adjusted amount for this biller.

HOSPITAL ADJUSTMENT AMOUNT
This field contains the total adjusted amount for the hospital (facility).

DIAGNOSTIC REVENUE CODES REPORT - FCRDRC

Description/Purpose

The Diagnostic Revenue Codes report provides a listing of the UB Revenue Codes that produce a Type of Bill second digit of 4 (diagnostic) in Locator 4 of the UB for patients with an outpatient patient indicator. If the account has only revenue codes listed in this table on the UB, has an outpatient patient indicator, and uses 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 prints a type of bill second digit of 4. If the account has revenue codes other than the ones listed in this table on the claim, then the system prints the default value for the second digit of the type of bill from the UB Claim Load and Edit Parameter.

This report prints by facility, and contains a facility indicator at the end of the report (for example, FCRDRCA).

Generating and Printing This Report

This report is requested through the Diagnostic Revenue Code Table option. After you access the table for the facility, you can enter the UB Revenue Codes for outpatient diagnostic services. When you exit the screen, the system displays the following prompt:

Do you want a printed list? (Y/N) [N]

Enter **Y** if you want to generate the report. The system references the spooler report definition to determine if the report is printed immediately or on demand and what printer is used for output. If the report is spooled for subsequent printing, the report name is FCRDRCX where X is the facility indicator.

The following is an example of the Diagnostic Revenue Codes Report.

Figure 4.10 FCRDRC - Diagnostic Revenue Codes Report

```
Date: 07/08/93                         General Hospital                         Page  : 1
Time: 10:10am                       Diagnostic Revenue Codes                    Report: FCRDRCA

        Revenue Code & Description
        320 - Radiology, Diagnostic
        341 - Nuc Med/Dx
        401 - Diagnostic Mammography
        920 - Other Diagnostic Services

                                     End of Report
```

Each report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used by the system.

REVENUE CODE AND DESCRIPTION
This field lists the UB revenue code and the description of the revenue codes that are considered to be outpatient diagnostic revenue codes.

DRG PAYMENT WINDOW REPORT - FBR072

Description/Purpose

The DRG Payment Window report identifies all DPW pairs of accounts.

The status of the DPW appears as Active or Inactive. If charges are reported, the DPW group for the charge (All, Evaluate Diagnostic, and Evaluate Non-Diagnostic) prints along with the status of the charge.

The DRG Payment Window Report prints nightly after the DPW Charge verification is complete. The primary sort is DRG Payment Window Code. The secondary sort is the inpatient account number. It is produced during midnight processing up-time.

If there are multiple outpatient windows, the inpatient account appears once followed by each outpatient account.

If the report is set up to print cumulative, the report contains a DPW printing with or without charge activity until the outpatient account is out of suspense and has no charges that require user review, or if the outpatient account is a series account, reporting can stop if the inpatient account is out of suspense and has no charges that require user review.

If the report is set up to print detail charges, the DPW detail charge activity prints on the day the activity occurs.

Potential DPWs for account charges due to events such as merge or transfer visit or other occurrences that require user review print on the date of occurrence only.

Generating and Printing This Report

The DRG Payment Window report is generated as part of midnight processing. The following is an example of the DRG Payment Window report.

Figure 4.11 FBR072 - DRG Payment Window Report

```
Date: 05/25/09                          General Hospital A                          Page : 1
Time: 03:06am                      DRG Payment Window for 05/24/09                  Report: FBR072A

                                   DPW Code: DMM  DPW TESTING

Inpatient Acct #  Name                 Admit Date     Disch Date  ICD Diagnosis                DPW Status
    Outpatient Acct #
              Dept Code  Description                   Rev/HCPCS  Svc Date  Qty   Price Qualify/Status  Billed

A0014400014     DELAWARE,GARY      05/23/07                                                    Deleted
    A0014200018                        05/21/07       05/21/07
              DPW deactivated. OP final billed.        MNP Uptime/Outpatient DPW deleted
              DPW deactivated. OP final billed.        MNP Uptime/Re-checking DPWs
              Charge Eval Done. OP has final billed.   MNP Uptime/Re-checking DPWs
Charges

A0014400025     KRINGLE,PEG        05/23/07                        10 TEST ICD10 DAGNOSIS       Active
    A0014200011                        05/21/07       05/21/07
              DPW Hold. ICD9/ICD10 Mismatch            MNP Uptime/Re-checking DPWs

Charges


A0014500037     ERICSON,VIGGO      05/24/07       05/24/07         9 HEART DISEASE NOS          Active
    A0014500045                        05/24/07       05/24/07     9 HEART DISEASE NOS
              DPW activated. IP bill request removed.  Registration
Charges

    A0014500045   LAB  2010 ACTIVATED CLOTTING TIME    305/85347 05/24/07    1    $13.00 Disch/Report      N
                  LAB  5051 ADDITIONAL SURGICAL TEST    123/      05/24/07    2    $0.00 Disch/Report       N
                  LAB  1210 ALBUMIN, SERUM              301/82040 05/24/07    3    $0.00 Disch/Report       N
```

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DRG PAYMENT WINDOW REPORT - FBR072   Chapter 4 - BILLING AND CLAIMS REPORTS

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

INPATIENT ACCOUNT #
This field contains the account number for the inpatient account. Charges are transferred *to* this account unless some change required charges to be returned.

NAME
This field contains the patient name.

ADMIT DATE
This field contains the admit date for the inpatient account.

DISCH DATE
This field contains the discharge date for the inpatient account.

ICD
This field prints contains either a 10 for ICD-10 or a 9 for ICD-9 based on the ICD-10 Effective Date field on the Final Billing Parameter on the TO account, and the Admission Date or Discharge Date of the TO account. The system looks to either the ICD-10 codes on the TO and FROM accounts, or the ICD-9 codes on the TO and FROM accounts, and not a mixture of the two coding methods.

When there is a mismatch on the TO and FROM account(s) for the coding methods, the accounts are listed on the report with the error message DPW Hold. ICD9/ICD10 Mismatch. The accounts are put on DPW Bill Hold.The system keeps the accounts on DPW bill hold until the mismatch is corrected (meaning, the needed version of the diagnosis codes are coded on the FROM accounts), or charges can be manually selected and moved via the DRG Payment Window Processor from the FROM account(s) to the TO account.

DIAGNOSIS
This field contains the principle diagnosis if available. If it is not available, this field contains the admitting diagnosis. Based on the ICD-10 Effective Date field on the Final Billing Parameter on the TO account, and the Admission Date or Discharge Date of the TO account, the system either looks to the ICD-10 diagnosis codes or the ICD-9 diagnosis codes. This field first looks for the Principle Diagnosis from Medical Records if available. If it is not available, the system then looks for the Admitting Diagnosis from Medical Records.

DPW STATUS
This field contains the status of the DPW: Active or Inactive.

OUTPATIENT ACCT #
This field contains the account number for the outpatient account. Charges are transferred *from* this account unless some change required charges to be returned.

ADMIT DATE
This field contains the admit date for the outpatient account.

DISCH DATE
This field contains the discharge date for the outpatient account.

DIAGNOSIS
This field contains the abstract diagnosis for the outpatient account.

DPW STATUS
This field contains the status of the DPW for the outpatient account.

DEPT
This field contains the SIM department for each charge.

CODE
This field contains the SIM code for each charge.

DESCRIPTION
This field contains the SIM description for each charge.

REV/HCPCS
This field contains either the Revenue code or HCPCS code or both for each charge.

SVC DATE
This field contains the service date for each charge. The date is preceded by a T if the charge is the top of a pro fee chain, and it is preceded by a P if the charge is in a pro fee chain.

QTY
This field contains the quantity for each charge.

PRICE
This field contains the price for each charge.

QUALIFY/STATUS
This column displays the DPW group for the charge along with the DPW status of the charge. If this column is preceded by an asterisk (*), the charge is associated with a DPW other than the one reported. Charges appear based on service date and the DPW time frame.

The DPW groups are

All	All
Diag	Evaluate Diagnostic
NDiag	Evaluate Non-Diagnostic

DPW status codes are identified in the following table:

DPW Status Code	DPW Status
Pnd	Pending
NAdm	Not admission related
Rpt	Report
Bill	Billed
NTrx	Not transferred
Exc	Excluded
Man	Manual review
ATrx	Automatic transfer IP
MTrx	Manual transfer IP
OATx	Transferred to IP automatically
OMTx	Transferred to IP manually
OARv	Automatic reversal for transfer to IP
OMRv	Manual reversal for transfer to IP
IATx	Transferred to OP automatically
IMTx	Transferred to OP manually
IARv	Automatic reversal for transfer to OP
IMRv	Manual reversal for transfer to OP
OARt	Automatic return from IP
OMRt	Manual return from IP

BILLED
This field indicates whether the charge appeared on a cycle bill before the DPW was created.

DRG PAYMENT WINDOW TABLE REPORT - FBRDPW

Description/Purpose

The DRG Payment Window Table report lists each of the DPW codes and the criteria for each one. The criteria is defined in the DRG Payment Window Parameters.

The primary sort criteria is the DPW Code.

Generating and Printing This Report

You can request this report to print when exiting the DRG Payment Window Parameters function.

The following is an example of the DRG Payment Window Table report.

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Figure 4.12 FBRDPW - DPW Table Report

```
Date: 04/04/00                              Windward Memorial Medical Center                            Page  : 1
Time: 01:54pm                                          DPW Table                                        Report: FBRDPWA


DPW Code  DPW Description                   All Charges  Diag. Chgs   Non-Diag Chgs  Disch Chgs  Rpt Detail Chgs  Rpt Cum  O/P Abstract



 MED      MEDICARE                          1/Transfer   3/Report     3/Report       Exclude          Yes          Yes        No

Transaction Codes:    S0005-DPW Initiated              S0006-DPW Changed/Modified        S0007-DPW Deleted
Financial Classes:    C
Patient Types:        OPC,IPC,I/P,SER
Insurance Plans:      500700
Excluded FIM Depts:
Excluded FIM Codes:
Facilities:           B
Effective date:       03/02/99

 MEM      MED MULTIFACILITY TEST            3/Report     3/Report                                       Yes          Yes        Yes

Transaction Codes:    S0005-DPW Initiated              S0006-DPW Changed/Modified        S0007-DPW Deleted
Financial Classes:    C
Patient Types:        IPC,OPC
Insurance Plans:      500700
Excluded FIM Depts:
Excluded FIM Codes:
Facilities:           B
Effective date:       09/14/98


Transaction Codes:    S0004-KEY DATA CHANGED           S0006-DPW Changed/Modified        S0006-DPW Changed/Modified
Financial Classes:    B
Patient Types:        OPB,ER,LEC,LIC
Insurance Plans:      400100,400200,400999
Excluded FIM Depts:
Excluded FIM Codes:
Facilities:           B,C
Effective date:       Keyed


                                              End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

DPW CODE
This field contains the DPW Code.

DPW DESCRIPTION
This field contains the DPW Description.

ALL CHARGES
This field contains the number of days for the All charge time frame and the automatic action taken for charges in this DPW time frame.

DIAG. CHGS
This field contains the number of days for the Evaluate time frame and the automatic action taken for diagnostic charges in this DPW time frame.

NON-DIAG CHGS
This field contains the number of days for the Evaluate time frame and the automatic action taken for non-diagnostic charges in this DPW time frame

RPT DETAIL CHGS
This field contains Yes or No for reporting detail charges.

RPT CUMULATIVE
This field contains Yes or No, indicating if the report is cumulative.

O/P ABSTRACT
This field contains Yes or No for whether the outpatient abstract is used to evaluate non-diagnostic charges.

TRANSACTION CODES
This field contains the transaction codes and descriptions used when a DPW is initiated, changed or modified, or deleted.

FINANCIAL CLASSES
This field contains the valid financial classes for this DPW Code.

PATIENT TYPES
This field contains the valid patient types for this DPW Code.

INSURANCE PLANS
This field contains the valid insurance plans for this DPW Code.

EXCLUDED FIM DEPTS
This field contains the FIM departments excluded from charge evaluation.

EXCLUDED FIM CODES
This field contains the FIM codes excluded from charge evaluation.

FACILITIES
This field contains the cross facilities used to report the initiation of DPWs.

EFFECTIVE DATE
This field contains the date when accounts begin evaluation for this DPW code.

FAILED BILLING REQUIREMENTS REPORT - FBR210

Description/Purpose

The Failed Billing Requirements Report lists accounts, selected for the production of a final bill, that failed the edit procedure due to missing or invalid information. The report also includes accounts in AR if they are failing edits and if the Edit Adj Bill or Edit Adj Bill for CPTAFB fields on PAAR Control Maintenance screen are defined to edit adjustment bills.

The system provides for two types of errors: F-Fatal and W-Warning. All hospital-defined billing requirements result in fatal errors if the required data is missing. A warning error is reported if the summary charges are less than zero (however, a bill is still produced).

The system primary sort for this report is by biller. Accounts can be excluded from this report by area of responsibility (data control codes). The accounts for each biller are listed by patient name within patient indicator. For each account failing billing requirements, the report lists the patient name, account number, patient indicator, financial class, patient type, admit and discharge date, number of days since discharge, admitting physician number, attending physician number, account balance, preregistration and registration initials, severity of error, error message, and department responsible for correcting the error. Subtotals are provided for the number and amount of failed accounts by patient indicator by the biller.

This report can be used to correct billing errors so patient bills can be produced. The system automatically produces patient bills after the maximum hold days for both PA and AR accounts is met in the Billing parameters.

Final bills use the patient's discharge date in calculating the Maximum Hold Days; AR accounts use the date of the adjustment bill request.

Generating and Printing This Report

The Failed Billing Requirements Report is generated as part of Midnight Processing. Refer to the Financial System Management section in the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide* for more information on setting up this report.

The following is an example of the Failed Billing Requirements Report.

Figure 4.13 FBR210 - Failed Billing Requirements Report

```
Date: 02/11/09                              General Hospital                      Page : 1
Time: 01:07am                          Failed Billing Requirement                 Report: FBR210A
                                       Accounts billed on 02/10/0


                                          5 BILLERFIVE,BILLER


                                              Days   Admit Attend Account
            Patient Name       Account No  P/I   F/C   P/T   Admit  Discharge Unbilled    DR    DR    Balance
Bill Parm  ICD Req Pre/Reg by Severity              Error Message               Ctrl By              Loc CPTAFB
-----------------------------------------------------------------------------------------------------------------
TEST,PEG                       0603000001  O    O     SER   01/16/07 04/01/07   315        1     1     $3,213.18
99    ICD-10 ABC/KEM  F   BILL. INS. CERT/SSN/HIC ID NUMBER is Required (COB 1) ADMISSIONS/BUS OFFICE PA  No
                       F      PRINCIPAL DIAGNOSIS CODE is Required               MEDICAL RECORDS
                       F      PRINC DX POA FOR BILL is Required                  MEDICAL RECORDS
HANSEN,JAN                     0603000002  O    O     SER   01/23/07 05/03/07   285        2     3     $5,032.25
54       ICD-9    /KEM  F   BILL. INS. CERT/SSN/HIC ID NUMBER is Required (COB 1) ADMISSIONS/BUS OFFICE  PA   No
                        F      PRINCIPAL DIAGNOSIS CODE is Required              MEDICAL RECORDS
                        F      PRINC DX POA FOR BILL is Require                  MEDICAL RECORDS
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

PATIENT NAME
This field contains the patient name.

ACCOUNT NO
This field contains the patient account number. The letter P following the account number indicates the account was part of the Pre-bill Edit process.

P/I
This field contains the patient indicator. Indicators include I-inpatient, O-outpatient and E-emergency.

F/C
This field contains the hospital-defined financial class code assigned to this patient's account. Financial classes categorize patients based on fiscal responsibilities. Examples of financial classes are S-self pay, C-commercial or M-Medicare.

P/T
This field contains the hospital-defined patient type code used to identify such patient segments as regular admission, emergency room, outpatient, same day surgery, and series patients.

ADMIT
This field contains the patient admission date.

DISCHARGE
This field contains the patient discharge date.

DAYS UNBILL
This field contains the number of days since the patient was discharged. For AR and PA accounts, the system uses the adjustment bill date to determine the number of days that the account has failed edits and as a result has not been billed.

ADMIT DR
This field contains the admitting physician code. The default doctor number is reported for override physicians. Up to 6 characters of the physician number are printed.

ATTEND DR
This field contains the attending physician code. The default doctor number is reported for override physicians. Up to 6 characters of the physician number are printed.

ACCOUNT BALANCE
This field contains the outstanding account balance.

BILL PARM
This field lists the Final Bill Parameter number at time of billing.

ICD REQ

This field contains the setting of the bill ICD flag on the account (which is determined based on the Final Bill Parameter field ICD-10 Effective Date and the admission date or discharge date of the account, or on the USA ICD-10 Effective Date in STAR Patient Processing, any Insurance Plan, Insurance Carrier, or Financial Class exception for the COB 1 plan, and on the admission date of the account). Valid values are blank (which assumes ICD-9), ICD-9, and ICD-10.

PRE/REG BY

This field contains the initials of the person who registered the patient. Three asterisks (***) in this field indicate that the system automatically registered the patient from the preregistration information.

SEVERITY

This field contains the warning severity indicator. The two valid types are F-fatal and W-warning. A fatal error is occurs when a hospital-defined billing requirement is missing. A warning error occurs when summary charges are less than zero.

ERROR MESSAGE

This field contains the description of why the bill failed to pass edits.

NOTE: If the error is due to an unbilled credit, a hyphen (-) follows the dollar amount for the credit.

CTRL BY

This field lists the department that is responsible for requiring this information.

LOC

This field indicates whether the account is in an Accounts Receivable (AR) location or a PA location. If the account has not been final billed, it is in a PA location.

CPTAFB

The CPTAFB field indicates if the next bill event is the first bill event after a CPTAFB transaction.

FAILED BILLING REQUIREMENTS REPORT - CONTROLLED BY - FBR220

Description/Purpose

The Failed Billing Requirements-Controlled By Report lists accounts selected for the production of a bill which failed edits due to missing or invalid information. It is similar to the Failed Billing Requirements report (FBR210) but is sorted by the area designated as responsible by the data control codes, rather than by biller. This enables the report to be distributed to areas of responsibility for timely correction of billing errors.

The report prints for inpatient accounts followed by outpatient accounts. Emergency patient indicators are included with the outpatient accounts. Within these account types, the report is further sorted by responsible area (data control code), by user-defined sort options within each data control code, and, finally, by patient name. Accounts may be excluded from this report by area of responsibility (error messages for an entire data control code can be excluded, or the account can be excluded if its total charges equal $0.00).

For each account, the report lists the patient name, account number, patient indicator, financial class, admit and discharge date, days since discharge, admit doctor number, unit number, account balance, admitting diagnosis, biller, severity of error, preregistration and registration initials, and error message. A total by area of responsibility is reported. Subtotals by the user-defined sort criteria are also reported.

Generating and Printing This Report

The Failed Billing Requirements report is generated as a part of midnight processing. Refer to the Financial System Management section in the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide* for more information on setting up this report.

The following is an example of the Failed Billing Requirements Report-Controlled By Report.

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Figure 4.14 FBR220 - Failed Billing Requirements-Controlled By Report

```
Date: 02/16/09                              General Hospital                         Page : 1
Time: 01:07am                           Failed Bill Req. by control                  Report: FBR220A
                                     Outpatients accounts for 02/15/08
                                     Controlled By MEDICAL RECORDS
                                           Days   Admit  Unit No. Account
Patient Name                     Account No  P/I   F/C   P/T   Admit   Discharge Unbill  Dr            Balance
  Admit/Working Diagnosis  Severity Pre/Reg By     Error Message FB Parm  ICD Req  Biller         Loc  CPTAFB
-----------------------------------------------------------------------------------------------------------
TEST,CLARK                        0603000001  O    O     SER   01/19/08 02/11/08   23  1 0000000056 5,432.67
                             /DMM                                                                       M48.50xA-
TESTING NEW DIAG                                          MCR   ICD-10     BILLER,TESTING  PA    No
                          F       PRINCIPAL DIAGNOSIS CODE is Required
                          F       PRINC DX POA FOR BILL is Required


HANSEN,OLAF                       0603000002  O    O     SER   01/21/08 02/12/08   22  5 0000000098 9,030.11
                             /DMM
900.02-INJ EXTERNAL CAROTID ART                          MCA   ICD-9      BILLER,TESTING  PA    No
                          F       PRINCIPAL DIAGNOSIS CODE is Required
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

PATIENT NAME
This field contains the patient name.

ACCOUNT NO
This field contains the patient account number. The letter P following the account number indicates the account was part of the Pre-bill Edit process.

P/I
This field contains the patient indicator. Indicators include I-inpatient, O-outpatient and E-emergency.

F/C
This field contains the hospital-defined financial class code assigned to this patient's account. Financial classes categorize patients based on fiscal responsibilities.

P/T
This field contains the hospital-defined patient type code used to identify such patient segments as regular admission, emergency room, outpatient, same day surgery, and series patients.

ADMIT
This field contains the patient admission date.

DISCHARGE
This field contains the patient discharge date.

DAYS UNBILLED
This field contains the number of days since the patient was discharged.

ADMIT DR
This field contains the admitting physician code. The default doctor number is reported for override physicians. Up to 6 characters of the physician number are printed.

UNIT NO.
This field contains the unit number of the account.

ACCOUNT BALANCE
This field contains the outstanding account balance.

ADMIT/WORKING DIAGNOSIS
This field contains the diagnosis that was assigned to the patient during the admitting process. The field contains the ICD-10 Admitting, or if blank, Working Diagnosis Code and Description. If blank, the field contains the ICD-9 Admitting, or if blank, Working Diagnosis Code and Description.

FB PARM
This field contains the Final Bill Parameter number at time of billing.

ICD REQ
This field contains the setting of the bill ICD flag on the account (which is determined based on the Final Bill Parameter field ICD-10 Effective Date and the admission date or discharge of the account, or on the USA ICD-10 Effective Date in STAR Patient Processing, any Insurance Plan, Insurance Carrier, or Financial Class exception for the COB 1 plan, and on the admission date of the account). Valid values are blank (which assumes ICD-9), ICD-9, and ICD-10.

BILLER
This field contains the name of the biller assigned to this account.

PRE/REG BY
This field contains the initials of the person who registered the patient. Three asterisks (***) in this field indicate that the system automatically registered the patient from the preregistration information.

SEVERITY
This field contains the warning severity indicator. The two valid types are F-fatal and W-warning. A fatal error is occurs when a hospital-defined billing requirement is missing. A warning error occurs when summary charges are less than zero.

ERROR MESSAGE
This field contains a description of why the bill failed to pass edits.

FAILED CLAIMS REQUIREMENTS REPORT - FCR250

Description/Purpose

The Failed Claims Requirement Report lists accounts that were loaded for claim production but failed edits. Claim requirements are hospital-defined to allow for requirements that vary by region or carrier. The system edits for the existence of data, specific values or if/then conditions (for example, if the Accident Hour field is required, an accident hour must be present). Claim demographic requirements are set in the Claim Load and Edit parameters. Claim charge requirements are set in the Charge Control parameters.

The report lists the patient name, medical record number, account number, patient indicator, financial class, patient type, admit and discharge date, admitting and attending physician, account balance, location/field, error message and contents of the field. Subtotals are reported by patient indicator and total account balance. Facility totals are reported by patient indicator for the number and amount of failed claims.

If the biller index indicates a failed claim but the claim data indicates otherwise, the claim does not appear in the report, and it is marked to be fixed during midnight processing.

Generating and Printing This Report

The Failed Claim Requirements Report is generated during midnight processing.

The following is an example of the Failed Claims Requirements Report.

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FAILED CLAIMS REQUIREMENTS REPORT - FCR250

Figure 4.15   FCR250 - Failed Claims Requirement Report - Page 1

```
Date: 07/25/05                              General Hospital                          Page  : 1
Time: 12:11am                           FAILED CLAIMS REQUIREMENTS                    Report: FCR250

                                       28 - Smith-Kerry, Tina

PATIENT NAME              MEDICAL REC #   ACCOUNT #    P FC P   ADMIT      DISCHARGE   ADMIT   ATTEND      ACCOUNT     WAIT
                                                      I    T   DATE       DATE        PHY     PHY         BALANCE     PYMT

DEVANEY,BRYANT U          A0000105229     0100-171-768 I 11 ADM  12/17/89 12/21/89    90005   90005       $1,100.00
SEQ: 1   TYPE: X-UB           CLAIM AMT:    $880.00   FAILED EDIT:  1  CARRIER: 403065 AMT:    $528.00  PENDING: 1
Split Claim Indicator: Primary                                                       ICD: ICD-9
     LOC-FLD: 19-1  ERROR:  Admission Type is Required         CONTENTS: BLANK
     LOC-FLD: 20-1  ERROR:  Admission Source is Required       CONTENTS: BLANK

TEST,CLARK                A100007486      06342-00001p O C  SER  12/08/07             630     630     $976.86

   Seq: 3   Type: UB04      Claim Amt: $930.11      Failed Edits: 21  Carrier: 500100 Amount: 430.00 Pending: 20
   Split Claim Indicator:                           ICD: ICD-10
     Loc-Fld:  67-1    Error: Principal Diagnosis Code is Required      Contents: BLANK
     Loc-Fld:  76-1    Error: Attend Physician NPI is Required          Contents: BLANK

   Seq: 4   Type: 1500-08/05 Claim Amt: $46.75       Failed Edits: 21  Carrier: 500200 Amount: 32.75 Pending: 20  Y
   Split Claim Indicator: 32 ADAIR,FRANK             ICD: ICD-10
     Loc-Fld:   1-8    Error: Insured's Policy # FL 1 is Required       Contents: BLANK
     Loc-Fld:   6-1    Error: Patient Rel to Insured FL 6 is Required   Contents: BLANK
     Loc-Fld:  31-1    Error: Physician Name FL 31 is Required          Contents: BLANK
     Loc-Fld:  33-2    Error: Supplier Name FL 33 is Required           Contents: BLANK
     Loc-Fld:  33-3    Error: Supplier Address FL 33 is Required        Contents: BLANK
     Loc-Fld:  33-4    Error: Supplier City FL 33 is Required           Contents: BLANK
     Loc-Fld:  33-5    Error: Supplier State FL 33 is Required          Contents: BLANK
     Loc-Fld:  33-6    Error: Supplier Zip Code FL 33 is Required       Contents: BLANK


KELLER,CHRISTINE          A0000105363     0100-171-792 I 11 ADM  12/16/89 12/16/89    31001   31001       $2,266.01
SEQ: 2   TYPE: X-             CLAIM AMT:  $2,266.01   FAILED EDIT:  1  CARRIER: 610015 AMT:    $100.00  PENDING: 4          Y
Split Claim Indicator: THERAPY                                                       ICD: ICD-9
     LOC-FLD: 67-1  ERROR:  Principal Diagnosis Code is Required      CONTENTS: BLANK

JACKSON,WILLIAM K         A0000104728     0100-171-826 O 11 O/P  12/16/89 12/16/89    90005   90005       $402.50
SEQ: 6   TYPE: X-UB    CLAIM AMT:    $402.50   FAILED EDIT:  1  CARRIER: 731824  AMT:    $125.00  PENDING: 2
Split Claim Indicator: THERAPY                                    ICD: ICD-9
     LOC-FLD: 24-1  ERROR:  Condition Code 1 is Required         CONTENTS: BLANK


                          BILLER TOTAL FAILED CLAIMS   I/P      2       $3,146.01
                                                       O/P      1         402.50
                                                       E/R      1         660.00
                                                       TOT      4       $4,208.51
```

Figure 4.16 FCR250 - Failed Claims Requirements Report - Page 2

```
Date: 12/21/89                              General Hospital                         Page  : 2
Time: 12:11am                           FAILED CLAIMS REQUIREMENTS                    Report: FCR250


                    FACILITY TOTAL FAILED CLAIMS    I/P    12      $10,146.01
                                                    O/P     7        2,502.50
                                                    E/R     3        2,060.00
                                                    TOT    22      $14,708.51


                                             End of Report
```

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Each report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

PATIENT NAME
This field contains the patient name.

MEDICAL REC #
This field contains the medical record number assigned to this account. The patient medical record number is maintained in the Master Patient Index.

ACCOUNT #
This field contains the patient account number. The letter P following the account number indicates the account was part of the Pre-bill Edit process.

PI
This field contains the patient indicator. Typical patient indicators are I-inpatient, O-outpatient, and E-emergency.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial classes categorize patients based on fiscal responsibilities. Examples of financial classes include S-self pay, C-commercial and M-Medicare.

PT
This field contains the hospital-defined patient type code which represents such patient segments as regular admission, emergency room, outpatient, same day surgery, and series patients.

ADMIT DATE
This field contains the patient admission date.

DISCHARGE DATE
This field contains the patient discharge date.

ADMIT PHY
This field contains the admitting physician code.

ATTEND PHY
This field contains the attending physician code.

ACCOUNT BALANCE
This field contains the outstanding account balance.

WAIT PYMT
If the claim status is Awaiting Payment, this field contains a Y.

SEQ
This field contains the system-assigned claim sequence number for this claim for this carrier.

SPLIT CLAIM INDICATOR
This field contains the name of the Split Claim Indicator for UB and 1500 claims, and any state claim form that can split.

ICD
This field currently only prints for claim types X-UB in the UB04 Format, R-Medi-Cal UB in the UB04 Format, B-1500 in the 08/05 Format, and Z-Non Pro Fee 1500 in the 08/05 Format. The report prints the ICD flag at time of claim load, based on the "ICD-10 Effective Date" field on the Claim Load Edit Parameter, and the admission date or discharge date of the patient, or on the USA ICD-10 Effective Date in STAR Patient Processing, any Insurance Plan, Insurance Carrier, or Financial Class exception, and on the admission date of the patient. This ICD flag does not change for the life of the claim. Valid values are blank, which defaults to ICD-9, ICD-9, and ICD-10. This ICD field allows the users to know if ICD-9 or ICD-10 diagnosis and procedure codes are loaded/required on the claim.

TYPE
This field contains the claim type associated with this patient's account. Valid claim types include U-UB82, X-UB, and B-1500.

CLAIM AMT
This field contains the amount of the claim. The report totals the claim amount by biller for I/P, O/P, and E/R patient indicators, at the end of each biller. The report also totals the claim amount for each patient indicator for the facility as a whole as shown on the last page of the report.

FAILED EDIT
This field contains the number of times the claim has gone through the Claim Reload process, either online by accessing the Reload Claim Demographic/Visit Errors option within Claims Management, or in Midnight Processing through the Claim Reload optional batch job.

CARRIER
This field contains the carrier/plan code.

AMT
This field contains the amount due from the carrier on the account.

PENDING
This field contains the number of days since Claim Load that this claim has failed edits.

LOC-FLD
This field contains the box position (LOC) and the field (FLD) on the claim form where the error for this entry can be found.

ERROR

This field contains a message(s) describing why the claim failed edits. Some examples include, *Admission Type is Required*, *Principal Diagnosis is Required*, and *Special Program Indicator.*

CONTENTS

This field describes the contents of the field in which the error(s) occurred. For example, the field may be blank or an invalid number may have been entered.

MED RECS HCPCS UB REV CODE RANGE TABLE REPORT - FCRMRUB

Description/Purpose

The Med Rec HCPCS UB Rev Code Range Table report provides a listing of those UB Revenue Codes set to look to additional UB Revenue Codes when pulling Medical Records HCPCS to the claim. This table allows hospitals to print HCPCS codes on claims even when there is not an exact match with the revenue code on the claim and the revenue codes linked to the HCPCS code. Once a Med Rec HCPCS UB Rev Code table is set up, it must be linked to the appropriate charge control parameter.

Generating and Printing this Report

This report is generated through the Med Rec HCPCS UB Rev Code Range Table option. After you access this table, you can enter the UB revenue codes and the additional UB revenue codes that should be used when pulling Medical Records HCPCS to the claim. When you exit the screen, the system displays the following prompt:

Do you want a printed list (Y/N) [N]

Enter Y if you want to generate the report. The system references the spooler report definition to determine if the report is to be printed immediately or on demand and what printer is used for output. If the report is spooled for subsequent printing, the report name is FCRMRUB.

The following is an example of the Med Recs HCPCS UB Rev Code Range Table report.

Figure 4.17 FCRMRUB - Med Records HCPCS UB Revenue Code
Range Report

```
Date: 06/01/01                          General Hospital                     Page:  1
Time: 12:28pm             Medical Records HCPCS UB Revenue Code Range Table   Report:FCRMRUB


                     MR HCPCS UB Revenue Code Range Table & Description


  1 - MEDICARE MED RECS HCPCS
  Edit Date: 05/09/01 11:29am
  Edit By: New, Nancy

  UB Rev Code/Description          Med Rec HCPCS Rev Codes

  361 - OPERATING ROOM                  360,490,760-761
  490 - Ambulatory Surgical Care        360-361,760-761
  760 - Treatment or Observation Ro     360-361,490
```

This report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

TABLE CODE AND DESCRIPTION
This field displays the table code and description.

EDIT DATE
This field contains the date and time this table was last edited.

EDIT BY
This field contains the name of the user who last edited this table.

UB REV CODE/DESCRIPTION
This field displays the UB revenue code and description of the UB revenue code set to pull Medical Records HCPCS to the claim.

MED RECS HCPCS REV CODES
This field displays the additional UB revenue codes that should be used when pulling Medical Records HCPCS to the claim for the revenue code listed in the UB Rev Code/ Description field.

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HCPCS PANEL CODES TABLE REPORT - FCRHPC

Description/Purpose

The HCPCS Panel Codes Table report provides a listing of the HCPCS Panel Codes and their components that cannot appear more than once on a UB claim for the same date of service. If a panel code included in this table appears on a charge line, the system uses this table when editing for other charges for the same date of service that have the same HCPCS code. The HCPCS Panel Codes Table is used in conjunction with the Non Duplicating HCPCS Range Table and the UB Charge Control Parameter to produce a Duplicate HCPCS Same Service Date error for the UB claim.

Generating and Printing this Report

This report is generated through the HCPCS Panel Code Table option. After you access this table, you can enter the HCPCS panels and their components. When you exit the screen, the system displays the following prompt:

Do you want a printed list (Y/N) [N]

Enter Y if you want to generate the report. The system references the spooler report definition to determine if the report is to be printed immediately or on demand and what printer is used for output. If the report is spooled for subsequent printing, the report name is FCRHPCf where f is the facility indicator.

The following is an example of the HCPCS Panel Codes Table report.

Figure 4.18   FCRHPCA - HCPCS Panel Codes Table

```
Date: 05/17/01                          General Hospital                    Page  : 1
Time: 10:05am                           HCPCS Panel Codes Table             Report: FCRHPCA

                          HCPCS Code & Description
              PANEL CODE:      80049 - PANEL 80049

              PANEL COMPONENTS: 82374 - ASSAY, BLOOD CARBON DIOXIDE
                                82435 - ASSAY OF BLOOD CHLORIDE
                                82565 - ASSAY OF CREATININE
                                82947 - ASSAY, GLUCOSE, BLOOD QUANT
                                84132 - ASSAY OF SERUM POTASSIUM
                                84295 - ASSAY OF SERUM SODIUM
                                84520 - ASSAY OF UREA NITROGEN


                 PANEL CODE:    80051 - ELECTROLYTE PANEL

              PANEL COMPONENTS: 82374 - ASSAY, BLOOD CARBON DIOXIDE
                                82435 - ASSAY OF BLOOD CHLORIDE
                                84132 - ASSAY OF SERUM POTASSIUM
                                84295 - ASSAY OF SERUM SODIUM


              PANEL CODE:       80054 - COMPREHEN METABOLIC PANEL

              PANEL COMPONENTS: 82040 - ASSAY OF SERUM ALBUMIN
                                82250 - ASSAY BILIRUBIN
                                82310 - ASSAY OF CALCIUM
                                82435 - ASSAY OF BLOOD CHLORIDE
                                82565 - ASSAY OF CREATININE
                                82947 - ASSAY, GLUCOSE, BLOOD QUANT
                                84075 - ASSAY ALKALINE PHOSPHATASE
                                84132 - ASSAY OF SERUM POTASSIUM
                                84155 - ASSAY OF PROTEIN
                                84295 - ASSAY OF SERUM SODIUM
                                84450 - TRANSFERASE (AST) (SGOT)
                                84520 - ASSAY OF UREA NITROGEN

              PANEL CODE:       80058 - HEPATIC FUNCTION PANEL

              PANEL COMPONENTS: 82040 - ASSAY OF SERUM ALBUMIN
                                82251 - ASSAY OF BILIRUBIN
                                84075 - ASSAY ALKALINE PHOSPHATASE
                                84450 - TRANSFERASE (AST) (SGOT)
                                84460 - ALANINE AMINO (ALT) (SGPT)
                                84480 - ASSAY, TRIIODOTHYRONINE (T3)
```

This report contains a header that includes the date and time the report is generated, your hospital's name, the report title, page number, and the report name as used in the system.

PANEL CODE
This field lists the HCPCS panel code and description.

PANEL COMPONENTS
This field lists the individual HCPCS codes and descriptions that make up the panel.

NON DUPLICATING HCPCS RANGE TABLE REPORT - FCRVHCP

Description/Purpose

The Non-Duplicating HCPCS Range Table report provides a listing of the HCPCS codes that the system uses to edit for duplicate HCPCS codes on the same day of service. The table allows the user to enter a range of HCPCS that cannot be duplicated for the same date of service for a claim. Individual HCPCS may be defined as well as ranges of HCPCS. The Non Duplicating HCPCS Range Table is used in conjunction with the HCPCS Panel Code Table and the UB Charge Control Parameter to produce a Duplicate HCPCS Same Service Date error for the UB claim.

Generating and Printing This Report

This report is generated through the Non Duplicating HCPCS Range Table option. After you access this table, you can enter the HCPCS codes to edit for duplicate HCPCS on the same day of service. When you exit the screen, the system displays the following prompt:

Do you want a printed list (Y/N) [N}

Enter Y if you want to generate the report. The system references the spooler report definition to determine if the report is to be printed immediately or on demand and what printer is used for output. If the report is spooled for subsequent printing, the report name is FCRVHCPf where f is the facility indicator.

The following is an example of the Non Duplicating HCPCS Range Table Report.

Figure 4.19 FCRVHCPA - Non Duplicating HCPCS Range Table

```
Date: 05/17/01                      General Hospital                    Page  : 1
Time: 09:50am                 Non Duplicating HCPCS Range Table         Report:  FCRVHCPA


          Starting HCPCS Code - Ending HCPCS Code
          80000 - 81000
          82040 - 84550


                                         End of Report
```

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This report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

STARTING HCPCS CODE
This field lists the starting HCPCS code for the range of HCPCS codes to edit for duplicate HCPCS on the same day of service.

ENDING HCPCS CODE
This field lists the ending HCPCS code for the range of HCPCS codes to edit for duplicate HCPCS on the same day of service. When a single HCPCS code is entered instead of a range, the starting HCPCS Code and the Ending HCPCS Code will be the same.

NON PRO FEE 1500 CHARGE CONTROL PARAMETER REPORT - FMRCCZ

Description/Purpose

The Non Pro Fee 1500 Charge Control Parameter report provides a list of all Non Pro Fee 1500 charge control values defined for all defined parameters. The hospital defines which departments are eligible to load charges to the Non Pro Fee 1500 claim form, whether the claims should be split by physician or department, whether charges should print on the claim form in summary or detail, if a HCPCS Cross Reference table or Type of Service Cross Reference table should be used, if units/type of service, physician ID, and EMG code should print, whether the Principal or Working diagnosis should be printed, and which defaults to use.

Generating and Printing This Report

This report is requested through the Non Pro 1500 Charge Control Parameters option. After exiting the table, the system displays the following prompt:

Do you want a printed list (Y/N) [N]--

Enter Y if you want to generate the report. The system references the spooler report definition to determine if the report is to be printed immediately or on demand and what printer is used for output. If the report is spooled for subsequent printing, the report name is FMRCCZ without a facility indicator.

If you answer Y, the system then displays the following prompt:

Enter code(C) sequence or alphabetic(A) [A]--

If you enter C for Code, the report sorts by Non Pro 1500 Charge Control Parameter code (for example, 1 then 2). If you enter A for Alphabetic, the report sorts by Non Pro Fee 1500 Charge Control Parameter description (for example, Blue Cross O/P before Medicare O/P). Once you answer the sort question, the system displays the following prompt:

Include entries filed as deleted (Y/N) [N]

If you include entries filed as deleted, they print ***INACTIVE*** to the right of the Non Pro Fee 1500 Charge Control Parameter description.

Figure 4.20 FMRCCZ - Non Pro 1500 Charge Control Parameter
Report

```
Date: 04/04/08                               STAR Development System                            Page  : 17
Time: 05:02pm                     Non Professional Fee 1500 Charge Control Parameters           Report: FMRCCZ


CODE  DESCRIPTION

707   PM TEST

      Separate Claims:             Yes
      Detail/Summarize Items:      Summarize                   Print UOS:                 Yes
      Place of Service:            53 Community Mental Health Center   24A Date Print:     MM  DD  YY
      Print TOS:                   Yes                         Print EMG:                 Yes
      HCPCS Cross Reference:       PM  PM TESTING              Default Diagnosis:         Principal/Admit Diagnosis
      Phys/Dept ID Upper (1992):   Yes UB92, Commercial        Default Physician:         Attending
      Phys/Dept ID Lower (1992):   Yes Medicare, Medicaid      EPSDT Value:               EE
      Phys/Dept ID Upper (08/05):  Yes Commercial, Medicaid    Upper ID Qual:             1B,1D
      Phys/Dept ID Lower (08/05):  Yes NPI, Soc Sec Nbr        TOS Cross Reference:       XX TOS X-REF DESCRIPTION
      PCON Phy/Dept ID             Lower/Upper                 EC2000:                    Claim
      Use Med Rec HCPCS:           Yes                         M/R HCPCS UB Rev Code:
      Print Anesth Time:           Yes                         Edit Charges:              Yes H,D,U,L
      Reference Facility:          Yes 101, 110
      IDE:                         Yes 111, 112
      NDC:                         Yes 270, 320, 985
      NDC Unit Qual/Units:         Default UN
      Edit Date:                   12/31/07 08:35am            Edit By:                   Moore,Jessie
      DEPARTMENTS TO INCLUDE
      CAR CSA CSR EEG RAD


      UB REVENUE CODES                        INCLUDE    HCPCS
      000   REVENUE CODE 000                    Yes      xxxx
      0002  UNKNOWN                             Yes      xxxx
      0033  NEW                                 Yes      xxxx
      022   RUG SCORE FOR SNF                   Yes      xxxx
      073   BLUE CROSS REHABILITATION           Yes      xxxx
      1     TEST FOR PAT                        Yes      xxxx
      100   ALL-INCLUSIVE R & B PLUS ANC        Yes      xxxx
      1000  REVENUE CODE 1000 TEST              Yes      xxxx
      101   ALL-INCLUSIVE ROOM & BOARD          Yes      xxxx
      110   ROOM & BOARD - PRIVATE              Yes      xxxx
      111   ROOM & BOARD - MED-SUR-GY/PVT       Yes      xxxx
      1111  MAXI LENGTH.................X       Yes      xxxx
      112   ROOM & BOARD - OB/PRIVATE           Yes      xxxx
      113   ROOM & BOARD - PEDS/PVT             Yes      xxxx
      114   ROOM & BOARD - PSTAY/PRIVATE        Yes      xxxx
      115   ROOM & BOARD - HOSPICE/PVT          Yes      xxxx
      116   ROOM & BOARD - DETOX/PVT            Yes      xxxx
      117   ROOM & BOARD - ONCOLOGY/PVT         Yes      xxxx
      118   ROOM & BOARD - REHAB/PVT            Yes      xxxx
      119   ROOM & BOARD - OTHER/PVT            Yes      xxxx
      120   ROOM & BOARD - SEMIPRIVATE          Yes      xxxx
      121   ROOM & BOARD - MED-SUR-GY/2BED      Yes      xxxx
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

SEPARATE CLAIMS
This field indicates if the 1500 claim form should split by physician or department, or not split.

DETAIL/SUMMARIZE ITEMS
This field indicates if charges should print in detail, or summarize for like service date, diagnosis, HCPCS code, and physician.

PLACE OF SERVICE
This field contains the place of service code that prints in locator 24B for any charge department without a place of service code in the 1500 Department/Supplier Override table.

PRINT TOS
This field indicates whether the type of service from the Financial Item Master should print on the charge line in locator 24C of the 1992 format. The 08/05 format of the 1500 does not have a TOS field.

PRINT EMG
This field indicates whether the EMG code from the Insurance Demographics screen should print on the charge line in locator 24I of the 1992 format or locator 24C of the 08/05 format.

HCPCS CROSS REFERENCE
This field indicates the Payer HCPCS Cross Reference table that is used in conjunction with this charge control parameter.

PRINT PHYS/DEPT ID UPPER (1992 Format)
This field indicates whether the Physician ID should print for the charge line in locator 24K Upper, and if it is printing, what field in the Physician Master table to use to pull the number. The report prints the first choice of ID to print in 24K Upper, followed by the second choice of ID to print in 24K Upper.

PRINT PHYS/DEPT ID LOWER (1992 Format)
This field indicates whether the physician ID should print for the charge line in locator 24K lower, and if it is printing, what field in the Physician Master to use to pull the number. The report prints the first choice of ID to print in 24K Lower, followed by the second choice of ID to print in 24K Lower.

PRINT PHYS/DEPT ID UPPER (08/05)
This field indicates whether the Physician ID should print for the charge line in locator 24J Upper, and if it is printing, what field in the Physician Master table to use to pull the number. The report prints the first choice of ID to print in 24J Upper, followed by the ID Qualifier, and then the second choice of ID to print in 24J Upper, followed by the ID Qualifier.

PRINT PHYS/DEPT ID LOWER (08/05)

This field indicates whether the physician ID should print for the charge line in locator 24J lower, and if it is printing, what field in the Physician Master to use to pull the number. The report prints the first choice of ID to print in 24J Lower, followed by the second choice of ID to print in 24J Lower. There is NO ID Qualifier in 24J Lower.

PCON PHY/DEPT ID

This field indicates whether the Physician ID Upper (24K Upper for the 1992 1500 Format, or 24J Upper for the 08/05 1500 Format), or Physician ID Lower (24K Lower for the 1992 1500 Format, or 24J Lower for the 08/05 1500 Format) should be sent in the 1500 PCON interface for the rendering provider. The 24K Upper or Lower value to send for the 1992 format of the claim prints, followed by the 24J Upper or Lower value to send for the 08/05 format of the claim.

EC2000

This field indicates whether the account (Account) or claim level charges (Claim) are sent to EC2000.

REFERENCE FACILITY

If the Non Pro Fee 1500 Charge Control Parameter has the Reference Facility field set to Yes, and specific revenue codes are listed in the RF Rev Codes field, the report displays *Reference Facility: Yes XXXX,XXXX,XXXX*, where XXXX is the revenue code selected. If the Non Pro Fee 1500 Charge Control Parameter has the Reference Facility field set to Yes, and the RF Rev Codes field is set to all revenue codes, the report displays *Reference Facility: Yes All Rev Codes.*

IDE

If the Non Pro Fee 1500 Charge Control Parameter has the IDE field set to Yes, and specific revenue codes are listed in the IDE Rev Codes field, the report displays *IDE: Yes XXXX,XXXX,XXXX*, where XXXX is the revenue code selected. If the Non Pro Fee 1500 Charge Control Parameter has the IDE field set to Yes, and the IDE Rev Codes field is set to all revenue codes, the report displays *IDE: Yes All Rev Codes.*

NDC

If the Non Pro Fee 1500 Charge Control Parameter has the NDC field set to Yes, and specific revenue codes are listed in the NDC Rev Codes field, the report displays *NDC: Yes XXXX,XXXX,XXXX*, where XXXX is the revenue code selected. If the Non Pro Fee 1500 Charge Control Parameter has the NDC field set to Yes, and the IDE Rev Codes field is set to all revenue codes, the report displays *NDC: Yes All Rev Codes.*

NDC UNIT QUAL/UNITS

If the NDC Unit Qual/Units field on the Non Pro Fee 1500 Charge Control Parameters is set to Edit HCPCS, the HCPCS ranges entered are printed. Any HCPCS exceptions are listed after the HCPCS range. For example:

 NDC Unit Qual/Units: Edit HCPCS J0001-J9999 J1234,J9876

TOS CROSS REFERENCE
This field indicates the Type of Service Cross Reference Table that is used in conjunction with this charge control parameter.

DEFAULT DIAGNOSIS
This field indicates if charges without a diagnosis should default to the Principal/ Admitting diagnosis, the Principal/Working diagnosis, or Reference Number 1.

DEFAULT PHYSICIAN
This field indicates if charges without a performing physician should default to the pro fee physician in the Pricing Information screen of the Service Item Master.

EDIT PRO FEE CHARGES
This field indicates if the claim should edit for HCPCS procedures (H), Diagnosis (D), or physician ID (I) on each charge line on the claim.

24A DATE PRINT
This field indicates the date print format for locator 24A; either MMDDYYYY or MM DD YY.

PRINT ANES TIMES
This field indicates if the claim should print the starting and ending anesthesia times that were entered in Medical Records for the HCPCS code.

EDIT BY
This field contains the name of the user who last edited this 1500 charge control parameter.

EDIT DATE
This field contains the date and time this 1500 charge control parameter was last edited.

PRO FEE EXCEPTIONS
This field lists the UB Code and Description of UB Revenue Codes set to Exclude (Yes) from the claim form.

SIM ITEMS TO EXCLUDE
This field lists the Service Item Master Department and SIM Item of those charges excluded from the claim form.

ZERO PRICED FIM ITEMS TO INCLUDE
This field lists the Financial Item Master Department and FIM Item of those $0.00 charge to include on the claim form.

PAYER HCPCS CROSS REFERENCE TABLE REPORT - FCRHCP

Description/Purpose

The Payer HCPCS Cross Reference Table report provides a listing of the HCPCS that are to use an alternate HCPCS or ICD-9-CM code on the claim form for the payer. The hospital can enter numerous Payer HCPCS Cross Reference tables for the payers that require alternate HCPCS, and then link the tables to the appropriate UB, HCFA 1500, or Non Professional Fee 1500 Charge Control Parameters for the payers. The report lists the HCPCS code and description, and the alternate HCPCS/ ICD-9-CM code and description to use on the claim form for this payer. When the HCPCS code is encountered on a charge for the payer, the alternate code loads and prints on the claim form. This table does not affect the patient bill.

Generating and Printing This Report

This report is requested through the Payer HCPCS Cross Reference Table option. After you access the table, you can enter the FIM HCPCS and the alternate HCPCS/ ICD-9-CM to use for the payer. When you exit the screen, the system displays the following prompt:

> *Do you want a printed list? (Y/N) [N]*

Enter Y if you want to generate the report. The system references the spooler report definition to determine if the report is to be printed immediately or on demand and what printer is used for output. If the report is spooled for subsequent printing, the report name is FCRHCP without a facility indicator.

If you answer Y, the system then displays the following prompt:

> *Include entries filed as deleted? (Y/N) [N]*

If you include entries filed as deleted, they print ***INACTIVE*** below the Payer HCPCS Cross Reference Table description.

The report page breaks between tables and sorts by the Payer HCPCS Cross Reference Table code (for example, table number 1 before table number 2).

The following is an example of the Payer HCPCS Cross Reference Table report.

Figure 4.21 FCRHCP - HCPCS Cross Reference Table Report

```
Date: 07/08/93                           General Hospital                          Page  : 1
Time: 10:42am                     Payer HCPCS Cross Reference Table                Report: FCRHCP

        Payer HCPCS Cross Reference Table    HCPCS                            Alternate HCPCS
        1 - MEDICARE HCPCS O/P

                                             80019-19 OR MORE BLOOD/URINE TESTS    80050-GENERAL HEALTH PANEL
                                             80100-DRUG SCREEN                     80102-DRUG CONFIRMATION
                                             82130-AMINO ACIDS ANALYSIS           82131-AMINO ACIDS


End of Report
```

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This report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

PAYER HCPCS CROSS REFERENCE TABLE
This field lists the Payer HCPCS Cross Reference table number and description.

HCPCS
This field lists the HCPCS codes and descriptions that are to use an alternate HCPCS code on the claim form.

ALTERNATE HCPCS/ALTERNATE ICD-9-CM CODES
This field lists the alternate HCPCS code and description or the alternate ICD-9-CM code and description to use on the claim form. The column heading on the report prints either Alternate HCPCS or Alternate ICD-9-CM Code depending on the setting of the HCPCS or ICD-9-CM field on the Payer HCPCS Cross Reference Table.

PENDING CLAIMS REPORT - FCR260

Description/Purpose

The Pending Claims Report is used to audit the number and status of claims outstanding by carrier/plan for each biller. It provides a list of all claim forms loaded for on-line review but not released for printing and includes the claim status (A-Awaiting payment, H-Hold, F-Failed system edits). This report is also used to maintain claims that have not been printed or produced electronically.

Included on the report are the carrier plan, account number, patient name, bill from date, claim type, claim sequence, bill days, financial class, patient type, claim status, medical service, attending doctor, carrier liability, claim amount, shared plans, and average audit days. Subtotals are provided by carrier/plan for number of claims outstanding, total carrier liability, total claim amount and a total by biller for all claims.

A separate summary page lists subtotals for the number of claims, claims amount, carrier, liability and average days by carrier/plan. A grand total of all pending claims, carrier liability, claim amounts and average days is also provided on the summary page.

Generating and Printing This Report

The Pending Claims Report is generated through the Optional Batch Job processing function. Refer to "Optional Batch Jobs" in Chapter 2: Financial System Management of the *General Information Volume* in the *STAR Financials Patient Accounting Reference Guide* for more information on setting up this report.

This report is sorted by biller, and subsorted by insurance carrier, insurance plan, bill thru date and patient account number. Page breaks for the report occur at the end of the page.

The following is an example of the Pending Claims Report.

Figure 4.22 FCR260 - Pending Claims Report

```
Date: 12/21/89                              General Hospital                                  Page  : 1
Time: 12:11am                         PENDING CLAIMS REPORT FOR 12/20/89                       Report: FCR260


* * *Carrier: 04-AETNA
* * * * Plan: 1577-AETNA/BANKHEAD ENTERPRISE

                          Bill  Cl Cl  Bill  Bill              Med Atnd    Carrier       Claim      Shared Audit
   Account    Patient Name  From  Ty Sq  Thru  Days  St F/c P/t Ser  Dr    Liability     Amount      Plans  Days

0100-171-826 WILLIAMSON,JAMES A   12/16/89  U  4 12/16/89  0   F  11  O/P 010 90005    $392.50      $402.50             4


           Plan:  1577    Claims Outstanding: 1              Totals:    $392.50      $402.50   Avg Days:   4.0


           Carrier:  04   Claims Outstanding: 1              Totals:    $392.50      $402.50   Avg Days:   4.0

* * *Carrier: 05-ALLSTATE
* * * * Plan: 1505-ALLSTATE/ACTIVE EMPLOYEES

0100-171-826 JACKSON,WILLIAM K    12/16/89  U  5 12/16/89  0   A  11  O/P 010 90005     $10.00      $402.50             4


           Plan:  1505    Claims Outstanding: 1              Totals:     $10.00      $402.50   Avg Days:   4.0


           Carrier:  05   Claims Outstanding: 1              Totals:     $10.00      $402.50   Avg Days:   4.0

* * *Carrier: 10-HARTFORD
* * * * Plan: 1545-HARTFORD/ALT METRO PLUMB

0100-171-792 DOUGLAS,STEVE        12/16/89  U  1 12/16/89  0   H  11  ADM 031 31001  $1,606.41    $2,266.01             4


           Plan:  1545    Claims Outstanding: 1              Totals:  $1,606.41    $2,266.01   Avg Days:   4.0


           Carrier:  10   Claims Outstanding: 1              Totals:  $1,606.41    $2,266.01   Avg Days:   4.0

* * *Carrier: 26-CNA
* * * * Plan: 1890-CNA/LAW ENGINEERING

0100-171-834 KELLER,CHRISTINE     12/16/89  U  1 12/18/89  2   F  11  ADM 012 10010    $368.00      $660.00             2


           Plan:  1890    Claims Outstanding: 1              Totals:    $368.00      $660.00   Avg Days:   2.0


           Carrier:  26   Claims Outstanding: 1              Totals:    $368.00      $660.00   Avg Days:   2.0


           Facility: P    Claims Outstanding: 8              Totals:  $2,376.91    $3,731.01   Avg Days:   3.5

                                           End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

ACCOUNT
This field contains the patient account number.

PATIENT NAME
This field contains the patient name.

BILL FROM
This field contains the bill from date.

CL TY
This field contains the claim form type associated with this patient's account. Valid types include U-UB82, X-UB, and B-1500.

CL SQ
The system-assigned claim sequence number assigned to this claim for this carrier for this patient's account.

BILL THRU
This field contains the bill through date.

BILL DAYS
This field contains the number of days billed for this claim. Outpatient claims display zero (0).

ST
This field contains the claim status associated with this patient's account. Valid types are A-awaiting payment, F-failed edits and H-hold.

F/C
This field contains the hospital-defined financial class code assigned to this patient's account. Financial classes categorize patients based on fiscal responsibilities. Some typical examples of financial classes include S-self pay, C-commercial and M-Medicare.

P/T
This field contains the hospital-defined patient type code representing such patient segments as regular admission, emergency room, outpatient, same day surgery and series patients.

MED SER
This field contains the medical services code.

ATND DR
This field contains the attending physician code.

CARRIER LIABILITY
This field contains the prorated amount due from the carrier for this claim.

CLAIM AMOUNT
This field contains the amount of charges included in the claim for this period.

SHARED PLANS
This field shows any other insurance carrier plan code included on this claim for billing purposes.

AUDIT DAYS
This field contains the number of days from the claim load date.

PRINCIPAL PROCEDURE REVENUE CODE TABLE REPORT - FCRPRC

Description/Purpose

The Principal Procedure Revenue Code Table report provides a listing of UB revenue codes that require an ICD-9-CM Procedure Code and Date in Locator 80 of the UB92 or Locator 74 of the UB04 claim form. If the claim has any of the revenue codes listed, but does not have a Principal Procedure Code and Date in Locator 80 of the UB92 or Locator 74 of the UB04, the claim has an error of *Revenue Code Requires Procedure Loc 74/80*. The Principal Procedure Revenue Code Table must be linked to the UB Charge Control Parameter in the Princ Proc Rev Code Table field.

Generating and Printing This Report

This report is requested through the Principal Procedure Revenue Code Table option. After you access this table, you can enter the UB Revenue Codes that require an ICD-9-CM procedure code and date in Locator 80 of the UB92 claim form and Locator 74 of the UB04 claim form. When you exit the screen, the system displays the following prompt:

> *Do you want a printed list (Y/N) [N]*

Enter Y if you want to generate the report. The system references the spooler report definition to determine if the report is to be printed immediately or on demand and what printer is used for output. If the report is spooled for subsequent printing, the report name is FCRPRC.

The following is an example of the Principal Procedure Revenue Code Table report.

Figure 4.23 Principal Procedure Revenue Codes Table

```
Date: 05/17/01                          General Hospital                       Page:  1
Time: 11:03am                  Principal Procedure Revenue Codes Table         Report: FCRPRC


        1 - MEDICARE PRINCIPAL PROC

        Revenue Code & Description

        360 -   OR Services
        361 -   OPERATING ROOM
        490 -   AMBULATORY SURGICAL CARE
        760 -   TREATMENT OR OBSERVATION ROOM
```

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This report contains a header that includes the date and time the report is generated, your hospital's name, the report title, page number, and the report name as used in the system.

Table Number and Description
This field lists the Principal Procedure Revenue Code Table code and description.

Revenue Code and Description
This field lists the UB revenue codes and descriptions of those UB revenue codes that require an ICD-9-CM Procedure Code and Date in Locator 80 of the UB claim form.

UB-82 CHARGE CONTROL PARAMETERS REPORT - FCRCC

Description/Purpose

The UB-82 Charge Control Parameters Report provides a list of all charge control values defined for each revenue code on the UB-82 claim form. The hospital defines whether the charges within the revenue codes should print on the claim form in summary or detail, if HCPCS procedures are required, and if units of service should print. This report lists the UB-82 Revenue Code/Description, print charges indicator, print summary/detail indicator, print units of service indicator, and active indicator.

Generating and Printing This Report

The UB-82 Charge Control Parameters Report is printed as a demand report. It enables you to print a selected parameter or all. The report is sorted by revenue code order within each charge control parameter defined. A page break occurs at each new parameter value and at the end of the page.

The following is an example of the UB-82 Charge Control Parameters Report.

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Figure 4.24 FCRCC - Charge Control Parameters Report

```
Date: 10/04/89                                                                       Page  : 1
Time: 09:39am                          UB82 CHARGE CONTROL PARAMETERS                 Report: FCRCC


        UB82 REVENUE CODE /DESCRIPTION      PRINT    PRINT       HCPCS      PROCEDURES     PRINT   INACTIVE
                                            CHARGES  SUM/DTL     SUMMARY                   UNITS


DEFAULTS  001 - I/P - SUMMARY               YES      DETAIL      YES        DO NOT PRINT   YES


       111 - RM+BD PRIVATE                  YES      SUMMARY                USE IF PRESENT YES
       119 - RM+BD PRIVATE WO BATH          YES      SUMMARY                               YES
       121 - RM+BD SEMI-PRIVATE             YES      SUMMARY                               YES
       129 - ECU SEMI-PRIVATE               YES      SUMMARY                               YES
       141 - DELUXE SUITE                   YES      DETAIL      NO         DO NOT PRINT   YES
       169 - ECU PRIVATE                    YES      SUMMARY                               YES
       968 - PRO FEE/                       NO
       954 - PRO FEE/ANS CRNA               NO


DEFAULTS  002 - O/P - LAB & RAD DETAIL + PROC  YES   DETAIL      YES        PRINT          YES


       111 - RM+BD PRIVATE                  YES      SUMMARY
       119 - RM+BD PRIVATE WO BATH          YES      SUMMARY
       121 - RM+BD SEMI-PRIVATE             YES      DETAIL      NO         DO NOT PRINT   YES
       129 - ECU SEMI-PRIVATE               YES      DETAIL      NO         DO NOT PRINT   YES
       307 - LAB/CHEMISTRY                  YES      DETAIL      YES        PRINT          YES
       308 - LAB DIALYSIS                   YES      DETAIL      YES        PRINT          YES


DEFAULTS  003 - O/P - LAB & RAD DETAIL      YES      SUMMARY     NO         DO NOT PRINT   YES


       111 - RM+BD PRIVATE                  YES      SUMMARY
       119 - RM+BD PRIVATE WO BATH          YES      SUMMARY
       121 - RM+BD SEMI-PRIVATE             YES      SUMMARY
       129 - ECU SEMI-PRIVATE               YES      SUMMARY
       141 - DELUXE SUITE                   YES      SUMMARY
       169 - ECU PRIVATE                    YES      SUMMARY
       171 - NURSERY-REGULAR                YES      SUMMARY
       306 - LAB/NR UROLOGY                 YES      DETAIL      YES        PRINT          YES
       .     .     .     .                  .        .           .          .             .
       921 - PERI VASCUL LAB                YES      SUMMARY
       929 - OTHER DIAGNOSTIC SVS           YES      SUMMARY
       942 - EDUCATION TRAINING             YES      SUMMARY
       943 - CARDIAC REHAB                  YES      SUMMARY                               YES


                                       End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

UB82 REVENUE CODE /DESCRIPTION
This field contains the code and description printed for this charge on the UB-82 form.

PRINT CHARGES
This field contains either *Yes* or *No* indicating whether charges should print for this revenue code on the UB-82 form.

PRINT SUM/DTL
The entry printed in this field - either Summary or Detail - determines the format of charges printed on the UB-82 form.

HCPCS SUMMARY
This field indicates if the HCPCS summary should print on the UB-82 form.

PROCEDURES
The entry printed in this field - either Print, Do Not Print or Use If Present - determines if HCPCS procedure codes are printed on the UB-82 form. In some instances, HCPCS procedure codes print if *Use if Present* is displayed in this field or the field can be left blank.

PRINT UNITS
The entry printed in this field - either Yes or No - determines if units of service are required on the UB-82 form for this revenue code.

UB CHARGE CONTROL PARAMETERS REPORT (FMRCCX)

Description/Purpose

The UB Charge Control Parameters report provides a list of all charge control values defined for each revenue code on the UB claim form. The hospital defines the following:

* which HCPCS to pull for the revenue code

* if the HCPCS are required for the revenue code

* if the HCPCS Summarization Master should be used for HCPCS from the FIM/Charge

* what the units should print for ancillary and room and bed charges and whether these units should be included in the total line

* if the service date should print in Locator 45 of the claim

* whether room and bed charges should print the room rate or the HCPCS code

* whether the system prints the load date or the generated date as the UB04 Creation Date

The report first lists the overall parameter settings, the default values for revenue codes not set up in the table, and then lists the detail for each revenue code that is set up in the table. Listed at the end of each UB Charge Control Parameter are the SIM Exclusions and the FIM Modifications for the parameter, and the Zero Dollar charges to load.

Generating and Printing This Report

This report is requested through the UB Charge Control Parameters Table option. After you access the table, you can update the default values and the values for the UB revenue codes in the table, the SIM Exclusions, the FIM Modifications, and the Zero Dollar Charges to load. When you exit the screen, the system displays the following prompt:

Do you want a printed list? (Y/N) [N]

Enter **Y** if you want to generate the report. The system references the spooler report definition to determine if the report is to be printed immediately or on demand and what printer is used for output. If the report is spooled for subsequent printing, the report name is FMRCCX without a facility indicator.

If you answer Y, the system then displays the following prompt:

Enter code (C) sequence or alphabetic (A) [A]

If you enter C for Code, the report sorts by UB Charge Control Parameter code (for example, 1 then 2). If you enter A for Alphabetic, the report sorts by UB Charge Control Parameter description (for example, Blue Cross O/P before Medicare O/P). Once you answer the sort question, the system displays the following prompt:

Include entries filed as deleted? (Y/N) [N]

If you include entries filed as deleted, they print ***INACTIVE*** below the UB Charge Control Parameter description. The report page breaks between parameters. The following is an example of the UB Charge Control Parameters Report.

Figure 4.25 FMRCCX - UB Charge Control Parameters Report

```
Date: 04/04/12                              General Hospital System                          Page  : 232
Time: 05:20pm                               UB Charge Control Parameters                     Report: FMRCCX


UB REVENUE CODE /DESCRIPTION                PRNT HCPCS       HCPCS HCPCS    HCPCS   ANC    R&B    TOTAL DATE  HCPCS OR
                                            CHGS PROC        REQ'D ROLLUP   SUM     UNITS  UNITS             ROOM RATE


707 - TEST FOR PAT

    Summarize By: Revenue Code within Service Date/No Supp
    Elec Claim Sys: Claim
    Edit Room Charges? No
    HCPCS Cross Reference:  -
    Prin Proc Rev Code:  -
    Med Rec HCPCS UB Revenue Code Table:  -
    Print Non Covered Charges? Yes ABN Not Signed, ABN Frq Not Signed, Pro Non Cov, Dup HCPCS,
                               Compt/Comph HCPCS, Mutl Excl
    Exclude ABN Self Pay?
    Print Non Covered portion on separate line? No
    Combine Prof Fees: No
    001/0001 Total Rev Code: 001
    Total First: No
    NY Claim: No
    Use RX Quantity: Yes
    Edit for I/P Rehab Rev Code 0024/024: No
    Edit Charge Service Dates: No
    Addtl Chg Srv Date Edits?  Hcg<AdmDt, Chg>DisDt, ChgStmt
    Zero fill UB revenue codes in print/electronic spool files: Yes
    Sort by NDC Code: Yes/Edit HCPCS: Yes  Prt NDC Info: Yes NDC Unit Qual/Units: Edit All
         HCPCS for NDC  12345

         HCPCS for NDC   J1455,J1460,J1470,J1480,J1490,J1500,J1510,J1520,J1530,

                         J1580,J1590,J1595,J1600,J1610,J1620,J1626,J1630,J1631

         HCPCS for Edit J1455,J1460,J1470,J1480,J1490,J1500,J1510,J1520,J1530,

                         J1580,J1590,J1595,J1600,J1610,J1620,J1626,J1630,J1631
    Sort by RF Code:  All
    Sort by IDE Code:  All
    Edit Unused Med Rec HCPCS: Yes
    Unused Med Rec HCPCS Prim or Prim/Split: Primary and Split
    Earliest Service Date UB Rev Codes: 762
    Required Rev Codes:
    Itemized Charges: CSR-62510119:BAGBAGS, DRAINAGE CYSTO FLO 4,CSR-62510146:PAD, COMB (ABD) 8X7-1/2",
                      CSR-62510178:TUBE, 5-IN-1 PLASTIC C,CSR-62510224:GAUZE, SPONGE 4 X 3 STERILE,
    UB04 Creation Date: Load Date
    Split Claims: THERAPY
    Load Admit Date for Charges: No
    Load Discharge Date for Charges: No
    California UB: No   California Modifier Table:
    Non-Specific HCPCS:
    Alternate Pricing (340B):
    Edit By: Moore,Jessie
    Edit Date: 04/02/1201:56pm


Defaults                                    Yes  FIM/Chg   No     REV    No          Srvc  No     Use   HCPCS


Detail
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

SUMMARIZE BY
This field indicates if the UB form should summarize by UB Revenue Code, Revenue Code within Service Date, or by Service Sate within Revenue Code. It also indicates if the service date should be suppressed for any claim charge lines with no HCPCS code.

ELEC CLAIM SYS
This field indicates whether the account (Account) or claim level charges (Claim) are sent to the Electronic Claim System.

EDIT ROOM CHARGES
This field contains either a Yes or No indicating whether the UB claim is edited to determine if total covered days plus the non covered days equals the room and bed charge units on the claim. If set to Yes to edit, it also lists any UB revenue codes that have been excluded from the edit. If the revenue codes that are excluded cannot all print on the report, the field lists those revenue codes it can, followed by "++".

HCPCS CROSS REFERENCE
This field indicates which, if any, Payer HCPCS Cross Reference Table is used in conjunction with this charge control parameter.

PRIN PROC REV CODE
This field indicates which, if any, Principal Procedure Revenue Code Table is used in conjunction with this charge control parameter.

MED REC HCPCS UB REVENUE CODE TABLE
This field indicates which, if any, Medical Records HCPCS UB Revenue Code Table is used in conjunction with this charge control parameter.

PRINT NON COVERED CHARGES
This field indicates whether non-covered charges should print in locator 48 of the claim form. If set to Yes, it also indicates which 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 HPCS Conflict

EXCLUDE ABN SELF PAY
This field indicates whether ABN self pay charges should be pointed off the claim.

COMBINE PROF FEES (COMBINE PROFESSIONAL FEES)
This field contains either a Yes or No indicating whether the professional fee will roll up into the ancillary charge on the claim form. This field is only used when the Summarize By field is set to Service Date within Revenue Code or Revenue Code within Service Date.

001/0001 TOTAL REV CODE:
This field contains either the value 001 or 0001 indicating whether the Total line in the charge area of the UB is reported using revenue code 001 or using 0001. The default is 001. If set to 001, the claim print program prints revenue code 001 for the Total line. If set to 0001, the claim print program prints revenue code 0001 for the Total line.

TOTAL FIRST
This field indicates whether the 001 or 0001 revenue code for total charges will print as the first or last revenue code on the claim.

NY CLAIM
This field indicates whether the claim uses NY prices and HCPCS codes or standard codes.

USE RX QUANTITY
This field indicates if the units of service on the claim for Pharmacy charges should be the quantity calculated by Pharmacy (Yes) or the quantity that was placed with the Pharmacy charge (No). The Units field for the Pharmacy revenue codes must be set to Quantity.

EDIT FOR I/P REHAB REV CODE 0024/024
This field indicates whether the system should check if Rehab Rev Code 0024 or 024 was loaded to the claim. If this field is set to Yes, and the claim does not have Revenue Code 0024, 024, or 24 in the Claim Charge Data area, the claim fails, and the Claim Charge Data screen displays **Yes** in the Rehab Rev Code Error field.

EDIT CHARGE SERVICE DATES
This field indicates if the system is to fail claims with service dates within a specified time frame.

ADDTL CHG SRV DATE EDITS
This indicates whether the system is to edit charges outside the billing dates

ZERO FILL UB REVENUE CODES IN PRINT/ELECTRONIC SPOOL FILES
This indicates whether the system should zero fill the UB Revenue Code on the UB claim in Claim Print/Spool. new

SORT BY NDC CODE
This indicates the value for Sort By NDC Code followed by the response to the Edit for NDC Code prompt. The report prints the following after the Sort By NDC Code:

Yes/Edit

Yes (which means no editing for the NDC Code itself)

No

When editing by HCPCS codes, these HCPCS codes print on the report

For example: ... Reference Facility: Yes All Rev Codes IDE: Yes All Rev Codes NDC: Yes/Edit 250, 636, 985, 986 NDC Unit Qual/Units: Edit HCPCS HCPCS for Edit J0120,J0128,J0129,J0130,J0132

HCPCS
This field indicates whether specific HCPCS only, that have one of the specified Revenue Codes, should load the NDC information. If set to Yes, the HCPCS display starting in the next line in the HCPCS for NDC field.

PRT NDC INFO
This field indicates whether the system should print NDC information on the paper UB in Locator 43.

NDC UNIT QUAL/UNITS
Valid values are Blank, Default (unit qualifier), and Edit. If the NDC Unit Qual/Units field on the UB Charge Control Parameters is set to Edit HCPCS, if the HCPCS to edit differ from those listed to load NDC information in the (NDC) HCPCS field of the UB Charge Control Parameter, the edited HCPCS are listed in the following line in the HCPCS for Edit field.

SORT BY RF CODE
This field indicates whether the system should sort claim charge lines by Reference Facility Codes (RF Code). If the Reference Facility field is set to Yes, and individual revenue codes are selected in the RF Rev Codes field of the UB Charge Control Parameter, the report displays *Sort by RF Code: Yes.* In the Detail section by UB revenue code, any revenue code selected has a second line, and *RF: Yes* is displayed

in the field. If the Reference Facility is set to Yes, and all revenue codes are selected in the RF Rev Codes fields, *Sort by RF Code: All* is displayed in the field.

SORT BY IDE CODE
This field indicates whether the system should sort claim charge lines by Investigational Device Exemption Codes (IDE Code). If the IDE field is set to Yes, and individual revenue codes are selected in the IDE Rev Codes field of the UB Charge Control Parameter, the report displays *Sort by IDE Code: Yes*. In the Detail section by UB revenue code, any revenue code selected has a second line, and *IDE: Yes* is displayed. If the IDE is set to Yes, and all revenue codes are selected in the IDE Rev Codes fields, the field displays *Sort by IDE Code: All.*

EDIT UNUSED MED REC HCPCS
This field indicates whether the system is to edit and fail claims for medical records HCPCS not reflected on the claim.

UNUSED MED REC HCPCS PRIM OR PRIM/SPLIT
This field indicates whether an Unused Medical Records HCPCS error fails both the primary and any split claims that load for that carrier and bill sequence or fails only the primary claim.

EARLIEST SERV DATE UB REV CODES
This field specifies 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.

REQ REV CODES
This field contains the revenue codes that are required on the claim.

ITEMIZED CHARGES
This field contains the specific FIM items that are printed in detail on the claim form.

UB04 CREATION DATE
This field indicates whether the UB04 creation date is the Load Date (the date the claim was loaded) or the Generated Date (the date the claim was spooled). If blank, the Load Date is used.

SPLIT CLAIMS
This field contains the names of split claim criteria and the order in which they are processed by the system.

LOAD ADMIT DATE FOR CHARGES
This field indicates if the claim should use the admission date for the claim charges after all processing has been completed.

LOAD DISCHARGE DATE FOR CHARGES
This field indicates if the claim should use the discharge date for the claim charges after all processing has been completed.

CALIFORNIA UB
This field indicates if the UB04 should process for California Medicaid requirements.

CALIFORNIA MODIFIER TABLE
This field lists any California Modifier Table number and description.

NON-SPECIFIC HCPCS
If non-specific HCPCS should be used for claims loading with a UB Charge Control parameter, the number of the table for NON-SPECIFIC HCPCS is indicated in this field.

ALTERNATE PRICING (340B)
If 340B pricing should be used for claims loading with a UB Charge Control parameter, the number of the table for Alternate Pricing (340B Pricing) is indicated in this field.

EDIT BY
This field contains the name of the user who last edited this UB Charge Control parameter.

EDIT DATE
This field contains the date and time this UB Charge Control parameter was last edited.

UB REVENUE CODE/DESCRIPTION
This field contains the code and the description for the UB revenue code. The revenue code description is pulled from the UB Revenue Code table for the claim.

PRNT CHGS (PRINT CHARGES)
This field contains either a Yes or No indicating whether charges should print for this revenue code on the UB claim form.

HCPCS PROC (HCPCS PROCEDURES)
This field indicates whether HCPCS codes should be loaded for the revenue code. Options are FIM/Chg (FIM/Charge), Chg/Df MR (Charge/Default Medical Records), Med Rec (Medical Records), Both/Det (Both/Detail), Both/Summ (Both/Summary), Override, or None.

HCPCS REQ'D (HCPCS REQUIRED)
This field contains either a Yes or No indicating whether a HCPCS code is required for the revenue code. A value of Yes means that if the revenue code does not have a HCPCS for the charge line, then there will be a Procedure Code Error on the Claim Charge Data screen within Claims Management. The Failed Claims Requirement Report (FCR250x) will list the HCPCS procedure errors as "Procedure Code is Required Quantity #". A value of No means that the revenue code may still pull a HCPCS, but if there is no HCPCS for the revenue code, the claim charge line will not have a procedure code error.

HCPCS ROLLUP
This field contains either FIM (FIM Department /Code) or REV (Revenue Code) to indicate how charges without a HCPCS procedure in Locator 44 should be

summarized. A value of REV means to roll up ancillary and room and bed charges without a HCPCS or room rate together in one line or a separate line by date if loading service date to the claim. A value of FIM means to roll up ancillary charges without a HCPCS by FIM Department and Code or FIM Department and Code by date if loading service date to the claim, and room and bed charges without a room rate (printing in Locator 44) by room rate or room rate by date if loading service date to the claim.

HCPCS SUM (HCPCS SUMMARIZATION)
This field contains either a Yes or No indicating whether the HCPCS Summarization Master should be used for revenue codes that have the HCPCS Procedures field set to C for FIM/Charge Procedures.

ANC UNITS (ANCILLARY UNITS)
This field indicates if the units field should print units of service (occurrence of the charge or credit), the true quantity on the charges, visit (which always equals 1), the number of hours, the number of days, or be blank. There are no defaults for this field.

R&B UNITS (ROOM AND BED UNITS)
This field indicates if the units field should print units of service (occurrence of the charge or credit), the true quantity on the charges, visit (which always equals 1), the number of hours, the number of days, or be blank. There are no defaults for this field.

TOTAL
This field indicates if the units in the individual charge lines should be included in the units in the 001 or 0001 Total line.

DATE
This field contains a value of either Edit (Yes), No, or Use indicating whether the charges should print the service date in Locator 45 of the UB form. A value of Edit means that the HCPCS is edited for duplicate HCPCS with the same date of service and loads the service date. A value of Use means to load the service date but not edit the HCPCS for same date of service. A value of No means not to load the service date. All these options are valid when the Summarize By field is set to UB Code. If the Summarize By field is set to either Revenue Code within Service Date or Service Date within Revenue Code, this field contains a value of either Yes (Edit) or Use.

HCPCS or ROOM RATE
This field indicates whether room and bed charges should print the room rate, the HCPCS code from the FIM, or a blank in Locator 44 of the UB claim form. The values that print are either HCPCS (HCPCS code), Room (room rate), or Blank (blank rate).

UB SIM EXCLUSIONS
The SIM Exclusions for the Charge Control Parameter print at the end of the report and list the Department code and description and the SIM Item number and description that are to be excluded from printing on the claim form. This field does not affect the patient bill.

UB FIM MODIFICATIONS
The FIM Modifications for the Charge Control Parameter print at the end of the report and list the Department code and description, the FIM Item number or All, the UB Revenue Code assigned to the FIM item in the FIM or the UB Revenue Code to search on if the All option is used, and the alternate UB Revenue Code for the FIM item to use on the claim form. This field does not affect the patient bill or the charges at the account level.

UB ZERO DOLLAR CHARGES TO LOAD
The UB Zero Dollar Charges to Load prints at the end of the report and lists the Department code and description, and the FIM Item Number of zero charge items that are to load to the UB. This field does not affect that patient bill.

CLAIMS GENERATED - NOT SUBMITTED REPORT - FCR300

Description/Purpose

The Claims Generated But Not Submitted Report lists all claims, by biller, that are printed but not mailed (submitted). The report lists claims by biller and carrier/ plan and includes the account number, account name, admit date, discharge date, claim generation date (print date), sequence date, and claim amount. Totals are provided by biller carrier, and plan. Total number of claims and amounts are provided for each biller. Facility totals are provided for total claims and total amount. This report is useful in monitoring the number of claims printed but not mailed to the carrier.

NOTE: Claims with a zero balance or credit balance for the carrier do not print on this report.

If the biller index indicates a generated claim but the claim data indicates otherwise, the claim does not appear in the report, and it is marked to be fixed during midnight processing.

Generating and Printing This Report

The Failed Billing Requirements Report is generated through the Optional Batch Job processing function. Refer to the Financial System Management section in the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide* for more information on setting up this report.

The following is an example of the Claims Generated - Not Submitted Report.

Figure 4.26 FCR300 - Claims Generated - Not Submitted Report

```
Date: 12/07/89                              GENERAL HOSPITAL                              Page  : 1
Time: 15:01                           CLAIMS GENERATED NOT SUBMITTED                      Report: FCR300
            Carrier/Plan: 201 002  MEDICARE O/P
Account #        Name                        Admitted    Discharged    Generated    COB   Seq   Claim Amount
89268-00009      POWERS,CYNTHIA F            09/25/89    09/28/89      11/30/89     1     2         40.90
     Plan Totals
          Total Claims:          1
          Total Amount:         40.90
            Carrier/Plan: 201 003  AETNA PROFEES
Account #        Name                        Admitted    Discharged    Generated    COB   Seq   Claim Amount
89268-00009      SIMMS,JAMES E              09/25/89    09/28/89      12/07/89     1     2         40.90
     Plan Totals
          Total Claims:          1
          Total Amount:         40.90
     Carrier Totals
          Total Claims:          2
          Total Amount:         81.80
            Carrier/Plan: 403 057  AETNA/PACIFIC P & L
Account #        Name                        Admitted    Discharged    Generated    COB   Seq   Claim Amount
89299-00001      PLANTE,ROBERT J            10/26/89    10/26/89      11/03/89     1     1        324.25
     Plan Totals
          Total Claims:          1
          Total Amount:        324.25
     Carrier Totals
          Total Claims:          1
          Total Amount:        324.25
     Biller Totals
          Total Claims:          3
          Total Amount:        406.05
     Facility Totals
          Total Claims:          3
          Total Amount:        406.05
                                          End of Report
```

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COMBINED BILLING REPORT - FBR290

Description/Purpose

The Combined Billing Report displays patients and charges that have been combined during midnight processing as a result of the Combine Billing function and the generation of bills. This report also lists accounts for which the system has not produced combined bills because one or more of the accounts was not scheduled for billing or failed billing. If accounts are unlinked and charges are uncombined, this report contains the accounts and charges that are uncombined. For more information on the Combine Billing function, refer to the Patient Billing section in the *Billing and Claims Volume* in the *STAR Financials Patient Accounting Reference Guide*.

The system sorts this report by the biller of the FROM account. For each biller, the FROM accounts are listed by patient name. Charges transferred for each FROM account are sorted by the department and service date. The report displays totals by biller for the FROM account balance and for the charges transferred.

NOTE: If the patient from which charges were transferred is a cycle billing patient, the system does not transfer charges that have already been billed; as such, these charges do not display on the report.

Generating and Printing This Report

The system generates the Combined Billing Report as part of midnight processing. The report can be printed on demand.

The following is an example of the Combined Billing Report.

Figure 4.27   FBR290 - Combined Billing Report

```
Date: 02/12/99                          Model Hospital A                        Page  : 1
Time: 02:08A                        Combined Billing Report                     Report: FBR290A

                                    3 - BILLERTHREE,BILLER

   Patient Name            Pat Number  Chg To #    Patient Name         M/B        Service Date Range        Type
    Pat Type FC  Adm Dt    Dis Dt       Pat Type FC  Adm Dt   Dis Dt    Dpt Sim#  Description               Serv Dt       Amount

   MOORE,BABY 1 BOY        9635300002  9635300001 MOORE,PAM             YES         EARLIEST - LATEST        Combined
      NEW   O  02/18/99                 I/P    O  02/18/99              No bill request for this FROM account.
    MOORE,BABY,2 GIRL      9635300003                                  No bill request for this FROM account.

   MOORE,BABY 2 GIRL       9635300003  9635300001 MOORE,PAM             YES         EARLIEST - LATEST        Combined
      NEW   O  02/18/99                 I/P    O  02/18/99              No bill request for this FROM account.
    MOORE,BABY,1 BOY       9635300002                                  No bill request for this FROM account.
   ANDERSON,SAM            9704200005  9704200007 ANDERSON,SAM          NO          EARLIEST - LATEST        Uncombined
      SER   M  02/01/99                 ER     M  02/09/99 02/09/99     LAB 1250  B-12, SERUM                02/08/99        1.00
                                                                       LAB 1000  ACETAMINOPHEN-CHG ONLY     02/09/99       16.50
                                                                       LAB 7777  LAB PROFESSIONAL FEE       02/09/99       82.50
                                                                       LAB 1200  ACETONE                    02/10/99        0.00
                                                                       PT  1011  BODY WHIRLPOOL I           02/08/99       31.80
                                                                       PT  1013  BODY WHIRLPOOL II          02/09/99       46.60
                                                                       PT  207   BODY WHIRLPOOL III         02/10/99       61.50

      Chg From Bal:     464.50                                                            TOTAL CHG        239.90
   TOTAL FROM BAL:      464.50                                          BILLER TOTAL COMBINED CHARGES       239.90

                                                End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

PATIENT NAME
This field displays the name of the patient from which charges were transferred (for example, the patient against whose account the charge was initially placed). For accounts whose charges are uncombined, this account is the Charge TO account.

PAT NUMBER
This field displays the number of the account from which charges were transferred.

CHARGE TO NUMBER
This field displays the number of the account to which charges were transferred.

PATIENT NAME
This field displays the name of the patient to which charges were transferred (that is, the patient whose account is now accountable for the charges).

M/B (MOM AND BABY FLAG)
This field displays Yes if this is a mother/baby billing combination, or No if this is not a mother/baby billing combination.

SERVICE DATE RANGE
The service date range from the combine bill request displays. This may be specific service dates or it may be Earliest to latest.

TYPE
This field indicates whether the account is Combined or Uncombined.

PAT TYPE
This field displays the patient type from the Charge FROM account.

FC
This field displays the financial class from the Charge FROM account.

ADM DT
This field displays the admission date from the Charge FROM account.

DIS DATE
This field displays the discharge date from the Charge FROM account.

PAT TYPE
This field displays the patient type from the Charge TO account.

FC
This field displays the financial class from the Charge TO account.

ADM DT
This field displays the admission date from the Charge TO account.

DIS DATE
This field displays the discharge date from the Charge TO account.

DEPARTMENT ID OR MESSAGE
If the system was unable to combine charges, this field of the report displays a message explaining the failure. These messages and their meaning are:

- If the From account has a bill request and the To account does not, the report displays *No bill request for the TO account*.

- If the To account has a system generated bill request and the From account does not have a bill request, the report displays *No bill request for this FROM account*.

- If a bill is not produced due to errors on the charge To account's bill, the report displays *TO final bill failed edits, FROM bill request rejected*.

- If the To account has not met the billing suspense days for a system generated bill, the report displays *TO acct has not met susp days, FROM bill request rejected.*

- If the From account has no charges within the charge service date range, the report displays, *FROM account has no charges to transfer to TO account*.

- If the From account has not met the billing suspense days for a system generated bill, the report displays *FROM acct has not met susp days, TO bill request rejected.*

- If another FROM account that is denied to the same To account has an error, the report displays *Error found from another FROM account*.

- If a specific service date range was specified and the FROM account failed edits, the report displays *FROM final bill failed edits; TO bill request rejected*.

If the From bill request is rejected, this means that bill request was rejected for last night's midnight processing run. You do not need to enter a new bill request for the From account. The system continues to try to bill the accounts until the To account passes edits, or the To account meets the bill suspense days, and both accounts bill.

If the system was able to combine charges, this field displays the ID of the department for which the charge was generated.

SIM #
This field displays the SIM item number of the charge.

DESCRIPTION
This field displays the description of the SIM item of the charge.

SERVICE DATE
This field displays the service date for the charge.

AMOUNT (AMOUNT OF CHARGE)
This field displays the amount of the charge for the SIM item.

CHG FROM BAL
This field displays the total of all charges transferred for the patient for this billing.

TOTAL CHG
The account balance of the charge from account after charges are transferred to the to account. This field prints only if the combine bill request is processed.

TOTAL FROM BAL
The total of the account balances for all charge from accounts for the biller.

BILLER TOTAL COMBINED CHARGES
This field displays the total of all charges transferred for this biller.

CLAIM SPOOLFILES

The table below lists the claim spoolfiles for the claim types supported by the system. The claim types are for the claim type as defined in the Claim Load and Edit Parameters.

UB Claim Types

The Facility Indicator and Account Number print, followed by 2 spaces, followed by the Payer Indicator, followed by 3 spaces, followed by the claim sequence number. The Payer Indicator informs you which payer, in Locator 50A, 50B, 50C, or 50D, if there was a line D, the claim is for. If the claim is for the payer in 50A, a 1 prints. If the claim is for the payer in 50B, a 2 prints. If the claim is for the payer in 50C, a 3 prints. And, if the claim is for the payer that would have printed in 50D, if there was a 4th line, a 4 prints. The following is an example of the top line of the UB.

A0201400001 2 8

If you do not want any data (account number, payer/COB, or claim sequence number) printing on the top line of a claim, you must access the appropriate Claim Load and Edit Parameter for the claim type, and on the first screen, set the field "Top Line Blank" to Yes. No data will then print on the top line.

If the UB claim loads in the UB04 Format, the claim spools to spoolfile names listed under the UB04 format. If the UB claim loads in the UB Format, the claim spools to the spoolfile names listed under the UB92 format.

UB Claim Type (1992 Format)

System Report Name	Description
FMRPAX	Paper and Paper Tracers
FMRRPX	Paper Batch Reprints
FMRELXA	Electronic Media A
FMRELXB	Electronic Media B
FMRELXC	Electronic Media C
FMRELXD	Electronic Media D
FMRELXE	Electronic Media E
FMRTPX	Electronic Media T
FMRLBX	UB-92 Paper Labels
FMRACX	UB-92 Archived
FMRDEX	UB-92 Deleted
FMRLEXA	UB-92 Labels Elec A

System Report Name	Description
FMRLEXB	UB-92 Labels Elec B
FMRLEXC	UB-92 Labels Elec C
FMRLEXD	UB-92 Labels Elec D
FMRLEXE	UB-92 Labels Elec E
FMRLEXT	UB-92 Labels Elec T

UB Claim Type (UB04 Format)

System Report Name	Description
FMR1PAXX	Paper and Paper Tracers
FMR1RPXX	Paper Batch Reprints
FMR1ELXXA	Electronic Media A
FMR1ELXXB	Electronic Media B
FMR1ELXXC	Electronic Media C
FMR1ELXXD	Electronic Media D
FMR1ELXXE	Electronic Media E
FMR1TPXX	Electronic Media T
FMR1LBXX	Paper Labels
FMR1ACXX	Archived
FMR1DEXX	Deleted
FMR1LEXXA	Labels Elec A
FMR1LEXXB	Labels Elec B
FMR1LEXXC	Labels Elec C
FMR1LEXXD	Labels Elec D
FMR1LEXXE	Labels Elec E
FMR1LEXXT	Labels Elec T

1500 Claim Types

When the claim is printed, the Facility Indicator and Account Number print, followed by 2 spaces, followed by the COB of the insurance, followed by 3 spaces, followed by the claim sequence number. The following is an example of the top line of the 1500 claim.

A0201400001 4   10   FINAL

If you do not want any data (account number, payer/COB, or claim sequence number) printing on the top line of a claim, you must access the appropriate Claim Load and Edit Parameter for the claim type, and on the first screen, set the Top Line Blank field to Yes. No data will print on the top line.

If the 1500 claim loads in the 08/05 1500 Format, the claim spools to the spoolfile names listed under the 08/05 Format. If the 1500 claim loads in the 1992 1500 Format, the claim spools to the existing spoolfile names.

If the Non Pro Fee 1500 claim loads in the 08/05 1500 Format, the claim spools to the spoolfile names listed under the 08/05 Non Pro Fee 1500 Format. If the Non Pro Fee 1500 claim loads in the 1992 1500 Format, the claim spools to the existing spoolfile names.

1500 'Rev 1992 (Revised 1500 for 1992, Claim Type 1500, Format 2)

System Report Name	Description
FCR1921	Paper and Paper Tracers
FCR1922	Paper Batch Reprints
FCR192A	Electronic Media A
FCR192B	Electronic Media B
FCR1923	Electronic Media C
FCR192D	Electronic Media D
FCR192E	Electronic Media E
FCR1924	Electronic Media T
FCR1925	'Rev 1992 Paper Labels
FCR1927	'Rev 1992 Archived
FCR1926	'Rev 1992 Deleted
FMRLEBA	1500 Labels Elec A
FMRLEBB	1500 Labels Elec B
FMRLEBC	1500 Labels Elec C
FMRLEBD	1500 Labels Elec D
FMRLEBE	1500 Labels Elec E
FMRLEBT	1500 Labels Elec T

1500 'Rev 08/05 (Revised 1500 08/05 Format, Claim Type 1500)'

System Report Name	Description
FCR1941	Paper and Paper Tracers
FCR1942	Paper Batch Reprints
FCR194A	Electronic Media A
FCR194B	Electronic Media B
FCR1943	Electronic Media C
FCR194D	Electronic Media D
FCR194E	Electronic Media E
FCR1944	Electronic Media T
FCR1945	Paper Labels
FCR1947	Archived

System Report Name	Description
FCR1946	Deleted
FMR1LEBBA	Labels Elect A
FMR1LEBBB	Labels Elect B
FMR1LEBBC	Labels Elect C
FMR1LEBBD	Labels Elect D
FMR1LEBBE	Labels Elect E
FMR1LEBBT	Labels Elect T

1500 Non Pro Fee (1992 Format)

When the claim is printed, the Facility Indicator and Account Number print, followed by 2 spaces, followed by the COB of the insurance, followed by 3 spaces, followed by the claim sequence number. The following is an example of the top line of the 1500 claim.

A0201400001 4   10   FINAL

If you do not want any data (account number, payer/COB, or claim sequence number) printing on the top line of a claim, you must access the appropriate Claim Load and Edit Parameter for the claim type, and on the first screen, set the Top Line Blank field to Yes. No data will print on the top line.

System Report Name	Description
FMRPAZ	Paper and Paper Tracer
FMRRPZ	Paper Batch Reprints
FMRELZA	Electronic Media A
FMRELZB	Electronic Media B
FMRELZC	Electronic Media C
FMRELZD	Electronic Media D
FMRELZE	Electronic Media E
FMRTPZ	Electronic Media T
FMRLBZ	Non Pro Fee 1500 Paper Labels
FMRACZ	Non Pro Fee 1500 Archived
FMRDEZ	Non Pro Fee 1500 Deleted
FMRLEZA	Non Pro Fee 1500 Labels Elec A
FMRLEZB	Non Pro Fee 1500 Labels Elec B
FMRLEZC	Non Pro Fee 1500 Labels Elec C

System Report Name	Description
FMRLEZD	Non Pro Fee 1500 Labels Elec D
FMRLEZE	Non Pro Fee 1500 Labels Elec E
FMRLEZT	Non Pro Fee 1500 Labels Elec T
FURLEZT	Non Pro Fee 1500 Labels Elec T

1500 Non Pro Fee (08/05 Format)

System Report Name	Description
FMR1PAZZ	Paper and Paper Tracers
FMR1RPZZ	Paper Batch Reprints
FMR1ELZZA	Electronic Media A
FMR1ELZZB	Electronic Media B
FMR1ELZZC	Electronic Media C
FMR1ELZZD	Electronic Media D
FMR1ELZZE	Electronic Media E
FMR1TPZZ	Electronic Media T
FMR1LBZZ	Paper Labels
FMR1ACZZ	Archived
FMR1DEZZ	Deleted
FMR1LEZZA	Labels Elect A
FMR1LEZZB	Labels Elect B
FMR1LEZZC	Labels Elect C
FMR1LEZZD	Labels Elect D
FMR1LEZZE	Labels Elect E
FMR1LEZZT	Labels Elect T

Canadian Claims

The following tables list Canadian-specific claims, alphabetically by province name.

ONTARIO

Universal Claim (K Claim Type)

System Report Name	Description
FMRPAK	Paper
FMRRPK	Paper Reprints and Tracers
FMRELKA	Electronic Media A
FMRELKB	Electronic Media B
FMRELKC	Electronic Media C
FMRELKD	Electronic Media D
FMRELKE	Electronic Media E
FMRTPK	Electronic Media T
FMRLBK	Universal Claim Labels
FMRACK	Universal Claim Archived
FMRDEK	Universal Claim Deleted

WCB Claim (W Claim Type)

System Report Name	Description
Community Clinic:	
FMRPAWC	Paper
FMRRPWC	Paper Reprints and Tracers
FMRACWC	Archived
FMRDEWC	Deleted
Inpatient:	
FMRPAWI	Paper
FMRRPWI	Paper Reprints and Tracers
FMRACWI	Archived
FMRDEWI	Deleted
Outpatient:	
FMRPAWO	Paper
FMRRPWO	Paper Reprints and Tracers

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System Report Name	Description
Community Clinic:	
FMRACWO	Archived
FMRDEWO	Deleted
Laboratory:	
FMRPAWL	Paper
FMRRPWL	Paper Reprints and Tracers
FMRACWL	Archived
FMRDEWL	Deleted
Radiology:	
FMRPAWR	Paper
FMRRPWR	Paper Reprints and Tracers
FMRACWR	Archived
FMRDEWR	Deleted
Therapy:	
FMRPAWT	Paper
FMRRPWT	Paper Reprints and Tracers
FMRACWT	Archived
FMRDEWT	Deleted

State Claims

The following tables list state-specific claims, alphabetically by state name.

CALIFORNIA

MEDI-CAL UB-92 Inpatient and Outpatient (R Claim Type)

System Report Name	Description
FMRPAR	Paper
FMRRPR	Paper Reprints and Tracers
FMRELRA	Electronic Media A
FMRELRB	Electronic Media B
FMRELRC	Electronic Media C
FMRELRD	Electronic Media D
FMRELRE	Electronic Media E
FMRLBR	Medi-Cal UB-92 Labels
FMRACR	Medi-Cal UB-92 Archived
FMRDER	Medi-Cal UB-92 Deleted

MEDI-CAL Inpatient (MCLI Claim Type)

System Report Name	Description
FMRPAI	Paper
FMRRPI	Paper Reprints and Tracers
FMRELIA	Electronic Media A
FMRELIB	Electronic Media B
FMRELIC	Electronic Media C
FMRELID	Electronic Media D
FMRELIE	Electronic Media E
FMRTPI	Electronic Media T
FMRLBI	Medi-Cal I/P Labels
FMRACI	Medi-Cal I/P Archived
FMRDEI	Medi-Cal I/P Deleted

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MEDI-CAL Outpatient (MCLO Claim Type)

System Report Name	Description
FMRPAO	Paper
FMRRPO	Paper Reprints and Tracers
FMRELOA	Electronic Media A
FMRELOB	Electronic Media B
FMRELOC	Electronic Media C
FMRELOD	Electronic Media D
FMRELOE	Electronic Media E
FMRTPO	Electronic Media T
FMRLBO	Medi-Cal O/P Labels
FMRACO	Medi-Cal O/P Archived
FMRDEO	Medi-Cal O/P Deleted

ILLINOIS

IPDA 2360 (2360 Claim Type)

System Report Name	Description
FMRPAL	Paper
FMRRPL	Paper Reprints and Tracers
FMRELLA	Electronic Media A
FMRELLB	Electronic Media B
FMRELLC	Electronic Media C
FMRELLD	Electronic Media D
FMRELLE	Electronic Media E
FMRTPL	Electronic Media T
FMRLBL	2360 Labels
FMRACL	2360 Archived
FMRDEL	2360 Deleted

MICHIGAN

Michigan Inpatient (MI1645 Claim Type)

System Report Name	Description
FMRPAE	Paper
FMRRPE	Paper Reprints and Tracers
FMRELEA	Electronic Media A
FMRELEB	Electronic Media B
FMRELEC	Electronic Media C
FMRELED	Electronic Media D
FMRELEE	Electronic Media E
FMRTPE	Electronic Media T
FMRLBE	Mich I/P Labels
FMRACE	Mich I/P Archived
FMRDEE	Mich I/P Deleted

Michigan Outpatient (MI1649 Claim Type)

System Report Name	Description
FMRPAF	Paper
FMRRPF	Paper Reprints and Tracers
FMRELFA	Electronic Media A
FMRELFB	Electronic Media B
FMRELFC	Electronic Media C
FMRELFD	Electronic Media D
FMRELFE	Electronic Media E
FMRTPF	Electronic Media T
FMRLBF	Mich O/P Labels
FMRACF	Mich O/P Archived
FMRDEF	Mich O/P Deleted

Michigan 1500 (MI1500 Claim Type)

System Report Name	Description
FMRPAG	Paper
FMRRPG	Paper Reprints and Tracers
FMRELGA	Electronic Media A
FMRELGB	Electronic Media B
FMRELGC	Electronic Media C
FMRELGD	Electronic Media D
FMRELGE	Electronic Media E
FMRTPG	Electronic Media T
FMRLBG	Mich 1500 Labels
FMRACG	Mich 1500 Archived
FMRDEG	Mich 1500 Deleted

PENNSYLVANIA

Medical Assistance 310 Inpatient (MA 310 Claim Type)

System Report Name	Description
FMRPAA	Paper
FMRRPA	Paper Reprints and Tracers
FMRELAA	Electronic Media A
FMRELAB	Electronic Media B
FMRELAC	Electronic Media C
FMRELAD	Electronic Media D
FMRELAE	Electronic Media E
FMRTPA	Electronic Media T
FMRLBA	310 I/P Labels
FMRACA	310 I/P Archived
FMRDEA	310 I/P Deleted

Medical Assistance 319, Physician's Invoice (MA 319 PI Claim Type)

System Report Name	Description
FMRPAC	Paper
FMRRPC	Paper Reprints and Tracers
FMRELCA	Electronic Media A
FMRELCB	Electronic Media B
FMRELCC	Electronic Media C
FMRELCD	Electronic Media D
FMRELCE	Electronic Media E
FMRTPC	Electronic Media T
FMRLBC	319 Phys Labels
FMRACC	319 Phys Archived
FMRDEC	319 Phys Deleted

Medical Assistance 319, Medical Service (MA 319 MS Claim Type)

System Report Name	Description
FMRPAD	Paper
FMRRPD	Paper Reprints and Tracers
FMRELDA	Electronic Media A
FMRELDB	Electronic Media B
FMRELDC	Electronic Media C
FMRELDD	Electronic Media D
FMRELDE	Electronic Media E
FMRTPD	Electronic Media T
FMRLBD	319 Med Labels
FMRACD	319 Med Archived
FMRDED	319 Med Deleted

CLAIM PRINTS SUPPRESSED REPORT - FCR310

Description/Purpose

The Claim Prints Suppressed Report is used to monitor the claims by insurance carrier/plan that have been released for printing but were not produced. Claims appear on this report if the Produce Claim indicator on the Billing/Claims Parameters table is set to No. In addition, claims also appear on this report if the Suppress indicator on the Billing/Claims Parameters table is set to Yes and the claim qualifies for suppression.

CN: Canadian OHIP claims appear if there are no pending claim charge lines to release for download to the Ministry.

The report includes the carrier/plan, account number, patient name, admit date, discharge date, claim generated date, claim sequence number, and claim amount. Subtotals are provided by plan and by carrier for number of claims and total claim amount. A separate page is provided for facility totals.

Generating and Printing This Report

The Claim Prints Suppressed Report is scheduled through the Optional Batch Jobs Processor and produced during midnight processing. Refer to the Financial System Management section in the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide* for information on setting up this report.

This report is sorted by insurance carrier/plan. Page breaks for the report occur at the end of the page.

The following is an example of the Claim Prints Suppressed Report.

Figure 4.28 FCR310 - Claim Prints Suppressed Report - Page 1

```
Date: 03/17/05                                General Hospital                              Page  : 1
Time: 12:39pm                                 Claim Prints Suppressed                       Report: FCR310A

         Carrier/Plan: 500 300   PATHWAYS COMMERCIAL

Account #           Name                                Admitted    Discharged   Generated    Seq   Claim Amount
9605200014          MOORE,REPRICEA                      02/21/05    02/22/05     03/15/05      3       2413.25  Produce=No
9610000015          STEWART, BOB                        08/11/05    08/12/05     08/30/05      2        100.00  Suppress=Yes


    Plan Totals
        Total Claims:            2
        Total Amount:       2513.25


    Carrier Totals
        Total Claims:            2
        Total Amount:       2513.25
```

Figure 4.29 FCR310 - Claim Prints Suppressed Report - Page 2

```
Date: 03/17/96                           General Hospital                        Page  : 2
Time: 12:39pm                          Claim Prints Suppressed                   Report: FCR310A


     Facility Totals
          Total Claims:          1
          Total Amount:       2413.25


                                        End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ACCOUNT #
This field contains the patient account number.

NAME
This field contains the patient name.

ADMITTED
This field contains the patient's admission date.

DISCHARGE
This field contains the patient's discharge date.

GENERATED
This field contains the date the claim was generated.

SEQ
This field contains the claim sequence number.

CLAIM AMOUNT
This field contains the amount of the claim.

Produce=No displays after the claim amount for those claims that have production indicators set to No.

Suppress=Yes displays after the claim amount for those claims that have suppression indicators set to Yes and this was the cause of the suppression.

If the Produce Claims field is set to No and the Suppress field is set to Yes, the report prints *Produce=No,* since this overrides the Suppress field.

ASB/Cross=Yes prints after the claim amount for those claims that are suppressed because of being an Accelerated Secondary Billing/Crossover claim.

CLAIMS ON HOLD REPORT - FCR320

Description/Purpose

The Claims on Hold Report is used to monitor the claims by insurance carrier/plan that have been loaded for online review but not released for printing because they have been placed on hold.

The report includes the carrier/plan, account number, patient name, admit date, discharge date, claim load date, claim generated date, claim sequence number, and claim amount. Subtotals are provided by plan and by carrier for number of claims and total claim amount. A separate page is provided for facility totals.

Generating and Printing This Report

The Claims on Hold Report is scheduled through the Optional Batch Jobs Processor and produced during midnight processing. Refer to the Financial System Management section in the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide* for information on setting up this report.

This report is sorted by insurance carrier/plan. Page breaks for the report occur at the end of the page.

The following is an example of the Claims On Hold Report.

Figure 4.30 FCR320 - Claims On Hold Report - Page 1

```
Date: 03/18/08                              General Hospital                         Page  : 1
Time: 07:29am                               Claims on Hold Report                    Report: FCR320A

       Carrier/Plan: 200 013   MEDICAID UB
Account #          Name                   Admitted  Discharged  Loaded    Generated   Seq ASB/Cross  Claim Amount
9605000013         MOTHERD,DAVID M        02/19/96              03/13/96               23  Yes       620.00
9605000013         MOTHERD,DAVID M        02/19/96              03/15/96               25            620.00

    Plan Totals
         Total Claims:           2
         Total Amount:        1240.00


    Carrier Totals
         Total Claims:           2
         Total Amount:        1240.00


       Carrier/Plan: 300 100   COB 3 TITLE XIX

Account #          Name                   Admitted  Discharged  Loaded    Generated   Seq ASB/Cross  Claim Amount
9528600010         CRAFT,ARON E           10/13/95  10/13/95    10/17/95               14  Yes       268.00

    Plan Totals
         Total Claims:           1
         Total Amount:         268.00


    Carrier Totals
         Total Claims:           1
         Total Amount:         268.00
```

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Figure 4.31 FCR320 - Claims On Hold Report - Page 2

```
Date: 03/18/96                          General Hospital                        Page  : 2
Time: 07:29am                           Claims on Hold Report                   Report: FCR320A

     Facility Totals
          Total Claims:          3
          Total Amount:       1508.00


                                         End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ACCOUNT #
This field contains the patient account number.

NAME
This field contains the patient name.

ADMITTED
This field contains the patient's admission date.

DISCHARGE
This field contains the patient's discharge date.

LOADED
This field contains the date the claim was loaded for online review.

GENERATED
This field contains the date the claim was generated. This field is blank for most claims. Canadian OHIP claims that are put on hold for resubmission display the original generation date.

SEQ
This field contains the claim sequence number.

ASB/CROSS
If this claim is on hold, and if there is an ASB/Crossover Link for the claim, a Yes is displayed in this column.

CLAIM AMOUNT
This field contains the amount of the claim.

PROVIDER MASTER REPORT - FTFBP

Description/Purpose

The Provider Master report provides a listing of the provider information used on bills and claims, including the hospital name and address, provider numbers, and condition, occurrence, occurrence span, and value codes to automatically load to the UB claim form. Numerous Provider Master tables can be set up to satisfy different provider requirements.

Generating and Printing This Report

This report is requested through the Provider Master Table option. After you access the table, you can update the hospital information, the provider numbers, and the codes that should automatically load to the UB claim form. When you exit the screen, the system displays the following prompt:

Do you want a printed list? (Y/N) [N]

Enter **Y** if you want to generate the report. The system references the spooler report definition to determine if the report is to be printed immediately or on demand and what printer is used for output. If the report is spooled for subsequent printing, the report name is FTFBPx where x is the facility indicator.

If you answer Y, the system then displays the following prompt:

Enter code (C) sequence or alphabetic (A) [A]

If you enter C for code, the report sorts by the Provider Master Table code, for example, 1 then 2. If you enter **A** for alphabetic, the report sorts by the Provider Master Table description, for example, Commercial before Medicare. Once you answer the sort question, the system displays the following prompt:

Include entries filed as deleted? (Y/N) [N]

If you include entries filed as deleted, they print *** below the INACTIVE report header on the right side of the report.

The following is an example of the Provider Master Table Report.

Figure 4.32 FTFBP - Provider Master Report - Page 1

```
Date: 6/31/07                              General Hospital Name                    Page  : 1
Time: 22:34                                PROVIDER MASTER                           Report: FTFBPA

 CODE  NAME                       UB CLAIMS                 1500 CLAIMS             MEDICAID CLAIMS

1-MODEL HOSPITAL ACUTE
      ATLANTA               NAME: MODEL HOSPITAL        MODEL HOSPITAL          MODEL HOSPITAL
      GA       30342-1234   ST:   301 PERIMETER CNTR    301 PERIMETER CENTER    301 PERIMETER CENTER
      Country Code: US      PROV: UB82NUMBER            1500NUMBER              GA-CAID11111111111111
      PHONE: (404)555-1212                                                      FL-CAID22222222222222
      FAX Phone Number: (404)111-2222                                          TN-CAID33333333333333
  FED TAX ID:          1234567890
  FED TAX SUB ID:      SUB1
  LAB CLIA #:          CLIA123456
  PROVIDER NPI #:      1234567890
  PT PROVIDER NPI #:   OT-1111111111,PSY-2222222222,OBS-9876543210
  TAXONOMY CODE:       282NC2000X
  PT TAXONOMY CODE:    PSY-1010101010,RHB-2929292929
  BC PROV NO:          BLUECROSSNUMBER0000001
  ALT PROV NAME:       ALT NAME
  ALT PROV ADDRESS 1:  ALT ADDRESS 1
  ALT PROV ADDRESS 2:  ALT ADDRESS 2
  ALT PROV CITY:       ALT CITY
  ALT STATE:           FL
  ALT ZIP:             12345
  ALT PROV PHONE:      (111)222-3333
  CONDITION CODES:     02,09,10,26,28,40,60,61
  OCCURRENCE CODES:    01,02,03,04,05,06,10,18,19,31,32,35,42,44,45,46,A1,B1
  OCCURRENCE SPAN CODES: 72,74,75,M0
  VALUE CODES:         01,02,05,07,08,09,12,14,16,24,24I,31,37,38,39,45,46,50,51,52.53,54,80,81,82,83,
                       A1,A2,A3,A8,A9,B1,B2,B3,C1,C2,C3,D3


                                        6 active entries
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

CODE
This field contains the code identifying the provider. This number, which is user-defined and not used on the claim form, identifies the facilities' need for multiple provider numbers.

NAME
This field contains the name of the provider. The name entered here is not used on the claim form.

CITY
This field contains the provider's city. This information is used for form locator 1 on the UB claim form, and for the provider city on other claim forms.

STATE
This field contains the provider's state. The U.S. Postal Service abbreviation is used. This information is used for form locator 1 on the UB claim form, and for the provider state on other claim forms.

COUNTRY CODE (25-AN-O)
This field contains the provider's country code.

ZIP CODE
This field contains the provider's zip code; either five or nine digits can be entered. This information is used in form locator 1 on the UB claim form, and for the provider zip on other claim forms.

PHONE NUMBER
This field contains the provider's phone number, printed in the format 4045551212. It is used for form locator 1 on the UB claim form, and for the provider's phone on other claim forms.

PROVIDER FAX NUMBER (25-AN-O)
This field contains the provider's fax phone number.

FED TAX ID
This field contains the provider's federal tax ID. This number is used on the UB claim form.

FED TAX SUB ID
This field contains the provider's federal tax sub ID number. This number is used on the UB claim form.

LAB CLIA #
This field contains the Lab Clinical Laboratory Improvement Amendment Number.

PROVIDER NPI #
This field contains the National Provider ID (NPI).

TAXONOMY CODE
This field contains the provider's taxonomy code.

BC PROV NO
This field contains the Blue Cross provider number used on the UB claim form.

ALT PROV NAME
This field contains the name of the alternate provider.

ALT PROV ADDRESS 1
This field contains line 1 of the alternate address.

ALT PROV ADDRESS 2
This field contains line 2 of the alternate address.

ALT STATE
This field contains the alternate provider's city.

ALT STATE
This field contains the alternate provider's state.

ALT ZIP
This field contains the alternate provider's ZIP code.

ALT PROV PHONE
This field contains the alternate provider's phone.

UB CLAIM NAME
This field contains the name the provider uses on the UB claim form in Locator 1. If different names or number are needed for this provider, multiple provider masters must be identified.

UB ST
This field contains the address the provider uses on the UB claim form in Locator 1.

UB PROV
This field contains the Medicare/Champus provider number used on the UB claim form.

1500 CLAIM NAME
This field contains the name the provider uses on the 1500 claim form if the *1500 Provider Claim Name* internal element is used.

1500 ST
This field contains the address the provider uses on the 1500 claim form if the *1500 Provider Street* internal element is used.

1500 PROV
This field contains the 1500 provider number pulled if the internal element *1500 Provider Number* is used.

MEDICAID CLAIM NAME
This field contains the name the provider uses on the Medicaid claim form if the *Provider Medicaid Claim Name* internal element is used.

MEDICAID ST
This field contains the address the provider uses on the Medicaid claim form if the *Provider Medicaid Street* internal element is used.

MEDICAID STATE AND PROV 1
This field contains the provider's Medicaid number for state #1. The Medicaid provider number is used on the UB claim form, and any separate Medicaid claim forms required. It is used for all patients unless the patient's state matches the state entered in either the Medicaid State 2 or Medicaid State 3 fields (if they are completed) of this provider master.

MEDICAID STATE AND PROV 2
This field contains the provider number that is used in lieu of the provider number for Medicaid State 1 if the patient's state matches the state entered in the Medicaid State 2 field. This number is used on the UB claim form, and on any separate Medicaid forms in the field designated for this number.

MEDICAID STATE AND PROV 3
This field contains the provider number that is used in lieu of the provider number for Medicaid State 1 or Medicaid State 2 if the patient's state matches the state entered in the Medicaid State 3 field. This number is used on the UB claim form, and on any separate Medicaid forms in the field designated for this number.

CONDITION CODES
This field contains the condition codes that are highlighted to automatically load on the UB claim form.

OCCURRENCE CODES
This field contains the occurrence codes that are highlighted to automatically load on the UB claim form.

OCCURRENCE SPAN CODES
This field contains the occurrence span codes that are highlighted to automatically load on the UB claim form.

VALUE CODES
This field contains the value codes that are highlighted to automatically load on the UB claim form.

FINAL CLAIMS WITH INSURANCE BALANCE - FCR330

Description/Purpose

The Final Claims with Insurance Balance Report is used to identify the insurance carrier/plans on an account that have an insurance balance but do not have any outstanding claims. A carrier/plan is included on this report if all claims for the carrier/plan have been marked as complete (by having a claim disposition of final, adjusted to zero, or denied) and the carrier/plan still has an insurance balance. The most recent claim for the carrier/plan is listed on the report so that the claim disposition for that claim may be set to clear.

The report includes the account number, patient name, carrier/plan, claim type, claim sequence number, bill from date, bill thru date, biller, claim production status, financial class, patient type, medical service, insurance balance, claim amount, claim disposition, expected number of payments, and claims outstanding. A separate page is provided for facility totals.

Generating and Printing This Report

The Final Claims with Insurance Balance Report is scheduled through the Optional Batch Jobs Processor and produced during midnight processing. Refer to the Financial System Management section in the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide* for information on setting up this report.

This report is sorted by patient name. Page breaks for the report occur at the end of the page.

The following is an example of the Final Claims with Insurance Balance Report.

Figure 4.33 FCR330 - Final Claims with Insurance Balance

```
Date: 12/13/96                              General Hospital                              Page  : 1
Time: 11:57A                     Final Claims with Insurance Balance for 01/05/97         Report: FCR330A
                       Carrier Cl Cl  Bill     Bill                    Med   Insurance      Claim    Claim Exp Claim
Account    Patient Name  Plan   Ty Sq  From     Thru  Biller St F/C P/T Ser   Balance      Amount    Disp  Pay Out
9525400001 CLARK,JOSEPHINE     100100  X  1 09/11/95 09/11/95   5    P   S  I/P MED    $191.00   $1,230.00    F    1    0
9608200016 DEYERLE,LOUISE      500999  U  1 03/22/96 05/29/96   3    F   O  LIC LEM  $8,480.00  $12,480.00    F    0    0
9605400129 FRANKLIN,TERRI      100100  X  1 02/23/96 02/23/96   5    P   S  O/P OPS    $675.00   $1,560.00    F    1    0
9524400101 GOODSON,ERIC        100100  X  1 09/01/95 09/01/95   5    P   S  I/P SUR    $534.00     $534.00    F    1    0
9607200254 OSTENSON,STEPHEN    300900  U  1 03/12/96 04/29/96   3    F   O  LIC SUR  $7,542.00   $7,542.00    F    0    0
9604400085 PARKER,KRISTINE     100100  X  1 02/13/96 02/13/96   5    P   S  O/P OPS    $212.00   $1,854.00    F    1    0
9525400101 SMITH,GEORGETTE     100100  X  1 09/11/95 09/11/95   5    P   S  I/P OBS    $305.00   $1,578.00    F    1    0
9606200254 THOMAS,LEONARD      400900  U  1 03/02/96 03/29/96   3    F   O  E/R ERM  $2,193.00  $10,256.00    F    0    0
9602300085 WESTWOOD,MARJORY    100100  X  1 01/23/96 01/23/96   5    P   S  O/P OPS    $415.00   $1,235.00    F    1    0


-----------------------------------------------------------Page Break-----------------------------------------------------------
-
Date: 12/13/96                              General Hospital                              Page  : 2
Time: 11:57A                     Final Claims with Insurance Balance for 01/05/97         Report: FCR330A
                                           Facility Totals
          Facility: A       Claims Outstanding:9                    Totals:    $ 20,547.00  $ 38,269.00

                                          End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ACCOUNT #
This field contains the patient account number.

PATIENT NAME
This field contains the patient name.

CARRIER PLAN
This field contains the carrier/plan code that has a balance and no outstanding claims.

CL TY
This field contains the claim type for the most recent claim for the carrier/plan.

CL SQ
This field contains the claim sequence number of the most recent claim.

BILL FROM
This field contains the bill from date of the most recent claim for the carrier/plan.

BILLTHRU
This field contains the bill thru date of the most recent claim for the carrier/plan.

BILLER
This field contains the biller code of the biller for the most recent claim for the carrier/plan.

ST
This field contains the claim production status for the most recent claim for the carrier/plan.

F/C
This field contains the financial class code for the account.

P/T
This field contains the patient type code for the account.

MED SER
This field contains the medical service code the account.

INSURANCE BALANCE
This field contains the insurance balance for the account.

CLAIM AMOUNT
This field contains the amount of the most recent claim.

CLAIM DISP
This field contains the claim disposition for the most recent claim for the carrier/plan.

EXP PAY
This field contains the expected number of payments for the carrier/plan.

CLAIM OUT
This field contains the number of outstanding claims for the carrier/plan.

1500 CHARGE CONTROL PARAMETERS REPORT - FCR15CC

Description/Purpose

The 1500 Charge Control Parameter report provides a list of all 1500 charge control values defined. The hospital defines whether the 1500 claims should be split by physician or department, whether charges should print on the claim form in summary or detail, if a HCPCS Cross Reference table should be used, if units of service, type of service, physician ID, and EMG code should print, which defaults to use, and what to edit for on the professional fee charges.

Generating and Printing This Report

This report is requested through the 1500 Charge Control Parameters table option. After you exit the table, the system displays the following prompt:

> *Do you want a printed list? (Y/N) [N]*

Enter **Y** if you want to generate the report. The system references the spooler report definition to determine if the report is to be printed immediately or on demand and what printer is used for output. If the report is spooled for subsequent printing, the report name is FCR15CC without a facility indicator.

If you answer Y, the system then displays the following prompt:

> *Enter code (C) sequence or alphabetic (A) [A]*

If you enter **C** for Code, the report sorts by 1500 Charge Control Parameter code (for example, 1 then 2). If you enter **A** for Alphabetic, the report sorts by 1500 Charge Control Parameter description (for example, Blue Cross O/P before Medicare O/P). Once you answer the sort question, the system displays the following prompt:

> *Include entries filed as deleted? (Y/N) [N]*

If you include entries filed as deleted, they print ***INACTIVE*** to the right of the 1500 Charge Control Parameter description.

The following is an example of the 1500 Charge Control Parameters Report.

Figure 4.34 FCR15CC - 1500 Charge Control Parameters Report

```
Date: 02/17/08                                     General Hospital                                    Page  : 1
Time: 10:00                                   1500 Charge Control Parameters                          Report: FCR15CC


107    LSS 1500 CHARGE CONTROL PARAM

       Separate Claims:              Yes by Physician        TOS Cross Reference
       Detail/Summarize Items:       Detail                  Place of Service:      21 Inpatient Hospital
       Diagnosis Print:              Diagnosis Code          Print EMG:             Yes
       HCPCS Cross Reference:        99  TEST                Default Diagnosis:
       Use Med Rec HCPCS:            No                      Default Physician:     No
       Med Rec HCPCS UB Rev Code:                            Edit Pro Fee Charges:  Yes H,D,I,U,L
       Print UOS:                    Yes                     24A Date Print:        MMDDYYYY
       Phys/Dept ID Upper (1992):    No                      Print Anes Times:
       Phys/Dept ID Lower (1992):    No                      EPSDT:
       Phys/Dept ID Upper (08/05):   Yes Upin, Medicare      ID Upper Qual (08/05): 1G,1C
       Phys/Dept ID Lower (08/05):   Yes NPI, Taxonomy No    Edit By:               Slick,Tom
       Print TOS:                    Yes                     Edit Date:             11/06/08 04:51pm
       PCON Phy/Dept ID:             Lower/Lower             EC2000:                Claim
       Reference Facility:           Yes 300, 301
       IDE:                          Yes 624
       NDC:                          Yes 985, 986
       NDC Unit Qual/Units:          Edit HCPCS


       PRO FEE EXCEPTIONS
            UB Code/Description                      Exclude
            960 Professional Fees                      Yes
            961 Professional Fees Psychiatric          Yes
            997 Admission Kit                          Yes


         SIM Items to Exclude:
            SIM Department                       SIM Item
            ANS-ANESTHESIA                       100-ANES ADM/STAFF
         Zero Priced FIM Items to Include:
            FIM Department                       FIM Item
            CSR-CENTRAL SERVICES              62510001-ENEMA, OIL RETENTION
            CSR-CENTRAL SERVICES              62511031-CIRCUIT WIRE HEATER LARGE
            EDP-EMER DPT PHYSICIANS           62330001-90500 MINIMAL SERVICE NEW PT
            EDP-EMER DPT PHYSICIANS           62330121-99171 CRITCAL CARE FOLLOW UP
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

SEPARATE CLAIMS
This field indicates if the 1500 claim form should split by physician or department, or not split.

DETAIL/SUMMARIZE ITEMS
This field indicates if charges should print in detail, or summarize for like service date, diagnosis, HCPCS code, and physician.

DIAGNOSIS PRINT
This field indicates whether the system should print the diagnosis code from the charge line, or the reference number from form locator 21 in form location 24E.

HCPCS CROSS REFERENCE
This field indicates the Payer HCPCS Cross Reference table that is used in conjunction with this charge control parameter.

USE MED RECS HCPCS
This field indicates whether charges without a FIM/Charge HCPCS should default to the Medical Records HCPCS linked to the same UB Revenue Code as the charge, with the same physician and service date.

MED RECS HCPCS UB REV CODE
This field indicates the Med Recs HCPCS UB Revenue Code Table used in conjunction with this charge control parameter.

PRINT UOS
This field indicates whether the units of service should print on the charge line in locator 24G.

PRINT PHYS/DEPT ID UPPER (1992)
This field indicates whether the Physician ID should print for the charge line in locator 24K Upper, and if it is printing, what field in the Physician Master table to use to pull the number. The report prints the first choice of ID to print in 24K Upper, followed by the second choice of ID to print in 24K Upper.

PRINT PHYS/DEPT ID LOWER (1992)
This field indicates whether the physician ID should print for the charge line in locator 24K lower, and if it is printing, what field in the Physician Master to use to pull the number. The report prints the first choice of ID to print in 24K Lower, followed by the second choice of ID to print in 24K Lower.

PRINT PHYS/DEPT ID UPPER (08/05)
This field indicates whether the Physician ID should print for the charge line in locator 24J Upper, and if it is printing, what field in the Physician Master table to use to pull the number. The report prints the first choice of ID to print in 24J Upper, followed by the ID

Qualifier, and then the second choice of ID to print in 24J Upper, followed by the ID Qualifier.

PRINT PHYS/DEPT ID LOWER (08/05)

This field indicates whether the physician ID should print for the charge line in locator 24J lower, and if it is printing, what field in the Physician Master to use to pull the number. The report prints the first choice of ID to print in 24J Lower, followed by the second choice of ID to print in 24J Lower. There is NO ID Qualifier in 24J Lower.

PRINT TOS

This field indicates whether the type of service from the Financial Item Master should print on the charge line in locator 24C of the 1992 format. The 08/05 format of the 1500 does not have a TOS field.

PCON PHY/DEPT ID

This field indicates whether the Physician ID Upper (24K Upper for the 1992 1500 Format, or 24J Upper for the 08/05 1500 Format), or Physician ID Lower (24K Lower for the 1992 1500 Format, or 24J Lower for the 08/05 1500 Format) should be sent in the 1500 PCON interface for the rendering provider. The value for the 1992 format of the claim prints (Upper or Lower for 24K) followed by the value for the 08/05 format of the claim (Upper or Lower for 24J).

EC2000

This field indicates whether the account (Account) or claim level charges (Claim) are sent to EC2000.

REFERENCE FACILITY

If the 1500 Charge Control Parameter has the Reference Facility field set to Yes, and specific revenue codes are listed in the RF Rev Codes field, the report displays *Reference Facility: Yes XXXX,XXXX,XXXX*, where XXXX is the revenue code selected. If the 1500 Charge Control Parameter has the Reference Facility field set to Yes, and the RF Rev Codes field is set to All revenue codes, the report displays *Reference Facility: Yes All Rev Codes*.

IDE CODES

If the 1500 Charge Control Parameter has the IDE Code field set to Yes, and specific revenue codes are listed in the IDE Rev Codes field, the report displays *IDE: Yes XXXX,XXXX,XXXX*, where XXXX is the revenue code selected. If the 1500 Charge Control Parameter has the IDE field set to Yes, and the IDE Rev Codes field is set to All revenue codes, the report displays *IDE: Yes All Rev Codes.*

NDC

If the Non Pro Fee 1500 Charge Control Parameter has the NDC field set to Yes, and specific revenue codes are listed in the NDC Rev Codes field, the report displays NDC: Yes XXXX,XXXX,XXXX, where XXXX is the revenue code selected. If the Non Pro Fee 1500 Charge Control Parameter has the NDC field set to Yes, and the NDC Rev Codes field is set to all revenue codes, the report displays NDC: Yes All Rev Codes.

NDC UNIT QUAL/UNITS
If the NDC Unit Qual/Units field on the Non Pro Fee 1500 Charge Control Parameters is set to Edit HCPCS, the HCPCS ranges entered are printed. For example:

NDC Unit Qual/Units: Edit HCPCS J0001-J9999

TOS CROSS REFERENCE
This field indicates the Type of Service Cross Reference Table that is used in conjunction with this charge control parameter.

PLACE OF SERVICE
This field contains the place of service code that prints in locator 24B for any charge department without a place of service code in the 1500 Department/Supplier Override table.

PRINT EMG
This field indicates whether the EMG code from the Insurance Demographics screen should print on the charge line in locator 24I for the 1992 Format of the 1500 claim, or in locator 24C for the 08/05 Format of the 1500 claim..

DEFAULT DIAGNOSIS
This field indicates if charges without a diagnosis should default to the Principal/ Admitting diagnosis, the Principal/Working diagnosis, or Reference Number 1.

DEFAULT PHYSICIAN
This field indicates if charges without a performing physician should default to the pro fee physician in the Pricing Information screen of the Service Item Master.

EDIT PRO FEE CHARGES
This field indicates if the claim should edit for HCPCS procedures (H), Diagnosis (D), an I if editing for Locator 24K Lower (1992 Format), a U for Locator 24J Upper (08/05 Format), and an L for Locator 24J Lower (08/05 Format). For example, if editing for all options, the field displays *H,D,I,U,L*.

24A DATE PRINT
This field indicates the date print format for locator 24A; either MMDDYYYY or MM DD YY.

EPSDT
This field indicates the Early and Periodic Screening, Diagnosis, and Treatment value to print in Locator 24H.

PRINT ANES TIMES
This field indicates if the claim should print the starting and ending anesthesia times that were entered in Medical Records for the HCPCS code.

EDIT BY
This field contains the name of the user who last edited this 1500 charge control parameter.

EDIT DATE
This field contains the date and time this 1500 charge control parameter was last edited.

PRO FEE EXCEPTIONS
This field lists the UB Code and Description of UB Revenue Codes set to Exclude (Yes) from the claim form.

SIM ITEMS TO EXCLUDE
This field lists the Service Item Master Department and SIM Item of those charges excluded from the claim form.

ZERO PRICED FIM ITEMS TO INCLUDE
This field lists the Financial Item Master Department and FIM Item of those $0.00 charge to include on the claim form.

BILLING PARAMETERS REPORT - FTFABP

Description/Purpose

The Billing Parameter report provides a list of all cycle and final billing parameters. The facility defines which type of bills to load (detail, summary, prorated), what bill message prints, when to bill and suspense days, billing requirements, and whether to automatically produce a late or adjustment bill based on late charges or credits, or on a change in DRG, principal diagnosis, or principal procedure, among other billing criteria.

Generating and Printing This Report

This report is requested through the Billing Parameters table option. After you exit the table, the system displays the following prompt:

Do you want a printed list? (Y/N) [N]

Enter **Y** if you want to generate the report. The system references the spooler report definition to determine if the report is to be printed immediately or on demand and what printer is used for output. If the report is spooled for subsequent printing, the report name is FTFABP without a facility indicator.

If you answer **Y**, the system then displays the following prompt:

Enter code (C) sequence or alphabetic (A) [A]

If you enter **C** for Code, the report sorts by Billing Parameter code (for example, 1 then 2). If you enter **A** for Alphabetic, the report sorts by Billing Parameter description (for example, Blue Cross O/P before Medicare O/P). Once you answer the sort question, the system displays the following prompt:

Include entries filed as deleted? (Y/N) [N]

If you include entries filed as deleted, they print INACTIVE to the right of the Susp Days header, with *** under the INACTIVE header.

The following is an example of the Billing Parameters Report.

Figure 4.35 FTFABP - Billing Parameters Report

```
       Date: 02/08/08                   General Hospital                            Page: 1
Time: 03:59pm                           BILLING PARAMETERS                          Report: FTFABP

CODE  DESCRIPTION                BILL  DTL  SUMM  PRO   COMB  SUSP           CYCLE ADJ BILL IND
                                 TYPE  BILL BILL  BILL  PRO FEE DAYS


 1    MEDICAID, FINAL            FINAL NO   YES   NO    NO    4

        Edit By: Hansen,Jan                      BILL TRAN CODE        : Y0002-FINAL BILL
           Date: 04/25/07 11:38am                BILL MESSAGE          : 1-BILL DIRECT
                                                 ICD-10 EFFECTIVE DATE : 01/01/2012 Discharge Date
                                                 BILLING REQUIR        : 21-MEDICAID OUTPATIENT
                                                 TYPE OF CHARGE        :
                                                 PRINT ADJ DETAIL      : NO
                                                 EDIT SUSP DAYS        : 0          ZERO CHG REPT DAYS:      5
                                                 MAX  HOLD DAYS        : UNLIMITED  ZERO CHG BILL DAYS:      5
                                                 AUTO LATE CHARGE BILL : NO  MIN # CHGS:      MIN AMT:    $0.00
                                                 AUTO LATE BILL - ZERO : NO  MIN # CRDT:      MIN AMT:    $0.00
                                                 AUTO ADJ   CHARGE BILL : NO  MIN # CHGS:      MIN AMT:    $0.00
                                                 AUTO ADJ   BILL - ZERO : NO  MIN # CRDT:      MIN AMT:    $0.00
                                                 AUTO ADJ   DRG/DX/PROC : REPORT ONLY
                                                 AUTO ADJ   CPTAFB      : NO
                                                 CHG BILL WINDOW       :
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

CODE
This field contains the code identifying the billing parameter.

DESCRIPTION
This field contains the description of the billing parameter.

BILL TYPE
This field indicates if this is a cycle or final billing parameter.

DTL BILL
This field indicates if a detail bill is loaded for accounts with this billing parameter.

SUMM BILL
This field indicates if a summary bill is loaded for accounts with this billing parameter.

PRO BILL
This field indicates if a prorated bill is loaded for accounts with this billing parameter.

COMB PRO FEE
This field indicates whether the hospital fee and professional fee for an item are combined as one line on the detail bill.

SUSP DAYS
This field contains the number of days to wait after bill selection before a bill is produced by the system.

CYC ADJ BILL IND
This field contains the setting of the Cycle Adjustment Billing Indicator on the Billing Parameters table. The parameter determines whether the rebilling of cycle bills is valid for accounts in location PA and AR. If the field is set to Yes, the parameters on the Cycle Adjustment Parameters screen are printed on this report.

TRAN CODE
This field contains the transaction code indicating that a bill has been produced.

BILL MESSAGE
This field contains the message that prints on the last page of the detail and summary bill.

ICD EFFECTIVE DATE
This field contains the value of the ICD-10 Effective Date field and either Admission Date or Discharge Date. The field can be blank, which assumes ICD-9 codes.

SERIES BILL (CYCLE PARAMETERS ONLY)
This field indicates whether the system should produce a series bill for accounts assigned to this billing parameter.

SERIES TRAN CODE (CYCLE PARAMETERS ONLY)
This field contains the transaction code indicating that a series bill has been produced.

SERIES BILL MESSAGE (CYCLE PARAMETERS ONLY)
This field contains the message that prints on the last page of the series bill.

CYC BILL TYPE (CYCLE PARAMETERS ONLY)
This field indicates the method used to generate cycle bills, Days After Admission, End of Month, Fixed Day, Unbilled Amount, or Service Date.

DAYS AFTER ADM (CYCLE PARAMETERS ONLY)
This field contains the number of days after admission/last bill if the cycle bill type is Days After Admission.

SUSPENSE DAYS (CYCLE PARAMETERS ONLY)
This field contains the number of days after bill selection to wait before a bill is produced by the system.

FIXED DAY (CYCLE PARAMETERS ONLY)
This field contains the day (for example, the 20th) to bill if the cycle bill type is Fixed Day.

UNBILLED BAL (CYCLE PARAMETERS ONLY)
This field contains the unbilled amount that must be reached to bill if the cycle bill type is unbilled amount.

AUDIT BILL (CYCLE PARAMETERS ONLY)
This field indicates whether audit bills are produced for this billing parameter.

AUDIT BILL SUSPENSE DAYS (CYCLE PARAMETERS ONLY)
This field contains the number of days after the billing period the system should wait before producing audit bills for this billing parameter.

AUTO CYCLE BILL (CYCLE PARAMETERS ONLY)
This field indicates whether an automatic bill should be produced for the account assigned this billing parameter if the same patient is admitted to the hospital while another active visit exists.

BILLING REQUIR (FINAL PARAMETERS ONLY)
This field contains the billing requirement parameter used in conjunction with this billing parameter.

EDIT SUSP DAYS (FINAL PARAMETERS ONLY)
This field contains the number of days after patient discharge to begin performing billing requirement edits.

ZERO CHG REPT DAYS
This field indicates the number of days after discharge to wait before reporting accounts with zero charges on the Unbilled Accounts with Zero Charges Report (FBR112).

MAX HOLD DAYS (FINAL PARAMETERS ONLY)
This field contains the number of days to hold a final bill if it fails billing requirements. A U prints for unlimited number of days.

ZERO CHG BILL DAYS
This field indicates 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 CHARGE BILL (FINAL PARAMETERS ONLY)
This field indicates whether a late bill should automatically be produced for late charges, and if so, the minimum number and minimum amount of the late charges required to generate a late bill.

AUTO LATE CREDIT BILL (FINAL PARAMETERS ONLY)
This field indicates whether a late bill should automatically be produced for late credits, and if so, the minimum number and minimum amount of the late credits required to generate a late bill.

AUTO ADJ CHARGE BILL (FINAL PARAMETERS ONLY)
This field indicates whether an adjustment bill should automatically be produced for late charges, and if so, the minimum number and minimum amount of the late charges required to generate an adjustment bill.

AUTO ADJ CREDIT BILL (FINAL PARAMETERS ONLY)
This field indicates whether an adjustment bill should automatically be produced for late credits, and if so, the minimum number and minimum amount of the late credits required to generate an adjustment bill.

AUTO ADJ DRG/DX/PROC (FINAL PARAMETERS ONLY)
This field indicates whether an adjustment bill should automatically be produced when there is a change in DRG, principal diagnosis, or principal procedure.

CYCA MAX DAYS SINCE SERVICE
This field indicates the valid period, after the service date of a charge, for billing a charge and the maximum number of days from charge service date that a charge can be included on a cycle adjustment bill.

CYCA ZERO BAL
This field indicates whether the system automatically generates a cycle adjustment bill if the account balance is zero.

MANUAL CYCA CHG/CR/DYS OVERRIDE FOR SUBSEQUENT BILLS
This field indicates whether the system should 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. A subsequent cycle adjustment bill is one that is loaded automatically as a result of a manual or automatic cycle adjustment bill request.

AUTO CYCLE ADJ
This field indicates whether the system should 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 on the Billing Parameters table.

MIN UNBILLED CHARGES
This field contains the minimum number of unbilled charges required to generate an automatic or a manual cycle adjustment bill. For manual cycle adjustment bills, this field is used to determine what charges are loaded on a subsequent cycle adjustment bill.

MIN UNBILLED CHARGE AMT
This field contains the minimum unbilled charge amount necessary to generate an automatic and manual cycle adjustment bill.

MIN UNBILLED CREDITS
This field contains the minimum number of unbilled credits required to generate an automatic cycle adjustment bill. The range is from 1 to 99 credits.

MIN UNBILLED CREDIT AMT
This field contains the minimum unbilled credit amount necessary to generate a cycle adjustment bill. The amount is from -1 to -9999.

CYCA SUPPRESS BILL/DO NOT LOAD CLM
This field indicates, for subsequent cycle adjustments bills, whether bills should be suppressed and claims not loaded if there are no new/qualifying charges for subsequent cycle adjustment bills. If a bill is suppressed because there are no new charges, the billing, proration, and reimbursement information is maintained, but the bill is not printed, and no claims are loaded for the bill.

DRG/DIAGNOSIS/PROCEDURE MODIFICATION REPORT - FBR400

Description/Purpose

The DRG/Diagnosis/Procedure Modification Report (FBR400) is designed to give the user information on AR accounts that have had DRG, diagnosis codes, or procedure code changes. The Medical Record changes along with some basic claim information are printed on the report. This report is generated by facility.

Generating and Printing This Report

This report is generated if the Auto Adj Rebill DRG/Dx/Proc parameter is set to Auto Adj Bill or Report Only. If this field is set to Auto Adj Bill or Report only, this report is processed every night during midnight processing. Accounts are selected for the report if they are in AR and had a DRG, procedure code or diagnosis code change.

The Auto Adj Rebill DRG/Dx/Proc field on the second screen of the Billing Parameters screen looks to the Final Billing Parameters ICD-10 Effective Date field and the bill ICD flag that is in turn set. If the field is set to A for generating an adjustment bill and report, or R for generating the report only, the system will only generate the adjustment bill and/or the report if the specified diagnosis or procedure was updated. For example, if the bill ICD flag for the patient is set to ICD-10, and the Auto Adj Rebill DRG/Dx/Proc is set to A for Adjustment Bill and Report, if the Principal ICD-9 Diagnosis Code is updated, this would not generate the adjustment bill and report. Only if an ICD-10 diagnosis code or procedure code (or DRG) is updated would the system produce the adjustment bill and report.

Therefore, for any patient on the report, the report prints the changes to the ICD-10 diagnosis and procedure codes, and the DRG, or changes to the ICD-9 diagnosis and procedure codes and the DRG, but not both. The report prints either ICD-10 or ICD-9 before listing the changed data.

If numerous changes were made to the diagnosis, procedure, or DRG, the report prints the original value for the day and the last value of the day. Therefore, changes made between the first and last value are not reported.

The report is sorted based upon primary biller and then by account number.

The following is an example of the DRG/Diagnosis/Procedure Modification Report.

Figure 4.36 FBR400 - DRG/Diagnosis/Procedure Modification Report

```
Date: 03/29/09                          General Hospital                        Page : 1
Time: 10:27am                        DRG/PROC/DX MODIFICATION RPT                Report: FBR400A

                                     Biller 5 - BILLERFIVE,BILLER

Account #      Patient Name     B CS Submit Dt  Dsp Dsp Dt  Serv From Serv Thru First Pay Last Pay Car/Pln Carrier Balance
9831700001     SMITH MARK       Y 1             R           11/13/98  11/13/98                      500100   $1,143.98
                                  2             R  02/17/99 11/13/98  11/13/98                      500200       $0.0
                                  3             R           11/13/98  11/13/98                      500100   $1,143.98
                                  4             R           11/13/98  11/13/98                      500200       $0.00
                                  5             R           11/13/98  11/13/98                      500100   $1,143.98
                                  6             R           11/13/98  11/13/98                      500200       $0.00
                                  7             R           11/13/98  11/13/98                      500100   $1,143.98
                                  8             R           11/13/98  11/13/98                      500200       $0.00
                                  9                         11/13/98  11/13/98                      500100   $1,143.98
                                 10                         11/13/98  11/13/98                      500200       $0.00
                                 DRG change from 123 to 9876
                                 ICD-10
                                 DX 4 M48.50xA Deleted
                                 Proc 1 0JPT0PZ Added
                                 Proc 2 0JH60P3 Added
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ACCOUNT
This field displays the patient's account number.

PATIENT NAME
This field displays the patient name. The name is displayed as last name, first name MI.

B
This field indicates whether or not the account had an automatic adjustment bill generated due to the Medical Record changes which occurred on the account. This is controlled by the Auto Adj Rebill DRG/Dx/Proc parameter on the Billing Parameter screen. A Y indicates that an adjustment bill was generated for that account during the previous night's midnight processing. An N indicates that an adjustment bill was not generated for the account.

CS
This field contains the claim sequence number. All claim sequences are listed on the report in claim sequence number order.

SUBMIT DT
This field displays the submit date of the claim.

DSP
This field displays the claim disposition code.

DSP DATE
This field displays the claim disposition date.

FIRST PAY
This field displays the first payment date for the claim.

LAST PAY
This field displays the last payment date for the claim.

CAR/PLN CODE
This field displays the carrier/plan code associated with the claim.

CARRIER BALANCE
This field displays the carrier balance for the carrier/plan code associated with this claim.

After the claim information the medical record changes are listed on the report.

SELF PAY SERVICES WITH SIGNED ABN FORM - FAHCFSY

Description/Purpose

This nightly report contains a list of ABN self pay patients who have at least one charge that does not meet the medical necessity requirement and are indicated to have a signed ABN on file. Thus, patients with charges received by STAR Patient Accounting that have an ABN indicator of SP/Y appear on this report.

For each patient, the report lists the account number, patient name, patient type, financial class, admit date, any applicable insurance plans (COB1-COB9, when assigned), department, FIM number, charge description, HCPCS code, order diagnosis, and price..

Generating and Printing This Report

This report is generated on a nightly basis during midnight processing.

The report is sorted by patient account number. If more than one FIM item has been ordered that meets the report's criteria, the patient name and account number are printed only on the first item. All other information is repeated for all subsequent items.

The following is an example of the report.

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Figure 4.37 FAHCFSYA - Self Pay Services With Signed
Advanced Beneficiary Form

```
Date: 06/16/08                       General Hospital                            Page  : 1
Time: 02:24am              Self Pay Services with Signed ABN Form    Report: FAHCFSYA
                                   Date:  Sunday April 4, 2009


Date: 04/03/06                       General Hospital                            Page : 1
Time: 6:12             Self Pay Services with Signed Advanced Beneficiary Notification    Report:FAHCFSYA
                              Date: Wednesday April 3, 2003
Acct No      Pt Name        Med Rcd #   PT   FC  Admit Dt  COB1  COB2  COB3  COB4  COB5  COB6  COB7  COB8  COB9
   Dept      FIM#         Charge Description        HCPCS          ICD Order DX                          Price
                                                                    ABN Reason

ADAIR,FRANK                        Office: (770)889-1111;2882 FAX:


A0115200008 COMSTOCK, MARIA   A123456789  OPO  M   06/01/01 888111 400100 400600 300100 300200 500100 500200 750100
750200
    LAB 70135050  GROSS AND MICROSCOPIC - TISSUE        88302GA       10 M12.34xA TEST DIAGNOSIS             840.50




                           Total Account Charges      1,246.87                    Total ABN Charges 84.16

Summary                    Accounts            1
                           Charges         $840.50

                                    End of Report



                                   End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ORDERING PHYSICIAN
This field contains the name of the ordering/charging physician. If charges appear on the report and Ordering/Charging physician information is missing, the report displays No Physician Indicated for the physician name.

OFFICE
This field contains the ordering physician's office phone.

FAX
This field contains the ordering physician's fax number.

ACCOUNT NO
This field contains the patient account number.

PT NAME
This field contains the name of the patient.

MED REC #
This field displays the medical records number for the patient.

PT
This field displays the patient type code used to categorize a specific portion of the patient community. This hospital-defined code categorizes such patient groups as regular admission, emergency room, outpatient, same-day surgery, series patients, and others.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self-pay, commercial insurance, Medicare, etc.

ADMIT DATE
This field contains the patient's admission date.

COB1
This field identifies the primary payor for this account.

COB2-COB9
These fields display any subsequent insurance payors for this account.

DEPT
This field contains the Service Item Master (SIM) department for this charge item.

FIM#
This field contains the Financial Item Master (FIM) for this charge item.

CHARGE DESCRIPTION
This field displays the description of the charge.

HCPCS
This field contains the HCPCS procedure code with any attached HCPCS modifiers for the charge.

ICD ORDER DX
This field contains the ordering diagnosis code and description for this charge item, preceded by the ICD version. This ICD flag tells you if the Ordering Diagnosis used in ABN processing was an ICD-10 code (the report field prints a 10), or an ICD-9 code (the report field prints a 9). If a charge has both an ICD-10 Ordering Diagnosis and an ICD-9 Ordering Diagnosis, the system uses the ICD-10 Ordering Diagnosis for ABN processing.

ABN REASON
This field can be blank or contain the ABN Reason selected by the ordering/charging employee to explain the need for the ABN.

PRICE
This field contains the price of the item ordered.

TOTAL ACCOUNT CHARGES
This field contains the total of the account charges.

TOTAL SELF PAY CHARGES
This field contains the total self pay charges related to the ABN process.

ACCOUNTS
This field contains the number of accounts on the report.

CHARGES
This field contains the total charges on the report.

SELF PAY SERVICES WITHOUT SIGNED ABN FORM - FAHCFSN

Description/Purpose

This nightly report contains a list of ABN self pay patients who have at least one charge that does not meet the medical necessity requirement and that does not have a signed ABN on file. Thus, patients with charges received by STAR Patient Accounting that have an ABN indicator of SP/N appear on this report.

For each patient, the report lists the account number, patient name, patient type, financial class, admit date, any applicable insurance plans (COB1-COB9, when assigned), department, FIM number, charge description, HCPCS code, order diagnosis, and price.

Generating and Printing This Report

This report is generated on a nightly basis during midnight processing.

The report is sorted by patient account number. If more than one FIM item has been ordered that meets the report's criteria, the patient name and account number are printed only on the first item. All other information is repeated for all subsequent items.

The following is an example of the report.

Figure 4.38 FAHCFY - Self Pay Services Without Signed Advanced Beneficiary Form

```
Date: 06/16/08                        General Hospital                          Page  : 1
Time: 02:24am              Self Pay Services Without Signed ABN Form    Report: FAHCFSNA
                                   Date:  Sunday June 15, 2008
Acct No     Pt Name              Med Rcd #   PT   FC   Admit Dt COB1   COB2   COB3   COB4   COB5   COB6   COB7   COB8   COB9

Dept   FIM#        Charge Description              HCPCS          ICD Order DX                                Price
                                                                    ABN Reason
ADAIR,FRANK C                    Office: (770)889-1111;2882  FAX:

A0115200008 COMSTOCK, MARIA        A123456789  OPO  M    06/01/01  888111 400100 400600 300100 300200 500100 500200 750100 750200
    LAB    70135050    GROSS AND MICROSCOPIC - TISSUE      88302GA           114.5 PL COCIDIOIDOMYCOSIS NO        840.50

                     Total Account Charges        1,246.87            Total Self Pay Charges          84.16


Summary                  Accounts              1
                         Charges          $840.50

                                    End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ORDERING PHYSICIAN
This field contains the name of the ordering/charging physician. If charges appear on the report and Ordering/Charging physician information is missing, the report displays No Physician Indicated for the physician name.

OFFICE
This field contains the ordering physician's office phone.

FAX
This field contains the ordering physician's fax number.

ACCOUNT NO
This field contains the patient account number.

PT NAME
This field contains the name of the patient.

MED REC #
This field displays the medical records number for the patient.

PT
This field displays the patient type code used to categorize a specific portion of the patient community. This hospital-defined code categorizes such patient groups as regular admission, emergency room, outpatient, same-day surgery, series patients, and others.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self-pay, commercial insurance, Medicare, etc.

ADMIT DATE
This field contains the patient's admission date.

COB1
This field identifies the primary payor for this account.

COB2-COB9
These fields display any subsequent insurance payors for this account.

DEPT
This field contains the Service Item Master (SIM) department for this charge item.

FIM#
This field contains the Financial Item Master (FIM) for this charge item.

CHARGE DESCRIPTION
This field displays the description of the charge.

HCPCS
This field contains the HCPCS procedure code with any attached HCPCS modifiers for the charge.

ICD ORDER DX
This field contains the ordering diagnosis code and description for this charge item, preceded by the ICD version. This ICD flag tells you if the Ordering Diagnosis used in ABN processing was an ICD-10 code (the report field prints a 10), or an ICD-9 code (the report field prints a 9). If a charge has both an ICD-10 Ordering Diagnosis and an ICD-9 Ordering Diagnosis, the system uses the ICD-10 Ordering Diagnosis for ABN processing. .

ABN REASON
This field can be blank or contain the ABN Reason selected by the ordering/charging employee to explain the need for the ABN.

PRICE
This field contains the price of the item ordered.

TOTAL ACCOUNT CHARGES
This field contains the total of the account charges.

TOTAL SELF PAY CHARGES
This field contains the total self pay charges. related to the ABN process.

ACCOUNTS
This field contains the number of accounts on the report.

CHARGES
This field contains the total charges on the report.

SELF PAY SERVICES SUBJECT TO FREQUENCY LIMIT WITH SIGNED ABN FORM - FAHCFSFY

Description/Purpose

This nightly report contains a list of ABN self pay patients who have at least one charge with a frequency limit that does not meet the medical necessity requirement and has a signed ABN on file. Thus, patients with charges received by STAR Patient Accounting that have an ABN indicator of SP/FQ/Y appear on this report.

For each patient, the report lists the account number, patient name, patient type, financial class, admit date, any applicable insurance plans (COB1-COB9, when assigned), department, FIM number, charge description, HCPCS code, order diagnosis, and price.

Generating and Printing This Report

This report is generated on a nightly basis during midnight processing.

The report is sorted by patient account number. If more than one FIM item has been ordered that meets the report's criteria, the patient name and account number are printed only on the first item. All other information is repeated for all subsequent items.

The following is an example of the report.

Figure 4.39 FAHCFSFYA - Self Pay Services Subject to Frequency Limit With Signed Advanced Beneficiary Form

```
Date: 06/16/08                              General Hospital                           Page  : 1
Time: 02:24am             Self Pay Services Subject to Frequency Limit With Signed ABN Form    Report: FAHCFSFYA
                                       Date:  Sunday June 15, 2008
Acct No      Pt Name              Med Rcd #   PT   FC   Admit Dt COB1   COB2   COB3   COB4   COB5   COB6   COB7   COB8   COB9
    Dept     FIM#       Charge Description             HCPCS          ICD Order DX                               Price
                                                                     ABN Reason
ADAIR,FRANK C                     Office: (770)889-1111;2882  FAX:

A0115200008 COMSTOCK, MARIA          A123456789  OPO  M    06/01/01  888111 400100 400600 300100 300200 500100 500200 750100 750200
    LAB     70135050   GROSS AND MICROSCOPIC - TISSUE      88302GA           114.5 PL COCIDIOIDOMYCOSIS NO        840.50

                       Total Account Charges       1,246.87            Total Self Pay Charges       84.16


Summary                      Accounts            1
                             Charges       $840.50

                                        End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ORDERING PHYSICIAN
This field contains the name of the ordering/charging physician. If charges appear on the report and Ordering/Charging physician information is missing, the report displays No Physician Indicated for the physician name.

OFFICE
This field contains the ordering physician's office phone.

FAX
This field contains the ordering physician's fax number.

ACCOUNT NO
This field contains the patient account number.

PT NAME
This field contains the name of the patient.

MED REC #
This field displays the medical records number for the patient.

PT
This field displays the patient type code used to categorize a specific portion of the patient community. This hospital-defined code categorizes such patient groups as regular admission, emergency room, outpatient, same-day surgery, series patients, and others.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self-pay, commercial insurance, Medicare, etc.

ADMIT DATE
This field contains the patient's admission date.

COB1
This field identifies the primary payor for this account.

COB2-COB9
These fields display any subsequent insurance payors for this account.

DEPT
This field contains the Service Item Master (SIM) department for this charge item.

FIM#
This field contains the Financial Item Master (FIM) for this charge item.

CHARGE DESCRIPTION
This field displays the description of the charge.

HCPCS
This field contains the HCPCS procedure code with any attached HCPCS modifiers for the charge.

ICD ORDER DX
This field contains the ordering diagnosis code and description for this charge item, preceded by the ICD version. This ICD flag tells you if the Ordering Diagnosis used in ABN processing was an ICD-10 code (the report field prints a 10), or an ICD-9 code (the report field prints a 9). If a charge has both an ICD-10 Ordering Diagnosis and an ICD-9 Ordering Diagnosis, the system uses the ICD-10 Ordering Diagnosis for ABN processing.

ABN REASON
This field can be blank or contain the ABN Reason selected by the ordering/charging employee to explain the need for the ABN.

PRICE
This field contains the price of the item ordered.

TOTAL ACCOUNT CHARGES
This field contains the total of the account charges.

TOTAL SELF PAY CHARGES
This field contains the total self pay charges. related to the ABN process.

ACCOUNTS
This field contains the number of accounts on the report.

CHARGES
This field contains the total charges on the report.

SELF PAY SERVICES SUBJECT TO FREQUENCY LIMIT WITHOUT SIGNED ABN FORM - FAHCFSFN

Description/Purpose

This nightly report lists ABN self pay patients who have at least one charge subject to a frequency limit that does not have a signed ABN on file. Thus, patients with charges received by STAR Financials Patient Accounting that have an ABN Indicator of SP/FQ/N appear on this nightly report.

For each patient, the report lists the account number, patient name, patient type, financial class, admit date, any applicable insurance plans (COB1-COB9, when assigned), department, FIM number, charge description, HCPCS code, order diagnosis, and price.

Generating and Printing This Report

This report is generated on a nightly basis during midnight processing.

The report is sorted by patient account number. If more than one FIM item has been ordered that meets the report's criteria, the patient name and account number are printed only on the first item. All other information is repeated for all subsequent items.

The following is an example of the report.

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Figure 4.40 FAHCFSFN - Self Pay Services Subject to Frequency Limit
Without Signed Advanced Beneficiary Form

```
Date: 06/16/08                              Model Hospital                              Page  : 1
Time: 02:24am            Self Pay Services Subject to Frequency Limit without Signed ABN Form    Report: FAHCFSFNA
                                         Date:  Sunday June 15, 2008
Acct No     Pt Name                 Med Rcd #   PT   FC   Admit Dt  COB1   COB2   COB3   COB4   COB5   COB6   COB7
COB8   COB9
    Dept   FIM#     Charge Description            HCPCS         ICD Order DX                          Price
                                                               ABN Reason

ADAIR,FRANK C                    Office: (770)889-1111;2882  FAX:

A0115200008 COMSTOCK, MARIA        A123456789  OPO  M    06/01/01  888111 400100 400600 300100 300200 500100 500200 750100 750200
    LAB    70135050   GROSS AND MICROSCOPIC - TISSUE      88302GA         114.5 PL COCIDIOIDOMYCOSIS NO      840.50

                     Total Account Charges       1,246.87           Total Self Pay Charges        84.16


Summary                  Accounts              1
                         Charges        $840.50

                                    End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ORDERING PHYSICIAN
This field contains the name of the ordering/charging physician. If charges appear on the report and Ordering/Charging physician information is missing, the report displays No Physician Indicated for the physician name.

ORDERING PHYSICIAN
This field contains the name of the ordering/charging physician. If charges appear on the report and Ordering/Charging physician information is missing, the report displays No Physician Indicated for the physician name.

OFFICE
This field contains the ordering physician's office phone.

FAX
This field contains the ordering physician's fax number.

ACCOUNT NO
This field contains the patient account number.

PT NAME
This field contains the name of the patient.

MED REC #
This field displays the medical records number for the patient.

PT
This field displays the patient type code used to categorize a specific portion of the patient community. This hospital-defined code categorizes such patient groups as regular admission, emergency room, outpatient, same-day surgery, series patients, and others.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self-pay, commercial insurance, Medicare, etc.

ADMIT DATE
This field contains the patient's admission date.

COB1
This field identifies the primary payor for this account.

COB2-COB9
These fields display any subsequent insurance payors for this account.

DEPT
This field contains the Service Item Master (SIM) department for this charge item.

FIM#
This field contains the Financial Item Master (FIM) for this charge item.

CHARGE DESCRIPTION
This field displays the description of the charge.

HCPCS
This field contains the HCPCS procedure code with any attached HCPCS modifiers for the charge.

ICD ORDER DX
This field contains the ordering diagnosis code and description for this charge item, preceded by the ICD version. This ICD flag tells you if the Ordering Diagnosis used in ABN processing was an ICD-10 code (the report field prints a 10), or an ICD-9 code (the report field prints a 9). If a charge has both an ICD-10 Ordering Diagnosis and an ICD-9 Ordering Diagnosis, the system uses the ICD-10 Ordering Diagnosis for ABN processing.

ABN REASON
This field can be blank or contain the ABN Reason selected by the ordering/charging employee to explain the need for the ABN.

PRICE
This field contains the price of the item ordered.

TOTAL ACCOUNT CHARGES
This field contains the total of the account charges.

TOTAL SELF PAY CHARGES
This field contains the total self pay charges. related to the ABN process.

ACCOUNTS
This field contains the number of accounts on the report.

CHARGES
This field contains the total charges on the report.

NON-COVERED SERVICES WITH SIGNED ADVANCED BENEFICIARY NOTIFICATION - FAHCFAY

Description/Purpose

This nightly report contains patients who have at least one charge that does not meet the medical necessity requirement and are indicated to have a signed ABN on file. Thus, patients with charges received by STAR Patient Accounting that have an ABN indicator of Yes appear on this nightly report.

For each ordering/charging physician, the report lists the office phone, and fax number.

For each patient, the report lists the account number, patient name, patient type, financial class, admit date, any applicable insurance plans (COB1-COB9, when assigned), department, FIM number, charge description, HCPCS code, order diagnosis, and price.

Generating and Printing This Report

This report is generated on a nightly basis during midnight processing.

The report is sorted by patient account number. If more than one FIM item has been ordered that meets the report's criteria, the patient name and account number are printed only on the first item. All other information is repeated for all subsequent items.

The following is an example of the Non-covered Services with Signed Advanced Beneficiary Notification report.

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Figure 4.41 FAHCFAY - Non-covered Services with Signed Advanced Beneficiary Notification

```
Date: 04/03/09                                    General Hospital                                   Page  : 1
Time: 6:12                  Non-covered Services with Signed Advanced Beneficiary Notification       Report:FAHCFAYA
                                            Date:  Wednesday April 3, 2009


Acct No     Pt Name                  Med Rcd #   PT   FC   Admit Dt  COB1   COB2   COB3   COB4   COB5   COB6   COB7   COB8   COB9
   Dept     FIM#          Charge Description          HCPCS            ICD Order DX                                     Price
                                                                    ABN Reason
ADAIR,FRANK C                        Office: (770)889-1111;2882  FAX:

A0115200008 COMSTOCK, MARIA          A123456789  OPO  M    06/01/01 888111 400100 400600 300100 300200 500100 500200 750100 750200
   A0115200008 COMSTOCK, MARIA       A123456789  OPO  M    06/01/01 888111 400100 400600 300100 300200 500100 500200 750100 750200
     LAB 70135050  GROSS AND MICROSCOPIC - TISSUE        88302GA        10 M12.34xA TEST DIAGNOSIS                     840.50
                                                                      Not Conscious

                        Total Account Charges        1,246.87                Total ABN Charges        84.16



Summary                  Accounts            1
                         Charges      $840.50

                                           End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ORDERING PHYSICIAN
This field contains the name of the ordering/charging physician. If charges appear on the report and Ordering/Charging physician information is missing, the report displays No Physician Indicated for the physician name.

OFFICE
This field contains the ordering physician's office phone.

FAX
This field contains the ordering physician's fax number.

ACCOUNT NO
This field contains the patient account number.

PT NAME
This field contains the name of the patient.

MED REC #
This field displays the medical records number for the patient.

PT
This field displays the patient type code used to categorize a specific portion of the patient community. This hospital-defined code categorizes such patient groups as regular admission, emergency room, outpatient, same-day surgery, series patients, and others.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self-pay, commercial insurance, Medicare, etc.

ADMIT DATE
This field contains the patient's admission date.

COB1
This field identifies the primary payor for this account.

COB2-COB9
These fields display any subsequent insurance payors for this account.

DEPT
This field contains the Service Item Master (SIM) department for this charge item.

FIM#
This field contains the Financial Item Master (FIM) for this charge item.

CHARGE DESCRIPTION
This field displays the description of the charge.

HCPCS
This field contains the HCPCS procedure code with any attached HCPCS modifiers for the charge.

ICD ORDER DX
This field contains the ordering diagnosis code and description for this charge item, preceded by the ICD version. This ICD flag tells you if the Ordering Diagnosis used in ABN processing was an ICD-10 code (the report field prints a 10), or an ICD-9 code (the report field prints a 9). If a charge has both an ICD-10 Ordering Diagnosis and an ICD-9 Ordering Diagnosis, the system uses the ICD-10 Ordering Diagnosis for ABN processing.

ABN REASON
This field can be blank or contain the ABN Reason selected by the ordering/charging employee to explain the need for the ABN.

PRICE
This field contains the price of the item ordered.

TOTAL ACCOUNT CHARGES
This field contains the total of the account charges.

TOTAL ABN CHARGES
This field contains the total charges related to the ABN process.

ACCOUNTS
This field contains the number of accounts on the report.

CHARGES
This field contains the total charges on the report.

NON-COVERED SERVICES WITHOUT SIGNED ADVANCED BENEFICIARY NOTIFICATION - FAHCFAN

Description/Purpose

This nightly report lists patients who have at least one charge that does not meet the medical necessity requirement and are not indicated to have a signed ABN on file. Thus, patients with charges received by STAR Financials Patient Accounting that have an ABN Indicator of No appear on this nightly report.

For each ordering/charging physician, the report lists the office phone and fax number.

For each patient, the report lists the account number, patient name, patient type, financial class, admit date, any applicable insurance plans (COB1-COB9, when assigned), department, FIM number, charge description, HCPCS code, order diagnosis, price, and the reason why an ABN has not been signed by the patient.

Generating and Printing This Report

This report is generated on a nightly basis during Midnight Processing.

The report is sorted by patient account number. If more than one FIM item has been ordered that meets the report's criteria, the patient name and account number are printed only on the first item. All other information is repeated for all subsequent items.

The following is an example of the Non-covered Services without Signed Advanced Beneficiary Notification report.

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Figure 4.42 FAHCFAN - Non-covered Services without Signed Advanced
Beneficiary Notification

```
Date: 04/03/09                          General Hospital                              Page : 1
Time: 6:12                Non-covered Services without Signed Advanced Beneficiary Notification      Report:FAHCFANA
                                   Date: Wednesday April 3, 2009
Acct No      Pt Name        Med Rcd #   PT  FC  Admit Dt  COB1  COB2   COB3    COB4    COB5    COB6    COB7    COB8    COB9
    Dept     FIM#          Charge Description          HCPCS          ICD Order DX                                    Price
                                                                      ABN Reason
ADAIR,FRANK                            Office: (770)889-1111;2882 FAX:

A0115200008 COMSTOCK, MARIA   A123456789  OPO  M   06/01/01 888111 400100 400600 300100 300200 500100 500200 750100
750200
    LAB 70135050   GROSS AND MICROSCOPIC - TISSUE      88302GA        10 M12.34xA TEST DIAGNOSIS                840.50
                                                                      Not Conscious


                         Total Account Charges       1,246.87                   Total ABN Charges 84.16

Summary                  Accounts           1
                         Charges        $840.50

                               End of Report

                                 End of Report
```

Column Explanations

BENEFICIARY NOTIFICATION
The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ORDERING PHYSICIAN
This field contains the name of the ordering/charging physician. If charges appear on the report and Ordering/Charging physician information is missing, the report displays No Physician Indicated for the physician name.

OFFICE
This field contains the ordering physician's office phone.

FAX
This field contains the ordering physician's fax number.

ACCOUNT NO
This field contains the patient account number.

PT NAME
This field contains the name of the patient.

MED REC #
This field contains the patient's medical records number.

PT
This field displays the patient type code used to categorize a specific portion of the patient community. This hospital-defined code categorizes such patient groups as regular admission, emergency room, outpatient, same-day surgery, series patients, and others.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self-pay, commercial insurance, Medicare, etc.

ADMIT DATE
This field contains the patient's admission date.

COB1
This field identifies the primary payor for this account.

COB2-COB9
These fields display any subsequent insurance payors for this account.

DEPT
This field contains the Service Item Master (SIM) department for this charge item.

FIM#
This field contains the Financial Item Master (FIM) for this charge item.

CHARGE DESCRIPTION
This field displays the description of the charge.

HCPCS
This field contains the HCPCS procedure code with any attached HCPCS modifiers for the charge.

ICD ORDER DX
This field contains the ordering diagnosis code and description for this charge item, preceded by the ICD version. This ICD flag tells you if the Ordering Diagnosis used in ABN processing was an ICD-10 code (the report field prints a 10), or an ICD-9 code (the report field prints a 9). If a charge has both an ICD-10 Ordering Diagnosis and an ICD-9 Ordering Diagnosis, the system uses the ICD-10 Ordering Diagnosis for ABN processing.

PRICE
This field contains the price of the item ordered.

REASON FOR NO ABN
This field contains the ABN Override Reason selected by the ordering/charging employee to explain the lack of a signed ABN.

ACCOUNTS
This field contains the number of accounts on the report.

TOTAL ACCOUNT CHARGES
This field contains the patient's total charges.

TOTAL ABN CHARGES
This field contains the total patient charges that are related to the ABN process.

NON-COVERED SERVICES WITHOUT SIGNED ADVANCED BENEFICIARY NOTIFICATION, BY EMPLOYEE - FAHCFAME

Description/Purpose

This end-of-month report shows, by employee, the occurrences of patients who have charges that do not meet the medical necessity requirement and are not indicated to have a signed ABN on file.   The report also shows a count for unidentified employees.

Information specific to individual patients is not shown on this report.

The report lists the ordering/charging employee's initials, the reason why there is no signed ABN, the number of times this month that the employee entered this reason, and the month-to-date non-covered charges for this employee related to this reason. For each employee, the report also includes the number of occurrences of unsigned ABNs for the month and the total amount of non-covered charges for the month.

The report also summarizes the number of monthly occurrences and the total monthly non-covered charges for the facility.

Generating and Printing This Report

This report is generated during midnight processing at month end.

The report is sorted by employee initials and includes information on a calendar month basis. Data reported summarizes, by employee, the number of occurrences of a required ABN not having been signed by the patient, by reason. The report is maintained for six weeks following each calendar month end.

The following is an example of the Non-covered Services without Advanced Beneficiary Notification report, sorted by employee initials.

Figure 4.43 FAHCFAME - Non-covered Services without Signed Advanced ABN

```
Date: 03/01/99                        General Hospital A                          Page  : 1
Time: 12:08am         Non-covered Services without Signed Advanced Beneficiary Notification    Report: FAHCFAME
                                          by Employee
                              Date:  Sunday February 28, 1999


                                                       Monthly              Non-Covered
Employee Initials                   Reason            Occurrences           Charges MTD


ALN                                 MD WILL PROVIDE DX LATER          5             $150.20

                                                               =====          ============
                                                                   5             $150.20

DAB                                 MD WILL PROVIDE DX LATER          2              $24.00
                                    PATIENT INSISTS ON PROCEDURE      1              $20.00

                                                               =====          ============
                                                                   3              $44.00

JWG                                 MD WILL PROVIDE DX LATER          2              $90.00
                                    PER PHYS OFFICE-TEST MUST BE DONE  9             $274.50
                                    PATIENT INSISTS ON PROCEDURE     15             $677.75
                                    EDITING FREE FORM TE              1              $11.00
                                    FREE FORM EDITED TES              1              $11.00
                                    Late Charge - Patient not here!   8             $278.00

                                                               =====          ============
                                                                  36           $1,342.25

LAB                                 MD WILL PROVIDE DX LATER          3             $143.10
                                    TEST ABN REASON 1000              4             $343.10
                                    PER PHYS OFFICE-TEST MUST BE DONE  1            $250.00
                                    PATIENT SEDATED                   2              $78.10

                                                               =====          ============
                                                                  11           $1,064.30

P M                                 MD WILL PROVIDE DX LATER          7              $92.00
                                    TEST ABN REASON 1000              1              $25.00
                                    Late Charge - Patient not here!   1              $20.00
                                    TEST OVERRIDE                     1               $4.00

                                                               =====          ============
                                                                  10             $141.00


Summary                                                           74           $3,465.85

                                     End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

EMPLOYEE INITIALS
This field displays the initials of the ordering/charging employee for this item.

REASON
This field contains the ABN Override Reason selected by the ordering/charging employee to explain the lack of a signed ABN.

MONTHLY OCCURRENCES
This field contains the number of times during the month this reason was entered by this employee.

NON-COVERED CHARGES MTD
This field contains the amount of month-to-date non-covered charges for this employee for each reason why there was no signed ABN.

NON-COVERED SERVICES WITHOUT SIGNED ADVANCED BENEFICIARY NOTIFICATION, BY PHYSICIAN - FAHCFAMP

Description/Purpose

This end-of-month report shows, by ordering/charging physician, the occurrences of patients who have charges that do not meet the medical necessity requirement and are not indicated to have a signed ABN on file.   This report includes a count for unidentified physicians.

Information specific to individual patients is not reflected on this report.

The report lists the ordering/charging physician's ID, the reason why there is no signed ABN, the number of times this month that this reason was entered for this physician, and the month-to-date non-covered charges for this physician related to this reason. For each physician, the report also includes the number of occurrences of unsigned ABNs for the month and the total amount of non-covered charges for the month.

The report also summarizes the number of monthly occurrences and the total monthly non-covered charges for the facility.

Generating and Printing This Report

This report is generated during Midnight Processing at month end.

The report is sorted in physician ID order and includes information on a calendar month basis. Data reported summarizes, by physician, the number of occurrences of a required ABN not having been signed by the patient, by reason. The report is maintained for six weeks following each calendar month end.

The following is an example of the Non-covered Services without Advanced Beneficiary Notification report, sorted by physician.

Figure 4.44   FAHCFAMP - Non-covered Services without Signed
Advanced ABN - by Physician

```
Date: 03/01/99                              General Hospital A                                    Page  : 1
Time: 12:08am              Non-covered Services without Signed Advanced Beneficiary Notification   Report: FAHCFAMP
                                                 by Physician
                                       Date:  Sunday February 28, 1999


                                                              Monthly              Non-Covered
Physician ID    Name                      Reason              Occurrences          Charges MTD


3232            CASTLY,DAVID SCOTT        MD WILL PROVIDE DX LATER          3            $120.55
                                          TEST ABN REASON 1000              5            $503.15
                                          PER PHYS OFFICE-TEST MUST BE DONE 1            $250.00
                                          PATIENT INSISTS ON PROCEDURE      3            $570.10
                                          SHOULD BE REJECTED                1             $27.50
                                          PATIENT SEDATED                   3            $238.15

                                                                        =====        ============
                                                                           16        $1,709.45

3234            CASTLY,CARLA              MD WILL PROVIDE DX LATER          9            $116.00
                                          TEST ABN REASON 1000              1             $25.00
                                          PER PHYS OFFICE-TEST MUST BE DONE 1             $15.90
                                          Late Charge - Patient not here!   1             $20.00
                                          TEST OVERRIDE                     1              $4.00

                                                                        =====        ============
                                                                           13          $180.90

9876            RENFROSON,BRENDA          MD WILL PROVIDE DX LATER         10            $303.25
                                          PER PHYS OFFICE-TEST MUST BE DONE 9            $274.50
                                          PATIENT INSISTS ON PROCEDURE     16            $697.75
                                          EDITING FREE FORM TE              1             $11.00
                                          FREE FORM EDITED TES              1             $11.00
                                          Late Charge - Patient not here!   8            $278.00

                                                                        =====        ============
                                                                           45        $1,575.50

Summary                                                                    74        $3,465.85


                                              End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

PHYSICIAN ID
This field contains the ID for the ordering/charging physician.

NAME
This field contains the ordering/charging physician's name.

REASON
This field contains the ABN Override Reason selected by the ordering/charging employee to explain the lack of a signed ABN.

MONTHLY OCCURRENCES
This field contains the number of times during the month this reason explaining the lack of a signed ABN occurred for the physician.

NON-COVERED CHARGES MTD
This field contains the amount of month-to-date non-covered charges for this physician for each reason why there was no signed ABN.

COVERED SERVICES SUBJECT TO A FREQUENCY LIMIT WITH SIGNED ABN FORM - FAHCFLY

Description/Purpose

This report identifies patients who have covered services that are subject to a frequency limitation and who have a signed ABN on file.

The report is sorted by physician, patient account number, and FIM number. Only services with the ABN Signed field of FQ/Y (the charge HCPCS has a frequency limit and an ABN was signed) are selected for this report.

The report also summarizes the number of monthly occurrences and the total covered charges included on the report for the facility.

Generating and Printing This Report

This report is generated during Midnight Processing each night.

The following is an example of the Covered Services Subject To A Frequency Limit With Signed ABN Form (FAHCFLY) report.

Figure 4.45 FAHCFLY - Covered Services Subject To A Frequency Limit
with Signed ABN Form

```
Date: 05/22/09                              Model Hospital A                                      Page  : 1
Time: 10:16                    Covered Services Subject to Frequency Limit without Signed ABN Form          Report:
FAHCFLNA
                                      Date:  Monday November 18, 2002


Acct No      Pt Name                  Med Rcd #   PT  FC   Admit Dt  COB1   COB2   COB3   COB4   COB5   COB6   COB7   COB8   COB9
    Dept     FIM#            Charge Description              HCPCS          ICD Order DX                              Price
                                                                                                                Frequency Limit


ADAIR,FRANK                           Office: (770)889-1111;2882 FAX:


A0115200008 COMSTOCK, MARIA   A123456789  OPO  M   06/01/01 888111 400100 400600 300100 300200 500100 500200 750100 750200
    RAD 98761234   DIAGNOSTIC MAMMOGRAM                 12345             10 M12.34xA TEST MAMMOGRAM
                                                84.16


                 Total Account Charges         1,246.87              Total ABN Charges           84.16



Summary                       Accounts              1
                              Charges          $84.16

                                             End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

Column Explanations

ACCOUNT NO
This column contains the patient account number.

PT NAME
This column contains the name of the patient.

MED REC #
This column contains the patient's medical records number.

PT
This column displays the patient type code used to categorize a specific portion of the patient community. This hospital-defined code categorizes such patient groups as regular admission, emergency room, outpatient, same-day surgery, series patients, and others.

FC
This column contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self-pay, commercial insurance, Medicare, etc.

ADMIT DATE
This column contains the patient's admission date.

COB1
This column identifies the primary payor for this account.

COB2-COB9
These columns display any subsequent insurance payors for this account.

DEPT
This column contains the Service Item Master (SIM) department for this charge item.

FIM#
This column contains the Financial Item Master (FIM) for this charge item.

CHARGE DESCRIPTION
This column displays the description of the charge.

HCPCS
This column contains the HCPCS procedure code with any attached HCPCS modifiers for the charge.

ICD ORDER DX
This field contains the ordering diagnosis code and description for this charge item, preceded by the ICD version. This ICD flag tells you if the Ordering Diagnosis used in ABN processing was an ICD-10 code (the report field prints a 10), or an ICD-9 code (the report field prints a 9). If a charge has both an ICD-10 Ordering Diagnosis and an ICD-9 Ordering Diagnosis, the system uses the ICD-10 Ordering Diagnosis for ABN processing.

ABN REASON
This field can be blank or can display the ABN Reason selected by the ordering/ charging employee to explain the need for the ABN.

PRICE
This column contains the price of the item ordered.

FREQUENCY LIMIT
This column contains the frequency limit associated with the HCPCS procedure.

ACCOUNTS
This column contains the number of accounts on the report.

TOTAL CHARGES
This column contains the total charges on the report.

TOTAL ABN CHARGES
This column contains the total charges related to the ABN process.

COVERED SERVICES SUBJECT TO A FREQUENCY LIMIT WITHOUT SIGNED ABN - FAHCFLN

Description/Purpose

This report identifies patients who have covered services that are subject to a frequency limitation and who do not have a signed ABN on file.

The report is sorted by physician, patient account number, and FIM number. Only services with the ABN Signed field of FQ/N (the charge has a frequency limit and no ABN was signed) are selected for this report.

The report also summarizes the number of monthly occurrences and the total covered charges included on the report for the facility.

Generating and Printing This Report

This report is generated during Midnight Processing each night.

The following is an example of the Covered Services Subject To A Frequency Limit Without Signed ABN Form (FAHCFLN) report.

Figure 4.46 FAHCFLN - Covered Services Subject To A Frequency Limit
without Signed ABN Form Report

```
Date: 07/01/09                          General Hospital                              Page  : 1
Time: 10:16         Covered Services Subject to Frequency Limit without Signed ABN Form   Report: FAHCFLNA
                                     Date:  Monday April 3, 2009

Acct No     Pt Name           Med Rcd #   PT   FC   Admit Dt  COB1   COB2   COB3   COB4   COB5   COB6   COB7   COB8   COB9
   Dept    FIM#         Charge Description           HCPCS          ICD Order DX                                      Price
                                                                                                           Frequency Limit


ONIEL,BRENDA                      Office:                    FAX:


A0204200001 KANE, MARY ------x  A123456789  PAT  O12  02/11/02  888111 400100 400600 300100 300200 500100 500200 750100
750200
     LAB    70253010     C-REACTIVE PROTEIN              86140                                                        84.16

               Total Account Charges        1,246.87              Total ABN Charges              84.16



Summary                      Accounts            1
                             Charges        $84.16

                                        End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

Column Explanations

ACCOUNT NO
This column contains the patient account number.

PT NAME
This column contains the name of the patient.

MED REC #
This column contains the patient's medical records number.

PT
This column displays the patient type code used to categorize a specific portion of the patient community. This hospital-defined code categorizes such patient groups as regular admission, emergency room, outpatient, same-day surgery, series patients, and others.

FC
This column contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self-pay, commercial insurance, Medicare, etc.

ADMIT DATE
This column contains the patient's admission date.

COB1
This column identifies the primary payor for this account.

COB2-COB9
These columns display any subsequent insurance payors for this account.

DEPT
This column contains the Service Item Master (SIM) department for this charge item.

FIM#
This column contains the Financial Item Master (FIM) for this charge item.

CHARGE DESCRIPTION
This column displays the description of the charge.

HCPCS
This column contains the HCPCS procedure code with any attached HCPCS modifiers for the charge.

ICD ORDER DX
This field contains the ordering diagnosis code and description for this charge item, preceded by the ICD version. This ICD flag tells you if the Ordering Diagnosis used in ABN processing was an ICD-10 code (the report field prints a 10), or an ICD-9 code (the report field prints a 9). If a charge has both an ICD-10 Ordering Diagnosis and an ICD-9 Ordering Diagnosis, the system uses the ICD-10 Ordering Diagnosis for ABN processing.

PRICE
This column contains the price of the item ordered.

REASON FOR NO ABN
This column contains the ABN Reason selected by the ordering/charging employee to explain the lack of a signed ABN.

FREQUENCY LIMIT
This column contains the frequency limit associated with the HCPCS procedure.

ACCOUNTS
This column contains the number of accounts on the report.

TOTAL CHARGES
This column contains the total charges on the report.

TOTAL ABN CHARGES
This column contains the total charges related to the ABN process.

COVERED SERVICES SUBJECT TO FREQUENCY LIMIT WITHOUT SIGNED ABN FORM, BY EMPLOYEE - FAHCLME

Description/Purpose

This end-of-month report shows, by employee, the occurrences of patients who have services subject to a frequency limit and do not have an ABN form on file. Only services with the ABN Signed field of FQ/N (the charge has a frequency limit and no ABN was signed) are selected for this report.

The report lists the ordering/charging employee's initials, the frequency limit for the HCPCS procedure, and the monthly occurrences and charges for services without an ABN form.

Generating and Printing This Report

This report is generated during Midnight Processing at month end.

The report is sorted by employee, SIM Department, and FIM Code.

The following is an example of the Covered Services Subject to Frequency Limit Without Signed ABN Form, by Employee (FAHCFLME).

Figure 4.47 FAHCFLME - Covered Services Subject to Frequency Limit Without Signed ABN Form, by Employee

```
Date: 05/07/02                         Windward Memorial Medical Center                    Page  : 1
Time: 12:40am              Covered Services Subject to Frequency Limit without Signed ABN Form    Report: FAHCFLME
                                                   by Employee
                                       Date:   Tuesday, April 30, 2002


Emp                                                                              Monthly           Covered
Init   Dept  FIM #     Charge Description           HCPCS    Frequency Limit     Occurrences     Charges MTD


ALN    RAD   70417691  MM MAMMOGRAM BILAT           76091    Once every 366 days     10           $2529.50
       RAD   70417795  BONE SURVEY                  76061    Once every 365 days      2             504.00

                                                                                   =====        ============
                                                                                     12           $3033.50

DAB    RAD   70417691  MM MAMMOGRAM BILAT           76091    Once every 366 days     10           $2529.50
       RAD   70417795  BONE SURVEY                  76061    Once every 365 days      2             504.00

                                                                                   =====        ============
                                                                                     12           $3033.50

JWG    RAD   70417691  MM MAMMOGRAM BILAT           76091    Once every 366 days     10           $2529.50
       RAD   70417795  BONE SURVEY                  76061    Once in a blue moon      2             504.00
Summary                                                                              36           $9100.50


                                            End of Report
```

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Column Explanations

EMP INIT
This column displays the initials of the ordering/charging employee for this item.

DEPT
This column contains the Service Item Master (SIM) department for this charge item.

FIM #
This column contains the Financial Item Master (FIM) number for this charge item.

CHARGE DESCRIPTION
This column contains the description of the charge.

HCPCS
This column contains the HCPCS procedure code (without the attached HCPCS modifiers) for the charge.

FREQUENCY LIMIT
This column contains the frequency limit description for the charge.

MONTHLY OCCURRENCES
This column contains the number of times during the month an ABN form was not signed for this FIM code

COVERED CHARGES MTD
This column contains the amount of month-to-date covered charges for this employee for each FIM code in which there was not a signed ABN form.

COVERED SERVICES SUBJECT TO FREQUENCY LIMIT WITHOUT SIGNED ABN FORM, MONTHLY BY PHYSICIAN - FAHCLME

Description/Purpose

This end-of-month report shows, by physician, the occurrences of patients who have services subject to a frequency limit and do not have an ABN form on file. Only services with the ABN Signed field of FQ/N (the charge has a frequency limit and no ABN was signed) are selected for this report.

The report lists the physician's name and initials, the frequency limit for the HCPCS procedure, and the monthly occurrences and charges for services without an ABN form.

Generating and Printing This Report

This report is generated during Midnight Processing at month end.

The report is sorted by physician ID, Charge Department, and FIM Code.

The following is an example of the Covered Services Subject to Frequency Limit Without Signed ABN Form, Monthly by Physician (FAHCFLME).

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Figure 4.48 FAHCFLMP - Covered Services Subject to Frequency Limit Without Signed ABN Form, Monthly by Physician

```
Date: 05/07/02                          General Hospital                          Page  : 1
Time: 12:40am          Covered Services Subject to Frequency Limit without Signed ABN Form   Report: FAHCFLMP
                                          by Physician
                               Date:  Tuesday, April 30, 2002


Phys ID      Physician Name                                                  Monthly          Covered
        Dept  FIM #       Charge Description          HCPCS    Frequency Limit        Occurrences      Charges MTD


3232         JONES,DAVID VINCENT

        RAD   70417691    MM MAMMOGRAM BILAT          76091    Once every 366 days        10          $2529.50
        RAD   70417795    BONE SURVEY                 76061    Once every 365 days         2            504.00

                                                                                        =====       ============
                                                                                          12          $3033.50
3234         HENDRICKSON,JEAN

        RAD   70417691    MM MAMMOGRAM BILAT          76091    Once every 366 days        10          $2529.50
        RAD   70417795    BONE SURVEY                 76061    Once every 365 days         2            504.00

                                                                                        =====       ============
                                                                                          12          $3033.50

9876         BARRETT,GEORGE

        RAD   70417691    MM MAMMOGRAM BILAT          76091    Once every 366 days        10          $2529.50
        RAD   70417795    BONE SURVEY                 76061    Once every 365 days         2            504.00

Summary                                                                                   36          $9100.50
```

Column Explanations

PHYSICIAN ID
This column displays the ID number the ordering/charging physician.

PHYSICIAN NAME
This column displays the ordering/charging physician's name.

DEPT
This column contains the Service Item Master (SIM) department for this charge item.

FIM #
This column contains the Financial Item Master (FIM) number for this charge item.

CHARGE DESCRIPTION
This column contains the Service Item Master description of the charge.

HCPCS
This field contains the HCPCS procedure code (without the attached HCPCS modifiers) for the charge.

FREQUENCY LIMIT
This column contains the frequency limit description for the HCPCS code associated with this charge.

MONTHLY OCCURRENCES
This column contains the number of times during the month an ABN form was not signed for this FIM code for this physician.

COVERED CHARGES MTD
This column contains the amount of month-to-date covered charges for this physician for each FIM code in which there was not a signed ABN form.

CONFLICTING HCPCS W/O MODIFIER DOCUMENTATION - FAHCFAD

Description/Purpose

This nightly report contains patients who have at least one duplicate charge that does not have documentation of medical necessity. Thus, patients with charges received by STAR Patient Accounting with a Duplicate HCPCS Indicator of No appear on this report.

For each ordering/charging physician, the report lists the office phone and fax number.

For each patient, the report lists the account number, patient name, patient type, financial class, admit date, any applicable insurance plans (COB1-COB9, when assigned), department, FIM number, charge description, HCPCS code, order diagnosis, and price. The report summarizes the number of accounts and the amount of charges.

Generating and Printing This Report

This report is generated on a nightly basis during midnight processing.

The report is sorted by patient account number. If more than one FIM item has been ordered that meets the report's criteria, the patient name and account number are printed only on the first item. All other information is repeated for all subsequent items.

Valid conflict types are defined at the bottom of the report

The following is an example of the Conflicting HCPCS without Documentation report.

Figure 4.49 FAHCFAD - Conflicting HCPCS without Modifier
Documentation

```
Date: 04/03/06                         General Hospital                          Page : 1
Time: 6:12                 Conflicting HCPCS without Modifier Documentation        Report:FAHCFADA
                                 Date: Wednesday April 3, 2009

Acct No      Pt Name          PT  FC  Admit Dt  COB1  COB2  COB3  COB4  COB5  COB6  COB7  COB8  COB9
    Dept    FIM#           Charge Description        HCPCS        ICD Order DX              Price        Conflict

ADAIR,FRANK                          Office: (770)889-1111;2882 FAX: (404)555-1212

A9904900001 JOHNSON,RICHARD OP    M   02/18/99 100100 100200
    LAB    70122490     URINALYSIS, ROUTINE              8100077        10 C12.34xA  TEST DIAGNOSIS           COMPT
    LAB    70194500     CULTURE,URINE                    87086QR        10 B12.34xD  ANOTHER TEST
    LAB   70194965   SENSITIVITY - CHRG ONLY     8707678       10 A98.76xD  YET ANOTHER TEST

A9904900003 SMITH,LANCELOT  OP    M   02/18/99 100100 100200
    RAD    70427460     CT ABDOMEN W CONTRAST           74150          9 789.00    ABDOMINAL PAIN E 200.00
    RAD    70417360     XR HUMERUS                      73060LT        9 959.2     SHLDR/UPPER ARM IN 50.00

Summary                      Accounts          7
                             Charges       $2,291.40

** Dup= Duplicate HCPCS, Excl = Mutually Exclusive HCPCS, Compt = Component of previous charge, Comph = Comprehensive of a previous
charge

                                              End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ORDERING PHYSICIAN
This field contains the name of the ordering/charging physician attached to this charge. If charges appear on the report and Ordering/Charging physician information is missing, the report displays No Physician Indicated for the physician name.

OFFICE
This field contains the ordering physician's office phone.

FAX
This field contains the ordering physician's fax number.

ACCOUNT NO
This field contains the patient account number.

PT NAME
This field contains the name of the patient.

PT
This field displays the patient type code used to categorize a specific portion of the patient community. This hospital-defined code categorizes such patient groups as regular admission, emergency room, outpatient, same-day surgery, series patients, and others.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self-pay, commercial insurance, Medicare, etc.

ADMIT DATE
This field contains the patient's admission date.

COB1
This field identifies the primary payor for this account.

COB2-COB9
These fields display any subsequent insurance payors for this account.

DEPT
This field contains the Service Item Master (SIM) department for this charge item.

FIM#
This field contains the Financial Item Master (FIM) for this charge item.

CHARGE DESCRIPTION
This field displays the description of the charge.

HCPCS
This field contains the HCPCS procedure code with any attached HCPCS modifiers for the charge.

ICD ORDER DX
This field contains the ordering diagnosis code and description for this charge item. This field has a preceding field of ICD. This ICD flag tells you if the Ordering Diagnosis used in ABN processing was an ICD-10 code (the report field prints a 10), or an ICD-9 code (the report field prints a 9). If a charge has both an ICD-10 Ordering Diagnosis and an ICD-9 Ordering Diagnosis, the system uses the ICD-10 Ordering Diagnosis for ABN processing.

PRICE
This field contains the price of the item ordered.

CONFLICT
The type of HCPCS conflict. Valid types are Dup, Excl, Compt, and Comph.

ACCOUNTS
This field contains the number of accounts on the report.

CHARGES
This field contains the total charges on the report.

TAKE HOME MEDICATIONS - FARXHM

Description/Purpose

This nightly report contains all patients who received medications that were designated in STAR Pharmacy as take home medications.

The report shows the account number, patient's name, patient type, financial class, admit date, FIM department, FIM description, price, ordering/charging physician, and ID and name of the employee who entered the order/charge. It contains a summary of the number of accounts and the total amount of charges.

Generating and Printing This Report

This report is generated during midnight processing. The report is by facility and is not cumulative.

The following is an example of the Take Home Medications report.

Figure 4.50 FARXHM - Take Home Medications

```
Date: 03/02/99                         General Hospital A                        Page : 1
Time: 12:07am                         Take Home Medications                      Report: FARXHMA
                                  Date:  Monday March 1, 1999

Acct No         Pt Name        PT   FC    Admit Date   FIM Dept  FIM#      FIM Desc                         Price
                                                       Ordering Physician            Ordering ID


A9708300002     STONE,LARRY    I/P  M     03/24/97     RXA       18000314  AMPICILLIN SODIUM 1G,INJECTIO    40.15
                                                       TICKERS,GIDGET                #16555 Rich,Bill
                                                       RXA       18000227  ALUMINUM HYDR 320MG/5ML,355 M    16.10
                                                       TICKERS,GIDGET                #16555 Rich,Bill




Summary                        Accounts            1
                               Charges         56.25

                                           End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ACCT NO
This field contains the patient account number.

PT NAME
This field contains the name of the patient.

PT
This field displays the patient type code used to categorize a specific portion of the patient community. This hospital-defined code categorizes such patient groups as regular admission, emergency room, outpatient, same-day surgery, series patients, and others.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self-pay, commercial insurance, Medicare, and so on.

ADMIT DATE
This field contains the patient's admission date.

FIM#
This field contains the Financial Item Master (FIM) for this charge item.

FIM DESC
This field contains the FIM (Financial Item Master) description for the item.

PRICE
This field contains the price of the item.

ORDERING PHYSICIAN
This field contains the name of the ordering/charging physician. If charges appear on the report and Ordering/Charging physician information is missing, the report displays No Physician Indicated for the physician name.

ORDERING ID
This field contains the ID of the employee who entered the order/charge.

ACCOUNTS
This field contains the number of accounts on the report.

CHARGES
This field contains the total charges on the report.

CANADA UNIVERSAL/WCB ACTIVITY REPORT - FARCUAX

Description/Purpose

This report reflects those accounts that received a payment, adjustment, or balance transfer from either a Universal insurance (claim type K) or WCB insurance (claim type W) that day, that also had another lower priority Universal insurance. This report can be used to update the COB 2 or greater universal insurance claim with the dollar amount that was transfered to the insurance.

If the Account Balance is $0.00 after the Universal/WCB Payment, Adjustment, or Balance Transfer, then you may have to delete secondary Universal claims that loaded with No Charges, since the claim is not needed. If the Account Balance is greater than $0.00 after the Universal/WCB Payment, Adjustment, or Balance Transfer, then you will have to determine if the next Universal claim should be updated with the charge amount remaining and manually released.

The report lists the account name and number, and for Universal and WCB plans only, the COB and Claim Sequence posted to, the amount that was posted as a Payment, Adjustment, or Balance Transfer, the current balance of this insurance (COB Balance), and the Account balance.

Generating/Printing This Report

This report is generated during Midnight Processing.

Following is an example of the Canadian Universal/WCB Activity report.

Figure 4.51 FARCUAx - Canada Universal/WCB Activity Report

```
Date: 02/08/29                              ST.JOSEPHS HOSPITAL                          Page:  1
Time: 09:30                         Canada - Universal/WCB Activity Report               Report:  FARCUAJ


Acct Number    Patient Name          COB   CS    Pmt Amt     Adj Amt     Bal Trans    COB Balance   Acct Balance


J10001201      BECKY,SEVEN            1    13                99.00-                     2000.00       5,075.00
J10001201      BECKY,SEVEN            1    13    5,000.00                               2000.00       5,075.00
J10001201      BECKY,SEVEN            1    13                            1000.00        2000.00       5,075.00
```

Column Explanations

ACCOUNT NUMBER
This column contains the patient's account number

PATIENT NAME
This column contains the patient's name.

COB
This column contains the COB to which the activity was posted.

CS
This column contains the claim sequence posted to.

PMT AMT
This column contains the amount that was posted as a payment for this claim.

ADJ AMT
This column contains the amount that was posted as an adjusment for this claim.

BAL TRANS
This column contains the amount that was posted as a balance transfer for this claim.

COB BALANCE
This column contains the balance of the insurance at the time of report generation.

ACCT BALANCE
This column contains the account balance.

PATIENT ACCOUNTING INTEGRITY ERRORS REPAIRED REPORT - FAIIER

Description/Purpose

The Patient Accounting Integrity Errors Repaired Report (FAIIER) documents accounts with insurance integrity errors, balance errors, or key data errors that have been repaired. It is generated during midnight processing.

A log is maintained documenting changes to insurance information during the course of the day. During midnight processing, the log is analyzed, and accounts with potential insurance integrity, balance, or key data errors are maintained in the log until no errors are found or McKesson removes the errors from the log. You can use this report to determine what changes may be required subsequent to the repair, such as modifying insurance information or requesting an adjustment bill. McKesson uses this log to document accounts with insurance integrity errors that have been repaired. The accounts are identified by patient name, account number, admission date, and discharge date. Each repair on the report includes the process for repair, the ID number of the person making the repair, the location of the account at the time of repair, the last claim sequence at the time of repair, the type of error, the insurance information, and carrier and plan. If the McKesson representative added information relevant to the account, it appears in the comment line.

Generating and Printing This Report

This report is generated during midnight processing.

The following is an example of a Patient Accounting Integrity Errors Repaired Report.

Figure 4.52 FAIIER - Patient Accounting Integrity Errors Repaired Report

```
Date: 04/27/98                              General Hospital B                                    Page  : 1
Time: 01:19am                Patient Accounting Integrity Errors Repaired on 04/26/98             Report: FAIIERB


Name                                Account#      Admit Date  Disch Date      Account Bal   Patient Bal    Insurance Bal
               Process              ID#           Loc         Last Clm Seq    Error Type
OSBORNE,MARTIN L                    E9732400001   11/20/97    11/20/97         1,741.85          0.00        1,741.85


               HBO Online          #32980         AR          7              Insurance
Ins on FIN:    103803/2 190001/1  190001/1
FIN Ins Detail:    190001   103803
Balance Info Before Repair    Account:    1,741.85  Patient:       0.00  Insurance:    1,741.85  3rd Party Excess:     0.00
Balance Info After Repair     Account:    1,741.85  Patient:       0.00  Insurance:    1,741.85  3rd Party Excess:     0.00


PAULSON,ALICIA                      E9801300011   01/13/98    01/13/98         2,615.69      2,615.69          0.00


               HBO Online          #32980         AR          1              Insurance

Ins on FIN:      404115/1
FIN Ins Detail:    404115
Balance Info Before Repair    Account:    2,615.69  Patient:   2,615.69  Insurance:        0.00  3rd Party Excess:     0.00
Balance Info After Repair     Account:    2,615.69  Patient:   2,615.69  Insurance:        0.00  3rd Party Excess:     0.00
ACCOUNT WAS REPAIRED MANUALLY


ROBERTSON,TINA                      E9801600104   01/16/98    01/17/98          200.00        269.30         69.30-


               HBO Online          #32980         AR          9              Insurance
Ins on FIN:      401902/9  401904/1
FIN Ins Detail:    401904
Balance Info Before Repair    Account:      200.00  Patient:       0.00  Insurance:      200.00  3rd Party Excess:     0.00
Balance Info After Repair     Account:      200.00  Patient:       0.00  Insurance:      69.30-  3rd Party Excess:     0.00


               HBO Online          #32980         AR          9              Balance
Ins on FIN:      401904/1
FIN Ins Detail:    401904
Balance Info Before Repair    Account:      200.00  Patient:       0.00  Insurance:      69.30-  3rd Party Excess:     0.00
Ins on FIN:      404115/1
FIN Ins Detail:    404115
Balance Info Before Repair    Account:    2,615.69  Patient:   2,615.69  Insurance:        0.00  3rd Party Excess:     0.00
Balance Info After Repair     Account:    2,615.69  Patient:   2,615.69  Insurance:        0.00  3rd Party Excess:     0.00
ACCOUNT WAS REPAIRED MANUALLY
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

PATIENT NAME
This field displays the name of the patient in the format LAST, FIRST MIDDLE.

ACCOUNT #
This field displays the account number of the patient.

ADMIT DATE
This field contains the patient's admission date.

DISCH DATE
This field contains the patient's discharge date.

ACCOUNT BAL
This is the current account balance of the selected account.

INSURANCE BAL
This field contains the insurance balance. The insurance balance is summed for each COB.

PROCESS
This field contains the process used to repair the error. The possible processes include HBO Online, Client Online, Midnight Process, After Insurance Update, and Before Insurance Update.

ID#
This field contains the ID number of the person making the repair.

LOC
This field contains the location of the account at the time of repair (i.e., PA or AR).

LAST CLM SEQ
This field contains the last claim sequence at the time of repair.

ERROR TYPE
This field indicates the type of error -- Insurance, Balance, Ins/Bal, or Key Data.

INS ON FIN
This field indicates the insurance information per Patient Accounting (Carrier, Plan, and COB) prior to the repair.

FIN INS DETAIL
This field indicates the carrier and plan per insurance detail information in Patient Accounting prior to the repair.

PC INS DETAIL
This field indicates the carrier and plan per insurance detail information in Patient Care prior to the repair if Patient Care resides on a different CPU.

BALANCE INFO BEFORE REPAIR
This field contains the account balance, the patient balance, the insurance balance summed for each COB, and third party excess before the repair.

BALANCE INFO AFTER REPAIR
This field contains the account balance, the patient balance, the insurance balance summed for each COB, and third party excess after the repair.

If the type of error was Key Data, the error messages related to the Key Data appear instead of the insurance and balance information.

If McKesson keyed a customer comment when making a repair, it is labeled as a Comment.

If repairs were made outside of this process, the message "ACCOUNT WAS REPAIRED MANUALLY" appears.

If the software was used to create a customer comment rather than making a repair, the message "CUSTOMER MESSAGE" appears.

UB THERAPY REVENUE CODES TABLE REPORT - FCRTRC

Description/Purpose

The UB Therapy Revenue Codes Table report provides a listing of the UB Revenue Codes used for physical therapy, occupational therapy, speech therapy, and cardiac rehab therapy on the UB claim form. This table is used in conjunction with the Provider Master in order to print the Occurrence Code for therapy start date on the UB claim form and in order to print the Value Code for the number of visits for therapy on the UB claim form.

Generating and Printing this Report

This report is generated through the UB Therapy Revenue Codes Table option. After you access this table, you can enter the UB Revenue Codes for physical therapy, occupational therapy, speech therapy, and cardiac rehab therapy. When you exit the screen, the system displays the following prompt:

Do you want a printed list (Y/N) [N]

Enter Y if you want to generate the report. The system references the spooler report definition to determine if the report is to be printed immediately or on demand and what printer is used for output. If the report is spooled for subsequent printing, the report name is FCRTRCf where f is the facility indicator.

The following is an example of the Therapy Revenue Codes Table Report.

Figure 4.53 FCRTRCA - UB Therapy Revenue Code Table

```
Date: 07/29/03                 General Hospital                  Page: 1
Time: 01:08pm             UB Therapy Revenue Code Table      Report: FCRTRCA



Physical Therapy UB Revenue Codes
        420 - Physical Therapy
        421 - Physical Therapy Visit

Occupational Therapy UB Revenue Codes
        430 - Occupational Therapy
        431 - Occupational Therapy Visit

Speech Therapy UB Revenue Codes
        440 - Speech-Language Therapy
        441 - Speech Therapy Visit

Cardiac Rehab Therapy UB Revenue Codes
        480 - Cardiology


Add Manual Value Code Amount:  No

                         END OF REPORT
```

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This report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

PHYSICAL THERAPY UB REVENUE CODES
This field contains the physical therapy UB revenue codes and their descriptions.

OCCUPATIONAL THERAPY UB REVENUE CODES
This field contains the occupational therapy UB revenue codes and their descriptions.

SPEECH THERAPY UB REVENUE CODES
This field contains the speech therapy UB revenue codes and their descriptions.

CARDIAC REHAB THERAPY UB REVENUE CODES
This field contains the cardiac rehab therapy UB revenue codes and their descriptions.

ADD MANUAL VALUE CODE AMOUNT:
If this field is set to Yes, if either Value Code 50, 51, 52, or 53 and the amount are manually entered, and the system also attempts to Auto Generate the same code on the UB, the Value Code Amount entered by the user (or copied over from a previous series auto discharge and re-reg account) on the account loading the claim is added to the system-calculated amount for the same value code. By doing this, past visits for the patient, that were either not in an auto series discharge and re-registration link, or that were on another system, can be added to the STAR calculated number of visits.

If this field is left blank or set to No, any manually entered Value Code 50, 51, 52 or 53 and Amount overrides the system calculated Value Code and Amount.

CLAIM BILLER INDEX REPAIRS REPORT - FCRFXBL

Description/Purpose

This report displays those claims corrected during midnight processing or by the optional batch job 112 - Claim Index and Workfile Repair.

Generating and Printing This Report

This report is generated during midnight processing for each facility.

The following is an example of the Claim Biller Index Repairs Report.

Figure 4.54 FCRFXBL - Claim Biller Index Repairs Report

```
Date: 04/17/00                              Model Hospital A                              Page  : 1
Time: 4:03                               Claim Biller Index Repairs                       Report: FCRFXBLA


                                                 Old/Current***********************
Account#             Name                  Disch Date  CS  Biller    Type       Prev Type   Error


A0009700001          SMITH,KRISTINE          04/06/00   1  99/99     Err/Rep       /         Corrected biller index type

A0009700001          SMITH,KRISTINE          04/06/00  42  5/5       Cmp/Cmp     Err/Err     Added biller index
A0009700001          SMITH,KRISTINE          04/06/00  42  5/5       Err/Cmp       /         Removed biller index

A0009700001          SMITH,KRISTINE          04/06/00  43  5/5       Rep/Rep       /         Added biller index
A0009700001          SMITH,KRISTINE          04/06/00  43  5/5       Err/Rep       /         Removed biller index

A0009700001          SMITH,KRISTINE          04/06/00  44  5/5       Err/Cmp     Err/Err     Corrected biller index type

A0009700001          SMITH,KRISTINE          04/06/00  45  5/5       Err/Rep       /         Corrected biller index type

A0009700001          SMITH,KRISTINE          04/06/00  47  5/5       Err/Sub       /         Corrected biller index type

A0009700001          SMITH,KRISTINE          04/06/00  48  5/5       Err/Err       /         Added biller index
A0009700001          SMITH,KRISTINE          04/06/00  48   /5       Err/Err       /         Removed biller index

A0009700001          SMITH,KRISTINE          04/06/00  49   /99      Err/Err       /         Added biller index
A0009700001          SMITH,KRISTINE          04/06/00  49   /99      Err/Err       /         Removed biller index

A0009700001          SMITH,KRISTINE          04/06/00  50  5/5       Err/Err       /         Added biller index
A0009700001          SMITH,KRISTINE          04/06/00  50   /5       Err/Err       /         Removed biller index

A0009700001          SMITH,KRISTINE          04/06/00  51  5/        Err/          /         Removed biller index

Total Changes: 15


Err=Failed edits    W/O=Passed edits     Gen=Generated not Submitted     Sub=Submitted     Rep=Replaced by Adj Claim     Cmp=Completed

                                                  End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ACCOUNT #
This field contains the patient's account number.

NAME
This field contains the Patient's name.

DISCH DATE
This field contains the patient's discharged date.

CS
This field contains the claim sequence.

OLD/CURRENT BILLER
This field contains the old and the current biller on the claim after the claim information was corrected.

OLD/CURRENT TYPE
This field contains the old and the current claim index type after the claim information was corrected. Types are:

- ERR (Failed)
- W/O (No Errors)
- GEN (Generated, not Submitted)
- SUB (Submitted)
- REP (Replaced)
- CMP (Complete)

OLD/CURRENT PREV TYPE
This field contains the old and the current previous claim index type after the claim information was corrected. This field only prints for claims that were, or are now, completed and is the claim index type before the claim was completed. Types are:

- ERR (Failed)
- W/O (No Errors)
- GEN (Generated, not Submitted)
- SUB (Submitted)
- REP (Replaced)
- CMP (Complete)

ERROR
This field contains the error message indicating what was wrong with the claim or biller index before the claim information was corrected. The error messages are:

- Removed incomplete claim
- Added biller index

- Corrected missing biller
- Corrected missing bill date
- Corrected biller index type
- Removed extra workfiles
- Blank biller
- Removed biller index

AUTO SERIES DISCHARGE/RE-REG PA ACCOUNTS REPORT

Description/Purpose

This report displays a listing of all accounts which are part of an auto series discharge and registration existing in location PA. The report sorts by Admit Date, Medical Service, and Patient Name. Visits are selected for printing on the report if they have a linked series patient who is still in location PA. If a patient has multiple linked accounts in PA they will all appear on the report; the first non-PA account will not print a Yes in the PA Visits column, and all subsequent visits print Yes.

This report is informational and can be used to assist you in getting the linked visits to bill in visit order. It gives you an idea of the number of linked series accounts that are on the system at the time the report is produced. When the accounts bill, they auto load the occurence and value codes to the linked accounts so that the information can be pulled forward from account to account. This occurs during the midnight processing in which the account final bills.

Generating and Printing This Report

The Auto Series Discharge/Re-Reg PA Accounts Report is generated through the Optional Batch Job processing function. Refer to the Financial System Management section in the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide* for more information on setting up this report

Following is a sample of this report.

Figure 4.55 FASEREG - Auto Series Discharge/Re-Reg PA Accounts
Report

```
                        General Hospital View Reports Processor
                              Tue May 22, 2001 02:08 pm
Report : FASEREGA  Auto Disch/Reg PA Accnts (A)   Position|##################|
Spooled: 05/22/01 0016                    Last Printed: Not Printed
Date: 05/22/01                              Model Hospital A                              Page  : 1
Time: 0:16                         Auto Series Discharge/Re-reg PA Accounts
Report: FASEREGA


Admit Date     Med Serv     Patient Name          Acct Number     PA Visits  No. Linked Accts.
------------------------------------------------------------------------------------------------

12/31/00        MED         CARLA,HANSON          A0036600039       Yes            3
12/31/00        MED         CARLA,HANSON          A0036600021       Yes            3
12/31/00        MED         CARLA,HANSON          A0036600013       Yes            1

04/04/01        MED         NEW, MICHAEL          A0109400002       Yes            5

04/27/01        MED         GRANT, BOB            A0111700004       Yes            1
04/27/01        MED         GRANT, BOB            A0111700001       Yes            9
04/27/01        MED         GRANT, BOB            A0111700002       Yes            7

   Page: 1 - 1                 Display Columns:  1  through 132    Maximum:132
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ADMIT DATE
This column contains the admit date for the account being reported.

MED SERV

This column contains the account's current medical service.

PATIENT NAME
This field contains the patient's name in Last, First order.

ACCOUNT NUMBER
This column contains the account number.

PA VISITS
This column contains a Yes only if this patient has prior linked accounts that are still in location PA.

NO (NUMBER) OF LINKED ACCOUNTS
This column contains the number of prior linked visits for this account.

INSTANT ADJUSTMENT BILL REQUESTS - FBR310

Description/Purpose

This report lists all Instant Adjustment bills created through the Instant Adjustment Bill function under Insurance Management.

The reports lists the patient's name and account number, bill sequence assigned to the instant adjustment bill, carrier/plans existing when the instant adjustment bill was created, and claim sequences and claim types for claims loaded for the instant adjustment bill via the Add Claim to Insurance process. If the current bill sequence is greater then the instant adjustment bill sequence, the report will reflect this bill sequence, the current carrier/plans, and claim sequences and claim types that were loaded for that bill sequence.

This report provides a daily audit trail of all accounts that were processed through the Instant Adjustment Bill process, along with a list of claims loaded for the instant adjustment bill from the Add Claim to Insurance process. Also, it documents whether a Single Bill Request was processed after the Instant Adjustment Bill process was performed. Finally, it identifies accounts needing claims to be loaded for adjustment bills. To ensure that replaced claims are documented properly and to ensure that applications such as Pathways Contract Management process claims correctly, claims should be loaded to adjustment bills created during midnight processing.

Generating and Printing This Report

The Instant Adjustment Bill Requests Report is a daily batch report and is printed through the Demand Print Function. The report is sorted by account number.

Following is a sample of this report.

Figure 4.56 FBR310 - Instant Adjustment Bill Requests

```
Date: 06/09/06                              General Hospital A                          Page  : 1
Time: 0:17                            Instant Adjustment Bill Requests                  Report: FBR310A


Account Number Name                     BS    BT   Bill From    Bill Thru         Car/Pln    CS-CT
Smith, Nancy                            2     C    05/01/06     05/30/06
A0113800006
```

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FIELD DESCRIPTIONS
The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

NAME
This field contains the patient name

ACCOUNT NUMBER
This field contains the patient account number.

INST ADJ BILL
This section of the report contains information about the bill created as part of the Instant Adjustment Bill process. If the process was used multiple times, all instances are displayed on this report. There are three columns of information that are displayed in this section.

BS
This field contains the bill sequence assigned by the Instant Adjustment Bill Process.

BT
This field contains the bill type assigned to this patient's account. Valid bill types are C-cycle, A-adjustment, F-final, L-late, and Z-cycle adjustment. The bill type of Z is preceded by an asterisk (*) if the bill has been suppressed and therefore not printed.

BILL FROM
This field contains the bill from date.

BILL TRRU
This field contains the bill through date.

CAR/PLN
This field contains the COB placement number along with the associated carrier/plan that existed when the Instant Adjustment Bill was created. This field will be blank if the account was self-pay.

CS-CT
This field contains the claim sequence and claim type that were loaded for the instant adjustment bill from the Add Claim to Insurance process. This field will be blank if either the account is self-pay or no claims were loaded using Add Claim to Insurance.

LATEST ADJ BILL
This section of the report contains the latest billing information for the account if a Single Bill Request was processed after the Instant Adjustment Bill appearing to the left. There are four columns of information that are displayed in this section. If the latest bill for the account was produced from the Instant Adjustment Bill process, no information appears in this section.

BS
This field contains the bill sequence for the latest adjustment bill loaded to the account as long as the adjustment bill was not generated as part of the Instant Adjustment Bill process.

CAR/PLN
This field contains the COB placement numbers along with the associated carrier/ plans present for the account when the report was created. This field will be blank if the account is self-pay.

CS
This field contains claim sequences and claim types loaded for the adjustment bill. These can be claims loaded during midnight processing or by the Add Claim to Insurance process. This field will be blank if either the account is self-pay or no claims exist for the bill.

REPLACED CLAIM-CT
If the claim in the CS column replaced other claims, the highest of these replaced claims appears. If this field is blank, then either Add Claim to Insurance was used to load the claim or a previous claim did not exist to be replaced. Also, this field contains the claim type for the claim reported under CS.

INSURANCE MANAGEMENT INSURANCE CHANGES - FBR320

Description/Purpose

The Insurance Management Insurance Changes report lists accounts that were accessed and/or modified by either the Delete Financial Insurance Activity function or the Insurance Revision function. Both functions are under Insurance Management.

If information was modified through the Delete Financial Insurance Activity function or if the account was accessed through the Insurance Revision function (even if the account was not modified), the account appears on the report.

This report provides a snapshot of all accounts that were processed through either of these two functions. It documents how the account looked before either process started and how the account looks currently. This provides a before and after picture for the account for one day of Insurance Management activity. In the fields reporting prior information, the system gives the information for the account when the account was used initially in that day by either the Delete Financial Insurance Activity or the Insurance Revision functions.

The report lists multiple lines of information for each patient. The first line contains the patient account number, patient name, current account balance, current patient balance, the prior bill sequence, the prior bill type, the current bill sequence, and the current bill type.   Prior bill sequence and prior bill type show information that was present before the first use during the day of Delete Financial Insurance Activity or Insurance Revision. After the first line of patient information, the report reflects, by COB number, the prior carrier plan, the prior claim sequence, the last claim sequence that the prior claim sequence replaced, the prior insurance balance, the current carrier/plan assigned to the COB sequence, the current claim sequence, the last claim sequence that the current claim replaced, and the current insurance balance. There is one line for each COB that was assigned to the account before either one of the two functions was used or at the time that the report was produced. It does not reflect the maximum number of COB's that may have been assigned at some time during the day. For example, if a patient has 3 insurances assigned when Insurance Revision is accessed, then two insurances were added via Insurance Revision, and one insurance was deleted via Account Revision, then the report will contain four lines of COB information to list the prior three COB's and the final four COB's.

Generating and Printing this Report

The Insurance Management Insurance Changes report is a daily batch report and is printed through the Demand Print function. The report is sorted by account number.

The following is sample of the report.

Figure 4.57 FBR320 - Insurance Management Insurance Changes Report

```
Date: 07/03/02                                General Hospital                               Page: 1
Time: 10:21am                        Insurance Management Insurance Changes                  Report: FBR320A


Account No.    Name                                Account Balance   Patient Balance  Prior BS/BT      Curr BS/BT
   Prior COB Info           Prior CS ( R)           Prior Ins Bal     Curr Car/Pln    Curr CS ( R)     Curr Ins Bal

A0114200009    Narrs, Bill                              1,966.63         1,966.63     1/Final          3/Adj

COB1           500700            1                          0.00           500700     3 (    1)             0.00
COB2           500500                                   1,766.63

A0119900001    Storey, Nancy                              492.50           469.00-    23/Adj           26/Adj
COB1           500700          22 (  20)                   192.50           500700                       192.50
COB2           500200          23 (  21)                   769.00           500200                       769.00
```

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Field Descriptions

For each account the following first line of information appears once.

ACCOUNT NO.
This field contains the patient account number.

NAME
This field contains the patient name.

ACCOUNT BALANCE
This field contains the current account balance at the time that the report is produced.

PATIENT BALANCE
This field contains the current patient balance at the time that the report is produced.

PRIOR BS/BT
This field reflects the last bill sequence and bill type that existed when the account was used for the first time in the day by either the Delete Financial Insurance Activity or the Insurance Revision functions found under Insurance Management. For Delete Financial Insurance Activity, an account is defined as used if an update is made. For Insurance Revision, an account is defined as used if the account is accessed.

CURR BS/BT
This field contains the last bill sequence and bill type that existed for the account when the report was produced. If the bill type is cycle adjustment bill, CycA prints for the bill type. If the bill type is cycle adjustment bill, and it was an instant adjustment bill, the bill type is I CycA.

For every account, the following information will appear once for each COB existing on the account when Delete Financial Insurance Activity or Insurance Revision was used or when the report is produced. For Delete Financial Insurance Activity, an account is defined as used if an update is made. For Insurance Revision, an account is defined as used if the account is accessed.

PRIOR COB INFO
This field reflects the COB sequence number and the associated carrier/plan that were assigned to the account when the account was used for the first time in the day by either the Delete Financial Insurance Activity or Insurance Revision. For Delete Financial Insurance Activity, an account is defined as used if an update is made. For Insurance Revision, an account is defined as used if the account is accessed. The carrier/plan information can be blank due to a carrier/plan added during the day. These carrier/plans will be reflected in the Curr Car/Pln column.

PRIOR CS (R)
This field reflects the last claim sequence that was loaded to the account for the carrier/plan when the account was used for the first time in the day by Delete Financial Insurance Activity or Insurance Revision. For Delete Financial Insurance Activity, an account is defined as used if an update is made. For Insurance Revision, an account

is defined as used if the account is accessed. If the claim listed replaced a prior claim, the last replaced claim sequence will appear in parentheses next to the claim sequence.

PRIOR INS BAL
This field reflects the insurance balance for the associated carrer/plan listed in the Prior COB Info column that existed when Delete Financial Insurance Activity or Insurance Revision was used for the first time in the day. For Delete Financial Insurance Activity, an account is defined as used if an update is made. For Insurance Revision, an account is defined as used if the account is accessed.

CURR CAR/PLN
This field reflects the carrier/plans assigned to the COB at the time that the report is produced.

CURR CS (R)
This field reflects the most recent claim sequence loaded for the current carrier/plan at the time that the report is produced. If this claim replaced a prior claim, the last replaced claim sequence will be reflected in parentheses.

CURR INS BAL
This field reflects the insurance balance assigned to the carrier/plans listed in the Curr Car/Pln column at the time that the report is produced.

ACCOUNTS SENT TO EC2000 CLAIMS ADMINISTRATOR (FCRPREECX)

Description/Purpose

This report lists the pre-bill accounts which were sent to EC2000 Claims Administrator. The report is sorted by date/time stamp (time received from Claims Administrator). A specific patient account can be listed multiple times, once for each time it is sent through the interface. An asterisk (*) next to the patient name indicates the account was sent through the batch process. A summary section at the end of the report displays totals for each claim status on the report.

Generating and Printing This Report

This report is generated during Midnight Processing for facilities that have the EC2000 Claims Administrator module.

The following is a sample of the Accounts Sent to EC2000 Claims Administrator report.

Figure 4.58 Accounts Sent to EC2000 (FCRPREECx)

```
Date:  02/15/0                          General Hospital A                          Page:    1
Time:  02:15                      Accounts Sent to EC 02/14/04                       Report: FCRPREECx


Account No.   Patient Name                 CS   Clm Type  Time Queued   Time Sent     Time Received    Status
-------------------------------------------------------------------------------------------------------------
A0412300123 * Kane, Bob                    1    X         02/14/04 1413 02/14/04 1426 02/14/04 1537    Not Accepted
A0411200012   Bob, Jim                     2    X         02/14/04 1823 02/14/04 1956 02/14/04 2223    Not Created

Total Claims

      Not Created           15
      Failed                 2
      Passed            999,999
      Not Proc             111
      Out-of-Date            3
      Unk Account            0
      Unknown                0


* = request came from the batch process (not user request)
```

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FIELD EXPLANATIONS

ACCOUNT NUMBER
This column contains the patient's account number.

PATIENT NAME
This column contains the patient's name.

CS
This column contains the claim sequence number.

CLM TYPE
This column contains the claim type. Valid claim types are X-UB and -1500.

TIME QUEUED
This column contains the time when the account entered the queue to be sent to EC2000 CA.

TIME SENT
This column contains the time when the account was actually sent to EC2000 CA and acknowledgement was received from EC2000 CA. The time in this column differs from the Time Queued column if, for example, the communication line was inactivated on STAR Patient Accounting or EC2000 CA.

TIME RECEIVED
This column contains the time when the account came back from EC2000 CA and was acknowledged by STAR Patient Accounting. This is the date used to distinguish which accounts are displayed on the report.

STATUS
This column contains the status that is applicable to the information sent back from EC2000 CA to STAR. Valid statuses are:

- Not Proc - Claim data was sent to EC2000 CA but could not be processed by EC2000 CA. An example is when the first record in the data packet was not a PAT record type.

- Not Created - EC2000 CA could not create a claim.

- Failed - The claim failed EC2000 CA claim edits.

- Passed - The claim passed EC2000 CA claim edits.

- Out of Date - The patient account was billed (final or cycle) after being sent through the pre-bill edit process but prior to the pre-bill claim(s) being processed by EC2000 CA or another pre-bill was created for the account. The pre-bill claim(s) edits were not processed on STAR Patient Accounting.

- Unk Account - The data files processed by EC2000 CA were in a format which did not allow for account information to be identified. For example, this status is used when the packet of data had information deleted within the transfer process (networking error).

- Unknown - This is a generic status for accounts which could not be processed. This status should not be used

TOTAL CLAIMS
This part of the report contains a summary of the total number of claims with each status.

PRE-BILL EDIT PARAMETERS REPORT (FIN)

Description/Purpose

The Pre-bill Edit Parameters report provides a detailed listing of the pre-bill edit parameters defined on the STAR Patient Accounting system. The hospital defines the following parameters for accounts affected by the pre-bill edit process:

- Batch process completion time

- The processes used to edit patient account visit information

- The insurances to be sent through the process (criteria are carrier/plan and excluded patient types)

- When the system begins editing patient account visit information

- The trigger events that cause the accounts to be sent through the process again

- Whether pre-bill edits have to be corrected before real (actual) billing occurs

- Whether accounts can final bill when small unbilled charges exist

- How edits are allocated to people/departments?

Generating and Printing This Report

This report is generated through the Pre-bill Edit Parameters Table option. After you access this table, you can enter the pre-bill edit parameters for a facility. When you exit the screen, the system displays the following prompt:

Do you want a printed list (Y/N) [N]

Enter Y if you want to generate the report. The system references the spooler report definition to determine if the report is to be printed immediately or on demand and what printer is used for output. If the report is spooled for subsequent printing, the report name is FINCf where f is the facility indicator.

The following is an example of the Pre-bill Edit Parameters report.

Figure 4.59 Pre-bill Edit Parameters Report (FIN) - Page 1

```
Date: 06/16/09                          General Hospital                         Page : 1
Time: 08:42am                      Pre-bill Edit Parameters Report              Report: FINC

Batch Processing    : Proration
Batch Hours         : 16
File Retention      :    5
Statistics Retention :   1
Active Processes    : STAR Billing, STAR Claims, OPPS, EAPG, EC2000, ICD charge
Include All Ins?    : Yes
Other Ins Edit Excl : E
FCRPRERES Report    : 111; Moore,Pat
FCRPREACT Report    : PBE Summary Statistics by PBE User
FCRPREANA Bill Susp : 3
CA UB No-$ Clm SIM  : CSA-5621 (3% SODIUM CHLORIDE SOLUTION)
Override STAR Cat   : No
Activate Adm GUI    : Yes-MLK TESTING ENVIRONMENT

                                 Send Through Pre-bill Edits


Inpatients                                      Excluded Patient Types
    400100 - 400100 BLUE CROSS OF GA
Outpatients                                     Excluded Patient Types
    400100 - 400100 BLUE CROSS OF GA
Emergency                                       Excluded Patient Types
    400100 - 400100 BLUE CROSS OF GA

                                  Begin Editing Parameters


Inpatients          : Discharge-1
Outpatients         : Admit-1
Emergency           : Admit-1
Bill Edits          : Admit-1
ICD Charge Edits    : Admit-0
                                      Trigger Events
Inpatient
                 Update Special Studies Information
                 Abstract Flagged as Complete
                 Charge Revision
                 Patient Discharge/Disposition
                 Patient Historization
```

Figure 4.60 Pre-bill Edit Parameters Report (FIN) - Page 2

```
Date: 06/16/04                             General Hospital                              Page  : 2
Time: 08:42am                         Pre-bill Edit Parameters Report                    Report: FINC

                                           Trigger Events
Inpatient
                   Update Abstract General Information
                   Update Abstract Newborn/Death Class
                   Update User Defined MPI Fields
                   Update User Defined Visit Fields
                   Update Medical Records HCPCS

Outpatient
                   Update Special Studies Information
                   Abstract Flagged as Complete
                   Charge Revision
                   Patient Discharge/Disposition
                   Patient Historization

Emergency
                   Abstract Flagged as Complete
                   Charge Revision
                   Patient Discharge/Disposition
                   Patient Historization
                   Combine Bill
                   DPW Addition/Change/Deletion
                   Cycle Bill
                   Proration
```

Figure 4.61 Pre-bill Edit Parameters Report (FIN) - Page 3

```
Date: 06/16/04                              General Hospital                                    Page  : 3
Time: 08:42am                           Pre-bill Edit Parameters Report                         Report: FINC

                                             Trigger Events
Bill/ICD Edits
               Update Special Studies Information
               Abstract Flagged as Complete
               Update Medical Records HCPCS

                                    Start Reviewing Medical Records Edits

Inpatients          : Med Rec Info Present
Outpatients         : Med Rec Info Present
Emergency           : Med Rec Info Present

                                    Request Final Bill If No Pre-Bill Edits

Inpatient           : Yes
Outpatient          : Yes
Emergency           : Yes
Patient Type Exceptions: ER,OBO,ONC

                                     Final Bill with Existing Pre-bill Edits

Inpatients                                          Excluded Patient Types
    917001 - 917001 COMMERICAL
Outpatients                                         Excluded Patient Types
    917001 - 917001 COMMERICAL
Emergency                                           Excluded Patient Types
    917001 - 917001 COMMERICAL

                                   Final Bill with Existing Edits Dollar Limits

Inpatient           :          10.00
Outpatient          :          11.00
Emergency           :          12.00
```

FIELD EXPLANATIONS

BATCH PROCESSING
This field contains the setting for when pre-bill accounts are analyzed and interface files generated for them (to be used in the batch process). The field contains either a **P** for Proration (pre-bill edits are performed during proration) or **C** for Claims Complete (pre-bill edits are performed when billing and claims processing completes in Midnight Processing).

FILE RETENTION
This field contains the number of days the system maintains the listing of accounts for which pre-bill edits were created.

STATISTICS RETENTION
This field contains the number of days the system maintains the statistical information used in reporting on pre-bill edits

ACTIVE PROCESSES
This field contains the processes for which pre-bill edits can be applied to patient visits. The options are:

- STAR Billing Requirements

- STAR Claim edits

- 3M OPPS edits

- EC2000 CA edits

FCRPRERES REPORT
This field contains pre-bill edit user groups and users that are reported on the FCRPRERES report generated in Midnight Processing.

FCRPREACT REPORT
This field contains the options by which the FCRPREACT report is aged:

- PBE Summary Statistics by PBE User

- Edit Messages by Days on PBE Worklist

- Edit Messages by Days Waiting to Final Bill

- Edit Messages by Days on PBE Worklist/SIM Dept Detail

- Edit Messages by Days on PBE Worklist/SIM Dept Detail

SEND THROUGH PRE-BILL EDITS
This field contains the carrier/plans that are eligible to be sent through the pre-bill edit process and patient type exceptions that are excluded from the pre-bill edit process. Patient type exceptions can include inpatient, outpatient, and emergency.

BEGIN EDITING PARAMETERS
This field contains the event that begins the editing process (Admission Date, Discharge Date, or Medical Record Completion Date) for inpatients, outpatients, and emergency patients. The field also contains the number of days after the event that editing begins for each patient type.

TRIGGER EVENTS
This field contains the trigger events, such as charge revision, combine bill, and cycle bill, which cause patient accounts to be sent through the pre-bill edit process after pre-bill editing has started. The trigger events are defined for inpatients, outpatients, and emergency patients.

START REVIEWING MEDICAL RECORDS EDITS
This field contains the time when the system begins accepting Medical Record-type edits into the workfile list. Medical Record errors have two different sources:

- HCPCS codes derived from medical record data on the pre-bill claim

- Medical record abstract information

Options for accepting Medical Record-type edits are: Admission Days, Discharge Days, Medical Records Done/Days, Never, or Medical Info Exists.

REQUEST FINAL BILL IF NO PRE-BILL EDITS
This field contains the setting that indicates that a request for a final bill can be created during the billing suspense days if no PBE edits are found, charges exist, and the suspense days for Patient Processing have elapsed ,meaning patient historization has occurred.

FINAL BILL WITH EXISTING PRE-BILL EDITS
This field contains the carriers and/or carrier/plans that can final bill if pre-bill edits exist (EC2000 CA, STAR billing, STAR claims, 3M 0PPS). Final bill edits are defined for inpatients, outpatients, and emergency patients.

FINAL BILL WITH EXISTING EDITS DOLLAR LIMITS
This field contains, for inpatients, outpatients, and emergency, the minimum dollar amount for which final billing is held when pre-bill edits exist.

SIM DEPTS RECEIVING PRE-BILL EDITS
This column contains the SIM Department (s) to which charge-type edits are assigned rather than the pre-bill edit user of CHG.

PRE-BILL EDIT WORKLIST ASSIGNMENT
This field contains work assignments, by pre-edit bill category, to users.

STATISTICS AGING CATEGORIES
This field contains the aging category time spans for the pre-bill edit statistics reports.

UB SPLIT CLAIMS CRITERIA REPORT - FCRUBS

Description/Purpose

The UB Split Claims Criteria Report reflects the criteria for which UB claims can be split, as defined on the UB Split Claims Criteria table:

- UB Revenue Codes

- FIM HCPCS

- FIM Departments/Items

- Service Date Split

- Charge Level PT Split

- Alternate Claim Load Edit Parameter

- Alternate Charge Control Parameter

- Alternate Provider Master

Generating and Printing This Report

This report is requested through the UB Split Claims Criteria Table option. When you exit the screen, the system displays the following prompt:

Do you want a printed list? (Y/N) [N]

Enter **Y** if you want to generate the report, and then select one or more facilities for the report or All facilities. The report spools immediately to FCRUBSx, where x is the facility. Each facility selected prints a separate report. Therefore, if A for All is selected, and if there is a UB Split Claim Criteria Table of VACC, and this has table settings for both Facility A and Facility B, there will be an FCRUBSA report with facility A's settings and an FCRUBSB report with facility B's settings.

The following is an example of the UB Split Claims Criteria Table report.

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Figure 4.62 Split Claims Criteria Table Report (FCRUBS)

```
Date: 07/09/05                         General Hospital                              FCRUBSA
Time: 10:43am                       UB Split Claim Criteria                          Page 1


AMB - AMBULANCE
UB Revenue Codes: 540
FIM HCPCS: 11111
FIM Departments/Items:
Service Date Split: No
Charge Level PT Split:
Alternate Claim Load Edit Parameter: 50  Ambulance
Alternate Charge Control Parameter: 51 Ambulance Charges
Alternate Provider Master:


MAMM - MAMMOGRAPHY
UB Revenue Codes: 401,403
FIM HCPCS:
FIM Departments/Items:
  RAD - 11112222 Diagnostic Mammography
  RAD - 11119999 Screening Mammography
Service Date Split: No
Charge Level PT Split:
Alternate Claim Load Edit Parameter: 95 Mammography
Alternate Charge Control Parameter: 45 Mammography Charges
Alternate Provider Master: 06 Radiology


VACC - VACCINE
UB Revenue Codes: 771
FIM HCPCS: G0008,G0009,G0010
FIM Departments/Items:
Service Date Split: No
Charge Level PT Split:
Alternate Claim Load Edit Parameter: 63 Vaccine
Alternate Charge Control Parameter: 02 General Outpatient
Alternate Provider Master: 02 Clinic
```

Field Explanations

UB REVENUE CODES
This field contains the revenue codes by which UB claims can be split.

FIM HCPCS
This field contains the FIM HCPCS codes by which UB claims can be split.

FIM DEPARTMENTS/ITEMS
This field contains the FIM Deparments and Items by which UB claims can be split.

SERVICE DATE SPLIT
This field reflects whether UB claims can be split by service date. If Yes is displayed in the field, it means that the system loads a split UB claim for each unique date of service on the charges. If No is displayed in the field, it means that the system does not load a split UB claim by unique service date on the charges.

CHARGE LEVEL PT SPLIT
This field contains the patient types by which UB claims can be split. The patient type at the charge level is used to split the charges, not the patient type at the account level.

ALTERNATE CLAIM LOAD EDIT PARAMETER
This field contains the number and description of the UB Claim Load and Edit Parameter to use for a split claim. If no alternate UB Claim Load and Edit Parameter is listed, the Claim Load Edit Parameter that is linked to the insurance plan is used for the primary claim and for the split claims.

ALTERNATE CHARGE CONTROL PARAMETER
This field contains the number and description of the UB Charge Control Parameter to use for a split claim. If no alternate UB Charge Control Parameter is listed, the Charge Control Parameter that is linked to the insurance plan is used for the primary claim and for the split claims.

ALTERNATE PROVIDER MASTER
This field contains the number and description of the Provider Master to use for a split claim. If no alternate Provider Master is listed, the Provider Master that is linked to the insurance plan is used for the primary claim and for the split claims.

UNUSED MED RECS HCPCS UB CLAIM REPORT - FCR350

Description/Purpose

The Unused Med Recs HCPCS on UB Report (FCR350x) reports on any Unused Medical Records HCPCS for the claim. The system reports the error either on the Primary claim only, or on the Primary and Split claims, based on the setting of the Unused Med Rec HCPCS Prim or Prim/Split field in the UB Charge Control Parameter. If the field is set to Primary, and no Primary claim loads for the bill sequence, the Unused Medical Records HCPCS error appears on the first split claim, based on the priority for the split claims in the UB Charge Control Parameter. If the field is set to Primary/Split, and both a primary and split claims are loaded, each of these claims is listed for the Unused Medical Records HCPCS.

If the service date on the Medical Records HCPCS is within the Bill From and Bill Through Dates, and the UB Charge Control Parameter has this UB Revenue Code set to edit for Unused Medical Records HCPCS, if the HCPCS does not appear on one of the claims (either primary or split), the account and Medical Records HCPCS are reflected on the report.

This report is sorted by the biller for the UB claim, and then alphabetically by patient name.

Generating and Printing This Report

The Unused Med Recs HCPCS on UB Report is generated as a part of Midnight Processing.

The following is an example of the report.

Figure 4.63 Unused Medical Records HCPCS UB CLAIM

```
Date: 10/05/05                           Model Hospital C                          Page  : 1
Time: 01:46pm                   Unused Medical Records HCPCS UB Claim              Report: FCR350C

                                    5 - BILLERFIVE,BILLER

Patient Name              Medical Record #    Account #      PI FC  PT   Admit Date    Discharge Date  Account Balance
                          Bill Seq/Claim Seq's  HCPCS/Mod              HCPCS Srv Date       UB Code
CRANE, NORMAN             C0000000057         0525100001     I  O   I/P  09/08/05      09/08/05           1,143.93
                          4/7,8               01472                    09/08/05             360
                          4/7,8               01486                    09/08/05             360
CRANE, NORMAN             C0000000057         0525600002p    O  O   O/P  09/13/05      09/13/05             996.57
                          9/17,18             90471                    09/13/05             510
                          9/17,18             90750                    09/13/05             490


                                    End of Report
```

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Field Explanations

PATIENT NAME
This field contains the patient name.

MEDICAL RECORD #
This field contains the patient Medical Records number.

ACCOUNT #
This field contains the patient account number.

PI
This field contains the patient indicator. Typical patient indicators are I-inpatient, O-outpatient, and E-emergency.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial classes categorize patients based on fiscal responsibilities. Examples of financial classes include S-self pay, C-commercial and M-Medicare.

PT
This field contains the hospital-defined patient type code which represents such patient segments as regular admission, emergency room, outpatient, same day surgery, and series patients.

ADMIT DATE
This field contains the patient admission date.

DISCHARGE DATE
This field contains the patient discharge date.

ACCOUNT BALANCE
The field contains the account balance.

BILL SEQ/CLAIM SEQ'S
This field contains the bill sequence number and the claim sequence number. The Claim Seq's portion of this field reports either the Primary claim sequence if the Unused Med Rec HCPCS Prim or Prim/Split field is set to Primary, or reports both the Primary and Split claim sequences if the Unused Med Rec HCPCS Prim or Prim/Split field is set to Primary/Split. If there are too many claim sequences to fit in the report column, the report lists as many as will fit and the plus (+) sign.

HCPCS/MOD
This field contains the Medical Records HCPCS procedure code with any attached HCPCS modifiers for Medical Records HCPCS.

HCPCS SRV DATE
This field contains the service date for the Medical Records HCPCS.

UB CODE
This field contains the UB code linked to the Medical Records HCPCS.

PA CHARGES EDITED ON MM/DD/YY BY ACCOUNT (FARCHGA)

Description/Purpose

The PA Charges Edited on MM/DD/YY by Account report (FARCHGAx) lists, by account, changes to HCPCS, HCPCS modifiers, diagnosis, ABN/ABN Reason, Freq ABN/Freq Limit, Dup HCPCS/Reason, and Mutual Excl/Compre/Comp HCPCS in STAR Patient Accounting charge information. The change to STAR Patient Accounting charge information can be made by any of the following functions or the changes can be made because a charge revision from STAR Order Management was received after charge information was edited in STAR Patient Accounting:

- Edit PA Charge function

- Edit PA Charge/Dept

- Pre-bill Edit Command Button Edit PA Charge

- Pre-bill Edit Command Button Edit PA Charge/Dept

This report is sorted by account. If multiple changes were made for a charge on the same day, all of those changes appear together. The account is identified by account number, patient name, financial class, patient indicator, and patient type. The charge is identified by SIM code and description, order number, quantity, charge amount, FIM code, service date, and whether the charge has appeared on a bill.

If the HCPCS code or HCPCS modifiers changed, both the old and new information is displayed, along with a description for the HCPCS code.

If the diagnosis changed, both the old and new diagnosis is displayed, along with a description for the diagnosis. For Diagnosis updates (DX), the system prefaces the Ordering Diagnosis information with either ICD-10 or ICD-9, depending on which is updated. If both the ICD-10 and the ICD-9 Ordering Diagnosis are updated for the charge, both are printed on the report.

If the ABN/ABN Reason, Freq ABN/Freq Limit, Dup HCPCS/Reason, or Mutual Excl/ Compre/Comp HCPCS changed, both the old and new information are displayed. For ABN/ABN Reason updates (ABN), the system will preface the ABN/ABN Reason with the ABN ICD flag of 9 or 10, a slash (/), the ABN, a dash, and the ABN Reason. A blank ABN ICD flag prints a 9.

If the changes occurred due to a charge revision from STAR Order Management, the value of *Yes* appears in the column labeled Charge Revision. If a charge revision is done subsequent to previous STAR Patient Accounting edits of the charge, and no data changed, the charge is displayed on the report with no differences in data reported.

Generating and Printing This Report

The PA Charges Edited on MM/DD/YY by Account can be generated on demand or requested to print during Midnight Processing.

The following is an example of the report.

Figure 4.64 PA Charges Edited by Account Report (FARCHGAx)

```
Date: 08/23/07                                    Model Hospital A                                       Page  : 1
Time: 2:07                                 PA Charges Edited on 08/22/07 by Account                      Report: FARCHGAA


Patient #     Name                                     F/C     IND      Pat Type
 Dept Code    Item Description                         Order   Qty      Chg Amt
  FIM Code     Srv Dte Time  Billed          User Making Change                          Edit Source
  Type          Prior Information                                 Updated Information
----------------------------------------------------------------------------------------------------------------------
A0721200002   NETWORK,FRED                              C       I          I/P
 EEG  3125    24 HR EEG / VIDEO---------------X         43      1       $900.00
   70333125     07/31/07 0000M ADJ-08/11/07-3   Moore,Lori S                            PA
   Serv Time    00:00

A0721200003   NETWORK,TEST                              C       I       I/P
 EEG 3125     24 HR EEG / VIDEO---------------X   43     1          $900.00
   70333125 07/31/07 0000M ADJ-08/11/07-3       Hansen,Peg                             PA
   DX           ICD-10: 124.987 TESTING HEART         ICD-10: 125.710 HEART DIAGNOSIS CODE
                ICD-9: 411.1 INTERMED CORONARY SYND    ICD-9: 414.02 CRN ATH ATLG VN BPS GRFT
   ABN          10/No/ABNN-PATIENT REFUSED TO SIGN    10/Yes/ABNY-PATIENT SIGNED AND WITNESSED
   NDC Info
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

PATIENT #
This field contains the account number.

NAME
This field contains the patient or guarantor name.

F/C
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc.

IND
This field contains the patient indicator. Classes for this field include I-inpatient, O-outpatient, and E-emergency.

PAT TYPE
This field contains the patient type code used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

DEPT CODE
This field contains the SIM code for the charge.

ITEM DESCRIPTION
This field contains the description for the charge. This is the SIM description unless a description override has been keyed manually.

ORDER
This field contains the order number from STAR Order Management.

QTY
This field contains the charge quantity.

CHG AMT
This field contains the charge amount.

FIM CODE
This field contains the FIM code for the charge.

SRV DTE TIME
This field contains the service date and time for the charge.

BILLED
Information is displayed in this column if the charge was billed at the time of the change. The type of bill is displayed, and the possible values are Cyc (Cycle Bill), Fin (Final Bill), Adj (Adjustment Bill), or Late (Late Bill). The bill type is followed by a dash, the bill date, another dash, and the bill sequence number.

USER MAKING CHANGE
This field contains the name of the user editing the STAR Patient Accounting charge.

CHARGE REVISION
If this field contains the value of *Yes*, it indicates that information was edited in STAR Patient Accounting and information was updated due to a charge revision from STAR Order Management. This indicates that the PA Edit flag is removed from the charge. No differences in data may be reported.

TYPE
This field indicates the type of change made and displays one of the following:

- If a change of HCPCS or HCPCS Modifiers is reported in the line, *HCPCS/Mod* is displayed.

- If changes to ABN Processing information are reported in the line, *ABN* is displayed.

- If changes to ABN Processing information concerning the frequency of tests are reported in the line, *Freq ABN* is displayed.

- If changes to duplicate HCPCS information are reported in the line, *Dup HCPCS* is displayed.

- If changes to conflicting HCPCS information are reported in the line, *Con HCPCS* is displayed.

- If a change to the Reference Facility is reported in the line, *Ref Fac* is displayed.

- If a change to the ordering diagnosis is reported in the line, *DX* is displayed.

PRIOR INFORMATION
This field displays the information prior to the change:

- If the change of HCPCS or HCPCS Modifiers is reported in the line, the HCPCS, HCPCS Modifiers, and HCPCS description existing before the change are displayed. This can be the STAR Patient Accounting HCPCS and HCPCS Modifiers or the HCPCS and HCPCS Modifiers from STAR Order Management, if STAR Patient Accounting charge edits did not exist previously. The field can be blank if no HCPCS information existed previously.

- If the change of diagnosis is reported in the line, the diagnosis and diagnosis description existing before the change are displayed. This can be the STAR Patient

Accounting diagnosis or the diagnosis from STAR Order Management, if STAR Patient Accounting charge edits did not exist previously. This field can be blank if no diagnosis existed previously.

- If the change to ABN processing information is reported in the line, *APP* is displayed for Approved, *Yes* is displayed for ABN signed, and *No* is displayed for ABN not signed. If the answer is Yes or No, the ABN Override Reason is displayed. This can be the STAR Patient Accounting ABN/ABN Reason or the ABN/ABN Reason from STAR Order Management, if STAR Patient Accounting charge edits did not exist previously. The field can be blank if no ABN/ABN Reason information existed previously. If the PA ABN indicator is *Yes* for ABN Signed or *No* for ABN Not Signed, and ABN Non Covered is selected in the Print Non-Covered Chgs? field in the UB Charge Control Parameters, the charge amount is included in the non-covered column on the UB.

- If the change to frequency limits for ABN processing information is reported in the line, *Yes* is displayed for ABN signed, and *No* is displayed for ABN not signed. The frequency limit from the Medical Records HCPCS table for the HCPCS is displayed. This can be the STAR Patient Accounting Freq ABN/Freq Limit or the Freq ABN/Freq Limit from STAR Order Management, if STAR Patient Accounting charge edits did not exist previously. This field can be blank if no Freq ABN/Freq Limit information existed previously.

- If the change to duplicate HCPCS information is reported in the line, *Yes* is displayed if the duplicate is medically necessary, and *No* is displayed if it is not. If the duplicate HCPCS is medically necessary, the duplicate override reason is reported. If the duplicate HCPCS is not medically necessary, no reason is reported. This can be the STAR Patient Accounting Dup HCPCS/Reason or the Dup HCPCS/Reason from STAR Order Management, if STAR Patient Accounting charge edits did not exist previously. This field can be blank if no Dup HCPCS/ Reason information existed previously. If the duplicate HCPCS is not medically necessary and Duplicate HCPCS is selected in Print Non-Covered Chgs? field in the UB Charge Control Parameters, the charge amount is included in the non-covered column on the UB.

- If the change to conflicting HCPCS information is reported in the line, the HCPCS for the charge is displayed, followed by the conflicting HCPCS, the type of conflict (Mutually Excl, Comprehensive, or Component), and a Yes/No flag indicating if an appropriate modifier exists. This can be the STAR Patient Accounting Mutual Excl/ Compre/Comp HCPCS or the Mutual Excl/Compre/Comp HCPCS from STAR Order Management, if STAR Patient Accounting charge edits did not exist previously. This field can be blank if no Mutual Excl/Compre/Comp HCPCS information existed previously. If an appropriate modifier does not exist, the conflict type is Mutually Exclusive, and Mutual Exclusive HCPCS Conflict is selected in Print Non-Covered Chgs? field in the UB Charge Control Parameters, the charge amount is included in the non-covered column on the UB. If an appropriate modifier does not exist, the conflict type is Comprehensive or Component, and Component/ Comprehensive HCPCS Conflict is selected in the Print Non-Covered Chgs? field

in the UB Charge Control Parameters, the charge amount is included in the non-covered column on the UB.

- For Diagnosis updates (DX), the system prefaces the Ordering Diagnosis information with either ICD-10 or ICD-9, depending on which is updated. If both the ICD-10 and the ICD-9 Ordering Diagnosis are updated for the charge, both are printed on the report. Both the code and the description print for each diagnosis.

- For ABN/ABN Reason updates (ABN), the system prefaces the ABN/ABN Reason with the ABN ICD flag of 9 or 10, a slash (/), the ABN, a dash, and the ABN Reason. A blank ABN ICD flag prints a 9.

UPDATED INFORMATION
This field displays the updated information:

- If the change of HCPCS or HCPCS Modifiers is reported, the updated HCPCS, HCPCS Modifiers, and HCPCS description are displayed. The field can be blank if the HCPCS information was removed.

- If the change of diagnosis is reported, the updated diagnosis and diagnosis description are displayed. The field can be blank if the diagnosis was removed.

- If the change to ABN processing information is reported in the line, *APP* is displayed for Approved, *Yes* is displayed for ABN signed, and *No* is displayed for ABN not signed. If the value is Yes or No, the ABN Override Reason is displayed.

- If the change to frequency limits for ABN processing information is reported in the line, *Yes* is displayed for ABN signed, and *No* is displayed for ABN not signed. The frequency limit from the Medical Records HCPCS table for the HCPCS is displayed.

- If the change to duplicate HCPCS information is reported in the line, *Yes* is displayed if the duplicate is medically necessary, and *No* is displayed if it is not. If the duplicate HCPCS is medically necessary, the duplicate override reason is reported. If the duplicate HCPCS is not medically necessary, no reason is reported.

- If the change to conflicting HCPCS information is reported in the line, the HCPCS for the charge is displayed, followed by the conflicting HCPCS, the type of conflict (Mutually Excl, Comprehensive, or Component), and a Yes/No flag indicating if an appropriate modifier exists.

- For Diagnosis updates (DX), the system prefaces the Ordering Diagnosis information with either ICD-10 or ICD-9, depending on which is updated. If both the ICD-10 and the ICD-9 Ordering Diagnosis are updated for the charge, both are printed on the report. Both the code and the description print for each diagnosis.

- For ABN/ABN Reason updates (ABN), the system prefaces the ABN/ABN Reason with the ABN ICD flag of 9 or 10, a slash (/), the ABN, a dash, and the ABN Reason. A blank ABN ICD flag prints a 9.

PA CHARGES EDITED ON MM/DD/YY BY DEPARTMENT (FARCHGD)

Description/Purpose

The PA Charges Edited on MM/DD/YY by Department report (FARCHGDx) lists, by department, changes to HCPCS, HCPCS modifiers, diagnosis, ABN/ABN Reason, Freq ABN/Freq Limit, Dup HCPCS/Reason, and Mutual Excl/Compre/Comp HCPCS in PA charge information. The change to STAR Patient Accounting charge information can be made by any of the following options, or the changes can be made because a charge revision from STAR Order Management was received after charge information was edited in STAR Patient Accounting:

- Edit PA Charge function

- Edit PA Charge/Dept function

- Pre-bill Edit Workstation Command Button, Edit PA Charge

- Pre-bill Edit Workstation Command Button Edit PA Charge/Dept

This report is the same as the PA Charges Edited on MM/DD/YY by Account (FARCHGA), except the PA Charges Edited on MM/DD/YY by Account is sorted by account, not department. For more information on these reports, see .

Generating and Printing This Report

The PA Charges Edited on MM/DD/YY by Account can be generated on demand or requested to print during Midnight Processing.

REVISED REFERENCE FACILITY POST BILLING (FBRRFPB)

Description/Purpose

The Revised Reference Facility Post Billing (FBRRFPBx, where x is the facility indicator) reflects the previously billed charges where the Reference Facility indicator was updated on the previous day. This report can be used by the hospital to determine if a new claim should be sent to the payor. If the billed charges were on either a final, adjustment, or late bill, you could use the Edit for Resubmission option to manually update the claim, use the Add Claim to Insurance function to load a new claim for the payor, or request an adjustment bill and claims. An adjustment bill and claim is the method recommended by McKesson, in order to send and replace the claim correctly on Pathways Contract Management and to replace the previous claim on STAR Patient Accounting.

The report reflects updates to the Reference Facility only on previously billed charges. If a user updates the Reference Facility on an unbilled charge, it is not reflected on this report.

The report sorts by Biller (for the Bill), and then Patient Name.

Generating and Printing This Report

This report is created automatically from Midnight Processing for changes made the previous day.

The following is an example of the report.

Figure 4.65 Revised Reference Facility Post Billing (FBRRFPB)

```
Date: 07/18/06                         General Hospital                       Page  : 1
Time: 01:08am                 Revised Reference Facility Post Billing         Report: FBRRFPBA


                                   3 - BILLERTHREE,BILLER

Patient Name                 Medical Rec #    Account #   P FC  P    Admit      Discharge      Account
                                                          I     T    Date       Date          Balance
CARROLL,AUTUMN               A000002256       0529400001  O O  SER  09/01/05                 $ 2,482.00

   BS:  1    Type:Cycle
   Dept: LBA Rev: 300  Srv Date: 09/20/05 FIM: 11112222 ALPHA-1-FETOPROTEIN       Units: 1  Chg:  45.00
                       Prior RF: SK SMITH KLINE              Revised RF: GL GENETICS LABORATORY
   Dept: LBA Rev: 300  Srv Date: 09/20/05 FIM: 11113333 ANTI SMOOTH MUSCLE        Units: 1  Chg:  32.00
                       Prior RF: SK SMITH KLINE              Revised RF: GL GENETICS LABORATORY
   BS:  2    Type:Cycle
   Dept: LBA Rev: 300  Srv Date: 10/30/05 FIM: 11114567 BLOOD ANTIBIOTIC LEVEL TEST  Units: 1  Chg:  25.00
                       Prior RF: SK SMITH KLINE              Revised RF: ARUP ARUP LABORATORY
   Dept: LBA Rev: 300  Srv Date: 10/30/05 FIM: 11119876 ASSAY ALKALINE PHOSPHATASE   Units: 1  Chg:  22.00
                       Prior RF: SK SMITH KLINE              Revised RF: ARUP ARUP LABORATORY
```

Field Explanations

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

PATIENT NAME
This field contains the patient name.

ACCOUNT NO
This field contains the patient account number. The letter *P* following the account number indicates the account was part of the Pre-bill Edit process.

P/I
This field contains the patient indicator. Indicators include I-inpatient, O-outpatient and E-emergency.

F/C
This field contains the hospital-defined financial class code assigned to this patient's account. Financial classes categorize patients based on fiscal responsibilities. Examples of financial classes are S-self pay, C-commercial or M-Medicare.

P/T
This field contains the hospital-defined patient type code used to identify such patient segments as regular admission, emergency room, outpatient, same day surgery, and series patients.

ADMIT
This field contains the patient admission date.

DISCHARGE
This field contains the patient discharge date.

ACCOUNT BALANCE
This field contains the patient's account balance.

BS
This field contains the bill sequence assigned by the system.

TYPE
This field contains the bill type assigned to this patient's account. Valid bill types are C-cycle, A-adjustment, F-final, and L-late.

DEPT
This field contains the charging department.

REV
This field contains the UB Revenue Code on the charge.

SRV DATE
This field contains the service date for the charge.

FIM
This field contains the Financial Item Master (FIM) for this charge item.

UNITS
This field contains the total units of service for the charge.

CHG
This field contains the charge amount.

PRIOR RF
This field contains the prior Reference Facility code and description.

REVISED RF
This field contains the revised Reference Facility code and description.

TODAY'S UNBILLED CHARGE WORKLIST (FAR013)

Description/Purpose

This report reflects all accounts and charges entered for the current processing date where the date of service on the charge was billed previously for the account.

Patient names are printed on this report in account number order. Within the account, the charge detail prints service date, then posting date order. A blank line is inserted if the service date changes for an individual patient.

Generating and Printing This Report

This report is generated nightly as part of Midnight Processing.

The following is an example of the report.

Figure 4.66 Today's Unbilled Charge Worklist (FAR013)

```
Date: 03/10/06                            General Hospital A                                Page  : 1
Time: 0:24                 Unbilled Charges Outside of Billing Window for 03/09/06          Report: FAR013A


Patient #    Name                            Carr/Pln    F/C  IND  Pat Type    Loc      Bill Hold
 Code   Item Description                      Int Order   Qty   Chg Amt   Srv Dte    P Date      Bill Win  Exceeds   BT/BS

--------------------------------------------------------------------------------------------------------------

0408500003   LONG,NATHAN                      500/100    B   I         I/P    AR              O      Old Chg Hold
 3125  24 HR EEG / VIDEO---------------       LSK 000634   1    900.00   01/07/06   03/09/06      60      Yes   CycA/1

 3125  24 HR EEG / VIDEO---------------       LSK 000634   1    900.00   02/07/06   03/09/06      60      No    C/3
 3125  24 HR EEG / VIDEO---------------       LSK 000634  -1   -900.00   02/07/06   03/09/06      60      No    C/3

 3125  24 HR EEG / VIDEO---------------       LSK 000634   1    900.00   02/11/06   03/09/06      60      No    F/7
 3125  24 HR EEG / VIDEO---------------       LSK 000634  -1   -900.00   02/11/06   03/09/06      60      No    F/7

                        Patient Total          5    900.00

0600500113   TALLWAY,SUSAN                    100/100    C   I      I/P  PA  O       Old Chg HOld
 6124  x-Ray of Left Tybia                     KJH 000945   1     90.00   01/07/06   02/09/06      60      Yes   Cyrb/1

                        Patient Total          1     90.00
0600500114   JOHNSON,AL                       100/100    C   I      I/P    AR
 6124  x-Ray of Left Tybia                     KJH 000945  -1    -90.00   02/07/06   03/08/06      30      Yes   F/1

                        Patient Total          1     90.00
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

PATIENT #
This field contains the patient's account number.

NAME
This field contains the patient's name.

CARR/PLAN
This field displays the patient's carrier and plan codes.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities. Examples include S-self pay, C-commercial or M-Medicare.

IND
This field contains the patient indicator. Classes for this field include I-inpatient, O-outpatient, and E-emergency.

PAT TYPE
This field contains the patient type code used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

LOC
This field indicates whether the account is in an Accounts Receivable (AR) location or a PA location. if the account has not been final billed, it is in a PA location.

BILL HOLD
This field contains the Bill Hold description if the account is on Bill Hold.

CODE ITEM DESCRIPTION
This field contains the SIM (Service Item Master) code and description of the item charge.

INT
This field contains the initials of the person entering the charge.

ORDER
This field contains the order number.

QTY
This field contains the quantity of the item ordered.

CHG AMT
This field contains the price of the item ordered.

SRV DTE
This field contains the date the service was performed.

P DATE
This field contains the posting date for the charge.

BILL WIN
This field contains the current value of the Chg Bill Window. This is not the value existing when the charge was evaluated upon receipt in STAR Patient Accounting.

EXCEEDS
This field contains the value of *Yes* if the difference between the posting date and the service date exceeds the current value for the billing window.

UNBILLED CHARGE WORKLIST (FBR116)

Description/Purpose

This report contains all of the accounts that are in the Unbilled Charge Worklist at the time that the report is generated.

Generating and Printing This Report

This report is generated daily as part of Midnight Processing and can also be generated on demand by selecting the Report option from the prompt displayed when you select the Unbilled Charge Worklist function from the Patient Billing Processor.

Figure 4.67 Unbilled Charge Worklist (FBR116)

```
Date: 06/25/07                          General Hospital                              Page  : 1
Time: 02:20am                 Filtered Unbilled Charge Worklist for 06/24/07          Report: FBR116A


Patient #    Name                    Blr  Carr/Pln F/C  IND Pat Type  Loc    Bill Hold                        Days
Dept Code Item Description           Int  Order    Qty      Chg Amt   Srv Dte P Date     Bill Win  Exceeds  BT/BS in W/F
------------------------------------------------------------------------------------------------------------------------
A0110600005  JOHNSON,TERRY           44   500/700  C    I       I/P   AR     Old Chg Bill Hold
 LAB  6102 17 CORTICOSTEROIDS NEW    T J           1-       57.54-  11/30/01 07/06/06        2      Yes     F/115  354
 RMB  1150 CCU ROOM CHARGE           ***           1-      450.50-  11/30/01 07/06/06        2      Yes     F/115  354
 LAB  6102 17 CORTICOSTEROIDS NEW    T J           1-       57.54-  12/01/01 07/06/06        2      Yes     F/115  354
 RMB  1150 CCU ROOM CHARGE           ***           1-      450.50-  12/01/01 07/06/06        2      Yes     F/115  354
 RMB  1150 CCU ROOM CHARGE           ***           1-      450.50-  12/02/01 07/06/06        2      Yes     F/115  354
 RMB  1150 CCU ROOM CHARGE           ***           1-      450.50-  12/03/01 07/06/06        2      Yes     F/115  354
 LAB  6102 17 CORTICOSTEROIDS NEW    T J           1-       57.54-  12/04/01 07/06/06        2      Yes     F/115  354
 LAB  6102 17 CORTICOSTEROIDS NEW    T J           1-       57.54-  12/04/01 07/06/06        2      Yes     F/115  354
 LAB  6102 17 CORTICOSTEROIDS NEW    T J           1-       57.54-  12/04/01 07/06/06        2      Yes     F/115  354
 LAB  6102 17 CORTICOSTEROIDS NEW    T J           1-       57.54-  12/04/01 07/06/06        2      Yes     F/115  354
 LAB  6102 17 CORTICOSTEROIDS NEW    T J           1-       57.54-  12/04/01 07/06/06        2      Yes     F/115  354
 RMB  1150 CCU ROOM CHARGE           ***           1-      450.50-  12/04/01 07/06/06        2      Yes     F/115  354
 LAB  6102 17 CORTICOSTEROIDS NEW    T J           1-       57.54-  12/05/01 07/06/06        2      Yes     F/115  354
                             Patient Total          13     2712.82-

A0113000011  HARDERSEN,WANDA         5              V    I       I/P   PA
 RAD  7364 XR KNEE 4 VIEW  73562     M W  001502    1        66.00  03/08/02 04/20/07        2      Yes     C/11   66
 RAD  9998 RADIOLOGY STAT PRIORITY CHARGE M W 001502 1       16.50  03/08/02 04/20/07        2      Yes     C/11   66
                             Patient Total          2         82.50

A0129500007  WALLS,INPATIENT          4   400/100  H    I       I/P   PA
 RAD  7420 XR ABD SUPINE & UPRIGHT  74020 CSS 000042 1       66.00  11/29/01 01/04/07        2      Yes     C/2    172
 RXA  287  AMERICAINE 20%,1 ML            EH  000031 1-      19.40-  09/23/04 09/19/06        2      Yes     C/35   279
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

PATIENT #
This field contains the patient's account number.

NAME
This field contains the patient's name.

BLR INT
This field contains the initials of the biller assigned to the account.

CARR/PLAN
This field displays the patient's carrier and plan codes.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities. Examples include S-self pay, C-commercial or M-Medicare.

IND
This field contains the patient indicator. Classes for this field include I-inpatient, O-outpatient, and E-emergency.

PAT TYPE
This field contains the patient type code used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

LOC
This field indicates whether the account is in an Accounts Receivable (AR) location or a PA location. If the account has not been final billed, it is in a PA location.

UNBILL CHGS
This field contains the value of all unbilled charges that are on the account.

BILL HOLD
This field contains the Bill Hold description if the account is on Bill Hold.

CODE ITEM DESCRIPTION
This field contains the SIM (Service Item Master) code and description of the item charge.

INT
This field contains the initials of the person entering the charge.

ORDER
This field contains the order number.

QTY
This field contains the quantity of the item ordered.

CHG AMT
This field contains the price of the item ordered.

SRV DTE
This field contains the date the service was performed.

P DATE
This field contains the posting date for the charge.

BILL WIN
This field contains the current value of the Chg Bill Window. This is not the value existing when the charge was evaluated upon receipt in Patient Accounting.

EXCEEDS
This field contains the value of *Yes* if the difference between the post date and the service date exceeds the current value for the billing window.

BT/BS
This field contains the Bill Type and Bill Sequence number associated with the posting date for the charge.

DAYS IN W/F
This field contains the number of days that a charge has appeared in the worklist.

UNBILLED CHARGE WORKLIST WITH PAYMENTS (FAR014)

Description/Purpose

This report lists all accounts that had a payment posted for the current day on an account that has unbilled charges in the Unbilled Charge worklist. Accounts are displayed on this report if a payment is posted to an account for the current day and the account also has charges in the Unbilled Charge Worklist when the report is produced.

Generating and Printing This Report

This report is generated nightly as part of Midnight Processing.

A sample of the report follows.

Figure 4.68 Unbilled Charge Worklist With Payments (FAR014)

```
Date: 03/10/06                              General Hospital                                  Page  : 1
Time: 0:29                       Unbilled Charge Worklist with Payments 03/09/06             Report: FAR014A


Patient #    Name                       Carr/Pln    F/C  IND  Pat Type  Loc  Unbil Chgs    Bill Hold            Pmnt Typ
  Code    Item Description                           Int  Order  Qty    Chg Amt   Srv Dte   P Date      Bill Win  Exceeds   BT/BS
--------------------------------------------------------------------------------------------------------------------------------

0608500003    LONG,SALLY                 500/100     B    I    I/P      AR       9.00    Old Chg Hold            Part
  3124   Tylenol 500mg                               LSK 00945   2      9.00    02/17/06   02/27/06      60      No     F/1

                                Patient Total             1      9.00
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

PATIENT #
This field contains the patient's account number.

NAME
This field contains the patient's name.

CARR/PLAN
This field displays the patient's carrier and plan codes.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities. Examples include S-self pay, C-commercial or M-Medicare.

IND
This field contains the patient indicator. Classes for this field include I-inpatient, O-outpatient, and E-emergency.

PAT TYPE
This field contains the patient type code used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

LOC
This field indicates whether the account is in an Accounts Receivable (AR) location or a PA location. If the account has not been final billed, it is in a PA location.

UNBILL CHGS
This field contains the value of all unbilled charges that are on the account.

BILL HOLD
This field contains the Bill Hold description if the account is on Bill Hold.

PMNT TYP
This field contains the type of payment that was posted to the account. If the account had multiple payments posted on the same date, the most recent type is shown on the report.

CODE ITEM DESCRIPTION
This field contains the SIM (Service Item Master) code and description of the item charge.

INT
This field contains the initials of the person entering the charge.

ORDER
This field contains the order number.

QTY
This field contains the quantity of the item ordered.

PRICE
This field contains the price of the item ordered.

SRV DTE
This field contains the date the service was performed.

P DATE
This field contains the posting date for the charge.

BILL WIN
This field contains the current value of the Chg Bill Window. This is not the value existing when the charge was evaluated upon receipt in STAR Patient Accounting.

EXCEEDS
This field contains the value of *Yes* if the difference between the post date and the service date exceeds the current value for the billing window.

BT/BS
This field contains the Bill Type and Bill Sequence number that is associated with the posting date for the charge.

REFERENCE FACILITY ID NUMBERS REPORT (FTFREF)

Description/Purpose

This report lists the Reference Facility ID Numbers table settings.

Generating and Printing This Report

You can request this report to print when exiting the Reference Facility ID Numbers table.

A sample of the report follows.

Figure 4.69 Reference Facility ID Numbers Report (FTFREF)

```
Date: 05/03/06                              Model Hospital A                        Page  : 1
Time: 01:08am                         Reference Facility ID Numbers                 Report: FTFREF

Code    Description

 1     Smith Kline              BLUE CROSS PROV #: BX1234567890123  BLUE SHIELD PROV #:      BS1234567890123
                                  MEDICARE PROV #:    CARE12345678901  MEDICAID PROV #:          CAID12345678901
                                  PROV UPIN #:        UPIN12345678901  CHAMPUS ID #:            CHAMPUS12345678
                                  PROV COMMERCIAL #: COMM12345678901  PROV PLAN NETWORK ID #: NET123456789012
                                  NPI:                1234567890       EMPLOYER'S ID #:         TAX123456789012
                                  CLIA #:             CLIA123456


 5     Mayo Clinic              BLUE CROSS PROV #: BX11111         BLUE SHIELD PROV #:      BS22222
                                  MEDICARE PROV #:    CARE33333        MEDICAID PROV #:         CAID44444
                                  PROV UPIN #:        UPIN55555        CHAMPUS ID #:            CHAMPUS66666
                                  PROV COMMERCIAL #: COMM77777        PROV PLAN NETWORK ID #: NET88888
                                  NPI:                9876543210       EMPLOYER'S ID #:         TAX99999
                                  CLIA #:             9090909090
```

Field Explanations

CODE
This field contains the ID number for the reference facility, from the Reference Facility ID Numbers table.

DESCRIPTION
This field contains the name of the reference facility.

UNBILLED CHARGES FOR CYCLE BILLS (FBR115)

Description/Purpose

This report contains unbilled charges for accounts that have cycle bills and the service date of the unbilled charges qualifies them to be included on a previously billed cycle bill. Unbilled charges are reported by account. An account is listed in the first section of the report on each date that a charge is posted qualifying for a cycle bill previously produced and the charge is not billed on an Instant Adjustment Bill or during Midnight Processing. Whenever an account is listed, all existing unbilled charges qualifying for a previous cycle bill also are listed.

An account appears in the second section of the report if a cycle adjustment bill was produced due to an Instant Adjustment Bill or was produced during Midnight Processing. The new charges on the cycle adjustment bill are reported.

The Outstanding Unbilled Charges section of the reports contains the reasons that the charges/credits were unbilled and the dollar amount and number of unbilled charges/credits. Accounts included on this report are in a PA or AR location. A transaction is unbilled if it is posted to an account after that account is cycle billed. A transaction could be considered a late charge because it occurred after the account final billed (transferred from PA to AR), but not all unbilled charges on this report are considered late charges, because this report includes accounts in STAR Patient Accounting that have produced cycle bills and haven't been final billed.

The system reviews unbilled charges every night and indicates which accounts had charges that remained unbilled and which ones produced a cycle adjustment bill with new charges. This report does not include accounts that had unbilled charges and didn't qualify for cycle adjustment billing because the CAdj Bill Loc parameter wasn't set to allow cycle adjustment billing.

Accounts with unbilled charges are included on this report if they couldn't be automatically cycle adjustment billed because of one of the following errors:

- Does Not Meet Min $ to Cycle Adj

- Does Not Meet Min # to Cycle Adj

- Cycle Adj Parms Don't exist for the account

- Not Within Number of Days Since Service

The report heading *Unbilled Error Msg.* displays errors that caused unbilled charges on the account. An account could have multiple error messages associated with it.

The report can assist the hospital in identifying which accounts need to be cycle adjustment billed and why an account didn't produce a cycle adjustment bill. Also, the hospital can determine which accounts are being cycle adjustment billed due to

unbilled charges/credits. This report can be used to monitor the type and amount of unbilled charges submitted (by revenue department).

Totals are reported for each patient account, and grand totals are reported for unbilled charge amounts/number by inpatients, outpatients and emergency room patients. Total amounts are reported by account location (PA and AR).

Generating this Report

This report, which is sorted by patient number, is generated during Midnight Processing. If there are no entries on the report, the report spools with the header information and no entries. The report can also be set up as a demand report and printed through the Demand Print function.

Figure 4.70 Unbilled Charges for Cycle Bills Report (FBR115)

```
Date: 02/07/06                              General Hospital                              Page  : 1
Time: 0:24                       UNBILLED CHARGES FOR CYCLE BILLS Report for 02/06/06     Report: FBR115A


UNBILLED ACCOUNTS


Account      Name                  Admit      Disch      PT    F/C                   Acct Balance      Loc
   BS   BT  Bill From/Through DT              Billed Amt    Unbilled Chg #/Total Amt
                  Max Elapsed Dys    Srv Date    Dept  Sim Code  Unbilled Chg Amt
0408500003  LONG,NATHAN           01/01/06   02/28/06    I/P   C                        $30,000.99      PA
    1   C  01/01/06  01/15/06                $1,200.44       3  $3,500.88
                  03/01/06          01/01/06    EEG   3333          $588.88
                                              EEG   3125        $1,000.00
                  03/02/06          01/02/06    EEG   3244        $2,000.00
            Unbilled Error Msg:  Does Not Meet Min $ to Cycle Adj
    4   Z  01/01/06  01/15/06      01/01/06    $1,200.44       2   $1,500.88
                                              EEG   3333          $588.88
                                              EEG   3125        $1,000.00
            Unbilled Error Msg:  Does Not Meet Min $ to Cycle Adj
                               :  Does Not Meet Min # to Cycle Adj
                                  Auto Cycle Adj Bill Not Set
                                  Not Within Elapsed Number of Days Since Service

                  Patient Unbilled Chg-Credit #/Amt     4         $3,000.88



                                  Unbilled Charges              Unbilled Credits
                               #Charges        Amount        #Credits         Amount
                           I/P    11         $8,020.35          999         -$5,000.99
                           O/P     0            .00
                           E/R     4          $318.25


                           Total  15         8,338.60           999         -$5000.99



            Total by Location     PA    15        8,338.60
                                  AR     0           .00

Account      Name                  Admit      Disch      PT    F/C                   Acct Balance      Loc
   BS   BT  Bill From/Through DT              Billed Amt    Unbilled Chg #/Total Amt
                  Max Elapsed Dys    Srv Date    Dept  Sim Code  Unbilled Chg Amt

BILLED ACCOUNTS

0408500003  LONG,NATHAN           01/01/06   02/28/06    I/P   C                        $30,000.99      PA    1   C  01/01/06  01/15/
06               $1,200.44       3  $3,500.88
                  03/01/06          01/01/06    EEG   3333          $588.88
                                              EEG   3125        $1,000.00
                  03/02/06          01/02/06    EEG   3244        $2,000.00
```

Each report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

FIELD EXPLANATIONS

ACCOUNT #
This field contains the patient's account number.

NAME
This field contains the patient's name.

ADMIT
This field contains the date the patient was admitted.

DSCH
This field contains the date the patient was discharged.

PT
This field contains the patient type code used to categorize the patient. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, and series patients.

F/C
This field contains the hospital-defined financial class code assigned to this patient's account.

ACCT BALANCE
This is the current account balance of the selected account.

LOC
This field indicates the location of the account.

BS
This field contains the bill sequence assigned by the system.

BT
This field contains the bill type of C (Cycle).

BILL FROM/THROUGH DT
This field contains the bill from and through dates.

BILLED AMT
This field contains the amount that was billed.

UNBILLED CHG #/TOTAL AMT
This field contains the number of charges/credits that are unbilled and the total dollar amount.

MAX ELAPSED DYS
This field contains the allowable number of elapsed days to qualify for an automatic adjustment bill, as defined in the CycA Max Days Since Service parameter in the Cycle Adjustment Billing Parameters.

SRV DATE
This field contains the service from and through dates.

DEPT
This field contains the department where the service was rendered.

SIM CODE
This field contains the SIM code for each charge.

UNBILLED CHG AMT
This field contains the amount of the unbilled charge.

UNBILLED ERROR MESSAGE
This field contains the reason that the charge was unbilled:

- Does Not Meet Min $ to Cycle Adj

- Does Not Meet Min # to Cycle Adj

- Cycle Adj Parms Don't exist for the account

- Not Within Number of Days Since Service

PATIENT UNBILLED CHG-CREDIT #/AMT
This field contains the number of unbilled charges and credits and the total amount.

UNBILLED CHARGES (# OF CHARGES)
This field contains the number of unbilled charges, by patient type.

UNBILLED CHARGES (AMOUNT)
This field contains the total amount of the unbilled charges, by patient type.

UNBILLED CREDITS (# OF CREDITS)
This field contains the number of unbilled credits, by patient type.

UNBILLED CHARGES (AMOUNT)
This field contains the total amount of the unbilled credits, by patient type.

TOTAL
This field contains the total of unbilled charges and credits.

PRE-BILL EDITS BY RESPONSIBLE PARTY (FCRPRERES)

Description/Purpose

This report lists the existing pre-bill edits by the person assigned to the edit.

The first page of the report lists the report criteria that was entered when requesting the report via the Pre-bill Edit Workfile. If the field is blank, then that data was not used as one of the criteria for the report. Possible criteria: Facility, User Group, SIM Dpt Grp (SIM Department Group), Biller Codes, Registration Clerk, Patient Types, Med Serv (Medical Service), Edit Source, Edit Categories, Carriers, Carrier/Plan, Patient Indicators, PBE Field, Chg SIM Depts (Charge SIM Departments), Chg ID (Charge ID), Chg Location (Charge Location).

When the report is produced out of Midnight Processing, the system reports on the users and user groups that are highlighted in the field "FCRPRERES Report" in the Pre-bill Edit Parameters.

 The beginning of the report has unassigned edits for billers followed by registration clerks. The report then prints by billers, then registration clerks, then other groups such as generic biller, and finally assignments by SIM or SIM Department. Within each responsible party, the accounts with the closest expected bill date and largest unbilled dollar amount are listed on the top of the list.

Generating and Printing This Report

Setup:

 Access the Pre-bill Edit Parameters, and access the field "FCRPRERES Report". Users must highlight the users and user groups that should be reported. This setup screen is used by the system to produce the report out of midnight processing.

Running the Report:

 Access the Pre-bill Edit Workfile, click on Reports on the top, click on Edits by Responsible Party, enter your criteria on the selection screen, click Run Report. NOTE: when requesting the report via the Pre-bill Edit Workfile, the report spools with the printer name based on the user's CRT Names Table entry. Users can enter a dash in the Printer Name field (-) when in View Spooled Reports.

The report can also be produced in Midnight Processing by accessing Tables, PA/AR Parameter Maintenance, Billing Parameters, Pre-bill Edit Parameters, screen 3, setting the field "FCRPRERES Report".

The following is a sample of the Pre-bill Edits by Responsible Party report.

Figure 4.71 Pre-bill Edits by Responsible Party (FCRPRERES)

```
Date: 04/11/12                              General Hospital                      Page  : 1
Time: 13:56                              PBE Edits by Resp Person                 Report: FCRPRERESC


           Facility: C
         User Group: BLL                                                    All Edits: No
        SIM Dpt Grp: CAR, EEG, OT, PT
        Biller Codes: 35, 25, 13, 5, 4, 3, 2, 52, 54, 12, 25, 99, 97, 926, 1, 36, 99, 25, 123, 50, 55, 56, 98, 6
          Reg Clerk:
      Patient Types:                                                        Edit Type: Worklisted
           Med Serv:
        Edit Source:
     Edit Categories:
           Carriers:
      Carrier / Plan:
 Patient Indicators:
          PBE Field:
      Chg SIM Depts:
             Chg ID:
       Chg Location:


See PBE Edit Cat Tbl. Src is (B)illing, (C)laims, (O)PPS, (E)C 2000 CA, EAP(G), (I)CD. Marks are * (reported). w (worked), t (transfer).
```

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Figure 4.72 Pre-bill Edits by Responsible Party (FCRPRERES)

```
Date: 04/11/12                              General Hospital                           Page  : 26
Time: 13:56                              PBE Edits by Resp Person                       Report: FCRPRERESC

                              Pre-bill Edit User PBE Group -Biller - Generic


Account No.      Patient Name          P.T.  Med Srv Admit Dt  Disch Dt Exp Bill Dt Abstract Comp   Unbilled Chgs   Account Bal
----------------------------------------------------------------------------------------------------------------------------
C1120200001     TEST,FACILITYC         O/P    MED   07/21/11  07/21/11  07/21/11                       $1,091.68      $1,091.68

Med Rec #: 0000000114                     Pre/Adm Int:   /KEC     Carrier Plan:  100/100      0

Cat Src Int Data Value                         Error Message
--- --- --- ----------------------------------  -----------------------------------------------------------------------------
 D   B                                          CONDITION CODE 11 is Required
                                                  COM: Some condition codes may be auto loaded per the Provider Master.
 D   B                                          TREATMENT AUTHORIZATION CODE is Required
 D   B                                          OCCURRENCE SPAN CODE 1 is Required
 M   B                                          ICD10 PRINCIPAL DIAGNOSIS CODE is Required
 M   B                                          ABSTRACT COMPLETE DATE is Required
 M   C                                          Unused Medical Records HCPCS 01486-07/21/11-370

 Account No.     Patient Name          P.T.  Med Srv Admit Dt  Disch Dt Exp Bill Dt Abstract Comp   Unbilled Chgs   Account Bal
----------------------------------------------------------------------------------------------------------------------------
C1122800001     SMITH,PATIENT          O/P    MED   08/16/11  08/16/11  08/16/11                       $3,681.02      $3,681.02

Med Rec #: 0000000114                     Pre/Adm Int:   /KEC     Carrier Plan:  100/100     100/200

Cat Src Int Data Value                         Error Message
--- --- --- ----------------------------------  -----------------------------------------------------------------------------
 I   C                                          Provider Other ID FL 32 is Required
                                                  COM: Determined from Provider Master for insurance or account provider.
 I   C                                          Insured's Policy # FL 1 is Required
 D   C                                          Refer Phy ID Upper FL 17 is Required
                                                  COM: Check physician table for referring physician.
 D   C                                          Refer Phy ID Lower FL 17 is Required
 M   C                                          ICD10 Reason for Visit DX C is Required
 M   B                                          ICD10 PRINCIPAL PROCEDURE CODE is Required
 C   I  KEC                                     ICD9 Needs ICD-9 diagnosis (CHG 4 CAR/1100/ECG 12 LEAD- 15-UPDATE 22) (PA/4)
 C   I  KEC                                     ICD9 Needs ICD-9 diagnosis (CHG 3 CAR/1104/ECG PROFESSIONAL FEE) (PA/3)
 C   C  KEC                                     0985            10/10/11 HCPCS required for UB Claim (CHG 3 CAR/1104)
                                                  COM: Required HCPCS is not present.
See PBE Edit Cat Tbl. Src is (B)illing, (C)laims, (O)PPS, (E)C 2000 CA, EAP(G), (I)CD. Marks are * (reported). w (worked), t (transfer).
```

Field Explanations

Report Selection Page:

FACILITY
This field contains the name of the facility selected to review.

USER GROUP
This field contains the name of the user group(s) selected to appear on the report.

SIM DEPARTMENT
This field contains the SIM Department(s) selected to appear on the report.

BILLER CODES
This field contains the pre-bill edit biller code(s) selected to appear on the report.

REG CLERK
This field contains the registration clerk(s) selected to appear on the report.

PATIENT TYPES
This field contains the patient types selected to appear on the report.

MED SERV
This field contains the medical services selected to appear on the report.

EDIT SOURCE
This field contains the source of the edit that are selected to appear on the report. Sources are Billing (B), Claims (C), OPPS (O), EC electronic claims (E), EAPG (G), and ICD (I).

EDIT CATEGORIES
This field contains the edit categories selected to appear on the report. Categories include Charge (C), Demographic (D), Insurance (I), No CA Claim (E), Medical Records (M), and Utilization Review (U).

CARRIERS
This field contains the carrier(s) selected to appear on the report.

CARRIER/PLAN
This field contains the carrier and plan code(s) selected to appear on the report.

PATIENT INDICATORS
This field contains the patient indicator(s) selected to appear on the report, for example I-inpatient or O-outpatient.

PBE FIELD
This field contains the pre-bill edit fields selected to appear on the report.

CHG SIM DEPTS
This field contains the charge SIM Departments selected to appear on the report.

CHG ID
This field contains the charge ID selected to appear on the report.

CHG LOCATION
This field contains the charge locations selected to appear on the report.

Body of Report:

ACCOUNT NUMBER
This field contains the patient's account number.

PATIENT NAME
This field contains the patient's name.

P.T.
This field contains the patient type.

MED SRV
This field contains the account's medical service.

ADMIT DT
This field contains the patient's date of admission.

DISCH DT
This field contains the patient's date of discharge.

EXP BILL DATE
This field contains the expected bill date, which is calculated by the system based on the Bill Suspense Days for the patient's final bill.

ABSTRACT COMP (ABSTRACT COMPLETE DATE)
This field contains the date the abstract was complete.

UNBILLED CHGS
This field contains the dollar amount of the unbilled charges.

ACCOUNT BAL
This field contains the dollar amount of the account balance.

MED REC #
This field contains the Medical Record Number.

PRE/ADM INT
This field contains the pre-admission and the admission registrar's Initials,

CARRIER PLAN
This field contains the carrier and plan codes.

CAT
This field contains the category from the PBE Edit Category Table. Categories include Charge (C), Demographic (D), Insurance (I), No CA Claim (E), Medical Records (M), and Utilization Review (U).

SRC
This field contains the source of the edit. Sources are Billing (B), Claims (C), OPPS (O), EC electronic claims (E), EAPG (G), and ICD (I).

INT
For charge edits, these are the Initials of the person that placed the charge.

DATA VALUE
This field contains the data in error if applicable. Since most edits are reporting on the absence of data, this field will be blank for the majority of edit lines.

ERROR MESSAGE
This field contains the error message for this edit.

CHARGES MISSING DIAGNOSES (FARDXMx))

Description/Purpose

The Charges Missing Diagnoses Report (FARDXMx) prints the accounts that have an Account ICD flag of B for Both, that have charges with an ICD-10 Ordering Diagnosis, but no ICD-9 Ordering Diagnosis, and charges with an ICD-9 Ordering Diagnosis, but no ICD-10 Ordering Diagnosis.

This report also prints the accounts that have an Account ICD flag of 9 for ICD-9, that have charges with only an ICD-10 Ordering Diagnosis, and accounts that have an Account ICD flag of 10 for ICD-10, that have charges with only an ICD-9 Ordering Diagnosis.

Charges that have no Ordering Diagnosis are not on the report.

The report sorts by Account Number.

Generating and Printing This Report

The report prints nightly during Midnight Processing, and charges appear on the Midnight Processing version of the report only once.

To produce a cumulative report, you can access Billing and Claims, Patient Billing, Rerun Charges Missing Diagnosis Report. After you select the facility, the system prompts:

> *Enter starting date for report--* |

The system can only produce a cumulative report for the last 35 days. If a starting date is entered that is prior to that, the system gives the following error message:

> *Error: Date cannot precede current date by more than 35 days!*

Once the starting date is entered, the system prompts for the ending date:

> *Enter ending date for report--* |

On the cumulative report, the Account ICD flag is re-checked, as are the charges, to see if either the Account ICD flag was updated to negate the charges being on the report, or the charges updated to have the missing ordering diagnosis.

The following is a sample of the report.

Figure 4.73 Charges Missing Diagnoses Report

```
Date: 07/02/08                         General Hospital                  Page : 1
Time: 02:38pm                    Charges Missing Diagnoses for 07/01/08           Report: FARDXMA


Patient #     Name                    Carr/Pln F/C  Pat Type Loc Acct ICD
 Dept Code Item Description           Int  Chg#   Qty     Chg Amt Srv Dte  Post Dte  DX              Type
--------------------------------------------------------------------------------------------------------
A0000500300   HANSEN,PEG              500/700  S    OPE      AR  B
 CSR  6070 CONNECTOR, "Y"----------------  P M  000001    1       5.00 07/01/08 07/01/08 M48.50xA-TESTING HEART 10
 EEG  3120 24 HOUR AMBULATORY EEG / SCAN   P M  000002    1      80.00 07/01/08 06/30/08 825.1-FRACTURE CALC     9
 CAR  1100 ECG 12 LEAD------------------   P M  000003    1     109.50 07/01/08 07/01/08 M79.661A-MORE 10 TEST  10
 CSR  6070 CONNECTOR, "Y"----------------  P M           1       5.00 07/01/08 07/01/08 823.11-FX FEMUR SHAFT   9
                          Patient Total    4             199.50 07/01/08 06/30/08 123.45xD-ANOTHER TEST  10
```

Each report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

Field Explanations

PATIENT #
This field contains the account number.

NAME
This field contains the patient name.

CARR/PLAN
This field displays the patient's carrier and plan codes.

F/C
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc.

PAT TYPE
This field contains the patient type code used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, series patients, etc.

LOC
This field contains the account's location: PA, AR, or BD.

ACCT ICD #
This field contains the account's ICD flag. Values are 10 for ICD-10, 9 for ICD-9, or B for Both.

DEPT CODE
This field contains the charge department.

CODE
This field contains the SIM code for the charge.

ITEM DESCRIPTION
This field contains the description for the charge. This is the SIM description unless a description override has been keyed manually.

INT
This field contains the Initials of the person placing the charge

CHG #
This field contains the charge number.

CHG AMT
This field contains the charge amount.

QTY
This field contains the quantity for each charge.

SRV DTE
This field contains the service date for the charge.

POST DTE
This field contains the date the charge was posted to the account.

DX
This field contains the ordering diagnosis code and description for this charge item.

TYPE
This field contains the ordering diagnosis that exists on the account, either 10 for ICD-10 or 9 for ICD-9.

COMBINE BILL EDIT MESSAGES (FBR293)

Description/Purpose

This report lists accounts for which the system has not produced combined bills because the Combine To account failed billing. The combine bill accounts on the report need to be reviewed because an edit is holding the To account from billing. The reviewing of this report needs to be added as a process at your hospital. The bill edit that is holding the To account can either be a specific combine bill edit or a regular bill edit that is associated with the To account. All of the combine bill billing requirements that the To Account is failing for will be included on the report. The report also contains the Combine From Account numbers that are associated with the Combine To Accounts. Accounts are considered for this report when the Combine To Account has a bill request and is failing a bill requirement(s). If the Combine To account can't bill because of a combine bill edit associated with the To account that indicates data is missing on the From Account. The associated combine bill edit will display on the report for the corresponding From account. If a Combine To account can't bill because it is failing bill edits associated with data on theTo account and all of the data on the From Account is fine (according to the combine bill edits defined) the account will still be listed on the report. The combine bill To/From combination won't have any edits listed under the From account so the biller will know that the reason the account remains on the report is because of issues with the To account. The report is sorted by To Biller and Account Name.

Generating the Report

The Combine Bill Edit Messages report is generated during Midnight Processing. The following is an example of the report.

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Figure 4.74 Combine Bill Edit Messages Report

```
Date: 08/06/09                              General Hospital                        Page  : 1
Time: 19:34                                 Bill Edit Msgs                          Report: FBR293


                                        3 - BILLERTHREE,BILLER



To:   Name                        Acct #      Pt  FC  Adm Dt   DC Dt    LOC                    Acct Bal
From: Name                        Acct #      Pt  FC  Adm Dt   DC Dt    LOC  M/B  Service Date Range   Acct Bal
        Message

   KING, MARK                     A0921100001 O/P O  07/30/09 07/30/09 AR                       624.90
   KING, MARK                     A0921100002 ER  O  07/30/09 07/30/09 PA   NO   EARLIEST - LATEST   0.00
        COMB BILL HCPCS CODE WITH FROM EDIT is Required
        COMB BILL FROM ACCT ON BILL HOLD

Date: 08/06/09                              General Hospital                        Page  : 2
Time: 19:34                                 Bill Edit Msgs                          Report: FBR293


                                        98 - WEISSMANN,NANCY L



To:   Name                        Acct #      Pt  FC  Adm Dt   DC Dt    LOC                    Acct Bal
From: Name                        Acct #      Pt  FC  Adm Dt   DC Dt    LOC  M/B  Service Date Range   Acct Bal
        Message

   TEST,MAUDE                     A0917000001 I/P M  06/19/09 07/10/09
```

Field Explanations

NAME
This field displays the name of the patient to which charges were transferred (that is, the patient whose account is now accountable for the charges).

ACCT #
This field displays the number of the account to which charges were transferred.

PT
This field displays the patient type from the Charge To account.

FC
This field displays the financial class from the Charge To account.

ADM DT
This field displays the admission date from the Charge To account.

DC DT
This field displays the discharge date from the Charge To account.

LOC
This field displays the account location for the Charge To account.

ACCT BAL
This field displays the account balance for the Charge To account.

NAME
This field displays the name of the patient from which charges were transferred (for example, the patient against whose account the charge was initially placed).

This field displays the name of the patient to which charges were transferred (that is, the patient whose account is now accountable for the charges).

ACCT #
This field displays the number of the account from which charges were transferred

PT
This field displays the patient type from the Charge FROM account.

FC
This field displays the financial class from the Charge FROM account.

ADM DT
This field displays the admission date from the Charge FROM account.

DC DT
This field displays the discharge date from the Charge FROM account.

LOC
This field displays the account location for the Charge FROM account.

M/B (MOM AND BABY FLAG)
This field displays Yes if this is a mother/baby billing combination, or No if this is not a mother/baby billing combination.

SERVICE DATE RANGE
The service date range from the combine bill request displays. This may be specific service dates or it may be Earliest to Latest.

ACCT BAL MESSAGE
This field displays the Combine Bill edit message. This message indicates what information is needed on the From Account or what is preventing the To account from billing. Valid bill edit messages are:

COMB BILL FROM ACCT ON BILL HOLD

COMB BILL ABSTRACT COMPLETE DATE is Required

COMB BILL HCPCS CODE is Required

COMB BILL PRINCIPAL DIAG is Required

COMB BILL PRINCIPAL DIAG (MR/ADM) is Required

COMB BILL PRINCIPAL PROCEDURE is Required

COMB BILL ABS COMP DT W/FR EDIT is Required

COMB BILL HCPCS CODE W/FR EDIT is Required

COMB BILL PRIN DX W/FR EDIT is Required

COMB PRIN DX (MR/ADM) W/FR EDIT is Required

COMB BILL PRIN PROC W/FR EDIT is Required

The edit logic for the edit messages above is as follows:

When a Charge To account is being reviewed for billing and a Combine Bill edit is associated with the account, the system reviews all Combine From accounts for the information specified in the billing edit as follows:

• COMB BILL ABSTRACT COMPLETE DATE

If this internal element is selected as a Billing Requirement, the following message is produced if the Abstract Complete Date is not indicated for one of the charge from accounts: COMB BILL ABSTRACT COMPLETE DATE is Required

- COMB BILL NO BILL HOLD

  If this internal element is selected as a Billing Requirement, the following message is produced if one of the charge from accounts is on bill hold. This occurs when H (billing (H)old) is selected for the Billing Status in Account Status. This does not apply to other bill hold statuses which are D (DPW billing hold), B (CPTAFB billing), or O (Old Charge Hold): COMB BILL FROM ACCT ON BILL HOLD

- COMB BILL HCPCS CODE 1

  If this internal element is selected as a Billing Requirement, the following message is produced if the first HCPCS code is not present for one of the charge from accounts: COMB BILL HCPCS CODE is Required

- COMB BILL PRINCIPAL DIAG

  If this internal element is selected as a Billing Requirement, the following message is produced if the Medical Records principal diagnosis is not present for one of the charge from accounts. COMB BILL PRINCIPAL DIAG is Required

- COMB BILL PRINCIPAL DIAG (MR/ADM)

  If this internal element is selected as a Billing Requirement, the following message is produced if the principal diagnosis is not present for one of the charge from account: COMB BILL PRINCIPAL DIAG (MR/ADM) is Required

  If this internal element is selected the system requires the presence of a principal diagnosis in Medical Records. Otherwise, the internal element requires the presence of a principal diagnosis in Patient Processing. This matches the logic used for the internal element PRINCIPAL DIAG CODE (MR/ADM).

- COMB BILL PRINCIPAL PROCEDURE

  If this internal element is selected as a Billing Requirement, the following message is produced if the Medical Records principal procedure is not present for one of the charge from accounts: COMB BILL PRINCIPAL PROCEDURE is Required

Combine Bill Internal elements with From Edit

The same combine bill internal elements are available as bill requirements for editing for medical records information are also available with an additional check called *from editing*. The way the combine bill requirements for From Edit internal elements work is that they check for the data specified in the To bill requirement on the From account. If the data needed for the bill requirement isn't present, the logic does additional check

to see if the From account has a bill requirement that corresponds to the bill requirement on the To account. If the From account has a bill requirement that corresponds to the bill requirement on the To account, the Combine To account fails the bill requirement. If the From account doesn't have a bill requirement that corresponds to the bill requirement on the To account, the Combine To account does not fail the bill requirement even if it is missing the information specified in the To Billing requirement.

 Here is a list of the internal elements and the associated internal element that is used in the *from edit* validation:

-COMB BILL ABS COMP DT W/FR EDIT is associated with Abstract Complete Date

-COMB BILL HCPCS CODE 1 W/FR EDIT is associated with HCPCS Code 1.

-COMB BILL PRIN DX W/FR EDIT is associated with Prin DX.

-COMB BILL PRIN DX (MR/ADM) W/FR EDIT is associated with Prin DX (MR/ADM).

-COMB BILL PRIN PROC W/FR EDIT is associated with Prin Procedure.

The following is an example of how a From Edit called COMB BILL ABS COMP DT W/ FR Edit functions when defined on the Billing Requirements for a To Account:

The system reviews all of the To account's corresponding From Accounts for the presence of the Abstract Complete Date data. If the Abstract Complete Date is not present on the Combine From Accoun, the system reviews the Bill Requirements on the From Account to see if the Abstract Complete Date Bill Requirement is defined. If the Abstract Complete Date Bill Requirement is defined for the From Account, an edit message is displayed for the From Account as follows:

  COMB BILL ABS COMP DT W/FR EDIT is Required

If the Abstract Complete Date Bill Requirement is not defined for the From Account, the To account does not fail the bill requirement and an error message is not displayed display for the From/To pair indicating the abstract complete date is required.

The From Edit logic is used so that if hospitals want to be specific on what medical records information is needed for a combine from account, they can define the billing requirements accordingly. This is for hospitals that have defined a unique billing requirement code for their outpatient and inpatients. If a hospital has just one billing requirement code for outpatients and inpatients or needs a general billing requirement to alert the biller that information is required from medical records, a combine bill internal element with from edit logic isn't needed. The hospital could then use one of the combine bill internal elements that don't review the From account for a corresponding bill edit.

Following is a scenario to illustrate why/where a Combine edit using From logic might be needed at your hospital depending on the processes and table setup at your hospital:

Establish two different combine bill links with one combine bill link between an outpatient Combine From account and an inpatient Combine To account and another combine bill link between an inpatient Combine From Account and an inpatient Combine To account. There should be a bill requirement code associated with the outpatient account and a different one associate with the inpatient account. Note the bill requirement code is associated with the Final Bill parameter.

Define the edits as follows:

On the inpatient billing requirements code, the following bill requirements should be defined:

  -COMB BILL PRIN PROC W/FR EDIT is associated with Prin Procedure.

  -COMB BILL HCPCS CODE 1 W/FR EDIT is associated with HCPCS Code 1.

  -PRIN PROCEDURE CODE

On the outpatient billing requirement code the following bill requirement should be defined:

HCPCS Code 1.

When editing the To accounts, the sytem first looks to see what specific combine bill requirements are defined. Next the system determines if the combine bill requirement mandated that a corresponding bill requirement be present on the bill requirements for the From account to proceed with the editing. If on the outpatient Combine From account the HCPCS Code 1 Bill Requirement is defined on the bill requirements code associated with From account, the system would review for the data specified in the Comb Bill HCPCS Code 1 W/FR Edit on the From Account. It would also look to see if the outpatient Combine From account the Principal Procedure edit is defined on the bill requirements on the From account. In our scenario the Principal Procedure edit was not defined as a bill edit on the outpatient Combine From account so the system wouldn't require a principal procedure code on the outpatient combine from account but it would require a HCPCS code. In our scenario, the inpatient Combine From account had the Principal Procedure Bill Requirement defined on the bill requirements code associated with the From account so the system would review for the data specified in the Comb Bill Prin Procedure Code W/FR Edit.

In our scenario, since we had different bill requirement codes for inpatients and outpatients so the hospital had the flexibility through the Combine bill Requirements with From Edit logic to determine what data it needed from medical records by inpatients and outpatients.

Here is how the system edits with the From Logic Combine Bill Requirements:

- COMB BILL HCPCS CODE 1 W/FR EDIT

  If this internal element is selected as a Billing Requirement, the following message is produced if the first HCPCS code is not present for one of the charge from accounts and the bill edit for HCPCS Code 1 is associated with the bill requirements for the Combine From account: COMB BILL HCPCS CODE WITH FROM EDIT is Required

- COMB BILL PRINCIPAL DIAG W/FR EDIT

  If this internal element is selected as a Billing Requirement, the following message is produced if the Medical Records principal diagnosis is not present for one of the charge from accounts and the bill edit for Principal Diagnosis is associated with the bill requirements for the Combine From account: COMB BILL PRINCIPAL DIAGNOSIS WITH FROM EDIT is Required.

- COMB BILL PRINCIPAL DIAG (MR/ADM) W/FR EDIT

  If this internal element is selected as a Billing Requirement, then the following message is produced if the principal diagnosis is not present for one of the charge from accounts and the bill edit for Principal Diagnosis Code (MR/ADM) or for Principal Diagnosis is associated with the bill requirements for the Combine From account: COMB BILL PRINCIPAL DIAGNOSIS (MR/ADM) WITH FROM EDIT is Required.

  If this internal element is selected the system requires the presence of a principal diagnosis in Medical Records. Otherwise, the internal element requires the presence of a principal diagnosis in Patient Processing. This matches the logic used for the internal element PRINCIPAL DIAG CODE (MR/ADM).

- COMB BILL PRINCIPAL PROCEDURE W/FR EDIT

  If this internal element is selected as a Billing Requirement,the following message is produced if the Medical Records principal procedure is not present for one of the charge from accounts and the   bill edit for Principal Procedure Code is associated with the bill requirements for the Combine From account: COMB BILL PROCEDURE CODE WITH FROM EDIT is Required.

ACCOUNTS WITH INSURANCE BALANCE > ZERO AND ACCOUNT BALANCE <= ZERO (FAR140)

Description/Purpose

The Accounts with Insurance Balance > Zero and Account Balance <=0 Report lists the accounts (AR accounts only) which have met the criteria for a balance transfer if the overall account balance is a credit, but the insurance balance is not a credit. The criteria that must be met by an account with a remaining insurance balance are:

- Account Balance<=0

- Disposition for the claim for the activity (payment or adjustment) is a final

- Disposition for other remaining claims for all insurances listed on the account is final

- Account is not in location PA

- Third Party Excess is zero

If the above criteria is met the payment is included on the FAR140 report with the following message: No balance transfer - Account Balance is 0 or less.

Two parameters determine whether the balance transfer can occur if the criteria are met:

- The No Bal Xfer Due to Acct Balance field on the Cash Exception Reporting Parameters screen

- The Xfer to Pat AB <=0 field on the Balance Designation Parameters in the Maintain Facility Information screen. This parameter can be set to include an account on the report only or transfer the balance and include the account on the report.

Generating the Report

The Accounts with Insurance Balance > Zero and Account Balance <=0 report is generated during Midnight Processing. The following is an example of the report.

Figure 4.75 Accounts with Insurance Balance>Zero and Account Balance
< Zero (FAR 140)

```
Date: 05/11/10                              Model Hospital A                              Page  : 1
Time: 1:03                  Accounts with Insurance Balance > Zero and Account Balance <= Zero          Report:
FAR170A


Account #        Patient Name                    COB CR/PL      Old Ins Bal  Old Accnt Bal     Old Pt Bal  Transc Date/Time
                                                                New Ins Bal  New Accnt Bal     New Pt Bal  Type    Batch#

A1012500001      PARKS,TONI                       1   750100        5.00        5.00-           10.00-  05/10/10 16:50
                                                                                                        Pymt      43

A1012600005      SMITH,JON                        1   750100        5.00        5.00-           10.00-  05/10/10 17:00
                                                                                                        Pymt      45

                                                End of Report
```

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Field Explanations

ACCOUNT NO
This field contains the patient account number.

PATIENT NAME
This field contains the patient name.

COB
This field displays the coordinate of benefits indicator for this claim. This field displays COB 1, 2, 3, or 4.

CR/PL
This field contains the carrier and carrier plan code associated with this account.

OLD INS BAL/NEW INS BAL
This field contains the insurance balance before and after the balance transfer.

OLD ACCNT BAL/NEW ACCNT BAL
This field contains the account balance before and after the balance transfer.

OLD PT BAL/NEW PAT BAL
This field contains the patient's balance before and after the balance transfer.

TRANSAC DATE/TIME TYPE
This field contains the transaction date and time.

BATCH #
This transaction contains the batch number for the transaction.

PRE-BILL EDITS BY CODE FOR AR ACCOUNTS (FCRPREERR)

Description and Purpose

This report lists the number of pre-bill edits by edit categories for final billed accounts. The report counts the number of edits that existed for accounts in the time frame entered, that are now in the AR file. Edits are counted even if they were corrected on the accounts prior to the account moving to AR.   The Billing/Claim Delays report displays the lag time from billing suspense days. The PBE information reflects accounts reviewed by Pre-bill Edit.The Non-PBE information reflects accounts not part of the Pre-bill Edit process. If working the Pre-bill Edit Workfile entries, the PBE lines of information should have most counts in the fewest days and the Non-PBE should have most counts in the larger number of days not being able to be billed.

The Pre-bill Edits by Code report is created when in the field "Report Options" of the optional batch job, the user enters E for Edits by Code, or B for Both reports. For the Edits by Code Report, the report prints each Category and Source, and the Edit Descriptions within each Category and Source, for the accounts that are now in the AR file that had the edit at any time before moving to AR. For each Edit Description, the report gives account counts by patient indicators Inpatient, Outpatient, and Emergency, and a Total count. The number of accounts included on the report is dependent on the "Time Frame for FCRPREERR" when scheduling the optional batch job.

The Billing/Claim Delays report is created when in the field "Report Options" of the optional batch job, the user enters D for Delays, or B for Both reports. The number of accounts included on the report is dependent on the "Time Frame for FCRPREERR" when scheduling the optional batch job. For the Billing/Claim Delays report, the system uses the aging categories in the Facility Pre-bill Edit Parameters. If the date is not known in order to place the count in one of the aging categories, the entry appears in the Unknown category. The report has counts for the following categories:

- Number of days billing delayed for non pre-bill accounts

- Number of days billing delayed for pre-bill accounts

- Number of days billing delayed for all accounts

- Number of days before non pre-bill claims passed edits

- Number of days before pre-bill claims passed edits

- Number of days before all claims passed edits

- Number of days before non pre-bill claims returned from Pre-bill EC 2000 CA (where CA is Claims Administrator)

- Number of days before pre-bill claims returned from Pre-bill EC 2000 CA

- Number of days before all claims returned from Pre-bill EC 2000 CA

Generating and Printing This Report

To run this report, access Financial System Management, Optional Batch Jobs, Optional Batch Jobs Processor, and enter job number 120 or do a table lookup and select the Pre-bill Edit Report FCRPREERR.

Within the optional batch job screen, enter the field "Time frame for FCRPREERR". The system prompts:

Enter number of previous days to include in the report—

Data is retained on the system based on the field "Stats Purge" on the Pre-bill Edit Parameters screen. Therefore, if the number of days entered in the optional batch job request is greater than the days in the Stats Purge field, the system will only have the data according to the Stats Purge.

In the field "Report Options" enter if you want just one of the reports (and specify which) or both:

Produce (E)dits by Code, Billing/Claim (D)elays, or (B)oth reports—

A sample of the two reports is shown on the following pages.

NOTE: The following is an example only of some of the edits that can appear on the Pre-bill Edits for AR Accounts report. There are many more possible edits, and the edits will differ by hospital depending on the requirements set.

Figure 4.76 Pre-bill Edits by Code for AR Accounts (FCRPREERA)

```
Date: 04/16/12                          General Hospital                       Page : 1
Time: 01:31am                   Number of Edits by Code for AR Accounts            Report: FCRPREERRA
                                        02/15/12 to 04/15/12


Category and Source
  Edit Description                                    Inpatient  Outpatient  Emergency    Total


Charge Edits for OPPS Edits
  MNE Error 1 Edits present on claim                                  1                      1
  UBRV HCPCSm1m2 MM/DD/YY Code not used by OPPS. Look for diff        1                      1
  UBRV HCPCSm1m2 MM/DD/YY Comp of xxxxx. Eval for modifier.          2                      2
  UBRV HCPCSm1m2 MM/DD/YY Duplicate radiology code                   1                      1
  UBRV HCPCSm1m2 MM/DD/YY HCPCS and Dx failed med necessity          3                      3
  Total                                                             8                      8



Charge Edits for Star Billing Requirements
  DX                                                    1            2                      3
  Total                                                 1            2                      3

Charge Edits for Star Claim Edits
  DOCTOR ADDRESS LINE 1\1500 PHYSICIAN (GROUP) (Required)     5            8                     13
  DOCTOR UPIN NUMBER\1500 PHYSICIAN (SUPPLIER) (Required)     6            9                     15
  Total                                                11           17                     28

Charge Edits for EC 2000 CA Edits
  28591 (Charges) Purchased Service- Provider ID is required w    1        12         3        16
  4205 (Charges) - FL42- Revenue Code is not valid for this FL    1         7         4        12
  4415 Commercial - (FL44) HCPCS Code is required with (FL42)              17                  17
  4511 (Charges) FL45- Service Date is required for each FL42-    1         5         2         8
  Total                                                 3        41         9        53

Charge Edits for ICD
  EEG#3120 Needs ICD-10 diagnosis                       1         4                   5
  RAD#6070 Needs ICD-9 diagnosis                        1        12                  13
  CAR#6070 Needs ICD-9 diagnosis not ICD-10 diagnosis.  1         7                   8
  LAB#3120 Needs ICD-10 diagnosis not ICD-9 diagnosis.  1         2         1         4
  Total                                                 4        25         1        30


                                        End of Report
```

Field Explanations

CATEGORY AND SOURCE
This field contains the pre-bill edit category and source. Categories include Charge (C), Demographic (D), Insurance (I), No CA Claim (E), Medical Records (M), and Utilization Review (U). Sources include Billing (B), Claims (C), OPPS (O), EC electronic claims (E), EAPG (G), and ICD (I).

EDIT DESCRIPTION
This field contains a description of the edit.

INPATIENT
This column contains the number of edits for inpatient accounts.

OUTPATIENT
This column contains the number of edits for outpatient accounts.

EMERGENCY
This column contains the number of edits for emergency accounts.

TOTAL
This column contains the total for the number of inpatient, outpatient, or emergency edits.

Figure 4.77 Billing and Claim Delays for AR Accounts (FCRPREERR)

```
Date: 04/12/12                           General Hospital                    Page  : 1
Time: 1:31                       Billing and Claim Delays for AR Accounts     Report: FCRPREERRC
                                        01/12/12 to 04/11/12

                                      Summary of Billing Delays

                      Total        2         4         6         8        10        >10       Unknown

Non Pre-bill Bills      22         0         0         0         7        12         3
Pre-bill Bills           2         1         1         0         0         0         0
Total                   24         1         1         0         7        12         3

                 Summary of Star Claim Delays

Non Pre-bill Claims     53         0         0         0         0        31        23
Pre-bill Claims         12         5         7         0         0         0         0
Total                   65         5         7         0         0        31        23


                              Summary of EC 2000 CA Claim Delays

Non Pre-bill Claims     71         0         0         2         4        26        39
Pre-bill Claims         14         5         9         0         0         0         0
Total                   85         5         9         2         4        26        39

                                      End of Report
```

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PRE-BILL EDITS BY CODE FOR AR ACCOUNTS (FCRPREERR)   Chapter 4 - BILLING AND CLAIMS REPORTS

Field Explanations

NON PRE-BILL BILLS
This column contains the number of bills not part of the pre-bill edit process.

PRE-BILL BILLS
This column contains the number of bills that were reviewed in the pre-bill edit process.

NON PRE-BILL CLAIMS
This column contains the number of claims that were not reviewed in the Pre-bill Edit process.

PRE-BILL CLAIMS
This column contains the number of claims that were reviewed in the pre-bill edit process.

PBE SUMMARY STATISTICS BY PBE USER (FCRPREACT)

Purpose and Description

There are five versions of the PBE Summary Statistics report. These are:

- PBE Summary Statistics by PBE User

  This report first prints the number of days in the worklist with the following field definitions:

  User: This is the Pre-bill Edit User or Worklist Assignment.

  Category: This is the edit category, such as Demographic, Medical Records, Charge, Insurance, Utilization Management, and any user defined edit groups.

  Total: Total number of days in the workfile.

  Aging: The total is broken into the aging categories as set in the Pre-bill Edit Parameters.

  The report then prints the Total Unbilled by User, and breaks this out by Number of Accounts, Number of Edits, and the Dollar amount.

  The report then prints the Number of Accounts with PBE Edits Reaching Bill Suspense Days by Inpatient, Outpatient, Emergency, and Total, with the Number of Accounts, Number of Edits, and the Dollar amount.

  The report then prints the Total Number of Accounts with Errors by Inpatient, Outpatient, Emergency, and Total, with the Number of Accounts, Number of Edits, and the Dollar amount.

- Edit Messages by Days on PBE Worklist

  This report prints each category and edit message, with the Total days and then by aging as set in the Pre-bill Edit Parameters.

  Edits with an edit number preceding the edit are edits returned from the electronic billing system. The number is assigned from the electronic billing system.

- Edit Messages by Days Waiting to Final Bill

  In order to be on this report, an account must be Discharged, and must have reached the expected bill date calculated by Pre-bill Edit using the Bill Suspense Days. The report prints the number of days past this expected bill date that the bill has been held up due to edits.

Edits with an edit number preceding the edit are edits returned from the electronic billing system. The number is assigned from the electronic billing system.

This report prints each category and edit message, with the Total and then by aging as set in the Pre-bill Edit Parameters.

- Edit Messages by Days on PBE Worklist/SIM Dept Detail

This report prints each category and edit message, with the Total days and then by aging as set in the Pre-bill Edit Parameters. For edits related to a particular charge item, the edit message has the SIM Department, a slash (/) and then the SIM number.

Edits with an edit number preceding the edit are edits returned from the electronic billing system. The number is assigned from the electronic billing system.

- Edit Messages by Days Waiting to Final Bill/SIM Dept Detail

In order for an account to be on this report, the account must be discharged and must have reached the expected bill date calculated by Pre-bill Edit using the Bill Suspense Days. The report prints the number of days past this expected bill date that the bill has been held up due to edits.

For edits related to a particular charge item, the edit message has the SIM Department, a slash (/), and then the SIM number.

Edits with an edit number preceding the edit are edits returned from the electronic billing system. The number is assigned from the electronic billing system.

This report prints each category and edit message, with the Total, and then by aging as set in the Pre-bill Edit Parameters.

Generating and Printing This Report

To print versions of the PBE Summary Statistics report, the available reports must first be highlighted in the Pre-bill Edit Parameters menu, in the FCRPREACT Report field. The Aging Categories must then be set in the Pre-bill Edit Parameters, in the Aging Categories field.

After setting up the parameters, run optional batch job 122 by accessing Financial System Management, Optional Batch Jobs, Optional Batch Jobs Processor, and entering the job number 122 or doing a table lookup and selecting Pre-bill Edit Report FCRPREACT.

Report examples are shown on the following pages.

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Figure 4.78 PBE Summary Statistics by PBE User (FCRPREACT)

```
Date: 03/27/12                           General Hospital                              Page  : 1
Time: 01:31am                    PBE Summary Statistics by PBE User                    Report: FCRPREACTA
                                   Number of Days in the Worklist

User                     Category                   Total    <=10   <=20   <=30   <=40    >40
------------------------------------------------------------------------------------------------------------


Blr Jones,Tom            Demographic                   2       1                           1

Blr BILLERTHREE,BILLER   Medical Records               1                                   1

Blr Snowflake,Suzy       Demographic                 299     158            5            136
                         Medical Records               3             2                     1

Biller - Generic         Charge                      116                                 116
                         Demographic                2070     542     6                  1522
                         No CA Claim                   7                                   7
                         Insurance                  1050     164            8             878
                         Medical Records             538     269                         269
                         Utilization Management        7                                   7

Charge Errors - Generic  Charge                     1361     404           24             933

Med Recs - Generic       Medical Records             582     204           17             361
                         test med record user defined  2                                   2

Util Man - Generic       Utilization Management       35      11                          24

Reg Regist,One           Demographic                   3                                   3
                         Insurance                     1
SIM EEG                  Charge                       53                                  53
```

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Figure 4.79 PBE Summary Statistics by PBE User (FCRPREACT) (Continued)

```
Date: 03/27/12                                    General Hospital                           Page  : 3
Time: 01:31am                              PBE Summary Statistics by PBE User                       Report: FCRPREACTA

Summary of Total Unbilled:    No. of Accounts      No. of edits              Dollars

Total                               323                 7613            $29,434,103.77
Blr Jones,Tom                         2                    2               $283,748.38
Blr BILLERTHREE,BILLER                1                    1                     $0.00
Blr Snowflake,Suzy                   45                  302             $7,206,476.94
Blr Biller,Johnny L                  24                  160             $6,942,357.64
Blr BILLERFIVE,BILLER                31                  224             $1,966,656.91
Blr Smith,Julie                       1                    1                     $0.00
New Group                             1                    2                   $150.00
Biller - Generic                    278                 3792            $20,944,560.79
Charge Errors - Generic             140                 1361            $25,467,384.62
Med Recs - Generic                  154                  584            $27,349,481.11
Util Man - Generic                   35                   35             $7,736,237.01
Reg Regist,One                        1                    4                     $0.00
Reg Regist,Two                        1                    1                     $0.00
Reg Regist,Three                      1                    1                $35,338.63
Reg Regist,Four                       1                    3                 $1,034.89
Reg Regist,Five                       2                    4                 $2,750.00
Reg Regist,Six                        5                    6                     $0.00
Reg Regist,Seven                      1                    2                     $0.00
Reg Regist,Eight                      1                    1                     $0.00
Reg Regist,Nine                       1                    2                 $9,839.20
Reg Regist,Ten                        1                    4                     $0.00
Reg Regist,Eleven                     1                    2                     $0.00
SIM Departments                     111                  722               $448,498.76
SIM CARDIOLOGY                       16                  138               $252,525.75
SIM EEG                              13                   53                $40,853.46
SIM PHYSICAL THERAPY                  6                  206               $160,969.22


                                 No. of Accounts      No. of edits              Dollars
Number of accounts with PBE edits reaching Bill Suspense Days:
     Inpatient                      104                 2652            $12,561,428.16
     Outpatient                     142                 3191             $1,792,426.82
     Emergency                       10                  187                $13,624.09
     Total                          256                 6030            $14,367,479.07


Total number of accounts with errors:
     Inpatient                      156                 3672            $27,434,040.01
     Outpatient                     154                 3717             $1,984,639.67
     Emergency                       11                  189                $15,424.09
     Total                          323                 7613            $29,434,103.77

                                       End of Report
```

Field Explanations

Users are sorted by their code (such as the biller code) and not on the name.

USER
This is the Pre-bill Edit User or Worklist Assignment.

CATEGORY
This is the edit category, such as Demographic, Medical Records, Charge, Insurance, Utilization Management, and any user defined edit groups.

TOTAL
This field contains the total number of days in the workfile.

AGING
The total is broken into the aging categories as set in the Pre-bill Edit Parameters.

TOTAL UNBILLED BY USER
These totals are broken out by Number of Accounts, Number of Edits, and the Dollar amount.

NUMBER OF ACCOUNTS WITH PBE EDITS REACHING BILL SUSPENSE DAYS
These totals are broken out by Inpatient, Outpatient, Emergency, and Total, with the Number of Accounts, Number of Edits, and the Dollar amount.

NUMBER OF ACCOUNTS WITH ERRORS
These totals are broken out by Inpatient, Outpatient, Emergency, and Total, with the Number of Accounts, Number of Edits, and the Dollar amount.

Figure 4.80 PBE Edit Message Statistics - Edit Messages by Days on PBE Worklist

```
Date: 03/27/12                                 Windward Medical University
Time: 01:31am                                  PBE Edit Message Statistics
                                        Edit Messages by Days on PBE Worklist

Category and Edit Message                                 Total   <=10   <=20   <=30   <=40    >40
-----------------------------------------------------------------------------------------------------
Charge
    4205 (Charges) - FL42- Revenue Code is not valid for this FL    72                             72
    4415 Commercial - (FL44) HCPCS Code is required with (FL42)     19                             19
    4511 (Charges) FL45- Service Date is required for each FL42-    84                             84
  DOCTOR'S NPI NUMBER\1500 PHYSICIAN (SUPPLIER) (Required)          57     12            2         43
    Diagnosis/Reference # required for 1500 Claim                   83     16                      67
    Duplicate HCPCS Same Service Date                                6      4                       2
    HCPCS required for 1500 Claim                                   33     17                      16
    HCPCS required for UB Claim                                    261     94                     167
    Missing Diagnosis                                               12     12
    Missing HCPCS                                                   23     23
    Missing Performing Physician                                    17     17
    Needs ICD-9 diagnosis                                           48     34                      14
    Needs ICD-9 diagnosis not ICD-10 diagnosis                     231    220      2      2         7
    Physician ID required for Loc 24J Lower on 1500 Claim           91     29                      62
    Physician ID required for Loc 24J Upper on 1500 Claim           58     27                      31
Demographic
    1500 DIAGNOSIS BOX 21 - FIELD 1 (Required)                      48     38                      10
    6702 Commercial - FL67- Principal Diagnosis Code required.       1                              1
    ADMITTING DIAGNOSIS CODE (MR/ADM) is Required                   67     35      1               31
    GUARANTOR ADDRESS 1 (Required)                                   3      1                       2
    GUARANTOR ADDRESS 2 (Required)                                   2                              2
    GUARANTOR CITY (Required)                                        3      1                       2
    GUARANTOR NAME (Required)                                        1                              1
    GUARANTOR STATE (Required)                                       3      1                       2
    GUARANTOR ZIP CODE (Required)                                    3      1                       2
    PRINCIPAL DIAG CODE (MR/ADM) is Required                       112     39      1      1        71
No CA Claim
    1000000000002 Claim not assigned to any form                     4                             4
    1000000009999 No edit message for claim failed by EC 2000 CA     3                             3
Insurance
    BILL. INS. INSURED'S B DAY (PRIM)   is Required                  3                             3
    INSURANCE GROUP NUMBER\UB CARRIER 1 (Required)                   4                             4
    PROVIDER NPI #\CARRIER OF REQUEST FOR CLAIM (Required)         111     23      1      2        85
Medical Records
    ABSTRACT COMPLETE DATE is Required                               9                             9
    FINAL DRG is Required                                           66     31             2        33
    PRINCIPAL DIAGNOSIS CODE is Required                           193    114             2        77
```

Field Explanations

The report sorts by Category (Charge, Demographic, No CA Claim, Insurance, Medical Records, Utilization Management, and any user defined categories), and within each category, the sort is first Numeric for those edits that start with a number, and then Alpha by the edit message.

CATEGORY AND EDIT MESSAGE
This field contains the pre-bill edit messages broken down by the edit category. The categories are: Charge, Demographic, No CA Claim, Insurance, Medical Records, Utilization Management, and any user defined categories. Edits with an edit number preceding the edit are edits returned from the electronic billing system. The number is assigned from the electronic billing system.

TOTAL
This field contains the total number of days in the workfile.

AGING
The total is broken into the aging categories as set in the Pre-bill Edit Parameters.

Figure 4.81 PBE Edit Messages by Days Waiting to Final Bill

```
Date: 03/27/12                              Windward Medical University                      Page  : 1
Time: 01:31am                               PBE Edit Message Statistics                      Report: FCRPREACTA
                                       Edit Messages by Days Waiting to Final Bill

Category and Edit Message                                     Total    <=10    <=20    <=30    <=40    >40
----------------------------------------------------------------------------------------------------------
Charge
    4415 Commercial - (FL44) HCPCS Code is required with (FL42)    19                                    19
    4511 (Charges) FL45- Service Date is required for each FL42-   84                                    84
    Diagnosis/Reference # required for 1500 Claim                  67                                    67
    Duplicate HCPCS Same Service Date                               2                                     2
    HCPCS required for 1500 Claim                                  16                                    16
    HCPCS required for UB Claim                                   167                                   167
    Needs ICD-9 diagnosis                                          14                                    14
    Needs ICD-9 diagnosis not ICD-10 diagnosis                      9                                     9
    Physician ID required for Loc 24J Lower on 1500 Claim          62                                    62
    Physician ID required for Loc 24J Upper on 1500 Claim          31                                    31
Demographic
    GUARANTOR ADDRESS 1 (Required)                                 2                                     2
    GUARANTOR ADDRESS 2 (Required)                                 2                                     2
    GUARANTOR CITY (Required)                                      2                                     2
    GUARANTOR NAME (Required)                                      1                                     1
    GUARANTOR PHONE (Required)                                     4                                     4
    GUARANTOR SOCIAL SECURITY NUMBER is Required                  3                                     3
    GUARANTOR STATE (Required)                                     2                                     2
    GUARANTOR ZIP CODE (Required)                                 2                                     2
    PRIN OR ADMIT DIAG CODE (MR/ADM) (Required)                  48       1                             47
No CA Claim
    1000000009999 No edit message for claim failed by EC 2000 CA  3                                     3
Insurance
    BILL. INS. VERIFICATION [PRIMARY] is Required                 7                                     7
    INSURANCE GROUP NUMBER\UB CARRIER 1 (Required)                4                                     4
    PROVIDER NPI #\CARRIER OF REQUEST FOR CLAIM (Required)      101      12                      2      87
Medical Records
    6701 (Demographic) FL67- Principal Diagnosis Code required w  16                                    16
    ABSTRACT COMPLETE DATE is Required                            9                                     9
    FINAL DRG is Required                                        38                                    38
    PRINCIPAL DIAGNOSIS CODE (Required)                          55                                    55
Utilization Management
    UM ABSTRACT COMPLETE is Required                            37                                    37


                                              End of Report
```

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Field Explanations

The report sorts by Category (Charge, Demographic, No CA Claim, Insurance, Medical Records, Utilization Management, and any user defined categories), and within each category, the sort is first Numeric for those edits that start with a number, and then Alpha by the edit message.

CATEGORY AND EDIT MESSAGE
This field contains the pre-bill edit messages broken down by the edit category. The categories are: Charge, Demographic, No CA Claim, Insurance, Medical Records, Utilization Management, and any user defined categories. For edits related to a particular charge item, the edit message has the SIM Department, a slash (/) and then the SIM number.

TOTAL
In order to be on this report, an account must be Discharged, and must have reached the expected bill date calculated by Pre-bill Edit using the Bill Suspense Days. The report prints the number of days past this expected bill date that the bill has been held up due to edits

AGING
The total is broken into the aging categories as set in the Pre-bill Edit Parameters.

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Figure 4.82 PBE Edit Messages Statistics - Edit Messages by Days on PBE Worklist with SIM Detail

```
Date: 03/27/12                             Windward Medical University                         Page  : 1
Time: 01:31am                              PBE Edit Message Statistics                         Report: FCRPREACTA
                                  Edit Messages by Days on PBE Worklist with SIM Detail

Category and Edit Message                                   Total    <=10     <=20     <=30     <=40     >40
-----------------------------------------------------------------------------------------------------------------
Charge
     4205 (Charges) - FL42- Revenue Code is not valid f CAR/9998      1                                         1
     4205 (Charges) - FL42- Revenue Code is not valid f CSR/6070      1                                         1
     4415 Commercial - (FL44) HCPCS Code is required wi CAR/1104      3                                         3
     4511 (Charges) FL45- Service Date is required for  EEG/3200      4                                         4
     4511 (Charges) FL45- Service Date is required for  RMB/1000      2                                         2
     DOCTOR UPIN NUMBER\1500 PHYSICIAN (SUPPLIER) (Requ             6                                         6
     Diagnosis/Reference # required for 1500 Claim EEG/3112          8                                         8
     Diagnosis/Reference # required for 1500 Claim LAB/1000          1        1
     Duplicate HCPCS Same Service Date LAB/6340                      2                                         2
     HCPCS required for 1500 Claim RAD/6666                          8        2                                6
     HCPCS required for 1500 Claim RAD/7400                          3                                         3
     HCPCS required for UB Claim EEG/3125                            6                                         6
     HCPCS required for UB Claim EEG/3200                            7        2                                5
     Missing Diagnosis LAB/7777                                      1        1
     Missing Diagnosis LAB/9993                                      3        3
     Missing Performing Physician PT/7777                            6        6
     Needs ICD-9 diagnosis ANS/100                                  1        1
     Needs ICD-9 diagnosis not ICD-10 diagnosis CSR/218             1        1
     Physician ID required for Loc 24J Lower on 1500 Cl ANS/100      3        3
     Physician ID required for Loc 24J Lower on 1500 Cl CAR/1104    16        4                               12
Demographic
     17510 (ANSI 837) Attending Provider- Last Name- At             8                                         8
     17511 (ANSI 837) Attending Provider- First Name- A             8                                         8
     DOCTOR UPIN NUMBER\PHYSICIAN, ATTENDING (Required)            20        9        1                      10
     DOCTOR UPIN NUMBER\PHYSICIAN, REFERRING (Required)            59       10                 2            47
     PRINCIPAL DIAG CODE (MR/ADM) is Required                     112       39        1        1            71
No CA Claim
     1000000000002 Claim not assigned to any form                  4                                         4
     1000000009999 No edit message for claim failed by             3                                         3
Insurance
     INSURANCE GROUP NUMBER\UB CARRIER 1 (Required)                4                                         4
     INSURANCE GROUP NUMBER\UB CARRIER 2 (Required)                4                                         4
     INSURANCE GROUP NUMBER\UB CARRIER 3 (Required)                5                                         5
     PROVIDER NPI #\CARRIER OF REQUEST FOR CLAIM (Requi          111       23        1        2            85


                                         End of Report
```

Field Explanations

The report sorts by Category (Charge, Demographic, No CA Claim, Insurance, Medical Records, Utilization Management, and any user defined categories), and within each category, the sort is first Numeric for those edits that start with a number, and then Alpha by the edit message.

CATEGORY AND EDIT MESSAGE
This field contains the pre-bill edit messages broken down by the edit category. The categories are: Charge, Demographic, No CA Claim, Insurance, Medical Records, Utilization Management, and any user defined categories. Edits with an edit number preceding the edit are edits returned from the electronic billing system. The number is assigned from the electronic billing system.

TOTAL
This field contains the total number of days in the workfile.

AGING
The total is broken into the aging categories as set in the Pre-bill Edit Parameters.

Figure 4.83 Edit Messages by Days Waiting to Final Bill with SIM Detail

```
Date: 03/27/12                                Windward Medical University                         Page  : 1
Time: 01:31am                                  PBE Edit Message Statistics                         Report: FCRPREACTA
                                 Edit Messages by Days Waiting to Final Bill with SIM Detail

Category and Edit Message                                        Total    <=10    <=20    <=30    <=40    >40
--------------------------------------------------------------------------------------------------------------------
Charge
    4205 (Charges) - FL42- Revenue Code is not valid f CAR/9998    1                                       1
    4205 (Charges) - FL42- Revenue Code is not valid f CSR/6070    1                                       1
    4415 Commercial - (FL44) HCPCS Code is required wi CAR/1104    3                                       3
    4511 (Charges) FL45- Service Date is required for  RMB/1300    2                                       2
    4511 (Charges) FL45- Service Date is required for  RXA/573    18                                      18
    Diagnosis/Reference # required for 1500 Claim EEG/3112         8                                       8
    Diagnosis/Reference # required for 1500 Claim PT/7777          2                                       2
    HCPCS required for 1500 Claim LAB/1000                         1                                       1
    HCPCS required for UB Claim CAR/1100                           9                                       9
    HCPCS required for UB Claim CAR/1103                          13                                      13
    Needs ICD-9 diagnosis not ICD-10 diagnosis RAD/7326           1                                       1
    Physician ID required for Loc 24J Lower on 1500 Cl CAR/1104   12                                      12
Demographic
    GUARANTOR ADDRESS 1 (Required)                                2                                       2
    GUARANTOR ADDRESS 2 (Required)                                2                                       2
    GUARANTOR CITY (Required)                                     2                                       2
    GUARANTOR NAME (Required)                                     1                                       1
    GUARANTOR PHONE (Required)                                    4                                       4
    GUARANTOR SOCIAL SECURITY NUMBER is Required                  3                                       3
    GUARANTOR STATE (Required)                                    2                                       2
    GUARANTOR ZIP CODE (Required)                                 2                                       2
    PRIN OR ADMIT DIAG CODE (MR/ADM) (Required)                  48       1                              47
No CA Claim
    1000000009999 No edit message for claim failed by            3                                       3
Insurance
    BILL. INS. VERIFICATION [PRIMARY] is Required                7                                       7
    INSURANCE GROUP NUMBER\UB CARRIER 1 (Required)               4                                       4
    PROVIDER NPI #\CARRIER OF REQUEST FOR CLAIM (Required)     101      12                      2        87
Medical Records
    6701 (Demographic) FL67- Principal Diagnosis Code required w 16                                      16
    ABSTRACT COMPLETE DATE is Required                           9                                       9
    FINAL DRG is Required                                       38                                      38
    PRINCIPAL DIAGNOSIS CODE (Required)                         55                                      55
Utilization Management
    UM ABSTRACT COMPLETE is Required                           37                                      37
                                                      End of Report
```

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Field Explanations

The report sorts by Category (Charge, Demographic, No CA Claim, Insurance, Medical Records, Utilization Management, and any user defined categories), and within each category, the sort is first Numeric for those edits that start with a number, and then Alpha by the edit message.

CATEGORY AND EDIT MESSAGE
This field contains the pre-bill edit messages broken down by the edit category. The categories are: Charge, Demographic, No CA Claim, Insurance, Medical Records, Utilization Management, and any user defined categories.

For edits related to a particular charge item, the edit message has the SIM Department, a slash (/) and then the SIM number.

Edits with an edit number preceding the edit are edits returned from the electronic billing system. The number is assigned from the electronic billing system.

TOTAL
This field contains the total number of days in the workfile.

AGING
The total is broken into the aging categories as set in the Pre-bill Edit Parameters.

PRE-BILL EDIT ANALYSIS REPORT FOR DISCHARGED ACCOUNTS (FCRPREANA)

Purpose and Description

This report includes accounts discharged not final billed that were processed by Pre-bill Edit. The report lists accounts passing all edits in the first section and accounts having edits in the second section. This report compares the first pre-bill edit date with the calculated bill suspense days date.

The report prints the First PBE Claim Load Date for each account, the Expected Final Bill Date (EFBD) for each account, and the Days Past EFBD for each account.

The accounts with the oldest Expected Final Bill Date are listed first, with the accounts with an Expected Final Bill Date closest to today's date at the end of the report.

Generating and Printing This Report

To generate this report:

Users must update the field "FCRPREANA Report" in the Pre-bill Edit Parameters. This field is used to identify the number of days prior to the expected bill date to include accounts. The report also requires accounts to be discharged. As an example: if an account is discharged 5/1 with an expected final billed date of 5/10, and the Pre-bill Edit Parameter field is defined as 3, the account will not be listed on the report until 5/7. The field "FCRPREANA Report" prompts:

Enter days before expected final bill date to select discharged accounts in billing suspense [3]-- next(/) or previous screen(/P) [/]

This is a demand report. When in the Pre-bill Edit Workfile, users must click Reports on the top of the screen, and then select Pre-bill Edit Analysis Report. A pop up screen appears that states "Print Pre-Bill Edit Analysis Report?". Click the Yes button to produce or the No button to exit the option. When clicking the Yes button, the system displays another pop up screen that states "Pre-Bill Analysis Report (FCRPREANAx) has started!". Click OK to close the pop up screen.

The report spools to the printer name as defined for the user in the CRT Names Table. You can enter a dash (-) in the Printer Name field in View Spooled Reports if the printer is not known.

Figure 4.84 Pre-bill Edit Analysis Report for Discharged Accounts (FCRPREANA)

```
Date: 04/17/12                  General Hospital              Page  : 1
Time: 19:55                Pre-bill Edit Analysis Report      Report: FCRPREANAC
                              for Discharged Accounts


PASSED ALL EDITS
                                          First PBE    Expected      Days
                                          Claim Load   Final Bill    Past
Acct Number      Patient Name             Date         Date (EFBD)   EFBD
C1207000001      HANSEN,ERIC              03/20/12     03/18/12       +2
C1208200005      CARROLL,CRAIG           03/25/12     03/26/12        1

FAILED EDITS

C1120200001      TEST,FACILITYC          10/10/11     07/21/11       271
C1128300001      JONES,PBE               10/10/11     10/10/11       190
C1208000002      SMITH,ANNE              03/20/12     03/20/12        28
C1208000001      YOUNG,CINDY             03/20/12     03/20/12        28


                        End of Report
```

Field Explanations

PATIENT NAME
This field contains the patient name.

ACCOUNT NO
This field contains the patient account number.

FIRST PBE CLAIM LOAD DATE
This field contains the first pre-bill edit date.

EXPECTED FINAL BILL DATE (EFBD)
This field contains the calculated final bill date (using the discharge date plus the bill suspense days).

DAYS PAST EFBD
This field contains the number of days the account is past the expected final bill date.

Chapter 5 - TRANSACTION REPORTS

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Illustrations

CASH POSTING AUDIT REPORT - FAR120

Description/Purpose

The Cash Posting Audit Report provides a paper copy of the contents of an unposted payments batch. This report can be used to verify the batch contents or to aid in balancing a batch.

Generating and Printing This Report

The Cash Posting Audit Report is printed through the Exit Cash Batch function. The report prints on the printer assigned to the CRT requesting the report.

The following is an example of the Cash Posting Audit report.

Figure 5.1 FAR120 - Cash Posting Audit Report

```
Date: 07/19/07                                Model Hospital A                              Page  : 1
Time: 15:13                          Cash Posting Audit - Batch 736 - INS CASH             Report: FAR120A

Seq Cash Type Account       Trans Amount   --Date-- Remittance - Check #     Trans Description        --Paid--       Receipt #
    Patient Name            Contract Adj   Post/Pay Carrier/Plan        Unapplied/Misc Cash Comments  Days DRG Out F CS# PtCls
    Payor Claim ID          Clm Subm Chgs  Clm Status                       Deductible   Coinsurance    Co-Pay        Pt Resp
    Denial Codes            Clm Adj Group    Den Amt   HCPCS           Charge Amount  Pymt Amount  Total Denial Amount
-------------------------------------------------------------------------------------------------------------------------

1   Insurance 0719200003        20.00     07/19/07                     COMMERCIAL  INSURANCE  PAYMEN
    KESLER,TESTD                           07/19/07 918100-PATRICE PCON PRIMA                                         1
                                                                            15.00       10.00
        18                  CO              10.00
        35                  CO              35.00
        18                  CO              30.00                                                       75.00


------------- Batch Status -------------
    Starting Balance:        0.00
       Total Entered:       20.00
      Cont Adj Total:                          0.00
         Batch Total:       20.00

    Denied Amt Total:       75.00


* Contractual adjustment code was modified or added

                                              End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

SEQ
This field contains the system-generated sequence assigned to the cash item in the batch.

NOTE: The X in front of the sequence number denotes the items that have not been posted.

CASH TYPE
This field specifies the cash type (for example, insurance, patient, guarantor, unapplied, or miscellaneous cash).

ACCOUNT
This field contains the patient's account number for which patient-related cash is posted.

TRANS AMOUNT
This field contains the total dollar amount of the transaction posted for this account.

POST DATE
This field contains the date on which this cash item will be posted.

PAY DATE
This field indicates the date the payment was received.

REMITTANCE - CHECK #
This field contains the remittance check number.

TRANSACTION DESCRIPTION
This field contains the transaction description of the cash item and if applicable of the contractual adjustment item.

RECEIPT #
This field indicates the receipt number for this transaction.

PATIENT NAME
This field contains the patient name.

CONTRACT ADJ
This field indicates the contractual adjustment amount posted for insurance cash. An asterisk indicates that the contractual adjustment code was modified or added. A lowercase d or s may be displayed to the right of the amount. Lowercase d indicates a potential denial (before the insurance cash batch is posted); lowercase s indicates a subsequent denial. The d and s indicators allow you to identify before a batch posts which transactions will not post/report a contractual adjustment if a denial or subsequent denial is posted/reported. If the report is produced after the batch is

posted, this information does not appear, because the contractual adjustment amount will have been changed to be zero. The d or s indicators appear only if Post/Rpt C/A if Den in the ERA Payment File Definition is N for Do Not Post (Variance Method) and the C/A method field equals Variance. There are no updates to this report if the C/A method field is set to Report.

PAID DAYS
This field provides the number of DRG days paid for insurance cash.

PAID DRG
This field provides the DRG code paid for insurance cash.

OUT
This field indicates whether Day (D) or Cost Outlier (C) is used for insurance cash.

F
This field contains Y for Yes if this transaction is a final insurance payment.

CLAIM SEQ
For insurance cash, this field indicates the sequence in which the claim was paid.

PATIENT CLASS
This field displays the financial patient classification combined with the alert and suppression indicators associated with the financial patient classification. The three-character patient classification code is displayed if a patient classification has been assigned to the account. Leading and trailing asterisks (**) display when the assigned patient classification has an alert designation. Finally, the follow-up suppression indicator is displayed as the final character in the field:

- a = alert only; follow-up is not suppressed

- c = suppression of follow-up has been cleared by a user

- s = follow-up is currently being suppressed

PAYOR CLAIM ID
This field displays the Payor Claim ID for the claim, which is the Facility Indicator + Account Number + Original Claim Sequence Number.

CLM SUBM CHGS
This field displays the submitted charge amount.

CLM STATUS
This field contains the claim work status code and description. The claim status is either D (deleted), M (manually released), A (awaiting payment), F (failed), R (released), E (edit), H (hold), or S (suppressed).

COINSURANCE (DISPLAY ONLY)
This column displays the coinsurance amount for the service line.

DEDUCTIBLE (DISPLAY ONLY)
This column displays the deductible amount for the service line.

CO-PAY
This field contains the amount of the first coverage period's co-pay.

DENIAL CODES
This field contains the payor's denial reason.

CLM ADJ GROUP
This field contains the claim adjustment group code which is the general grouping of reasons for denials. The standard ANSI X12 835 codes are CO for Contractual Obligations, CR- Correction and Reversals, OA- Other Adjustments, PI- Payor Initiated Reductions, Pr-Patient Responsibility.

DENIAL AMT
This field contains the denial amount for this denial reason code.

HCPCS CODE)
This field contains the HCPCS procedure code with any attached HCPCS modifiers for the charge. This field is used only for ERA claims.

LINE ITEM CHARGE AMT
This field contains the charge amount that is related to the service line on the claim. This field is used only for ERA claims.

LINE ITEM PYMT AMT
This field contains the payment that is related to the service line on the claim. This field is used only for ERA claims.

STARTING BALANCE
This field contains the starting balance that was entered on the setup screen.

TOTAL ENTERED
This field contains the total amount entered during this batch.

BATCH TOTAL
This field contains the total amount entered during this batch plus the starting balance.

X = UNPOSTED ENTRIES
The X in front of the sequence number indicates that this has not been posted.

UNPOSTED TOTAL
This field indicates the unbalanced total amount entered during this batch.

TOTAL DENIED AMOUNT
 This field contains the total denied amount of all denial reason codes.

CASH AND ADJUSTMENT BATCH REPORT - FAR160

Description/Purpose

The Cash and Adjustment Batch Report provides a list of cash batches and their status (balanced or unbalanced). For cash batches that are in balance, the report shows whether the batch is unposted.

Generating and Printing This Report

The Cash and Adjustment Batch Report can be printed in Midnight Processing, on demand through the Demand Print function, or from the Account Transactions Reports menu.

The following is an example of the Cash and Adjustment Batch Report.

Figure 5.2 FAR160 - Cash and Adjustment Batch Report

```
              General Hospital View Spooled Reports Processor
                                 Report :FAR160  Cash/Adjustment Batch Report     Position:###################
Spooled: 06/18/02 0018                          Last Printed: Not Printed
Date: 06/18/02              STAR Development System          Page  : 1
Time: 0:18                  Cash/Adjustment Batch Report     Report: FAR160


Type: GUARANTOR CASH

Code  Status      Type  Creation Date      By   Description/Comment
----  ----------  ----  -----------------  ---  -----------------------------
 13   Hold         G    June 17, 2002      BM   MAILBOX CHECKS 6/17
 19   Unbalanced   G    June 17, 2002      DAC  D.COLLINS COLLECTIONS
 31   Unbalanced   G    June 17, 2002      K B  BARRETT MAILBOX 6/17
 32   Unbalanced   G    June 17, 2002      K B  BARRETT CORRECTIONS
 34   Unbalanced   G    June 17, 2002      K B  BARRETT - VISA BATCH
 35   Unbalanced   G    June 17, 2002      K B  BARRETT - MASTER CARD
 36   Unbalanced   G    June 17, 2002      K B  BROWN - CO PAYS
 37   Unbalanced   G    June 17, 2002      K B  BROWN - LOCKBOX 6/17
         Page: 1 to 1 of 1      Line:1               Column:  1 -  79
      F1Page up  F2Page Dn  F3GoTo  F4Skip 10%  F5Print  F6Nxt Rpt  F7Exit  ?
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

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Column Explanations

TYPE
This column contains the type of cash batch that is being reported on. The types are:

- Cash

- Line Item Cash

- Window Cash

- Guarantor Cash

- Agency Cash

- Adjustments

CODE
This column contains the batch code, assigned by either the user or the system.

STATUS
This column contains the batch status. Valid statuses include Hold, Balanced, and Unbalanced.

TYPE
This column contains the code for the batch type. Valid types are:

- A-Agency Cash

- I-Insurance Cash

- N-Contract Cash

- P-Patient Cash

- W-Window Cash

- L-Line Item Cash

- G-Guarantor Cash

- C-Contractual Adjustments

- D-Patient Discount Adjustments

CREATION DATE
This column contains the date that the cash batch was created.

BY

This column contains the initials of the person who created the cash batch.

DESCRIPTION/COMMENT

This column contains comments entered when the cash batch was created.

GUARANTOR CASH POSTING AUDIT REPORT - FAR125

Description/Purpose

The Guarantor Cash Posting Audit Report provides a paper copy of the contents of a batch that has been entered by guarantor. This report can be used to verify the batch contents or to aid in balancing a batch.

Generating and Printing This Report

This Guarantor Cash Posting Audit Report is printed through the Exit Cash Batch function. The report prints on the printer assigned to the CRT requesting the report.

The following is an example of the Guarantor Cash Posting Audit Report.

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Figure 5.3 FAR125 - Guarantor Cash Posting Audit Report - Page 1

```
Date: 10/07/93                                  General Hospital                              Page  : 1
Time: 02:51pm                        Guarantor Cash Posting Audit - batch 5 - GUARANTOR BATCH      Report: FAR125
Seq Cash Type        Account Trans Amount  --Date-- Remittance - Check #      Trans Description       --Paid--      Receipt #
    Patient Name             Contract Adj  Post/Pay Carrier/Plan          Guarantor Cash Comments    Days DRG Out F  Claim Seq
-------------------------------------------------------------------------------------------------------------------------------
1   Guarantor A9304000003       10.00- 10/07/93                           PERSONAL PAYMENT-CHECK                       350
    WEATHFORD,AVI                      10/07/93

                                                                  MULTI FACILITY CASH BATCH.
                                                                  ALL PAYMENTS RECEIVED IN SATURDAY'S MAIL.
                                                                  POSTED BY DP STAFF B/C BUSINESS OFFICE CLOSED.
2   Guarantor C009324300002      40.00  10/07/93                           PERSONAL PAYMENT-CHECK                       351
    WEST,BILL                          10/07/93

                                                                  MULTI FACILITY CASH BATCH.
                                                                  ALL PAYMENTS RECEIVED IN SATURDAY'S MAIL.
                                                                  POSTED BY DP STAFF B/C BUSINESS OFFICE CLOSED.
3   Guarantor A9304600001         1.00  10/07/93                           PERSONAL PAYMENT-CHECK                       352
    THOMPSON,AL                        10/07/93

                                                                  MULTI FACILITY CASH BATCH.
                                                                  ALL PAYMENTS RECEIVED IN SATURDAY'S MAIL.
                                                                  POSTED BY DP STAFF B/C BUSINESS OFFICE CLOSED.
4   Guarantor B9305300001         2.30  10/07/93                           PERSONAL PAYMENT-CHECK                       353
    GRANT,MURBLE                       10/07/93

                                                                  MULTI FACILITY CASH BATCH.
                                                                  ALL PAYMENTS RECEIVED IN SATURDAY'S MAIL.
                                                                  POSTED BY DP STAFF B/C BUSINESS OFFICE CLOSED.
5   Guarantor A9304000003         1.00  10/07/93                           PERSONAL PAYMENT-CHECK                       354
    WEISS,NANCY                        10/07/93

                                                                  MULTI FACILITY CASH BATCH.
                                                                  ALL PAYMENTS RECEIVED IN SATURDAY'S MAIL.
                                                                  POSTED BY DP STAFF B/C BUSINESS OFFICE CLOSED.
6   Guarantor A93131000001       50.00  10/07/93                           PERSONAL PAYMENT-CHECK                       355
    LACK,SUSAN                         10/07/93

                                                                  THIS IS THE OVERRIDE COMMENT ENTERED ON THE
                                                                  INDIVIDUAL PATIENT ACCOUNT
7   Guarantor A93042000001        2.00  10/07/93                           PERSONAL PAYMENT-CHECK                       356
    HALLS,SAM                          10/07/93

                                                                  MULTI FACILITY CASH BATCH.
                                                                  ALL PAYMENTS RECEIVED IN SATURDAY'S MAIL.
                                                                  POSTED BY DP STAFF B/C BUSINESS OFFICE CLOSED.
8   Guarantor A93270000001       23.00  10/07/93                           PERSONAL PAYMENT-CHECK                       357
    IRCONV,PAT                         10/07/93

                                                                  MULTI FACILITY CASH BATCH.
                                                                  ALL PAYMENTS RECEIVED IN SATURDAY'S MAIL.
                                                                  POSTED BY DP STAFF B/C BUSINESS OFFICE CLOSED.
9   Guarantor A93237000002       23.00  10/07/93                           PERSONAL PAYMENT-CHECK                       358
    SIMMONS,ANDRA                      10/07/93

                                                                  MULTI FACILITY CASH BATCH.
                                                                  ALL PAYMENTS RECEIVED IN SATURDAY'S MAIL.
                                                                  POSTED BY DP STAFF B/C BUSINESS OFFICE CLOSED.
```

NOTE: Since guarantor batches are not facility specific, this report does not have a facility indicator at the end of the report name.

Figure 5.4 FAR125 - Guarantor Cash Posting Audit Report - Page 2

```
Date: 10/07/93                                  General Hospital                                Page  : 2
Time: 02:51pm                        Guarantor Cash Posting Audit - Batch 5 - GUARANTOR BATCH      Report: FAR125


Seq Cash Type      Account Trans Amount  --Date-- Remittance - Check #     Trans Description        --Paid--       Receipt #
    Patient Name           Contract Adj  Post/Pay Carrier/Plan            Guarantor Cash Comments   Days DRG Out F Claim Seq
-------------------------------------------------------------------------------------------------------------------------

 10   Guarantor C009325600001     10.00  10/07/93                            PERSONAL PAYMENT-CHECK                    359
      SMITH,SUSAN                        10/07/93
                                                                  MULTI FACILITY CASH BATCH.
                                                                  ALL PAYMENTS RECEIVED IN SATURDAY'S MAIL.
                                                                  POSTED BY DP STAFF B/C BUSINESS OFFICE CLOSED.


 11   Guarantor A93046000002      10.00  10/07/93                            PERSONAL PAYMENT-CHECK                    360
      SMALL,ROBIN                        10/07/93
                                                                  MULTI FACILITY CASH BATCH.
                                                                  ALL PAYMENTS RECEIVED IN SATURDAY'S MAIL.
                                                                  POSTED BY DP STAFF B/C BUSINESS OFFICE CLOSED.


X12   Guarantor C009325600001      7.00  10/07/93                            PERSONAL PAYMENT-CHECK                    361
      COOKE,TERRI                        10/07/93
                                                                  MULTI FACILITY CASH BATCH.
                                                                  ALL PAYMENTS RECEIVED IN SATURDAY'S MAIL.
                                                                  POSTED BY DP STAFF B/C BUSINESS OFFICE CLOSED.


------------- Batch Status -------------
          Starting Balance:       0.00
          Total Facility A:      80.00
          Total Facility B:       2.30
          Total Facility C:      57.00
Balanced    Total Entered:      139.30
              Batch Total:      139.30

      X = Unposted Entries
          Unposted Total        7.00
```

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This report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

SEQ
This field contains the system-generated sequence assigned to the cash item in the batch.

NOTE: The X in front of the sequence number denotes the items that have not been posted.

CASH TYPE
This field specifies the cash type (for example, insurance, patient, guarantor, unapplied, or miscellaneous cash).

ACCOUNT
This field contains the patient's account number and facility indicator for which cash is posted.

TRANS AMOUNT
This field contains the total dollar amount of the transaction posted for this account.

POST DATE
This field contains the date on which this cash item will be posted.

REMITTANCE - CHECK #
This field contains the remittance check number.

TRANSACTION DESCRIPTION
This field contains the transaction description of the cash item.

RECEIPT #
This field indicates the receipt number for this transaction.

PATIENT NAME
This field contains the patient name.

CONTRACT ADJ
This field indicates the contractual adjustment posted for insurance cash. For guarantor cash posting, this field is blank.

PAY DATE
This field indicates the date the payment was received.

CARRIER/PLAN
This field indicates the insurance carrier/plan code for the insurance. For guarantor cash posting, this field is blank.

GUARANTOR CASH COMMENTS
This field is the comment entered for the transaction. If a comment was entered in the setup screen, it is displayed for each entry in the batch.

PAID DAYS
This field provides the number of DRG days paid for insurance cash. For guarantor cash posting, this field is blank.

PAID DRG
This field provides the DRG code paid for insurance cash. For guarantor cash posting, this field is blank.

OUT
This field indicates whether Day (D) or Cost Outlier (C) is used for insurance cash. For guarantor cash posting, this field is blank.

F
This field contains Y for Yes if this transaction is a final insurance payment. For guarantor cash posting, this field is blank.

CLAIM SEQ
For insurance cash, this field indicates the sequence in which the claim was paid. For guarantor cash posting, this field is blank.

STARTING BALANCE
This field contains the starting balance that was entered on the setup screen.

TOTAL FACILITY X (A, B, C . . .)
This field contains the batch total for facility X (A, B, C . . .).

TOTAL ENTERED
This field contains the total amount entered during this batch.

BATCH TOTAL
This field contains the total amount entered during this batch plus the starting balance.

X = UNPOSTED ENTRIES
The X in front of the sequence number indicates that this has not been posted.

UNPOSTED TOTAL
This field indicates the unbalanced total amount entered during this batch.

ADJUSTMENT POSTING AUDIT REPORT - FAR200

Description/Purpose

The Adjustment Posting Audit Report provides a paper copy of the contents of an unposted adjustments batch. This report can be used to verify the batch contents or to aid in balancing a batch.

Generating and Printing This Report

The Adjustment Posting Audit Report is printed through the Exit Adjustment Batch function. The report prints on the printer assigned to the CRT requesting the report.

The following is an example of the Adjustment Posting Audit report.

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Figure 5.5 FAR200 - Adjustment Posting Audit Report

```
Date: 02/11/99                          Model Hospital A                         Page  : 1
Time: 12:20                   Adjustment Posting Audit - Batch 6 - ADJ           Report: FAR200A

 Seq Adj Type       Account          Post
     Patient Name               Trans Amount  Date   Carrier/Plan              Transaction Description      Claim Type PtCls
-------------------------------------------------------------------------------------------------------------------------

1    Contractual   9900100038      500.00- 02/02/99 COMMERCIAL BASIC PLAN      O/P M'CARE B HOSPITAL ALLOW    1   Flat BNK*a
     BECKMAN,DENISE

2    Insurance     9900100042      100.00- 02/02/99 COMMERCIAL BASIC PLAN      I/P MEDICARE PART A ALLOWANCE  1   Flat VIP
     SWANSON,JOE

3    Insurance     9900100039      100.00- 02/02/99 COMMERCIAL BASIC PLAN      I/P MEDICARE PART A ALLOWANCE  1   Flat PHY*s
     GRANT,TINA

4    Insurance     9900100039       10.00- 02/02/99 COMMERCIAL BASIC PLAN      O/P M'CARE B HOSPITAL ALLOW    1   Flat PHY*s
     HOWELL,JERARD

5    Patient Disc  9900100041       10.00- 02/02/99                            CONVERSION BALANCE FORWARD         Flat EMP
     MOSER,MARIE

6    Patient Disc  9900100042       19.00- 02/02/99                            CONVERSION BALANCE FORWARD         Flat VIP
     TAYLOR,JEFF

7    Patient       9900100041       33.00- 02/02/99                            CONVERSION BALANCE FORWARD              EMP
     DENNIS,ANN

8    Patient       9900100038      200.00- 02/02/99                            CONVERSION BALANCE FORWARD              BNK*a
     HUGHES,JOHN


------------- Batch Status -------------
Unbalanced  Total Entered:      972.00-
            Batch Total:      1,000.00



                                       End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

SEQ
This field contains the system-generated sequence assigned to the adjustment in the batch.

NOTE: The X in front of the sequence number denotes the items that have not been posted.

ADJ TYPE
This field specifies the adjustment type (for example, patient discount or contractual).

ACCOUNT
This field contains the patient's account number for which an adjustment is posted.

PATIENT NAME
This field contains the patient name.

TRANS AMOUNT
This field contains the total dollar amount of the transaction posted for this account.

POST DATE
This field contains the date on which this adjustment will be posted.

CARRIER/PLAN
This field contains the carrier/plan code.

TRANSACTION DESCRIPTION
This field contains the transaction description for the adjustment.

CLAIM TYPE
This field indicates the claim type for the adjustment.

PATIENT CLASS
This field displays the financial patient classification combined with the alert and suppression indicators associated with the financial patient classification. The three-character patient classification code is displayed if a patient classification has been assigned to the account. Leading and trailing asterisks (**) display when the assigned patient classification has an alert designation. Finally, the follow-up suppression indicator is displayed as the final character in the field:

- a = alert only; follow-up is not suppressed

- c = suppression of follow-up has been cleared by a user

- s = follow-up is currently being suppressed

TOTAL ENTERED
This field contains the total amount entered during this batch.

BATCH TOTAL
This field contains the total amount entered during this batch plus the starting balance.

X = UNPOSTED ENTRIES
The X in front of the sequence number indicates that this has not been posted.

UNPOSTED TOTAL
This field indicates the unbalanced total amount entered during this batch.

COLLECTION AGENCY CASH ADJUSTMENT REPORT - FAR150

Description/Purpose

The Collection Agency Cash Adjustment Report provides a listing of cash collected by the hospital and adjustments made to accounts in Bad Debt. This report is used to notify the collection agencies of the account's activity and includes all activity between printings.

Included are the patient name, account number, guarantor name, payment or adjustment amount, transaction date, Carrier/Plan, financial class, patient type, discharge date, transaction code and description, and the account balance. Facility totals are provided for the total number of accounts and amount.

Generating and Printing This Report

The Agency Cash Adjustment Report is requested from the Transaction Reports menu. It is printed as a demand report through the Demand Print function. This report is facility-specific and is sorted by collection agency and subsorted by account name and number. Page breaks occur at collection agency code and end of page.

The following is an example of the Agency Cash Adjustment Report.

Figure 5.6 FAR150 - Agency Cash Adjustment Report

```
Date: 12/30/89                              General Hospital                        Page  : 1
Time: 12:11am                          Collection Agency Cash/Adj Report            Report: FAR150


Patient Name              Pat Account    Guarantor Name              FC   PT   Dischg   Acct Balance   Trans Date
      Trans Code/Description             Pay/Adj Amt   Trans Dt    CR/PL  Description
_____

SIMS,JOHN G               89034-00005    SIMS,LINDA F               01   IP   08/01/89   3,125.00     11/30/89
      P0001 Patient Cash Payment            100.00     12/30/89   150001 Adjusted Ins

BARRINGTON,CYNTHIA S       89123-00060    BARRINGTON,JOHN D          16   IP   09/23/89     728.32     12/13/89
      A0003 Adjustment                      130.00     12/30/89   487001 Blue Cross, MI


Agency Total:    Accounts 2          Amount: 230.00
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

PATIENT NAME
This field contains the patient name.

PAT ACCOUNT
This field contains the patient account number.

GUARANTOR NAME
This field contains the guarantor name.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial classes categorize patients based on fiscal responsibilities.

PT
This field contains the hospital-defined patient type code used to identify such patient segments as regular admission, emergency room, outpatient, same day surgery, and series patients.

DISCHG
This field contains the date the patient was discharged.

ACCT BALANCE
This field contains the outstanding balance due on this account.

TRANS DATE
This field contains the date the payment or adjustment was posted.

TRANS CODE/DESCRIPTION
This field contains the transaction code and description corresponding to the payment or adjustment activity printed.

PAY/ADJ AMT
This field contains the dollar amount of the payment or adjustment.

TRANS DT
This field contains the date the account was transferred to a collection agency.

CR/PL DESCRIPTION
This field contains the description of the carrier plan code associated with this account.

PENDING REFUND DETAIL REPORT - FPREFDE

Description/Purpose

The Pending Refund Detail Report lists the accounts that have met the criteria for receiving a refund according to the refund selection parameters or have been manually selected for a refund. The accounts are loaded to an invoice file with a hold status until they are excluded, deleted, or approved for payment.

This report is used to research the reason for the overpayment and to ensure the proper refund is sent to a carrier or guarantor. It contains the account number, patient name, type of refund, admit/discharge date, financial class, vendor, carrier/plan, current balance, billed charges, unbilled charges, and transaction code, description, amount, and the name of the last person who edited (approved) the refund request and the name of the person who created the refund request.

Generating and Printing This Report

This report is created when refund selection is run. It can also be selected from the on-line Pending Refund Detail Report option. If this report is selected from this menu option, you have the option of including approved refunds. The report is sorted by patient account number with page breaks occurring after each patient account or at the end of the page.

The following is an example of the Pending Refund Detail Report.

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Figure 5.7 FPREFDE - Pending Refund Detail Report

```
Date: 04/24/06              General Hospital            Page  : 1
Time: 01:05pm               PENDING REFUND DETAIL       Report: FPREFDE


Account No    Patient Name              TYP    Adm Date  Dsch Date  FC
   0100172303 SOUTHERLAND,RACE           G     12/26/89  12/26/89  11


Created By : Jane Smith
Assigned   : Mary Jones
Approved By: Brenda Brown


  Vendor No   Vendor Name/Address             Carr/Pl  Current Balance
         70 SOUTHERLAND,RACE                  041859            215.00
            432 FALLS WAY

            WOODSTOCK, GA  30188
            (404)323-4543                     Excess               .00
                                              Patient          -215.00
                                              Total                .00


            Billed Charges                                       360.40
            Unbilled Charges                                        .00


   Date     Tran Type Code and Description              Amount
12/26/89  P8000   PATIENT PAYMENT                                360.40
12/27/89  Y0160   FINAL BILL GENERATED                           360.40
12/27/89  S0100   Account Transfer PA to AR                         .00
12/27/89  Z0202   FINAL CLAIM                                    360.40
12/30/89  Z0202   FINAL CLAIM                                    360.40



                              End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

ACCOUNT NO
This field contains the patient account number.

PATIENT NAME
This field contains the patient name.

TYP
This field contains the refund type. Valid types are C-carrier, G-guarantor, or U-unapplied.

ADM DATE
This field contains the date the patient was admitted.

DSCH DATE
This field contains the date the patient was discharged.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial classes categorize patients based on fiscal responsibilities.

VENDOR NO
Depending on the refund type displayed in the TYP field, either the guarantor's number or the carrier plan number is displayed in this field.

VENDOR NAME
Depending upon the refund type displayed in the TYP field, either the guarantor's name or the name assigned to the patient's insurance plan is displayed. The name printed in this field is the recipient of the refund.

VENDOR ADDRESS
This field is completed with either the insurance carrier's address or the guarantor's address, depending on where the refund is to be sent. This field displays the confidential address, if applicable.

CARR/PL
This field contains the carrier plans assigned to this patient.

PENDING REFUND REPORT - FPRENREF

Description/Purpose

The Pending Refund Report lists the accounts that have met the criteria for receiving refunds according to the refund selection parameters. The accounts are loaded to an invoice file with a hold status until they are excluded, deleted, or approved for payment. This report also lists all accounts on hold from previous refund requests.

Included on this report is the account number, patient name, refund type, financial class, total charges, carrier/plan, plan balance, patient balance, account balance, and generation type for each account selected. This report is useful in the review and auditing of refunds pending approval.

Generating and Printing This Report

This report is a demand report. It is sorted by patient account number. You can also select this report from the on-line Pending Refund Report option.

The following is an example of the Pending Refund Report.

Figure 5.8 FPRENREF - Pending Refund Report

```
Date: 05/10/06                              General Hospital                              Page  : 1
Time: 09:45am                            PENDING REFUNDS REPORT                           Report: FPRENREF


Account No    Patient Name              Typ FC   Total Charges  Carr/Pl    Plan Balance  Patient Balance  Account Balance  Gen

 0000000059  DAVIS,ANNE                  C  11         .00  051505          -50.00             .00           -50.00  Sys
            Created By : Jane Smith                        400999
            Assigned   : Mary Jones                        100100
            Approved By: Brenda Brown                       100200


                                                            Excess            .00
                                                            Total          -50.00


 0000000067  DAVIS,ANNE                  C  11         .00  051505         -100.00             .00          -100.00  Sys
            Created By : Jane Smith                        400999
            Assigned   : Mary Jones                        100100
            Approved By: Brenda Brown                       100200


                                                            Excess            .00
                                                            Total         -100.00


 0000000075  DAVIS,ANNE                  C  11         .00  051505          -50.00             .00           -50.00  Sys
            Created By : Jane Smith                        400999
            Assigned   : Mary Jones                        100100
            Approved By: Brenda Brown                       100200


                                                            Excess            .00
                                                            Total          -50.00


 0000000083  DARNELL,JOHN               C  11         .00  051505          -50.00          -50.00          -100.00  Sys
            Created By : Jane Smith                        400999
            Assigned   : Mary Jones                        100100
            Approved By: Brenda Brown                       100200


                                                            Excess            .00
                                                            Total          -50.00


                                            Facility Totals               -30.13         -127.87          -158.00

                                            Grand Totals                  -30.13         -127.87          -158.00

                                                    End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

ACCOUNT NO
This field contains the patient account number.

PATIENT NAME
This field contains the patient name.

TYP
This field contains the refund type. Valid types are C-carrier, G-guarantor, or U-unapplied.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial classes categorize patients based on fiscal responsibilities. Examples of financial classes include S-self pay, C-commercial and M-Medicare.

TOTAL CHARGES
This field contains the total charges applied to this account.

CARR/PL
This field contains the carrier plan code assigned to this patient.

PLAN BALANCE
This field contains the portion of the account balance for which the insurance plan is responsible.

PATIENT BALANCE
This field contains the portion of the account balance for which the patient is responsible.

ACCOUNT BALANCE
This field contains the total dollar amount owed on the account.

GEN
This field contains the source of the refund. Valid refund sources are Sys (system-generated) or Man (manually entered).

CREATED BY
This field contains the name of the person who created the refund request.

ASSIGNED
This field contains the person assigned to the refund.

APPROVED BY
This field contains the name of the person who approved the refund request.

PRE-CHECK LIST (REFUNDS) REPORT- FPRCKLST

Description/Purpose

The Pre-Check List Report lists accounts that have approved refunds. It includes the vendor number, vendor name, patient/vendor or reference number amount of the check, and account total. This report may be used to audit pre-check refunds and as a cash requirements report.

Generating and Printing This Report

The Pre-Check List Report is printed on demand through the refund check process screen. The report is sorted by patient number, voucher number or reference number as applicable to this report. Page breaks occur at the end of the page.

NOTE: If refund checks print from Accounts Payable, this report is not valid.

The following is an example of the Pre-Check List Report.

Figure 5.9 FPRCKLST - Pre-Check List Report

```
Date:07/13/06                        General Hospital                        Page  : 1
Time: 09:45am                        PRE-CHECK LIST                          Report: FPRCKLST


Vendor #  Vendor Name                Approved By                      Account #        Amount
   15   John Brown                   Smith, Mary                      Unapplied        200.00
                                                                      Account Total    200.00


   16   PAYMENT BY                   Lyle, Mike                       Unapplied        100.00
                                                                      Account Total    100.00


                                                                      Facility Total   300.00
                                     End of Report                    Report Total     300.00
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

VENDOR #
This field contains the vendor's account number if this is a patient refund.

VENDOR NAME
This field contains the patient or vendor name.

APPROVED BY
This field contains the name of the person who approved the refund.

ACCOUNT #
This field contains the account number for the refund.

AMOUNT
This field contains the total dollar amount to be refunded to the guarantor or carrier.

REFUND EXCEPTIONS REPORT - FPREFEXC

Description/Purpose

The Refund Exceptions Report prints as part of the refund selection process and includes accounts having an exclusion flag, a deleted flag, or a guarantor who has other open accounts. The system treats these accounts as exceptions and does not issue an automatic refund. The report lists the account number, patient name, financial class, account balance, and exception description.

The Refund Exceptions Report can be used to manually approve refunds for accounts and as a guide to transfer money from one account to another in the case of guarantor overpayments.

Generating and Printing This Report

This report, which is sorted by account number, is a demand report and is printed through the demand print function.

The following is an example of the Refund Exception Report.

Figure 5.10 FPREFEXC - Refund Exception Report

```
Date: 11/13/89                          General Hospital                          Page  : 1
Time: 09:45am                        REFUND EXCEPTION REPORT                       Report: FPREFEXC

FC    Guarantor Name      Corp #      Patient Name        Account No    Account Balance    Exception Description

08    BARTON,MICHAEL S    91092381    BARTON,MICHAEL S    8927019101        -6,500.00       Deleted
08    CLARKE,WILLIAM O    81928111    CLARKE,WILLIAM O    8963810982         2,387.00       Deleted
08    DAVIS,ROBERT Y      00425142    DAVIS,ELAINE P      8963819171           500.00       Deleted
85    EDWARDS,MANFRED F   09251415    EDWARDS,MANFRED JR  8923142315           400.00       Guarantor has other accts
85    FOLEY,JAQUELINE D   66152717    FOLEY,MICHAEL D     8963716187        -7,987.20       Deleted
85    GARLAND,MARIE R     71517187    GARLAND,JACK V      8915343265           100.00       Guarantor has other accts




                                        End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial classes categorize patients based on fiscal responsibilities.

GUARANTOR NAME
This field contains the guarantor name.

CORP #
This field contains the guarantor's corporate number, if any.

PATIENT NAME
This field contains the patient name.

ACCOUNT NO
This field contains the patient account number.

ACCOUNT BALANCE
This field contains the balance due on this account.

EXCEPTION DESCRIPTION
This field contains a description of the refund exception.

REFUNDS APPROVED DELETED REPORT - FPREPPR

Description/Purpose

The Refunds Approved/Deleted Report lists all refunds approved and approved refunds deleted for patient accounts for the business day. It is used in balancing Patient Accounting, Accounts Receivable, Bad Debt, and Unapplied Cash.

The report lists the vendor number, account number, patient name, vendor information, financial class, transaction code/description, override description (modification of vendor name, address or refund amount), type of refund (guarantor, insurance, or unapplied), status of refund (approved or cancelled), CRT identifier, refund amount, account balance, account locations, and person who approved/deleted the refund. Subtotals and grand totals of refunds that have been both approved and deleted are provided by patient indicator and account location (PA, AR, or BD).

NOTE: Unapplied refunds are reported only in the Account Location Totals column. They are designated as UN in the Account Location Totals column.

Generating and Printing This Report

The Refunds Approved/Deleted Report is generated nightly during midnight processing. If no refund approvals or deletions have occurred for the business day, the system generates the report with only the header information and zero totals. The report is printed through the demand print function and is sorted by account number.

The following is an example of a Refunds Approved/Deleted Report.

Figure 5.11 FPREPPR - Refunds Approved/Deleted Report

```
Date: 06/03/06                                    Model Hospital A                                    Page  : 2
Time: 02:20pm                               Refund Approved/Deleted Report                          Report: FPREPPRPA


Account  Nbr     Patient Name                    FC    Tran Code and Description    Refund Amount   Account Balance   Loc
Vendor Nbr       Vendor Information              Override Description       Type  Status  CRT ID   Approved/Deleted By

  9801600001     SHORE,MARTIN                     O    0001 GUARANTOR REFUND                7,000.00        1,179.82   AR
       640       SHORE,MARTIN                                             G      A     FIN      Mann,Larry S
                 301 PERIMETER CENTER NORT
                 CityForModelHosp.A  GA  30346


  9802800003     MERRITT,VERA                     M    0001 GUARANTOR REFUND                2,793.38        3,259.26   AR
      2210       MERRITT,VERA                                             G      A     FIN      Mann,Larry S
                 AD
                 CITYFORMODELHOSP.A  GA   30346


  9802800003     MERRITT,VERA                     M    0001 GUARANTOR REFUND                2,793.38        3,259.26   AR
      2210       MERRITT,VERA                                             G      C     FIN      Mann,Larry S
                 AD
                 CITYFORMODELHOSP.A  GA   30346


  9805800006     KESLER,ROBERT                    S2   0001 GUARANTOR REFUND                   10.00          765.00   AR
      2670       KESLER,ROBERT                                            G      C     FIN      Mann,Larry S
                 22 SPRUCE
                 =                                    Refund Amount Modified
                 CITYFORMODELHOSP.A  GA   30346



                          Account Location Totals        Inpatient        Outpatient            E/R              Total
                              Approved  PA                     .00               .00             .00                .00
                                        AR                9,793.38               .00             .00           9,793.38
                                        BD                     .00               .00             .00                .00
                                        UN                     .00               .00             .00             300.00
                                 Total Approved           9,793.38               .00             .00          10,093.38

                              Deleted   PA                     .00               .00             .00                .00
                                        AR                2,793.38             10.00             .00           2,803.38
                                        BD                     .00               .00             .00                .00
                                        UN                     .00               .00             .00             250.00
                                 Total Deleted            2,793.38             10.00             .00           3,053.38
                          Grand Total                     7,000.00            -10.00             .00           7,040.00


                                             End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

ACCOUNT NBR
This field contains the patient's account number if this is a patient refund.

PATIENT NAME
This field contains the patient's name.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial classes categorize patients based on fiscal responsibilities.

TRAN CODE AND DESCRIPTION
This field contains the four-digit transaction code and description identifying this transaction in the account's transaction history. Valid descriptions include *Refund Processed* and *Insurance Refund*.

REFUND AMOUNT
This field contains the total dollar amount to be refunded to the guarantor or carrier.

ACCOUNT BALANCE
This field contains the balance owed on the account.

LOC
This field contains the account's location. The location can be PA-patient accounting, AR-accounts receivable, or BD-bad debt.

VENDOR NBR
This field contains the vendor's account number if this is a vendor refund.

VENDOR INFORMATION
This field contains either the vendor's or the patient's address, depending on the type of refund. This field displays the confidential address, if applicable.

OVERRIDE DESCRIPTION
If the vendor's name or address is modified from the invoice, or if the refund amount is modified, this field contains a message to that effect.

TYPE
This field contains the type of refund. Either R-guarantor, D-insurance, or U-unapplied is printed here.

STATUS
This field contains the refund status. Valid statuses include A-approved or C-cancelled.

CRT ID
This field contains the CRT code of the person completing, revising or deleting the refund.

APPROVED/DELETED BY
This field contains the name of the person(s) approving or deleting the refund.

REFUND CHECK REGISTER - FPREFREG

Description/Purpose

The Refund Check Register provides a list of all refund checks processed. It includes the check number, pay date, vendor number, vendor name, voucher reference number, distribution account and check amount. A grand total is provided for all check amounts. At the end of the report, totals are provided for each account location and for all account locations. This report is used as an audit trail for issued refund checks.

Generating and Printing This Report

The Refund Check Register is generated as a result of running refund checks and is sorted by check number. This report is not valid for those hospitals producing refund checks from Accounts Payable.

The following is an example of the Refund Check Register.

Figure 5.12 FPREFREG - Refund Check Register

```
Date: 11/17/89                          GENERAL HOSPITAL                      Page  : 1
Time: 12:57 am                          Ref Check Reg                         Report: FPREFREG

GL Cash Account Number 1101   001.10

Check #     Pay Date      Vendor #    Vendor Name           Voucher/Ref #    Loc    Distribution Acct        Amount

300000                    void                                              A/R    Check Total               0.00

300001     11/17/89       123456      William Allen         1234567890       A/R                222222       50.00
                                                                                    Check Total              50.00

300002     11/17/89       789101      Barbara Dowd          0192039101       A/R                222222      100.00
                                                                                    Check Total             100.00

300003     11/17/89       817911      Cletis Edwards        0091810189       A/R                222222       25.00
                                                                             A/R                222222       30.00
                                                                                    Check Total              55.00

300004     11/17/89       819106      Jane Barber           3121312541       A/R                222222       10.00
                                                                                    Check Total              10.00

                                                          GL Cash Account Total                             215.00

                                      Location Totals

                              Total A/R Accounts              215.00

                              Total All Locations             215.00

                                      End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

GL CASH ACCOUNT #
This field contains the cash account number from the general ledger.

CHECK #
This field contains the system-assigned check number.

PAY DATE
This field contains the date of the refund check.

VENDOR NBR
This field contains the vendor's account number if this is a vendor refund.

VENDOR NAME
This field contains the vendor's name if this is a vendor refund.

VOUCHER/REF #
This field contains the patient account number of the account receiving the refund.

LOC
This field specifies the account location (AR, PA, or BD).

DISTRIBUTION ACCT
This field contains the account number deleted in the General Ledger due to liability being satisfied.

AMOUNT
This field contains the refund amount.

TRANSACTION CODE LIST REPORT - FTRTC

Description/Purpose

The Transaction Code List Report lists all transaction codes and associated information defined in the Transaction Code table. The report is separated by transaction type and prints the codes in transaction code order within each transaction type.

Generating and Printing This Report

This report is generated by selecting the Transaction Code table and requesting that the report be generated. It can be printed immediately or through the demand print function.

The following is an example of the Transaction Code List Report.

Figure 5.13 FTRTC - Transaction Code List Report

```
Date: 07/23/90                                          Page :    1
Time: 13:29                                             Report: FTRTC
                            TRANSACTION CODE LIST


Transaction type: A - Adjustment

Transaction                          Valid                    Combined to
Code  Description                    Accounts    Option       Type  Code
------------------------------------------------------------------------------

0010  AUGUST/AUGNET CONT ADJ         Any
0030  BESTCARE CONT ADJ              Any
0050  BCBSO PPO CONT ADJ             Any
0051  BLUE CROSS/BLUE SHIELD MRI ADJ Any
0052  BLUE CROSS COMMERCIAL CONT/ADJ Any
0090  COLUMBIA HEALTH CONT ADJ       Any
0099  ADJUSTMENT                     Any         Combined     I - 0030
0100  TEST COMBINING TRANSACTIONS    Any         Combined     I - 0050
0110  LINCOLN HLTH/FAM HLTH CONT ADJ Any
0130  FOUNDATION HEALTH CONT ADJ     Any
0150  GHP CONT ADJ                   Any
0151  GHP PCT W/O                     Any
0152  GHP MEDICARE CONT ADJ          Any
0153  GHP MEDICARE PCT W/O           Any
0154  GHP PHARM DISC COMM            Any
0156  GHP PHARM DISC PMC EMPL        Any
0157  GHP PMC EMP PCT W/O            Any
0158  GHP PMC EMPL CONT ADJ          Any
0210  MID COLUMBIA CONT ADJ          Any
0230  PACIFIC MUTUAL CONT ADJ        Any
0250  PACIFICARE CONT ADJ            Any
0270  PACC CONT ADJ                  Any
0290  SUBURBAN CONT ADJ              Any
0310  SECURE HORIZONS CONT ADJ       Any
0330  TRAVELERS PPO CONT ADJ         Any
0360  SELECTCARE CONT ADJ            Any
0390  UNION PACIFIC CONT ADJ         Any
0400  PRIN MUT/VANT CONT ADJ         Any
0410  PAC HERITAGE/VANT CONT ADJ     Any
0420  GREAT OR HLTH/VANT CONT ADJ    Any
0440  ADV BENEFIT/VANT CONT ADJ      Any
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

TRANSACTION TYPE
This field contains the one-character code representing the type of transaction. For example, transaction type I represents insurance payments and transaction type P represents patient payments. The transaction type code and description print on the report.

TRANSACTION CODE
This field contains the code assigned to the transaction. It is possible to use the same transaction code in multiple transaction types.

TRANSACTION DESCRIPTION
This field contains the description associated with this transaction code.

VALID ACCOUNTS
This field indicates the type of accounts that can use this transaction code. Options are Any, Collection, and A/R where:

- *Any* is an account in location PA, AR or BD.
- *Collection* is an account in BD.
- *A/R* is an account in PA or AR.

OPTION
This field indicates whether the transaction code is combined with another transaction code on bills and statements. This field contains Combined or is blank.

COMBINED TO TYPE/CODE
These two fields print the transaction type and code with which this transaction code is combined on bills and statements.

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Chapter 6 - STATISTICS REPORTS

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Illustrations

STATISTICS OVERVIEW

The following table provides you with an overview of the statistics function within STAR and how the statistics group is updated for these functions.

FUNCTION	STATISTICS GROUP UPDATED
Admissions	Medical Service Census
Cancel Admission	Nurse Station
Registration	Doctor Census Admitting
Cancel Registration	Doctor Census Attending
Revise/Admit/Discharge Dates	Employer Census
	Patient Type Census
	Zip Code
	Financial Class Census
Discharge	Medical Service Census
Cancel Discharge	Nurse Station
Death	Doctor Census Admitting
	Doctor Census Attending
	Employer Census
	Patient Type Census
	Zip Code
	Financial Class Census
	Discharge
Revise Medical Service	Doctor Census Admitting
	Doctor Census Attending
	Nurse Station
	Patient Type Census
	Zip Code
	Medical Service Census
	Medical Service Revenue
	Patient Type Revenue
Revise Financial Class	Employer Census
	Medical Service

FUNCTION	**STATISTICS GROUP UPDATED**
	Nurse Station
	Patient Type Census
	Financial Class Census
	Transaction
	Zip Code
	Discharge
	Financial Class Revenue
	Doctor Revenue Admitting
	Doctor Revenue Ordering
	Doctor Revenue Attending
	Collector
	Biller
	Collection Agency
	Revenue Center
	Patient Type Revenue
Revise Patient Type	Doctor Census Admitting
	Doctor Census Attending
	Employer Census
	Medical Service Census
	Nurse Station
	Patient Type Census
	Transaction
	Zip Code
	Financial Class Census
	Discharge
	Financial Class Revenue
	Collector
	Biller
	Employer Revenue
	Patient Type Revenue
Revise Physician	Doctor Census Admitting

FUNCTION	STATISTICS GROUP UPDATED
	Doctor Census Attending
	Doctor Revenue Admitting
	Doctor Revenue Ordering
	Doctor Revenue Attending
Bed Transfer	Nurse Station
Outpatient in Bed	
One Day Stay	
Visit Check-in	Patient Type Census
	Medical Service Census
	Doctor Census Admitting
	Doctor Census Attending
	Employer Census
	Zip Code
	Financial Class Census
Charge	Doctor Revenue Admitting
Credit	Doctor Revenue Attending
Order	Doctor Revenue Ordering
	Employer Revenue
	Medical Service Revenue
	Revenue Center
	Patient Type Revenue
	Zip Code
	Financial Class Revenue
	Contract Revenue by Revenue Department
	Contract Revenue
Late Charge	Late Charge
Late Credit	Doctor Revenue Admitting
	Doctor Revenue Attending
	Doctor Revenue Ordering
	Employer Revenue

FUNCTION	STATISTICS GROUP UPDATED
	Medical Service
	Revenue Center
	Patient Type Revenue
	Zip Code
	Financial Class Revenue
	Contract Revenue by Revenue Department
	Contract Revenue
PA to AR Transfer	Collector
	Transaction
BD Prelist	Transaction
Account Archive	
Add AR Master	
Unapplied Cash Posting	
Billing	
Claim Delete	
Claim Archive	
Claim Purge	
Insurance Time Out	
Refund Processing	
Notes	
AR to BD Transfer	Collection Agency
	Collector
	Transaction
	Doctor Census Admitting
	Doctor Census Attending
	Employer Census
BD to AR Transfer	Collection Agency
Add BD Master Agency	Transaction
Cash Posting	

FUNCTION	STATISTICS GROUP UPDATED
BD Archive/Purge	Collection Agency
Revise Collection Agency	
Cash Posting (Insurance)	Collection Agency (BD account)
Adjustment Posting (Insurance)	Collector
	Transaction
	Insurance
Cash Posting (Patient)	Collection Agency (BD account)
Adjustment Posting (Patient)	Collector
	Transaction
Revise Biller	Biller
Transfer Workload	
Claim Release	
Claim/Load Edit	Biller
	Transaction
Claim Submit	Collector
Revise Collector	
Transfer Collector	

GENERAL STATISTICS TERMS

The following data is provided to help you to better understand your statistics.

CHG - Charge Amount
This is the dollar amount of charges for the revenue department.

CHQ - Charge Quantity
This is the amount of an item given. If two aspirin are given at one time, the CHQ is two.

DD - Discharge Days
This is the number of patient days for inpatient type accounts that have been discharged.

LCA - Late Charge Amounts
This is the dollar amount of patient accounting late charges.

LCQ - Late Charge Quantity
This is the amount of an item given - where the item is a late charge.

ADM - Number of Admissions
This contains the number of inpatients admitted to the hospital.

DIS - Number of Discharges
This contains the number of inpatients who are discharged from the hospital.

EXP - Number of Expirations
This contains the number of inpatients who are discharged from the hospital with a disposition of Death.

ITR - Number of Internal Transfers
This is the number of patients transferred within a nurse station from one bed to another.

OPV - Number of O/P Departmental Visits
This is the number of outpatients who were registered at the hospital. It also includes the number of patients who had a visit check-in done on the account.

NOTE: Only one OPV is counted on the initial day of registration, even if a visit check-in is done on that day. If it is not the initial day of registration then one OPV is calculated for every time that the visit check-in function is used, not for every department that the patient is checked into.

ODS - One-day Stays
This is the number of inpatients who were admitted and discharged on the same day.

PTD - Number of Patient Days
This number is calculated by taking the number of inpatients who are in bed at midnight + the number of one day stays. If a patient's admit or discharge date is revised in any way - then patient days are revised accordingly.

REG - Number of Registrations
This is the number of outpatients who were registered into the hospital. Outpatients include Emergency Room patients.

TRI - Number of Transfers In
This statistic is kept by both nurse station and patient type. In relation to the Nurse Station Statistics, it counts the number of patients that are transferred into this nurse station from another nurse station. In relation to Patient Type Statistics, it is the number of patients that are transferred into this patient type from another patient type.

TRO - Number of Transfers Out
This statistic is kept by both nurse station and patient type. In relation to the Nurse Station Statistics, it counts the number of patients that are transferred out of this nurse station from another nurse station. In relation to Patient Type Statistics, it is the number of patients that are transferred out of this patient type from another patient type.

OIB - Outpatients in Bed
This is the number of days that an outpatient was in a bed.

RVL - Relative Value
This figure is hospital defined on the SIM and is not on every charge.

UOS - Units of Service
This figure contains the number of times that a service was performed. In relation to giving two aspirin at one time, the UOS are be one.

The following provides you with additional information about statistics.

There are two fields on Patient Care's Patient Type table that control Statistics. These are the Statistics flag and the Revenue flag.

The statistics flag can be set to either Count or Reclassify. Count leaves the old statistics alone and only builds new census type statistics for this patient. Reclassify removes the census statistics for the old patient type and then builds new Census Statistics based on the new patient type.

The Revenue flag can be set to either Yes or No. Yes reclassifies the revenue when the patient type is changed. No does not reclassify the revenue when the patient type is changed.

USING STATISTICS REPORTS

Statistics reports provide you with a valuable tool to use in analyzing trends at your facility. The system maintains the following statistic groups that you can use to create reports:

Code	Description
AGY	Collection Agency Statistics
BIL	Biller Statistics
COL	Collector Statistics
CON	Contract Revenue Statistics (Contract Sort)
COR	Contract Revenue by Revenue Department Statistics
DIS	Discharge Statistics
DCA	Doctor Census Admitting 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
ZIP	ZIP Code Statistics

Statistics reports sort by keys, which are defined for each statistic group. Each statistic group has at least a primary and secondary key. The system displays data by primary key, further delineating this statistical data by secondary key. If the group has a tertiary

key, secondary key data is broken out by the tertiary key. This process of further delineating the statistical data continues for quaternary (fourth-level) keys and later.

For example, for Collection Agency Statistics, the primary key is Collection Agency Code, the secondary key is Patient Indicator, and the tertiary key is Financial Class. The Collection Agency Statistics Report is sorted by Collection Agency Code, broken out by Patient Indicator. For each Patient Indicator, information is broken out by Financial Class. The system also allows you to select the keys you want to report on to define the desired level of detail for your report.

If a key is missing or has been set as inactive in Statistics Maintenance, the system displays the following for the data on the report:

~ (one tilde)	Key is inactive
~~ (two tildes)	Key is missing
~~ (eight tildes)	Primary key is missing

For more information on maintaining statistical information, refer to the Statistics Maintenance section of the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

GENERATING STATISTICS REPORTS

Statistics reports are generated from the Financial System Management menu option (select Financial Statistics Functions and then the Create Statistical Reports option).

After you access this function, the system prompts you to enter the Statistic Group for the report to be processed. You can enter the appropriate statistic group code or display and select from a list of groups.

Once the statistic group code is entered or selected, you are prompted to enter the desired fiscal year for the report. You can enter an equal sign (=) to use the current fiscal year or display and select from a list of fiscal years available for reporting.

After the fiscal year is entered, the system displays a list of periods available for that year. Select the desired period for the report. The system then displays the following screen:

```
            General Hospital Create Statistical Reports Processor
                                        Wed Jul 29, 1992 10:12 am
                               Fiscal Yr: 92
                              Period Ending: 7
 1 Group             2 Description                    3 Statistic Type
   DRT                 Doctor Revenue Attending Statistics    Revenue
 4 Edit date         5 Edit by
   04/30/90 1041am     Mitchell,Sam
 6 Active?           7 Primary Key
   Yes                 Attending Physician

 8 ## Key        Description             Report on
   1  RD         Revenue Department      Yes
   2  PI         Patient Indicator       Yes
   3  FC         Financial Class         Yes








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

Field Explanations

1. GROUP (DISPLAY ONLY)
This field displays the statistic group code you selected when you first accessed this function.

2. DESCRIPTION (DISPLAY ONLY)
This field displays the name of the statistic group you selected when you first accessed this function.

3. STATISTIC TYPE (DISPLAY ONLY)
This field displays the type of statistics represented by this group: Revenue, Census, Both, or Neither.

4.   EDIT DATE (DISPLAY ONLY)
This field displays the date on which setup information for this statistic group was last changed.

5.   EDIT BY (DISPLAY ONLY)
This field displays the name of the user who last edited setup information for this statistics group.

6.   ACTIVE? (DISPLAY ONLY)
This field displays whether this statistic group is active or inactive.

7.   PRIMARY KEY (DISPLAY ONLY)
This field displays the primary key for this statistic group.

8.   ## KEY (DISPLAY ONLY)
This field displays the secondary keys and the order in which the system sorts by each on the report.

DESCRIPTION (DISPLAY ONLY)
This field displays the description of the secondary keys.

REPORT ON (1-A-R)
This field identifies whether the system should include this sort on the report. Entry options are **Y** for Yes or **N** for No.

You use this field to determine the level of detail you want to include on the report. For example, the example screen displays information for the Doctor Revenue Attending Statistics. This statistic group contains the following secondary keys, in order:

- Revenue Department
- Patient Indicator
- Financial Class

The primary key for this statistic group is Attending Physician. If you only desire totals information for all attending physicians in the facility, enter **N** on the first row (Revenue Department) for this field. The system completes this field for the remaining rows (Patient Indicator and Financial Class) with No, since the exclusion of detail from one secondary key makes it impossible to further sort detail by subsequent secondary keys. If you desire information for all attending physicians sorted by Revenue Department, enter **Y** to the first row (Revenue Department) for this field, then enter **N** to the second row (Patient Indicator) for this field. The system completes this field for the third row (Financial Class) with No.

NOTE: The example reports in this section are sorted by all secondary keys; in other words, an entry of Yes was made to this field for all rows.

When you complete the fields of this screen the system prompts you to accept the screen. When you accept this screen the system displays the following prompt:

Spool Report?-- (Y/N) [Y]

Enter **Y** or press ENTER to begin processing the report. Enter **N** to exit this function without creating a report.

You can also schedule the system to create detail and/or summary statistics reports as an optional batch job. For more information, refer to the Optional Batch Jobs in the Financial System Management section in the *General Information Volume* in the *STAR Financials Patient Accounting Reference Guide*.

BILLER STATISTICS REPORT - FSR111

Description/Purpose

For each biller included on the report, the Biller Statistics Report displays:

- the number and dollar amount of new claims loaded
- the number and dollar amount of claims released
- the number and dollar amount of claims transferred in and out
- the number and dollar amount of claims that failed edits

The report displays totals for period-to-date and year-to-date.

Generating and Printing This Report

For detailed instructions for generating and printing this report, refer to "GENERATING STATISTICS REPORTS" on page 6-14 for more information on this topic.

The following is an example of the Biller Statistics Report.

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Figure 6.1 FSR111 - Biller Statistics Report - Page 1

```
Date: 09/04/92                              GENERAL HOSPITAL                             Page  : 3
Time: 02:58am                            Biller Statistics Report                        Report: FSR111
                                         Fiscal Year: 92  Period: 9


           New Claims          Claims Released        Claims Failed Edits    Claims Transferred Out  Claims Transferred In
Biller        Number      Amount   Number      Amount   Number      Amount   Number      Amount   Number      Amount
---------------------------------------------------------------------------------------------------------------------

   44 Collier,David A.
     O Outpatient
       O/P Regular Outpatient
           C Commercial
           PTD     4    13,152.10     3     9,540.10     1      624.22     0        0.00     0        0.00
           YTD     4    13,152.10     3     9,540.10     1      624.22     0        0.00     0        0.00
        ** Total Patient Type: O/P
           PTD     4    13,152.10     3     9,540.10     1      624.22     0        0.00     0        0.00
           YTD     4    13,152.10     3     9,540.10     1      624.22     0        0.00     0        0.00
        * Total Patient Indicator: O
           PTD     4    13,152.10     3     9,540.10     1      624.22     0        0.00     0        0.00
           YTD     4    13,152.10     3     9,540.10     1      624.22     0        0.00     0        0.00


    Total Biller Code: 44

  Fiscal Period                        Year to Date
  New Claims #          :     4         YTD New Claims #          :     4
  New Claims Amount     :    13,152.10  YTD New Claims Amount     :    13,152.10
  Claims Released #     :     3         YTD Claims Released #     :     3
  Claims Released Amt   :     9,540.10  YTD Claims Released Amt   :     9,540.10
  Claims Trans In #     :     0         YTD Claims Trans Out #    :     0
  Claims Trans Out Amt  :        0.00   YTD Claims Trans Out Amt  :        0.00
  Claims Failed Edits # :     1         YTD Claims Failed Edits # :     1
  Claims Failed Edits Amt:      624.22  YTD Claims Failed Edits Amt :      624.22
  Claims Trans Out #    :     0         YTD Claims Trans Out #    :     0
  Claims Trans Out Amt  :        0.00   YTD Claims Trans Out Amt  :        0.00
```

Figure 6.2 FSR111 - Biller Statistics Report - Page 2

```
Date: 09/04/92                             GENERAL HOSPITAL                              Page : 8
Time: 02:58am                           Biller Statistics Report                        Report: FSR111
                                       Fiscal Year: 92  Period: 9


              New Claims          Claims Released       Claims Failed Edits   Claims Transferred Out  Claims Transferred In
Biller        Number      Amount  Number      Amount    Number      Amount    Number      Amount      Number      Amount
----------------------------------------------------------------------------------------------------------------------------


Total Facility: A GENERAL HOSPITAL
       PTD      10    67138.50      17    75326.50       8     61403.25       1        727.31        0          0.00
       YTD    1935  8231234.58    2053 26275321.75     434   8321354.25      82      34242.56       28       8342.23

                                             End of Report
```

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BILLER STATISTICS REPORT - FSR111

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

For each biller, the system displays period-to-date and year-to-date statistics for each patient type and patient indicator:

NEW CLAIMS
This field displays the number and dollar amount of new claims assigned to this biller.

CLAIMS RELEASED
This field displays the number and dollar amount of claims released by this biller.

CLAIMS FAILED EDITS
This field displays the number and dollar amount of claims assigned to this biller that failed edits.

CLAIMS TRANSFERRED OUT
This field displays the number and dollar amount of accounts transferred out of this biller's workfile.

CLAIMS TRANSFERRED IN
This field displays the number and dollar amount of accounts transferred into this biller's workfile.

The system then displays totals for the biller. The system displays fiscal period and year-to-date statistics for the following:

NEW CLAIMS #
This field displays the number of new claims assigned to this biller.

NEW CLAIMS AMOUNT
This field displays the dollar amount of new claims assigned to this biller.

CLAIMS RELEASED #
This field displays the number of claims released by this biller.

CLAIMS RELEASED AMT
This field displays the dollar amount of claims released by this biller.

CLAIMS TRANS IN #
This field displays the number of claims transferred into this biller's workfile.

CLAIMS TRANS IN AMT
This field displays the dollar amount of claims transferred into this biller's workfile.

CLAIMS FAILED EDITS #
This field displays the number of claims assigned to this biller that failed edits.

CLAIMS FAILED EDITS AMT
This field displays the dollar amount of claims assigned to this biller that failed edits.

CLAIMS TRANS OUT #
This field displays the number of claims transferred out of this biller's workfile.

CLAIMS TRANS OUT AMT
This field displays the dollar amount of claims transferred out of this biller's workfile.

The last page(s) of the report display totals for the facility.

COLLECTION AGENCY STATISTICS REPORT - FSR420

Description/Purpose

The Collection Agency Statistics Report displays information on the number and dollar amount of accounts that have been placed with a collection agency. Information on the report includes the number and total dollar amount of accounts placed and returned from the agency, accounts deleted, total adjustment dollars, and total dollars collected.

This report is not designed to judge the performance of an agency but instead to display only the dollars placed and dollars collected. For a performance analysis use the Collection Agency Analysis report (FFR250).

Generating and Printing This Report

For detailed instructions for generating and printing this report, refer to "GENERATING STATISTICS REPORTS" on page 6-14 for more information on this topic.

The following is an example of the Collection Agency Statistics Report.

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Figure 6.3 FSR420 - Collection Agency Statistics Report

```
Date: 08/09/92                              GENERAL HOSPITAL                              Page  : 1
Time: 11:36am                          Collection Agency Statistics                      Report: FSR420
                                        Fiscal Year: 92  Period: 7
                                 Accounts Placed    Accounts Withdrawn    Adj.     Amount    Accounts Deleted
Collection Agency Statistics     Number   Amount    Number   Amount     Amount    Coll'd    Number   Amount
----------------------------------------------------------------------------------------------------------
  X ABC Collection Agency
   I Inpatient
      L Special              PTD     1     367.45      0      0.00       0.00      0.00      0       0.00
                            YTD     1     367.45      0      0.00       0.00      0.00      0       0.00
      S Self Pay             PTD     1     100.50      0      0.00       0.00      0.00      0       0.00
                            YTD     1     100.50      0      0.00       0.00      0.00      0       0.00
      Z Employee             PTD     1    1746.00      1   1746.00       0.00      0.00      0       0.00
                            YTD     1    1746.00      1   1746.00       0.00      0.00      0       0.00
   * Total Patient Indicator: I  PTD  3    2213.95      1   1746.00       0.00      0.00      0       0.00
                            YTD     3    2213.95      1   1746.00       0.00      0.00      0       0.00
   O Outpatient
      C Commercial           PTD     1    6543.84      1   6543.84       0.00      0.00      0       0.00
                            YTD     1    6543.84      1   6543.84       0.00      0.00      0       0.00
   * Total Patient Indicator: O  PTD  1    6543.84      1   6543.84       0.00      0.00      0       0.00
                            YTD     1    6543.84      1   6543.84       0.00      0.00      0       0.00
  Total Collection Agency Code: X
  Fiscal Period                    Year to Date
  Accounts Placed #     :      4        YTD Accounts Placed #      :        4
  Accounts Placed Amt   :   8757.79     YTD Accounts Placed Amt    :     8757.79
  Accounts Withdrawn #  :      2        YTD Accounts Withdrawn #   :     2
  Accounts Withdrawn Amt:   8289.84     YTD Accounts Withdrawn Amt :     8289.84
  Adjustment Amount     :      0.00     YTD Adjustment Amount      :        0.00
  Amount Collected      :      0.00     YTD Amount Collected       :        0.00
  Accounts Deleted #    :      0        YTD Accounts Deleted #     :     0
  Accounts Deleted Amt  :      0.00     YTD Accounts Deleted Amt   :        0.00
==========================================================================================================
Date: 08/09/92                              GENERAL HOSPITAL                              Page  : 6
Time: 11:36am                          Collection Agency Statistics                      Report: FSR420
                                        Fiscal Year: 92  Period: 7
                                 Accounts Placed    Accounts Withdrawn    Adj.     Amount    Accounts Deleted
Collection Agency Statistics     Number   Amount    Number   Amount     Amount    Coll'd    Number   Amount
----------------------------------------------------------------------------------------------------------
Total Facility: A GENERAL HOSPITAL  PTD  17  14894.45  19  11778.48    20.00      8.00    308      92.00
                                   YTD  19  14896.45  25  11786.48    30.00     12.00    462     138.00
                                      End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

For each Collection Agency, the system displays period-to-date and year-to-date statistics for each patient indicator and financial class.

ACCOUNTS PLACED NUMBER
This field contains the total number of accounts transferred to the collection agency. The system updates this field using values generated by the AR to Bad Debt Transfer optional batch job.

ACCOUNTS PLACED AMOUNT
This field contains the total account balance of accounts transferred to the collection agency. The system updates this field using values generated by the AR to Bad Debt Transfer optional batch job.

ACCOUNTS WITHDRAWN NUMBER
This field contains the number of accounts transferred from the collection agency to Accounts Receivable.

ACCOUNTS WITHDRAWN AMOUNT
This field contains balance of accounts transferred from the collection agency to Accounts Receivable.

ADJ AMOUNT
This field contains the amount of adjustments posted to accounts assigned to the collection agency.

AMOUNT COLL'D
This field contains the amount of payments posted to accounts assigned to the collection agency.

ACCOUNTS DELETED NUMBER
This field contains the number of accounts deleted from the collection agency.

ACCOUNTS DELETED AMOUNT
This field contains the balance of accounts deleted from the collection agency.

The system then displays totals for the collection agency. The system displays fiscal period and year-to-date statistics for the following:

ACCOUNTS PLACED #
This field contains the total number of accounts transferred to the collection agency.

ACCOUNTS PLACED AMT
This field contains the total account balance of accounts transferred to the collection agency.

ACCOUNTS WITHDRAWN #
This field contains the number of accounts transferred from the collection agency to Accounts Receivable.

ACCOUNTS WITHDRAWN AMT
This field contains balance of accounts transferred from the collection agency to Accounts Receivable.

ADJUSTMENT AMT
This field contains the amount of adjustments posted to accounts assigned to the collection agency.

AMOUNT COLLECTED
This field contains the amount of payments posted to accounts assigned to the collection agency.

ACCOUNTS DELETED #
This field contains the number of accounts deleted from the collection agency.

ACCOUNTS DELETED AMT
This field contains the balance of accounts deleted from the collection agency.

The last page(s) of the report display totals for the facility.

COLLECTOR STATISTICS - FSR121

Description/Purpose

For each collector on the report, the Collector Statistics Report displays a two-part report. Part one of the report shows the following:

- the number and amount of new accounts received
- the number and amount of accounts paid
- the number and amount of accounts transferred to a collection agency
- the number and amount of accounts adjusted

Part two of the Collector Statistics report shows the following:

- the number and amount of accounts transferred to another collector
- the number of collector statements
- the number of collector calls

The report displays totals for period-to-date and year-to-date.

This report can be used as a collector performance report.

Generating and Printing This Report

For detailed instructions for generating and printing this report, refer to for more information on this topic.

The following is an example of the Collector Statistics Report (part one and part two).

Figure 6.4 FSR121 - Collector Statistics (Part One) - Page 1

```
Date: 08/09/92                                GENERAL HOSPITAL                                Page  : 1
Time: 11:36am                                Collector Statistics                            Report: FSR121
                                          Fiscal Year: 92  Period: 7
                             New Accounts              Payments Received        Adjustments Made       BD Accounts Transferred
Collector                    Number      Amount        Number      Amount       Number      Amount     Number      Amount
------------------------------------------------------------------------------------------------------------------------------
   1 Anderson,Amy
     I Inpatient
      I/P Regular Admission
          C Commercial
                       PTD        0        0.00          0        0.00           0        0.00           0        0.00
                       YTD        0        0.00          0        0.00           0        0.00           0        0.00
          T Blue Cross
                       PTD        0        0.00          0        0.00           0        0.00           0        0.00
                       YTD        0        0.00          0        0.00           0        0.00           0        0.00
       ** Total Patient Type: I/P
                       PTD        0        0.00          0        0.00           0        0.00           0        0.00
                       YTD        0        0.00          0        0.00           0        0.00           0        0.00
      * Total Patient Indicator: I
                       PTD        0        0.00          0        0.00           0        0.00           0        0.00
                       YTD        0        0.00          0        0.00           0        0.00           0        0.00
     O Outpatient
      O/P Regular Outpatient
          C Commercial
                       PTD        0        0.00          0        0.00           0        0.00           0        0.00
                       YTD        0        0.00          0        0.00           0        0.00           0        0.00
          G Medicaid
                       PTD        0        0.00          0        0.00           0        0.00           0        0.00
                       YTD        0        0.00          0        0.00           0        0.00           0        0.00
          M Medicare
                       PTD        0        0.00          0        0.00           0        0.00           0        0.00
                       YTD        0        0.00          0        0.00           0        0.00           0        0.00
          S Self Pay
                       PTD        0        0.00          0        0.00           0        0.00           0        0.00
                       YTD        0        0.00          0        0.00           0        0.00           0        0.00
          T Blue Cross
                       PTD        0        0.00          0        0.00           0        0.00           0        0.00
                       YTD        0        0.00          0        0.00           0        0.00           0        0.00
       ** Total Patient Type: O/P
                       PTD        0        0.00          0        0.00           0        0.00           0        0.00
                       YTD        0        0.00          0        0.00           0        0.00           0        0.00
      * Total Patient Indicator: O
                       PTD        0        0.00          0        0.00           0        0.00           0        0.00
                       YTD        0        0.00          0        0.00           0        0.00           0        0.00
```

Figure 6.5 FSR121 - Collector Statistics (Part One) - Page 2

```
Date: 08/09/92                              GENERAL HOSPITAL                          Page  : 2
Time: 11:36am                             Collector Statistics                       Report: FSR121
                                       Fiscal Year: 92  Period: 7


                            New Accounts           Payments Received     Adjustments Made      BD Accounts Transferred
Collector                   Number      Amount     Number      Amount    Number      Amount    Number      Amount
---------------------------------------------------------------------------------------------------------------------


   Total Collector Code: 1

 Fiscal Period                          Year to Date
  New Accounts #       :     4           YTD New Accounts #        :      4
  New Accounts Amount  :     15717.69    YTD New Accounts Amount   :      15717.69
  Payments Received #  :     0           YTD Payments Received #   :      0
  Payments Received Amt :        0.00    YTD Payments Received Amt :         0.00
  Adjustments Made #   :     4           YTD Adjustments Made #    :      4
  Adjustments Made Amt :     15717.69    YTD Adjustments Made Amt  :      15717.69
  Accounts Trans Out # :     4           YTD Accounts Trans Out #  :      4
  Accounts Trans Out Amt:    15717.69    YTD Accounts Trans Out Amt :     15717.69
```

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Figure 6.6 FSR121 - Collector Statistics (Part Two) - Page 1

```
Date: 08/09/94                              GENERAL HOSPITAL                              Page  : 1
Time: 11:36am                              Collector Statistics                          Report: FSR121
                                        Fiscal Year: 92  Period: 7
                        Accounts Transferred          Collector Statements          Collector Calls
Collector                 Number       Amount              Number                        Number
-----------------------------------------------------------------------------------------------------------------
  1 Anderson,Amy
    I Inpatient
      I/P Regular Admission
          C Commercial
                          PTD      0          0.00              1                          0
                          YTD      0          0.00              5                          0
          T Blue Cross
                          PTD      0          0.00              0                          0
                          YTD      1        327.00              6                          0
      ** Total Patient Type: I/P
                          PTD      0          0.00              0                          0
                          YTD      0        327.00             12                          0
    * Total Patient Indicator: I
                          PTD      0          0.00              0                          0
                          YTD      0        327.00             12                          0
    O Outpatient
      O/P Regular Outpatient
          C Commercial
                          PTD      0          0.00              0                          0
                          YTD      0        247.00              0                          0
          G Medicaid
                          PTD      0          0.00              0                          0
                          YTD      0          0.00              0                          0
          M Medicare
                          PTD      0          0.00              0                          0
                          YTD      0          0.00              0                          0
          S Self Pay
                          PTD      0          0.00              0                          0
                          YTD      0          0.00              0                          0
          T Blue Cross
                          PTD      0          0.00              0                          0
                          YTD      0          0.00              0                          0
      ** Total Patient Type: O/P
                          PTD      0          0.00              0                          0
                          YTD      0        247.00              0                          0
    * Total Patient Indicator: O
                          PTD      0          0.00              0                          0
                          YTD      0        247.00              0                          0
```

Figure 6.7 FSR121 - Collector Statistics (Part Two) - Page 2

```
Date: 08/09/94                            GENERAL HOSPITAL                            Page  : 2
Time: 11:36am                            Collector Statistics                        Report: FSR121
                                      Fiscal Year: 94  Period: 7


                        Accounts Transferred    Collector Statements       Collector Calls
Collector               Number      Amount       Number                    Number
---------------------------------------------------------------------------------------------------------


   Total Collector Code: 1

Fiscal Period                          Year to Date
# Accounts Transferred      :      0          YTD # Accounts Transferred  :      0
Amount Accounts Transferred :      0.00       YTD Amount Accounts Trans   :      0.00
# Collector Statements      :      12         YTD # Collector Statement   :      12
# Collector Calls           :      0          YTD # Collector Calls       :      0
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

For each collector, the system displays period-to-date and year-to-date statistics for each patient type, patient indicator, financial class, and totals for patient type and indicator:

NEW ACCOUNTS
This field displays the number and dollar amount of new accounts assigned to this collector.

PAYMENTS RECEIVED
This field displays the number and dollar amount of payments received for accounts assigned to this collector.

ADJUSTMENTS MADE
This field displays the number and dollar amount of adjustments made to accounts assigned to this collector.

BD ACCOUNTS TRANSFERRED
This field displays the number and dollar amount of accounts transferred to a collection agency (Bad Debt).

TOTAL PATIENT TYPE
The number and dollar amounts per patient type for New Accounts, Payments Received, Adjustments Made, and BD Accounts Transferred for period-to-date and year-to-date displays for each patient type for each collector.

TOTAL PATIENT INDICATOR
The number and dollar amounts per patient indicator for New Accounts, Payments Received, Adjustments Made, and BD Accounts Transferred for period-to-date and year-to-date displays for each patient indicator for each collector.

The system then displays totals for the collector, as shown on the second example page. The system displays fiscal period and year-to-date statistics for the following:

NEW ACCOUNTS #
This field displays the number of new accounts assigned to this collector.

NEW ACCOUNTS AMOUNT
This field displays the dollar amount of new accounts assigned to this collector.

PAYMENTS RECEIVED #
This field displays the number of payments received for accounts assigned to this collector.

PAYMENTS RECEIVED AMT
This field displays the dollar amount of payments received for accounts assigned to this collector.

ADJUSTMENTS MADE #
This field displays the number of adjustments made to accounts assigned to this collector.

ADJUSTMENTS MADE AMT
This field displays the dollar amount of adjustments made to accounts assigned to this collector.

 # ACCOUNTS TRANS TO BD
This field displays the number of accounts transferred out to a collection agency (Bad Debt).

ACCOUNTS TRANS TO BD AMT
This field displays the dollar amount of accounts transferred out to a collection agency.

The last page(s) of the report display totals for the facility.

The second part of the report displays the same information as displayed on part one of the report with the following additions.

The system then displays totals for the collector, as shown on the second example page. The system displays fiscal period and year-to-date statistics for the following:

ACCOUNTS TRANSFERRED
This field displays the number and dollar amount transferred to another collector.

COLLECTOR STATEMENTS
This field displays the number of paper follow-ups sent by the collector. This field is updated by the detail statements, demand insurance follow-up, follow-up letters, and insurance follow-up letters.

COLLECTOR CALLS
This field displays the number of phone calls completed by the collector.

DISCHARGE STATISTICS - FSR205

Description/Purpose

The Discharge Statistics Report displays the number of discharges and discharge patient days for each nursing station.

Generating and Printing This Report

For detailed instructions for generating and printing this report, refer to "GENERATING STATISTICS REPORTS" on page 6-14 for more information on this topic.

The following is an example of the Discharge Statistics Report.

Figure 6.8 FSR205 - Discharge Statistics Report

```
Date: 09/09/92                          GENERAL HOSPITAL                      Page  : 1
Time: 02:34am                       Discharge Statistic Report                Report: FSR205
                                    Fiscal Year: 92  Period: 9


Discharge                                Discharges    Discharge Days
-----------------------------------------------------------------------------------------

    1E 1 East
      S SELF PAY
          ECU Extended Care Unit    PTD        2            4
                                    YTD       10            5
          I/P Regular Admission     PTD       31            3
                                    YTD      295            3
       * Total Financial Class: S   PTD       33            3
                                    YTD      305            4

    Total Nurse Station: 2S

   Fiscal Period                       Year to Date
   Discharges          :      33       YTD Discharges          :          305
   Discharge Days      :       3       YTD Discharge Days      :            4


========================================================================================
===
Date: 09/09/92                          GENERAL HOSPITAL                      Page  : 1
Time: 02:34am                       Discharge Statistic Report                Report: FSR205
                                    Fiscal Year: 92  Period: 9


Discharge                                Discharges    Discharge Days
-----------------------------------------------------------------------------------------



Total Facility: A GENERAL HOSPITAL  PTD       63            3
                                    YTD    2,863            2

                                    End of Report
```

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For each nursing station, the system displays period-to-date and year-to-date statistics for each financial class and patient type.

DISCHARGES
This field contains the number of discharges for this nursing station.

DISCHARGE DAYS
This field contains the number of patient days for this nursing station for accounts that have been discharged.

The system then displays totals for the discharges by nursing station. The system displays fiscal period and year-to-date statistics for the following:

DISCHARGES
This field contains the number of discharges for this nursing station.

DISCHARGE DAYS
This field contains the number of patient days for this nursing station for accounts that have been discharged.

The last page(s) of the report display totals for the facility.

EMPLOYER CENSUS STATISTICS REPORT - FSR400

Description/Purpose

The Employer Census Statistics Report displays the number of admissions, discharges, patient days, registrations, outpatient visits, and the number and amount of accounts transferred to a collection agency for employers associated with the patient's primary insurance carrier. The report displays totals for period-to-date and year-to-date.

This report can be used as a planning tool for administrative personnel and for marketing purposes.

Generating and Printing This Report

For detailed instructions for generating and printing this report, refer to "GENERATING STATISTICS REPORTS" on page 6-14 for more information on this topic.

The following is an example of a Employer Census Statistics Report.

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Figure 6.9 FSR400 - Employer Census Statistics Report

```
Date: 09/04/92                              GENERAL HOSPITAL                              Page  : 1
Time: 03:07am                          Employer Census Statistics                        Report: FSR400
                                       Fiscal Year: 92  Period: 9


                       Number        Number        Number        Number        Number
Employer             Admissions    Discharges    Pt Days   Registrations    OP Visits   CA Accts      CA Dollars
-----------------------------------------------------------------------------------------------------------------


   HBO HBO & COMPANY
     IP1 Admission
          C Commercial
                       PTD        1             1             2             0             0          0           0.00
                       YTD        1             1             2             0             0          0           0.00
      * Total Patient Type: IP1
                       PTD        1             1             2             0             0          0           0.00
                       YTD        1             1             2             0             0          0           0.00

    Total Employer Code: HBO

    Fiscal Period                    Year to Date
    Admissions        :       1      YTD Admissions         :        1
    Discharges        :       1      YTD Discharges         :        1
    Patient Days      :       2      YTD Patient Days       :        2
    Registrations     :       0      YTD Registrations      :        0
    Outpatient Visits :       0      YTD Outpatient Visits  :        0
    CA Accounts       :       0      YTD CA Accounts        :        0
    CA Dollars        :    0.00      YTD CA Dollars         :     0.00


=================================================================================================================
Date: 09/04/92                              GENERAL HOSPITAL                              Page  : 10
Time: 03:07am                          Employer Census Statistics                        Report: FSR400
                                       Fiscal Year: 92  Period: 9


                       Number        Number        Number        Number        Number
Employer             Admissions    Discharges    Pt Days   Registrations    OP Visits   CA Accts      CA Dollars
-----------------------------------------------------------------------------------------------------------------

Total Facility: A GENERAL HOSPITAL
                       PTD      304           296             6           131           273         24        8452.23
                       YTD    29634         29427             5         18226         73132        182      126380.21

                                            End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

For each employer the system displays period-to-date and year-to-date statistics for each patient type and financial class.

EMPLOYER
This field contains the employer code and name.

NUMBER ADMISSIONS
This field contains the number of admissions for this employer.

NUMBER DISCHARGES
This field contains the number of discharges for this employer.

NUMBER PT DAYS
This field contains the number of patient days for this employer.

NUMBER REGISTRATIONS
This field contains the number of outpatient registrations for this employer.

NUMBER OP VISITS
This field contains the number of outpatient visits for this employer.

CA ACCTS
This field displays the number of accounts transferred to a collection agency for this employer.

CA DOLLARS
This field displays the dollar amount of accounts transferred to a collection agency for this employer.

TOTAL PATIENT TYPE
This field displays period-to-date and year-to-date totals for the number of admissions, number of discharges, number of patient days, number of registrations, number of OP visits, and the number and dollar amount for accounts transferred to a collection agency for each patient type for each employer.

The system then displays totals for the employer. The system displays fiscal period and year-to-date statistics for the following:

ADMISSIONS
This field contains the number of admissions for this employer.

DISCHARGES
This field contains the number of discharges for this employer.

PATIENT DAYS
This field contains the number of patient days for this employer.

REGISTRATIONS
This field contains the number of outpatient registrations for this employer.

OUTPATIENT VISITS
This field contains the number of outpatient visits for this employer.

CA ACCTS
This field displays the number of accounts transferred to a collection agency for this employer.

CA DOLLARS
This field displays the dollar amount of accounts transferred to a collection agency for this employer.

The last page(s) of the report display totals for the facility.

EMPLOYER REVENUE STATISTICS REPORT - FSR405

Description/Purpose

The Employer Revenue Statistics Report displays the number and dollar amount of charges for employers associated with the patient's primary insurance carrier. The report displays totals for period-to-date and year-to-date.

This report can be used as a planning tool for administrative personnel.

Generating and Printing This Report

For detailed instructions for generating and printing this report, refer to "GENERATING STATISTICS REPORTS" on page 6-14 for more information on this topic.

The following is an example of the Employer Revenue Statistics Report.

Figure 6.10 FSR405 - Employer Revenue Statistics Report

```
Date: 09/04/92                              GENERAL HOSPITAL                              Page  : 3
Time: 03:08am                          Employer Revenue Statistics                      Report: FSR405
                                       Fiscal Year: 92  Period: 9


                                        ** Period to Date **                        ** Year to Date **
Employer                            Quantity          Charge Amount            Quantity              Charge Amount
--------------------------------------------------------------------------------------------------------------------

  20 ATLANTIC WIDGETS
    7300 EEG
       IP1 Admission                    9                 137.26                  9                      137.26
  * Total Revenue Department: 7300      9                 137.26                  9                      137.26

    ~~ Missing
       IP1 Admission                    2                 499.29                  2                      499.29
  * Total Revenue Department: ~~        2                 499.29                  2                      499.29

   Total Employer Code: 20

  Fiscal Period                  Year to Date
  Charge Quantity     :          11       YTD Charge Quantity     :          11
  Amount of Charges   :      636.55       YTD Amount of Charges   :      636.55

====================================================================================================================
Date: 09/04/92                              GENERAL HOSPITAL                              Page  : 8
Time: 03:08am                          Employer Revenue Statistics                      Report: FSR405
                                       Fiscal Year: 92  Period: 9

                                        ** Period to Date **                        ** Year to Date **
Employer                            Quantity          Charge Amount            Quantity              Charge Amount
--------------------------------------------------------------------------------------------------------------------


Total Facility: A GENERAL HOSPITAL     764              103081.41                764                    103081.41

                                            End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

For each employer the system displays period-to-date and year-to-date statistics for each revenue department and patient type.

EMPLOYER
This field contains the employer code and name.

PERIOD TO DATE QUANTITY
This field contains the total number of charges for this employer.

PERIOD TO DATE CHARGE AMOUNT
This field contains the total dollar amount of charges for this employer.

YEAR TO DATE QUANTITY
This field contains the year-to-date total number of charges for this employer.

YEAR TO DATE CHARGE AMOUNT
This field contains the year-to-date total dollar amount of charges for this employer.

The system then displays totals for the employer. The system displays fiscal period and year-to-date statistics for the following:

CHARGE QUANTITY
This field contains the total number of charges for this employer.

AMOUNT OF CHARGES
This field contains the total dollar amount of charges for this employer.

The last page(s) of the report display totals for the facility.

FINANCIAL CLASS CENSUS STATISTICS REPORT - FSR202

Description/Purpose

The Financial Class Census Statistics Report displays the census statistics for each financial class and patient type.

This report can be used as an information tool for patient accounting and a planning tool for administrative personnel.

Generating and Printing This Report

For detailed instructions for generating and printing this report, refer to "GENERATING STATISTICS REPORTS" on page 6-14 for more information on this topic.

The following is an example of the Financial Class Census Statistics Report.

Figure 6.11 FSR202 - Financial Class Census Statistics Report

```
Date: 09/04/92                                   GENERAL HOSPITAL                                        Page  : 1
Time: 03:09am                           Financial Class Census Statistic Report                         Report: FSR202
                                            Fiscal Year: 92  Period: 9
                        Number       Number        Number           Number        Number        Number
Financial Class         Admissions   Discharges    Pt Days          Deaths        Registrations OP Visits
-----------------------------------------------------------------------------------------------------------------
  S Self Pay
    I/P Regular Admission
                    PTD      3          0              48              0              0            0
                    YTD      3          0              48              0              0            0
    O/P Regular Outpatient
                    PTD      0          0              12              0              0            0
                    YTD      0          0              12              0              0            0
    QAA QUICK ADMIT WITHOUT M
                    PTD      0          0               7              0              0            0
                    YTD      0          0               7              0              0            0
    ~~ Missing
                    PTD      0          0               1              0              0            0
                    YTD      0          0               1              0              0            0
   Total Financial Class: S
  Fiscal Period                      Year to Date
  Admissions        :      3         YTD Admissions        :        3
  Discharges        :      0         YTD Discharges        :        0
  Patient Days      :     86         YTD Patient Days      :       86
  Deaths            :      0         YTD Deaths            :        0
  Registrations     :      1         YTD Registrations     :        1
  Outpatient Visits :      1         YTD Outpatient Visits :        1
=================================================================================================================
Date: 09/04/92                                   GENERAL HOSPITAL                                        Page  : 10
Time: 03:09am                           Financial Class Census Statistic Report                         Report: FSR202
                                            Fiscal Year: 92  Period: 9
                        Number       Number        Number           Number        Number        Number
Financial Class         Admissions   Discharges    Pt Days          Deaths        Registrations OP Visits
-----------------------------------------------------------------------------------------------------------------
Total Facility: A GENERAL HOSPITAL
                    PTD      5          1             126              0              1            1
                    YTD      5          1             126              0              1            1
                                            End of Report
```

FINANCIAL CLASS CENSUS STATISTICS REPORT - FSR202

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

For each financial class the system displays period-to-date and year-to-date statistics for each patient type.

NUMBER ADMISSIONS
This field contains the number of admissions for this financial class.

NUMBER DISCHARGES
This field contains the number of discharges for this financial class.

NUMBER PT DAYS
This field contains the number of patient days for this financial class.

NUMBER DEATHS
This field contains the number of deaths for this financial class.

NUMBER REGISTRATIONS
This field contains the number of outpatient registrations for this financial class.

NUMBER OP VISITS
This field contains the number of outpatient visits for this financial class.

The system then displays totals for the employer. The system displays fiscal period and year-to-date statistics for the following:

ADMISSIONS
This field contains the number of admissions for this financial class.

DISCHARGES
This field contains the number of discharges for this financial class.

PATIENT DAYS
This field contains the number of patient days for this financial class.

DEATHS
This field contains the number of deaths for this financial class.

REGISTRATIONS
This field contains the number of outpatient registrations for this financial class.

OUTPATIENT VISITS
This field contains the number of outpatient visits for this financial class.

The last page(s) of the report display totals for the facility.

FINANCIAL CLASS REVENUE STATISTICS REPORT - FSR203

Description/Purpose

The Financial Class Revenue Statistics Report displays revenue statistics for each financial class and patient type.

This report can be used as an information tool for patient accounting and a planning tool for administrative personnel.

Generating and Printing This Report

For detailed instructions on generating this report, refer to "GENERATING STATISTICS REPORTS" on page 6-14 for more information on this topic.

The following is an example of the Financial Class Revenue Statistics Report.

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Figure 6.12 FSR203 - Financial Class Revenue Statistics Report

```
Date: 09/04/92                                    GENERAL HOSPITAL                                    Page  : 1
Time: 03:09am                           Financial Class Revenue Statistic Report                     Report: FSR203
                                            Fiscal Year: 92  Period: 9


                                          ** Period to Date **                        ** Year to Date **
Financial Class                        Quantity          Charge Amount          Quantity              Charge Amount
------------------------------------------------------------------------------------------------------------------

   H General HMO Programs
      I/P Regular Admission                26                 603.97                26                    603.97

    Total Financial Class: H

   Fiscal Period                        Year to Date
   Charge Quantity    :            26     YTD Charge Quantity      :            941
   Amount of Charges  :        603.97     YTD Amount of Charges    :      23,509.04


==================================================================================================================
Date: 09/04/92                                    GENERAL HOSPITAL                                    Page  : 9
Time: 03:09am                           Financial Class Revenue Statistic Report                     Report: FSR203
                                            Fiscal Year: 92  Period: 9


                                          ** Period to Date **                        ** Year to Date **
Financial Class                        Quantity          Charge Amount          Quantity              Charge Amount
------------------------------------------------------------------------------------------------------------------



Total Facility: A GENERAL HOSPITAL        1231               7350323.41           23082               1202841346.72

                                                   End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

For each financial class the system displays period-to-date and year-to-date statistics for each patient type.

PERIOD TO DATE QUANTITY
This field contains the number of charges for the financial class.

PERIOD TO DATE CHARGE AMOUNT
This field contains the dollar amount total for the charges for the financial class.

YEAR TO DATE QUANTITY
This field contains the year-to-date number of charges for the financial class.

YEAR TO DATE CHARGE AMOUNT
This field contains the year-to-date dollar amount total for the charges for the financial class.

The system then displays totals for the financial class. The system displays fiscal period-to-date and year-to-date statistics for the following:

CHARGE QUANTITY
This field contains the number of charges for the financial class.

AMOUNT OF CHARGES
This field contains the dollar amount total for the charges for the financial class.

The last page(s) of the report display totals for the facility.

INSURANCE STATISTICS REPORT - FSR201

Description/Purpose

The Insurance Statistics Report displays a statistical analysis of insurance payment performance for the primary insurance carrier for an account. The report displays the number and amount of claims submitted, paid, and adjusted.

The report displays totals for period-to-date and year-to-date.

Generating and Printing This Report

For detailed instructions for generating and printing this report, refer to "GENERATING STATISTICS REPORTS" on page 6-14 for more information on this topic.

The following is an example of the Insurance Statistics Report.

Figure 6.13 FSR201 - Insurance Statistics Report

```
Date: 09/04/92                              GENERAL HOSPITAL                          Page  : 1
Time: 03:09am                           Insurance Statistic Report                    Report: FSR201
                                        Fiscal Year: 92  Period: 9


                             Claims                  Payments               Adjustments
Insurance                Number      Amount      Number      Amount      Number      Amount
------------------------------------------------------------------------------------------------------

   130094 AMALGAMATED MUTUAL FIDELITY
        O Outpatient
                         PTD     1      203.00      0         0.00        0          0.00
                         YTD    14   12,946.22     11     8,499.81        6        821.04-

   Total Carrier/Plan Code: 130094

  Fiscal Period                      Year to Date
  Claims #             :      1           YTD Claims #              :      14
  Claims Amount        :        203.00    YTD Claims Amount         :   12,946.22
  Payments #           :      0           YTD Payments #            :      11
  Payments Amount      :          0.00    YTD Payments Amount       :    8,499.81
  Adjustments #        :      0           YTD Adjustments #         :       6
  Adjustments Amount   :          0.00    YTD Adjustments Amount    :      821.04-
======================================================================================================
Date: 09/04/92                              GENERAL HOSPITAL                          Page  : 6
Time: 03:09am                           Insurance Statistic Report                    Report: FSR201
                                        Fiscal Year: 92  Period: 9


                             Claims                  Payments               Adjustments
Insurance                Number      Amount      Number      Amount      Number      Amount
------------------------------------------------------------------------------------------------------


Total Facility: A GENERAL HOSPITAL
                         PTD    85    2,645.02     78     3,863.08       19      7,422.05-
                         YTD 2,364  203,874.29  2,391   877,571.23      869    838,801.74-

                                          End of Report
```

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For each primary insurance company, the system displays period-to-date and year-to-date statistics for each patient indicator:

CLAIMS
This field displays the number and dollar amount of claims for this insurance carrier.

PAYMENTS
This field displays the number and dollar amount of payments made on claims for this insurance carrier.

ADJUSTMENTS
This field displays the number and dollar amount of adjustments made to claims for this insurance carrier.

The system then displays totals for the primary insurance company. The system displays fiscal period and year-to-date statistics for the following:

CLAIMS #
This field displays the number of claims for this insurance carrier.

CLAIMS AMOUNT
This field displays the dollar amount of claims for this insurance carrier.

PAYMENTS #
This field displays the number of payments made on claims for this insurance carrier.

PAYMENTS AMT
This field displays the dollar amount of payments made on claims for this insurance carrier.

ADJUSTMENTS #
This field displays the number of adjustments made to claims for this insurance carrier.

ADJUSTMENTS AMT
This field displays the dollar amount of adjustments made to claims for this insurance carrier.

The last page(s) of the report display totals for the facility.

LATE CHARGE STATISTICS REPORT - FSR360

Description/Purpose

The Late Charge Statistics Report provides the period-to-date quantity and amount of late charges/credits for the selected fiscal period. Year-to-date quantity and amount are also reported. The data is reported by patient indicator for inpatients, outpatients, and emergency room patients. Facility totals are listed at the end of the report.

NOTE: The system does not offer a summary version of this report.

Generating and Printing This Report

For detailed instructions for generating and printing this report, refer to "GENERATING STATISTICS REPORTS" on page 6-14 for more information on this topic.

The following is an example of the Late Charge Statistics Report.

Figure 6.14 FSR360 - Late Charge Statistics Report - Page 1

```
Date: 09/06/92                              GENERAL HOSPITAL                                    Page  : 1
Time: 02:40am                            Late Charge Statistics                              Report: FSR360
                                          GENERAL HOSPITAL A
                                        Fiscal Year:92  Period:9
DEPARTMENT                         INPATIENT         OUTPATIENT      EMERGENCY ROOM      MISSING KEY           TOTAL
   1000 DIET PLANNING
               PTD     QTY              4                 0                 0                 0                   4
                       AMT         200.00              0.00              0.00              0.00              200.00
               YTD     QTY              4                 0                 0                 0                   4
                       AMT         200.00              0.00              0.00              0.00              200.00
   6450 NURSERY
               PTD     QTY              2                 0                 0                 0                   2
                       AMT       2,100.00              0.00              0.00              0.00            2,100.00
               YTD     QTY              2                 0                 0                 0                   2
                       AMT       2,100.00              0.00              0.00              0.00            2,100.00
   7100 LABORATORY
               PTD     QTY              0                 0                 0                 0                   0
                       AMT           0.00              0.00              0.00              0.00                0.00
               YTD     QTY              0                 0                 0                 0                   0
                       AMT           0.00              0.00              0.00              0.00                0.00
   7330 CENTRAL SUPPLY
               PTD     QTY              1                 0                 0                 0                   1
                       AMT           0.50              0.00              0.00              0.00                0.50
               YTD     QTY              1                 0                 0                 0                   1
                       AMT           0.50              0.00              0.00              0.00                0.50
   7380 ANESTHESIA
               PTD     QTY              1                 0                 0                 0                   1
                       AMT          14.50              0.00              0.00              0.00               14.50
               YTD     QTY              1                 0                 0                 0                   1
                       AMT          14.50              0.00              0.00              0.00               14.50
   7660 RADIOLOGY
               PTD     QTY              1                 0                 0                 0                   1
                       AMT         293.00              0.00              0.00              0.00              293.00
               YTD     QTY              1                 0                 0                 0                   1
                       AMT         293.00              0.00              0.00              0.00              293.00
   7990 MISCELLANEOUS
               PTD     QTY              5                 0                 0                 0                   5
                       AMT       2,523.75              0.00              0.00              0.00            2,523.75
               YTD     QTY              5                 0                 0                 0                   5
                       AMT       2,523.75              0.00              0.00              0.00            2,523.75
               PTD     QTY             10                 0                 0                 0                  10
                       AMT         532.13              0.00              0.00              0.00              532.13
               YTD     QTY             10                 0                 0                 0                  10
                       AMT         532.13              0.00              0.00              0.00              532.13
```

Figure 6.15 FSR360 - Late Charge Statistics Report - Page 2

```
Date: 12/02/92                         GENERAL HOSPITAL                              Page  : 4
Time: 09:53am                        Late Charge Statistics                         Report: FSR360
                                       GENERAL HOSPITAL A
                                     Fiscal Year:92  Period:11

                                     *****FACILITY TOTALS*****

                         INPATIENT        OUTPATIENT      EMERGENCY ROOM      MISSING KEY        TOTAL

        PTD     QTY         1,332              124               0                 0             1,456
                AMT    133,775.67         17,742.89            0.00              0.00        151,518.56
        YTD     QTY         1,332              124               0                 0             1,456
                AMT    133,775.67         17,742.89            0.00              0.00        151,518.56

                                         End of Report
```

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Each page of the report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the fiscal period selected, the page number, and the report name as used in the system.

DEPARTMENT
This field contains the revenue department code and description (from the STAR Patient Care Revenue Center Code table).

INPATIENT PTD
This field contains the period-to-date quantity and amount of late charges and credits for inpatients for the fiscal period selected for the specified revenue department.

INPATIENT YTD
This field indicates the year-to-date quantity and amount of late charges and credits for outpatients for the corresponding fiscal year for the specified revenue department.

OUTPATIENT PTD
This field contains the period-to-date quantity and amount of late charges and credits for outpatients for the fiscal period selected for the specified revenue department.

OUTPATIENT YTD
This field contains the year-to-date quantity and amount of late charges and credits for outpatients for the corresponding fiscal year for the specified revenue department.

EMERGENCY ROOM PTD
This field contains the period-to-date quantity and amount of late charges and credits for emergency room patients for the fiscal period selected for the specified revenue department.

EMERGENCY ROOM YTD
This field contains the year-to-date quantity and amount of late charges and credits for emergency room patients for the corresponding fiscal year for the specified revenue department.

MISSING KEY PTD
This field displays the period-to-date quantity and amount of late charges and credits for patients for whom no patient indicator was assigned for the fiscal period selected for the specified revenue department.

MISSING KEY YTD
This field displays the year-to-date quantity and amount of late charges and credits for patients for whom no patient indicator was assigned for the corresponding fiscal year for the specified revenue department.

TOTAL PTD
This field contains the period-to-date total quantity and amount of late charges and credits for all patients for the specified revenue department.

TOTAL YTD
This field contains the year-to-date quantity and amount of late charges and credits for all patients for the specified revenue department.

The second page of the example report displays facility totals for the report. The system prints this information at the end of the Late Charge Statistics report.

MEDICAL SERVICES CENSUS STATISTICS REPORT - FSR300

Description/Purpose

The Medical Services Statistics Report displays number of admissions, discharges, patient days, deaths, registrations, and outpatient visits for a medical service. The report displays totals for period-to-date and year-to-date.

This report can be used as a planning tool for administrative personnel.

Generating and Printing This Report

For detailed instructions for generating and printing this report, refer to "GENERATING STATISTICS REPORTS" on page 6-14 for more information on this topic.

The following is an example of the Medical Service Statistics Report.

Figure 6.16 FSR300 - Medical Service Statistics (Census)

```
Date: 09/04/92                              GENERAL HOSPITAL                         Page  : 1
Time: 03:10am                          Medical Service Statistics                   Report: FSR300
                                       Fiscal Year: 92  Period: 9


                    Number          Number          Number          Number          Number          Number
Medical Service     Admissions      Discharges      Pt Days         Deaths          Registrations   OP Visits
-------------------------------------------------------------------------------------------------------------

  OPH OPHTHALMOLOGY
   I Inpatient
        G Medicaid
                    PTD     0             0               1               0               0               0
                    YTD     0             0               1               0               0               0
        M Medicare
                    PTD     0             0               2               0               0               0
                    YTD     0             0               2               0               0               0
        S Self Pay
                    PTD     0             0               1               0               0               0
                    YTD     0             0               1               0               0               0
    * Total Patient Indicator: I
                    PTD     0             0               4               0               0               0
                    YTD     0             0               4               0               0               0

   Total Medical Service: OPH

 Fiscal Period                          Year to Date
 Admissions          :       0          YTD Admissions          :       0
 Discharges          :       0          YTD Discharges          :       0
 Patient Days        :       4          YTD Patient Days        :       4
 Deaths              :       0          YTD Deaths              :       0
 Registrations       :       0          YTD Registrations       :       0
 Outpatient Visits   :       0          YTD Outpatient Visits   :       0
=============================================================================================================
Date: 09/04/92                              GENERAL HOSPITAL                         Page  : 16
Time: 03:10am                          Medical Service Statistics                   Report: FSR300
                                       Fiscal Year: 92  Period: 9


                    Number          Number          Number          Number          Number          Number
Medical Service     Admissions      Discharges      Pt Days         Deaths          Registrations   OP Visits
-------------------------------------------------------------------------------------------------------------

Total Facility: A GENERAL HOSPITAL
                    PTD     4             1             126               0               1               1
                    YTD     4             1             126               0               1               1

                                         End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

For each medical service the system displays period-to-date and year-to-date statistics for each patient indicator:

MEDICAL SERVICE
This field contains the code and name of the medical service.

NUMBER ADMISSIONS
This field contains the number of admissions for this medical service.

NUMBER DISCHARGES
This field contains the number of discharges for this medical service.

NUMBER PT DAYS
This field contains the number of patient days for this medical service.

NUMBER DEATHS
This field contains the number of deaths for this medical service.

NUMBER REGISTRATIONS
This field contains the number of outpatient registrations for this medical service.

NUMBER OP VISITS
This field contains the number of outpatient visits for this medical service.

The system then displays totals for the medical service. The system displays fiscal period and year-to-date statistics for the following:

ADMISSIONS
This field contains the number of admissions for this medical service.

DISCHARGES
This field contains the number of discharges for this medical service.

PATIENT DAYS
This field contains the number of patient days for this medical service.

DEATHS
This field contains the number of deaths for this medical service.

REGISTRATIONS
This field contains the number of outpatient registrations for this medical service.

OUTPATIENT VISITS
This field contains the number of outpatient visits for this medical service.

The last page(s) of the report display totals for the facility.

MEDICAL SERVICES REVENUE STATISTICS REPORT - FSR305

Description/Purpose

The Medical Service Revenue Report displays the quantity, relative value, units of service, and dollar amount for charges for each medical service. The report displays totals for period-to-date and year-to-date.

This report can be used as a planning tool for administrative personnel.

Generating and Printing This Report

For detailed instructions for generating and printing this report, refer to "GENERATING STATISTICS REPORTS" on page 6-14 for more information on this topic.

The following is an example of the Medical Service Revenue Report.

Figure 6.17 FSR305 - Medical Service Revenue Statistics Report

```
Date: 09/04/92                              GENERAL HOSPITAL                                    Page  : 1
Time: 03:10am                            Medical Service Revenue                                Report: FSR305
                                        Fiscal Year: 92  Period: 9
                                    ** Period to Date **                         ** Year to Date **
Medical Service                      Qty    RV   UOS    Charge Amount        Qty      RV    UOS     Charge Amount
------------------------------------------------------------------------------------------------------------------
  DSU DAY SURGERY
   7990 MISCELLANEOUS
        I Inpatient                   2     2     0       1100.00             10      10     0        5500.00
    * Total Revenue Department: 7990  2     2     0       1100.00             10      10     0        5500.00
   Total Medical Service: DSU
  Fiscal Period                   Year to Date
  Charge Quantity    :     2          YTD Charge Quantity    :     10
  Number of Rv    :     2          YTD Number of Rv       :     10
  Units of Service   :     0          YTD Units of Service   :      0
  Amount of Charges  :     1100.00          YTD Amount of Charges  :     5500.00
==================================================================================================================
Date: 09/04/92                              GENERAL HOSPITAL                                    Page  : 13
Time: 03:10am                            Medical Service Revenue                                Report: FSR305
                                        Fiscal Year: 92  Period: 9
                                    ** Period to Date **                         ** Year to Date **
Medical Service                      Qty    RV   UOS    Charge Amount        Qty      RV    UOS     Charge Amount
------------------------------------------------------------------------------------------------------------------
Total Facility: A GENERAL HOSPITAL   764   364    4      103081.41          764      364     4       103081.41
                                        End of Report
```

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MEDICAL SERVICES REVENUE STATISTICS REPORT -

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

For each medical service the system displays period-to-date and year-to-date statistics for each revenue department and patient indicator.

MEDICAL SERVICE
This field contains the medical service code and description.

PERIOD TO DATE QTY
This field contains the period-to-date quantity of charges for this medical service.

PERIOD TO DATE RV
This field contains the quantity of relative value units for the period-to-date for this medical service.

PERIOD TO DATE UOS
This field contains the units of service for the period-to-date for this medical service.

PERIOD TO DATE CHARGE AMOUNT
This field contains the period-to-date dollar total for the charges for this medical service.

YEAR TO DATE QTY
This field contains the year-to-date quantity of charges for this medical service.

YEAR TO DATE RV
This field contains the quantity of relative value units for the year-to-date for this medical service.

YEAR TO DATE UOS
This field contains the units of service for the year-to-date for this medical service.

YEAR TO DATE CHARGE AMOUNT
This field contains the year-to-date dollar total for the charges for this medical service.

The system then displays totals for the medical service. The system displays fiscal period and year-to-date statistics for the following:

CHARGE QUANTITY
This field contains the total quantity of charges for this medical service.

NUMBER OF RV
This field contains the total quantity of relative value units for the medical service.

UNITS OF SERVICE
This field contains the total units of service for the medical service.

AMOUNT OF CHARGES
This field contains the total dollar total for the charges for this medical service.

The last page(s) of the report display totals for the facility.

NURSE STATION STATISTICS REPORT - FSR330

Description/Purpose

The Nurse Station Statistics Report displays the number of admissions, discharges, patient days, deaths, transfers in and out of the department, internal transfers, one-day stays, outpatients in beds, and number of bed charges for each nursing station. The report displays totals for period-to-date and year-to-date.

This report can be used as a planning tool for administrative personnel and a budgeting tool.

Generating and Printing This Report

For detailed instructions for generating and printing this report, refer to "GENERATING STATISTICS REPORTS" on page 6-14 for more information on this topic.

The following is an example of the Nurse Station Statistics Report.

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Figure 6.18 FSR330 - Nurse Station Statistics Report

```
Date: 09/04/92                              GENERAL HOSPITAL                              Page  : 1
Time: 03:11am                           Nurse Station Statistics                       Report: FSR330
                                       Fiscal Year: 92  Period: 9


                     Number  Number  Patient  Number   Trans    Trans    Int  One-Day  Number    Bed
Nurse Station        Admits  Dischs   Days    Deaths    In       Out     Trans  Stays  OP Beds  Charges


  3S 3 South
   C Commercial
    I/P Regular Admission
       EMR EMERGENCY      PTD    12      11      38       0       2       7       2       6       2       38
                         YTD    152     120     325       2      56      70      25      40      18      823
       MED MEDICAL        PTD     51      20      40       1      11      15       7       5       0       46
                         YTD    305     282     548       5      99     126      30      93      70     1275
    ** Total Patient Type: I/P PTD  63    31      78       1      13      22       9      11       2       84
                         YTD    457     402     873       7     155     196      55     133      88     2098
    * Total Financial Class: C  PTD  63    31      78       1      13      22       9      11       2       84
                         YTD    457     402     873       7     155     196      55     133      88     2098


   Total Nurse Station: 3S

  Fiscal Period                      Year to Date
  Admissions        :     63         YTD Admissions          :     457
  Discharges        :     31         YTD Discharges          :     402
  Patient Days      :     78         YTD Patient Days        :     873
  Deaths            :      1         YTD Deaths              :       7
  Transfers In      :     13         YTD Transfers In        :     155
  Transfers Out     :     22         YTD Transfers Out       :     196
  Internal Transfers :     9         YTD Internal Transfers  :      55
  One-Day Stays     :     11         YTD One-Day Stays       :     133
  Outpatient Beds   :      2         YTD Outpatient Beds     :      88
  Bed Charges       :     84         YTD Bed Charges         :    2098


===================================================================================================
Date: 09/04/92                              GENERAL HOSPITAL                              Page  : 25
Time: 03:11am                           Nurse Station Statistics                       Report: FSR330
                                       Fiscal Year: 92  Period: 9


                     Number  Number  Patient  Number   Trans    Trans    Int  One-Day  Number    Bed
Nurse Station        Admits  Dischs   Days    Deaths    In       Out     Trans  Stays  OP Beds  Charges


Total Facility: A GENERAL HOSPITAL PTD   63    31      78       1      13      22       9      11       2       84
                         YTD    457     402     873       7     155     196      55     133      88     2098

                                       End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

For each nurse station the system displays period-to-date and year-to-date statistics for each financial class, patient type, and medical service.

NUMBER ADMITS
This field contains the number of admissions for this nurse station.

NUMBER DISCHS
This field contains the number of discharges for this nurse station.

PATIENT DAYS
This field contains the number of patient days for this nurse station.

NUMBER DEATHS
This field contains the number of deaths for this nurse station.

TRANS IN
This field contains the number of patients transferred in for this nurse station.

TRANS OUT
This field contains the number of patients transferred out from this nurse station.

INT TRANS
This field contains the number of bed-to-bed transfers within the same nurse station.

ONE-DAY STAYS
This field contains the number of one-day stays at this nurse station.

NUMBER OP BEDS
This field contains the number of outpatients assigned to a bed for this nurse station.

BED CHARGES
This field contains the number of bed charges generated for the nurse station.

The system then displays totals for the nurse station. The system displays fiscal period and year-to-date statistics for the following:

ADMISSIONS
This field contains the number of admissions for this nurse station.

DISCHARGES
This field contains the number of discharges for this nurse station.

PATIENT DAYS
This field contains the number of patient days for this nurse station.

DEATHS
This field contains the number of deaths for this nurse station.

TRANSFERS IN
This field contains the number of patients transferred in for this nurse station.

TRANSFERS OUT
This field contains the number of patients transferred out from this nurse station.

INTERNAL TRANSFERS
This field contains the number of bed-to-bed transfers within the same nurse station.

ONE-DAY STAYS
This field contains the number of one-day stays at this nurse station.

OUTPATIENT BEDS
This field contains the number of outpatients assigned to a bed for this nurse station.

BED CHARGES
This field contains the number of bed charges generated for the nurse station.

The last page(s) of the report display totals for the facility.

PATIENT TYPE CENSUS STATISTICS REPORT - FSR310

Description/Purpose

The Patient Type Census Statistics Report displays the number of admissions, discharges, patient days, deaths, registrations, outpatient visits, transfers in, and transfers out for each patient type. The report displays totals for period-to-date and year-to-date.

This report can be used as a planning tool for administrative personnel and a budgeting tool.

Generating and Printing This Report

For detailed instructions for generating and printing this report, refer to "GENERATING STATISTICS REPORTS" on page 6-14 for more information on this topic.

The following is an example of the Patient Type Statistic Report.

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Figure 6.19 FSR310 - Patient Type Census Statistic Report

```
Date: 09/04/92                              GENERAL HOSPITAL                               Page  : 1
Time: 03:12am                            Patient Type Statistics                          Report: FSR310
                                        Fiscal Year: 92  Period: 9
                     Number      Number      Number      Number      Number      Number      Transfer    Transfer
Patient Type         Admissions  Discharges  Pt Days     Deaths      Reg         OP Visits   In          Out
-------------------------------------------------------------------------------------------------------------
  I/P Regular Admission
   MED MEDICAL
        C Commercial
                     PTD     0           0           3           0           0           0           0           0
                     YTD     0           0           3           0           0           0           0           0
        H General HMO Program
                     PTD     0           0           1           0           0           0           0           0
                     YTD     0           0           1           0           0           0           0           0
        M Medicare
                     PTD     0           0           5           0           0           0           0           0
                     YTD     1           0          12           0           0           0           0           0
        S Self Pay
                     PTD     2           0          34           0           0           0           0           0
                     YTD     1           0          27           0           0           0           0           0
        T Blue Cross
                     PTD     0           0           4           0           0           0           0           0
                     YTD     0           0           4           0           0           0           0           0
     * Total Medical Service: MED
                     PTD     2           0          57           0           0           0           0           0
                     YTD     2           0          57           0           0           0           0           0
   Total Patient Type: I/P
   Fiscal Period                    Year to Date
   Admissions        :      2       YTD Admissions          :        2
   Discharges        :      0       YTD Discharges          :        0
   Patient Days      :     57       YTD Patient Days        :       57
   Deaths            :      0       YTD Deaths              :        0
   Registrations     :      0       YTD Registrations       :        0
   Outpatient Visits :      0       YTD Outpatient Visits   :        0
=============================================================================================================
Date: 09/04/92                              GENERAL HOSPITAL                               Page  : 8
Time: 03:12am                            Patient Type Statistics                          Report: FSR310
                                        Fiscal Year: 92  Period: 9
                     Number      Number      Number      Number      Number      Number      Transfer    Transfer
Patient Type         Admissions  Discharges  Pt Days     Deaths      Reg         OP Visits   In          Out
-------------------------------------------------------------------------------------------------------------
Total Facility: A GENERAL HOSPITAL
                     PTD     4           1         126           0           1           1           0           0
                     YTD     4           1         126           0           1           1           0           0
                                        End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

For each patient type the system displays period-to-date and year-to-date statistics for each medical service and financial class:

PATIENT TYPE
This field contains the patient type code and description that identifies a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, etc.

NUMBER ADMISSIONS
This field contains the number of admissions for this patient type.

NUMBER DISCHARGES
This field contains the number of discharges for this patient type.

NUMBER PT DAYS
This field contains the number of patient days for this patient type.

NUMBER DEATHS
This field contains the number of deaths for this patient type.

NUMBER REG
This field contains the number of outpatient registrations for this patient type.

NUMBER OP VISITS
This field contains the number of outpatient visits for this patient type.

TRANSFER IN
This field contains the number of patients transferred in for this patient type.

TRANSFER OUT
This field contains the number of patients transferred out from this patient type.

The system then displays totals for the patient type. The system displays fiscal period and year-to-date statistics for the following:

ADMISSIONS
This field contains the number of admissions for this patient type.

DISCHARGES
This field contains the number of discharges for this patient type.

PATIENT DAYS
This field contains the number of patient days for this patient type.

DEATHS
This field contains the number of deaths for this patient type.

REGISTRATIONS
This field contains the number of outpatient registrations for this patient type.

OUTPATIENT VISITS
This field contains the number of outpatient visits for this patient type.

The last page(s) of the report display totals for the facility.

PATIENT TYPE REVENUE STATISTICS REPORT - FSR204

Description/Purpose

The Patient Type Revenue Statistics Report displays the number and dollar amount of charges for each patient type. The report displays totals for period-to-date and year-to-date.

This report can be used as a planning tool for administrative personnel.

Generating and Printing This Report

For detailed instructions for generating and printing this report, refer to "GENERATING STATISTICS REPORTS" on page 6-14 for more information on this topic.

The following is an example of the Patient Type Revenue Statistic Report.

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Figure 6.20 FSR204 - Patient Type Revenue Statistic Report

```
Date: 09/05/92                                     GENERAL HOSPITAL                                    Page  : 1
Time: 03:30am                                  Patient Type Statistic Report                          Report: FSR204
                                                Fiscal Year: 92  Period: 9


                                             ** Period to Date **                            ** Year to Date **
Patient Days                              Quantity          Charge Amount              Quantity              Charge Amount
------------------------------------------------------------------------------------------------------------------


   IP INPATIENT
     OPH OPHTHALMOLOGY
         M Medicare                          1                  600.00                    1                      600.00
     * Total Medical Service: OPH            1                  600.00                    1                      600.00

   Total Patient Type: IP

 Fiscal Period                          Year to Date
 Charge Quantity    :            1      YTD Charge Quantity    :             1
 Amount of Charges  :       600.00      YTD Amount of Charges  :        600.00

==================================================================================================================
Date: 09/05/92                                     GENERAL HOSPITAL                                    Page  : 9
Time: 03:30am                                  Patient Type Statistic Report                          Report: FSR204
                                                Fiscal Year: 92  Period: 9


                                             ** Period to Date **                            ** Year to Date **
Patient Days                              Quantity          Charge Amount              Quantity              Charge Amount
------------------------------------------------------------------------------------------------------------------


Total Facility: A GENERAL HOSPITAL         1418               136888.42                 1418                  136888.42

                                                  End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

For each patient type the system displays period-to-date and year-to-date statistics for each medical service and financial class:

PERIOD TO DATE QUANTITY
This field contains the number of charges for the financial class.

PERIOD TO DATE CHARGE AMOUNT
This field contains the dollar amount total for the charges for the financial class.

YEAR TO DATE QUANTITY
This field contains the year-to-date number of charges for the financial class.

YEAR TO DATE CHARGE AMOUNT
This field contains the year-to-date dollar amount total for the charges for the financial class.

The system then displays totals for the patient type. The system displays fiscal period and year-to-date statistics for the following:

CHARGE QUANTITY
This field contains the number of charges for the financial class.

AMOUNT OF CHARGES
This field contains the dollar amount total for the charges for the financial class.

The last page(s) of the report display totals for the facility.

PHYSICIAN CENSUS STATISTICS REPORT, ADMITTING/ ATTENDING PHYSICIAN - FSR320

Description/Purpose

The Physician Census Statistics Report provides a summary of the number of admissions, discharges, patient days, deaths, number of accounts and total dollar amounts transferred to collection agencies, registrations, and outpatient visits for each physician with financial activity on the system.

This report includes information from both the Doctor Census Admitting Statistics (DCA) and Doctor Census Attending Statistics (DCT) groups. This report can be used as a planning tool by administration.

Generating and Printing This Report

For detailed instructions for generating and printing this report, refer to "GENERATING STATISTICS REPORTS" on page 6-14 for more information on this topic.

The following is an example of the Physician Census Statistics Report.

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Figure 6.21 FSR320 - Physician Census Statistics Report

```
Date: 09/09/92                                 GENERAL HOSPITAL                              Page  : 1
Time: 02:30am                              Physician Census Statistics                       Report: FSR320
                                           Fiscal Year: 92  Period: 9

Admitting                         Admissions  Discharges   Pt Days      Deaths     CA Dollars   CA Accts      Regs     OP Visits
-----------------------------------------------------------------------------------------------------------------------------


  171 ADAIR,FRANKLIN B
   I Inpatient
      CCU CORONARY CARE           PTD      1          1          6           0         0.00          0          1          0
                                  YTD     12         10         59           0         0.00          0          4          2
    * Total Patient Indicator: I  PTD      1          1          6           0         0.00          0          1          0
                                  YTD     12         10         59           0         0.00          0          4          2


   Total Admitting Physician: 0

  Fiscal Period                          Year to Date
  Admissions        :       1            YTD Admissions         :        12
  Discharges        :       1            YTD Discharges         :        10
  Patient Days      :       6            YTD Patient Days       :        59
  Deaths            :       0            YTD Deaths             :         0
  CA Dollars        :        0.00        YTD CA Dollars         :         0.00
  CA Accounts       :       0            YTD CA Accounts        :         0
  Registrations     :       1            YTD Registrations      :         4
  Outpatient Visits :       0            YTD Outpatient Visits  :         2


===============================================================================================================================
Date: 09/09/92                                 GENERAL HOSPITAL                              Page  : 43
Time: 02:30am                              Physician Census Statistics                       Report: FSR320
                                           Fiscal Year: 92  Period: 9

Admitting                         Admissions  Discharges   Pt Days      Deaths     CA Dollars   CA Accts      Regs     OP Visits
-----------------------------------------------------------------------------------------------------------------------------



Total Facility: A GENERAL HOSPITAL PTD    224        240        722           2     8,450.75         11         83        371
                                   YTD 63,818     63,763    823,530          52    70,047.22        105        931     67,931

                                                End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

For each physician the system displays period-to-date and year-to-date statistics for each medical service and patient indicator:

PHYSICIAN
This field contains the physician's code and name as defined in the STAR Patient Care physician table. The heading indicates Admitting or Attending physician based on your report selection.

ADMISSIONS
This field contains the number of admissions for this physician.

DISCHARGES
This field contains the number of discharges for this physician.

PT DAYS
This field contains the number of patient days for this physician.

DEATHS
This field contains the number of deaths for this physician.

CA DOLLARS
This field contains the dollar amount totals for this physician which have been transferred to a collection agency.

CA ACCTS
This field contains the total number of accounts for this physician which have been transferred to a collection agency.

REGS
This field contains the number of outpatient registrations for this physician.

OP VISITS
This field contains the number of outpatient visits for this physician.

The system then displays totals for the physician. The system displays fiscal period and year-to-date statistics for the following:

ADMISSIONS
This field contains the number of admissions for this physician.

DISCHARGES
This field contains the number of discharges for this physician.

PATIENT DAYS
This field contains the number of patient days for this physician.

DEATHS
This field contains the number of deaths for this physician.

CA DOLLARS
This field contains the dollar amount totals for this physician which have been transferred to a collection agency.

CA ACCOUNTS
This field contains the total number of accounts for this physician which have been transferred to a collection agency.

REGISTRATIONS
This field contains the number of outpatient registrations for this physician.

OUTPATIENT VISITS
This field contains the number of outpatient visits for this physician.

The last page(s) of the report display totals for the facility.

PHYSICIAN REVENUE STATISTICS REPORT, ATTENDING/ ORDERING /ADMITTING PHYSICIAN - FSR325

Description/Purpose

The Physician Revenue Statistics Report displays the total charge quantity and amount for a physician for period-to-date and year-to-date. The report provides a period-to-date summary of the number of charges, the total dollar amount, and the YTD number of charges and total dollar amount for the charges.

This report includes information from both the Doctor Revenue Admitting Statistics (DRA), Doctor Revenue Attending Statistics (DRT), and Doctor Revenue Ordering Statistics (DRO) groups.

Generating and Printing This Report

For detailed instructions for generating and printing this report, refer to "GENERATING STATISTICS REPORTS" on page 6-14 for more information on this topic.

The following is an example of a Physician Revenue Statistics Report.

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Figure 6.22 FSR325 - Physician Revenue Statistics Report, Attending/
Ordering/Admitting Physician

```
Date: 09/09/92                              GENERAL HOSPITAL                                 Page  : 1
Time: 02:34am                          Physician Revenue Statistics                          Report: FSR325
                                        Fiscal Year: 92  Period: 9
                                       ** Period to Date **                         ** Year to Date **
Admitting                        Quantity           Charge Amount          Quantity                Charge Amount
-----------------------------------------------------------------------------------------------------------------
   2 LEES,JACK R
     2983
       I Inpatient
           S Self Pay                  1                    100.00             13                      2,675.20
       ** Total Patient Indicator: I   1                    100.00             13                      2,675.20
     * Total Revenue Department: 1234  1                    100.00             13                      2,675.20
     7060 EMERGENCY ROOM
       I Inpatient
           S Self Pay                  3                     89.00             20                      1,946.77
       ** Total Patient Indicator: I   3                     89.00             20                      1,946.77
     * Total Revenue Department: 7060  3                     89.00             20                      1,946.77
     7990 MISCELLANEOUS
       I Inpatient
           S Self Pay                  0                      0.00              1                        504.75
       ** Total Patient Indicator: I   0                      0.00              1                        504.75
     * Total Revenue Department: 7990  0                      0.00              1                        504.75
     ~~ Missing
       I Inpatient
           S Self Pay                  0                      0.00              3                         85.00
       ** Total Patient Indicator: I   0                      0.00              3                         85.00
     * Total Revenue Department: ~~    0                      0.00              3                         85.00
    Total Admitting Physician: 2
   Fiscal Period                   Year to Date
   Charge Quantity    :           4     YTD Charge Quantity    :           37
   Amount of Charges  :      189.00     YTD Amount of Charges  :      5,211.72
=================================================================================================================
Date: 09/09/92                              GENERAL HOSPITAL                                 Page  : 41
Time: 02:34am                          Physician Revenue Statistics                          Report: FSR325
                                        Fiscal Year: 92  Period: 9
                                       ** Period to Date **                         ** Year to Date **
Admitting                        Quantity           Charge Amount          Quantity                Charge Amount
-----------------------------------------------------------------------------------------------------------------
Total Facility: A GENERAL HOSPITAL   3843              294931.85             39237                  8294931.85
                                          End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

For each physician the system displays period-to-date and year-to-date statistics for each revenue department, patient indicator, and financial class:

PHYSICIAN
This field contains the physician's code and name as defined in the STAR Patient Care physician table. The heading indicates Admitting, Attending, or Ordering physician based on your report selection.

PERIOD TO DATE QUANTITY
This field contains the number of charges for the physician.

PERIOD TO DATE CHARGE AMOUNT
This field contains the dollar amount total for the charges for the physician.

YEAR TO DATE QUANTITY
This field contains the year-to-date number of charges for the physician.

YEAR TO DATE CHARGE AMOUNT
This field contains the year-to-date dollar amount total for the charges for the physician.

The system then displays totals for the physician. The system displays fiscal period and year-to-date statistics for the following:

CHARGE QUANTITY
This field contains the total number of charges for the physician.

AMOUNT OF CHARGES
This field contains the total dollar amount total for the charges for the physician.

The last page(s) of the report display totals for the facility.

REVENUE CENTER STATISTICS REPORT - FSR340

Description/Purpose

The Revenue Center Statistics Report displays the quantity of charges, the number of relative value units, the units of service, and the total amount of charges for each revenue department. The report displays totals for period-to-date and year-to-date.

This report can be used as a planning tool for administrative personnel and as a budgeting tool.

Generating and Printing This Report

For detailed instructions for generating and printing this report, refer to for more information on this topic.

In addition to the standard prompts, for this report the system also displays the following prompt:

> *Do you want financial class grouped version (Y/N)? [N]*

To generate the Revenue Center Statistics Report, displaying statistics by individual financial class, enter **N** or press ENTER. To generate the Revenue Center Statistics by FC Group Report, enter **Y**.

The system then displays the following prompt:

> *Do you want all revenue centers (Y/N)?*

To include statistics for all revenue centers, enter **Y**. To include statistics for specific revenue centers enter **N**, then select the desired revenue centers from the displayed table.

The following is an example of a Revenue Department Statistics Report.

Figure 6.23 FSR340 - Revenue Center Statistics Report

```
Date: 09/07/92                                GENERAL HOSPITAL                               Page  : 1
Time: 03:24pm                             Revenue Center Statistics                          Report: FSR340
                                          Fiscal Year: 92  Period: 9


                                            ** Period to Date **                       ** Year to Date **
Revenue Center Statistics              Qty    RV   UOS   Charge Amount            Qty    RV   UOS    Charge Amount
-----------------------------------------------------------------------------------------------------------------


   7380 ANESTHESIA
     S Self Pay
       ANS Anesthesia
         3950 3-WAY STOPCOCK MANIFOLD
             I Inpatient              1      0    1         14.50              1      0    1          14.50
          *** Total SIM Item: 3950    1      0    1         14.50              1      0    1          14.50
        ** Total SIM Department: ANS  1      0    1         14.50              1      0    1          14.50
      * Total Financial Class: S      1      0    1         14.50              1      0    1          14.50

    Total Revenue Department: 7380


  Fiscal Period                        Year to Date
  Charge Quantity    :       1         YTD Charge Quantity    :        1
  Number of Rv    :      0             YTD Number of Rv     :        0
  Units of Service   :       1         YTD Units of Service     :        1
  Amount of Charges  :         14.50   YTD Amount of Charges    :          14.50

                                          End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

For each revenue center the system displays period-to-date and year-to-date statistics for each financial class, SIM department, SIM item, and patient indicator:

REVENUE CENTER
This field contains the revenue center (department) code and description.

PERIOD TO DATE QTY
This field contains the period-to-date quantity of charges for each revenue department.

PERIOD TO DATE RV
This field contains the period-to-date quantity of relative value units used by each revenue department.

PERIOD TO DATE UOS
This field contains the period-to-date units of service for the specified revenue department.

PERIOD TO DATE CHARGE AMOUNT
This field contains the period-to-date dollar amount of charges for each revenue department.

YEAR TO DATE QTY
This field contains the year-to-date quantity of charges for each revenue department.

YEAR TO DATE RV
This field contains the year-to-date quantity of relative value units used by each revenue department.

YEAR TO DATE UOS
This field contains the year-to-date units of service for the specified revenue department.

YEAR TO DATE CHARGE AMOUNT
This field contains the year-to-date dollar amount of charges for each revenue department.

The system then displays totals for the revenue center. The system displays fiscal period and year-to-date statistics for the following:

CHARGE QUANTITY
This field contains the total quantity of charges for the revenue department.

NUMBER OF RVUS
This field contains the total quantity of relative value units used by the revenue department.

UNITS OF SERVICE
This field contains the total units of service for the revenue department.

AMOUNT OF CHARGES
This field contains the total dollar amount of charges for the revenue department.

REVENUE CENTER STATISTICS BY FC GROUP REPORT - FSR350

Description/Purpose

The Revenue Center Statistics by Financial Class Group Report displays a breakdown of revenue by financial class statistical group. This report enables you to group revenue into up to nine hospital-defined groups.

This report can be used as a planning tool for administrative personnel.

Generating and Printing This Report

For detailed instructions for generating and printing this report, refer to "GENERATING STATISTICS REPORTS" on page 6-14 for more information on this topic.

In addition to the standard prompts, for this report the system also displays the following prompt:

> *Do you want financial class grouped version (Y/N)? [N]*

To generate the Revenue Center Statistics by FC Group Report, displaying statistics by financial class group, enter **Y**. This report is sorted by revenue center, SIM department, SIM item number, financial group, and patient indicator. To generate the Revenue Center Statistics Report, enter **N** or press ENTER.

The system then displays the following prompt:

> *Do you want all revenue centers (Y/N)?*

To include statistics for all revenue centers, enter **Y**. To include statistics for specific revenue centers enter **N**, then select the desired revenue centers from the displayed table.

The following is an example of a Revenue Statistics By FC Group Report.

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Figure 6.24 FSR350 - Revenue Center Statistics by Financial Class
Group Report

```
Date: 02/13/90                          GENERAL HOSPITAL                        Page  : 1
Time: 12:57 am                        Revenue Stats by FC Group                 Report: FSR350
                                      Fiscal Year:90    Period:2
                                         LAB-NUCLEAR MED

                       QUANTITY            RELATIVE VALUE        UNITS OF SERVICE          DOLLARS
                    PTD        YTD        PTD         YTD        PTD         YTD        PTD        YTD

ITEM:2025 BLOOD VOLUME CR-51 RBC MASS
 MEDICARE FIN GROUP 1E/R     1          1        40.00       40.00      1           1        100.00     100.00
                    I/P      2          2        80.00       80.00      2           2        200.00     200.00
        TOTAL                3          3       120.00      120.00      3           3        300.00     300.00

   ITEM TOTALS    E/R        1          1        40.00       40.00      1           1        100.00     100.00
                  I/P        2          2        80.00       80.00      2           2        200.00     200.00
                  O/P        0          0         0.00        0.00      0           0          0.00       0.00
      TOTAL ITEM             3          3       120.00      120.00      3           3        300.00     300.00

REVENUE CENTER TOTAL:
E/R: MEDICARE FIN GROUP 1    1          1        40.00       40.00      1           1        100.00     100.00
         TOTAL E/R           1          1        40.00       40.00      1           1        100.00     100.00

I/P: MEDICARE FIN GROUP 1    2          2        80.00       80.00      2           2        200.00     200.00
         TOTAL I/P           2          2        80.00       80.00      2           2        200.00     200.00

O/P: MEDICARE FIN GROUP 1    0          0         0.00        0.00      0           0          0.00       0.00
         TOTAL O/P           0          0         0.00        0.00      0           0          0.00       0.00

BY GROUP:
    MEDICARE FIN GROUP 1     3          3       120.00      120.00      3           3        300.00     300.00
        TOTAL                3          3       120.00      120.00      3           3        300.00     300.00

                                          End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

FINANCIAL GROUP
This field contains the user-defined financial group code which can be a number from 1 through 9.

NOTE: Accounts without a financial class are included into financial statistics group one.

TOTALS BY REVENUE CENTER
This field contains the revenue center totals which are provided by patient indicator within financial group for the revenue center and by financial group in total.

TRANSACTIONS STATISTICS REPORT - FSR430

Description/Purpose

The Transaction Statistics Report displays the number and dollar amounts of transactions by defined transaction type. The report displays totals for period-to-date and year-to-date.

This report can be used as a transaction counter for patient accounting and a tool for general ledger.

Generating and Printing This Report

For detailed instructions for generating and printing this report, refer to "GENERATING STATISTICS REPORTS" on page 6-14 for more information on this topic.

The following is an example of a Transaction Statistics Report.

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Figure 6.25 FSR430 - Transactions Statistics Report

```
Date: 08/09/92                                  GENERAL HOSPITAL                                        Page  : 1
Time: 11:37am                                 Transaction Statistics                                    Report: FSR430
                                            Fiscal Year: 92  Period: 7
                                            Number          Transaction
Transaction                                Transactions        Amount
--------------------------------------------------------------------------------------------------------------------
   A Adjustment
     0009 CIGNA - Per Diem Adjustment
        L Special
           I/P Regular Admission       PTD         5              6040.00
                                       YTD         5              6040.00
        ** Total Financial Class: L    PTD         5              6040.00
                                       YTD         5              6040.00
      * Total Transaction Code: 0009   PTD         5              6040.00
                                       YTD         5              6040.00

     0011 ALTA PPO Adjustment
        S Self Pay
           IP1 Admission               PTD         1               -15.00
                                       YTD         1               -15.00
        ** Total Financial Class: S    PTD         1               -15.00
                                       YTD         1               -15.00
      * Total Transaction Code: 0011   PTD         1               -15.00
                                       YTD         1               -15.00

     0013 Charity Allowance
        L Special
           I/P Regular Admission       PTD         3                83.00
                                       YTD         3                83.00
        M Medicare
           I/P Regular Admission       PTD         3                 8.24
                                       YTD         3                 8.24
        S Self Pay
            ER Emergency Room          PTD         4             -1242.20
                                       YTD         4             -1242.20
        T Blue Cross
            ER Emergency Room          PTD         1               -15.00
                                       YTD         1               -15.00
        ** Total Financial Class: L    PTD         3                83.00
                                       YTD         3                83.00
        ** Total Financial Class: M    PTD         3                 8.24
                                       YTD         3                 8.24
        ** Total Financial Class: S    PTD         4             -1242.20
                                       YTD         4             -1242.20
        ** Total Financial Class: T    PTD         1               -15.00
                                       YTD         1               -15.00
      * Total Transaction Code: 0013   PTD        11             -1165.96
                                       YTD        11             -1165.96
    Total Transaction Type: A
    Fiscal Period                      Year to Date
    Number of Transactions :      104          YTD Number of Transactions  :      104
    Transactions Amount    :   -121525.18      YTD Transactions Amount      :   -121525.18
                                            End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

For each transaction type the system displays period-to-date and year-to-date statistics for each transaction code, financial class, and patient type:

TRANSACTION
This field contains a description of the transaction type.

NUMBER TRANSACTIONS
This field specifies the number of transactions for the specified transaction type. The system displays this information for period-to-date and year-to-date.

TRANSACTION AMOUNT
This field specifies the dollar amount for the specified transaction type. The system displays this information for period-to-date and year-to-date.

The system then displays totals for the transaction type. The system displays fiscal period and year-to-date statistics for the following:

NUMBER OF TRANSACTIONS
This field specifies the total number of transactions for the specified transaction type. The system displays this information for period-to-date and year-to-date.

TRANSACTIONS AMOUNT
This field specifies the total dollar amount for the specified transaction type. The system displays this information for period-to-date and year-to-date.

The last page(s) of the report display totals for the facility.

CONTRACT BY REVENUE DEPARTMENT STATISTICS - FSR207

Description/Purpose

The Contract By Revenue Department Statistics Report displays period-to-date and year-to-date quantity of charges, number of relative value units, units of service, and total amount of charges for revenue departments having contract activity.

Generating and Printing This Report

For detailed instructions on generating and printing this report, refer to "GENERATING STATISTICS REPORTS" on page 6-14 for more information on this topic.

The following is an example of the Contract By Revenue Department Statistics Report.

Figure 6.26 FSR207 - Contract by Revenue Department Statistics
Report

```
Date: 09/10/92                              GENERAL HOSPITAL                           Page  : 1
Time: 02:38am                    Contract by Revenue Department Statistic Report       Report: FSR207
                                         Fiscal Year: 92  Period: 9


                                        ** Period to Date **                      ** Year to Date **
Contract Revenue by Revenue Dept         Qty    RV   UOS   Charge Amount      Qty    RV   UOS   Charge Amount
----------------------------------------------------------------------------------------------------------


  7100 LABORATORY
    LAB Community Lab
      3046                                15     0    1       1317.00          60     0    12      16482.12
    * Total SIM Department: LAB           15     0    1       1317.00          60     0    12      16482.12

  Total Revenue Department: 7100

  Fiscal Period                        Year to Date
  Charge Quantity    :     15          YTD Charge Quantity    :      60
  Number of Rv       :      0          YTD Number of Rv       :       0
  Units of Service   :      1          YTD Units of Service   :      12
  Amount of Charges  :        1317.00  YTD Amount of Charges  :      16482.12


==========================================================================================================
Date: 09/10/92                              GENERAL HOSPITAL                           Page  : 4
Time: 02:38am                    Contract by Revenue Department Statistic Report       Report: FSR207
                                         Fiscal Year: 92  Period: 9


                                        ** Period to Date **                      ** Year to Date **
Contract Revenue by Revenue Dept         Qty    RV   UOS   Charge Amount      Qty    RV   UOS   Charge Amount
----------------------------------------------------------------------------------------------------------



Total Facility: A GENERAL HOSPITAL      422     2   123     346323.22       35713    3   2342    7344323.31

                                          End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

For each revenue department that had revenue from contract accounts the system displays period-to-date and year-to-date statistics for each SIM department and SIM item.

PERIOD TO DATE QTY
This field contains the period-to-date number of charges.

PERIOD TO DATE RV
This field contains the period-to-date quantity of relative value units used by each revenue department.

PERIOD TO DATE UOS
This field contains the period-to-date units of service for this revenue department.

PERIOD TO DATE CHARGE AMOUNT
This field contains the period-to-date dollar amount of charges for each revenue department.

YEAR TO DATE QTY
This field contains the year-to-date quantity of charges for the revenue department.

YEAR TO DATE RV
This field contains the year-to-date quantity of relative value units used by the revenue department.

YEAR TO DATE UOS
This field contains the year-to-date units of service for the revenue department.

YEAR TO DATE CHARGE AMOUNT
This field contains the year-to-date dollar amount of charges for the revenue department.

The system then displays totals for the revenue department's contract revenue. The system displays fiscal period and year-to-date statistics for the following:

CHARGE QUANTITY
This field contains the total quantity of charges for the revenue department.

NUMBER OF RV
This field contains the total quantity of relative value units used by the revenue department.

UNITS OF SERVICE
This field contains the total units of service for the revenue department.

AMOUNT OF CHARGES
This field contains the total dollar amount of charges for the revenue department.

The last page(s) of the report display totals for the facility.

CONTRACT STATISTICS - FSR206

Description/Purpose

The Contract Statistics Report displays the period-to-date and year-to-date quantity of charges, number of relative value units, units of service, and total amount of charges for contract accounts.

Generating and Printing This Report

For detailed instructions for generating and printing this report, refer to for more information on this topic.

The following is an example of the Contract Statistics Report.

Figure 6.27 FSR206 - Contract Statistics Report

```
Date: 09/10/92                          GENERAL HOSPITAL                              Page  : 1
Time: 02:38am                          Contract Statistic Rpt                        Report: FSR206
                                       Fiscal Year: 92  Period: 9


                                    ** Period to Date **                      ** Year to Date **
Contract Revenue                   Qty    RV   UOS   Charge Amount       Qty      RV   UOS    Charge Amount
----------------------------------------------------------------------------------------------------------


SMI1 SMITH-HARDISON
  3046 LABORATORY
   LAB Community Lab
        200 PROFESSIONAL FEE       25     0    2       2317.00           120      0    62        26482.12
        300 PRO FEE #2             10     0    1        200.00            50      0    25         1200.00
   ** Total SIM Department: LAB    37     0    3       2517.00           170      0    87        27682.12
   * Total Revenue Department: 3046 37     0    3       2517.00          170      0    87        27682.12

   4010 RADIOLOGY
    RAD Radiology
        200 PROFESSIONAL FEE       17     0    2       1570.32           93      0    40        17342.88
   ** Total SIM Department: RAD    17     0    2       1570.32           93      0    40        17342.88
   * Total Revenue Department: 4010 17    0    2       1570.32           93      0    40        17342.88


Total Contract Code: SMI1         54     0    5       4087.32           263      0   127        45025.00

 Fiscal Period                   Year to Date
 Charge Quantity   :      54        YTD Charge Quantity     :      263
 Number of Rv      :       0     YTD Number of Rv        :        0
 Units of Service  :       5        YTD Units of Service    :      127
 Amount of Charges :     4087.32    YTD Amount of Charges   :    45025.00


==========================================================================================================
Date: 09/10/92                          GENERAL HOSPITAL                              Page  : 5
Time: 02:38am                          Contract Statistic Rpt                        Report: FSR206
                                       Fiscal Year: 92  Period: 9


                                    ** Period to Date **                      ** Year to Date **
Contract Revenue                   Qty    RV   UOS   Charge Amount       Qty      RV   UOS    Charge Amount
----------------------------------------------------------------------------------------------------------


Total Facility: A GENERAL HOSPITAL  422    2   123     346323.22        35713     3  2342      7344323.31

                                           End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

For each contract account the system displays period-to-date and year-to-date statistics for each SIM department and SIM item.

PERIOD TO DATE QTY
This field contains the period-to-date number of charges.

PERIOD TO DATE RV
This field contains the period-to-date quantity of relative value units used by each revenue department.

PERIOD TO DATE UOS
This field contains the period-to-date units of service for this revenue department.

PERIOD TO DATE CHARGE AMOUNT
This field contains the period-to-date dollar amount of charges.

YEAR TO DATE QTY
This field contains the year-to-date number of charges.

YEAR TO DATE RV
This field contains the year-to-date quantity of relative value units used by the revenue department.

YEAR TO DATE UOS
This field contains the year-to-date units of service for the revenue department.

YEAR TO DATE CHARGE AMOUNT
This field contains the year-to-date dollar amount of charges.

The system then displays totals for the contract account revenue. The system displays fiscal period and year-to-date statistics for the following:

CHARGE QUANTITY
This field contains the total quantity of charges.

NUMBER OF RV
This field contains the total quantity of relative value units used by the revenue department.

UNITS OF SERVICE
This field contains the total units of service for the revenue department.

AMOUNT OF CHARGES
This field contains the total dollar amount of charges.

The last page(s) of the report display totals for the facility.

ZIP CODE STATISTICS REPORT - FSR410

Description/Purpose

The ZIP Code Statistics Report displays the number of admissions, discharges, patient days, deaths, charges, registrations, and outpatient visits for each patient ZIP code. The report displays totals for period-to-date and year-to-date.

This report can be used as a marketing tool.

Generating and Printing This Report

For detailed instructions on generating and printing this report, refer to "GENERATING STATISTICS REPORTS" on page 6-14 for more information on this topic.

The following is an example of a ZIP Code Statistics Report.

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Figure 6.28 FSR410 - ZIP Code Statistics Report

```
Date: 09/10/92                              General Hospital A                              Page  : 1
Time: 3:12pm                                Zip Code Statistics                            Report: FSR410
                                          Fiscal Year: 92  Period: 9


                          Number       Number       Number       Number       Number       Number       Total        Charge
Zip Code                  Admissions   Discharges   Pt Days      Deaths       Reg's        OP Visits    Charges      Qty
-----------------------------------------------------------------------------------------------------------------------------

    30346 ATLANTA,GA 30346
     I/P Regular Admission
       CCU CORONARY CARE
            S SELF PAY
                          PTD     1         0            9            0            8            2         5920.00        81
                          YTD    12        13           58            0           41           17        87440.00       205
         ** Total Medical Service: CCU
                          PTD     1         0            9            0            8            2         5920.00        81
                          YTD    12        13           58            0           41           17        87440.00       205
       * Total Patient Type: I/P
                          PTD     1         0            9            0            8            2         5920.00        81
                          YTD    12        13           58            0           41           17        87440.00       205


=============================================================================================================================
Date: 09/10/92                              General Hospital A                              Page  : 23
Time: 3:12pm                                Zip Code Statistics                            Report: FSR410
                                          Fiscal Year: 92  Period: 9


   Total Zip Code: 30346

 Fiscal Period                          Year to Date
 Admissions           :      29         YTD Admissions        :       192
 Discharges           :      27         YTD Discharges        :       180
 Patient Days         :     298         YTD Patient Days      :      1061
 Deaths               :       2         YTD Deaths            :         7
 Registrations        :     213         YTD Registrations     :       872
 Outpatient Visits    :     820         YTD Outpatient Visits :      1029
 Total Charges        :    5920.00      YTD Total Charges     :     87440.00
 Charge Quantity      :    3298         YTD Charge Quantity   :     89092
                                        End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

For each ZIP code the system displays period-to-date and year-to-date statistics for each patient type, medical service, and financial class.

NUMBER ADMISSIONS
This field contains the number of admissions for this ZIP code.

NUMBER DISCHARGES
This field contains the number of discharges for this ZIP code.

NUMBER PT DAYS
This field contains the number of patient days for this ZIP code.

NUMBER DEATHS
This field contains the number of deaths for this ZIP code.

CHARGE QUANTITY
This field contains the total dollar amount of charges for this ZIP code.

NUMBER REG'S
This field contains the number of outpatient registrations for this ZIP code.

NUMBER OP VISITS
This field contains the number of outpatient visits for this ZIP code.

The system then displays totals for the contract account revenue. The system displays fiscal period and year-to-date statistics for the following:

ADMISSIONS
This field contains the total number of admissions for this ZIP code.

DISCHARGES
This field contains the total number of discharges for this ZIP code.

PATIENT DAYS
This field contains the total number of patient days for this ZIP code.

DEATHS
This field contains the total number of deaths for this ZIP code.

REGISTRATIONS
This field contains the total number of outpatient registrations for this ZIP code.

OUTPATIENT VISITS
This field contains the total number of outpatient visits for this ZIP code.

TOTAL CHARGES
This field contains the total dollar amount of charges for this ZIP code.

The last page(s) of the report display totals for the facility.

PATIENT DAY BALANCING REPORT - FSRDPB

Description/Purpose

The Patient Day Balancing report is created nightly as part of Midnight Processing. The report shows, sorted by nurse station, all outpatients in beds, one day stays, cancel admissions, cancel discharges, backdated admits, backdated discharges, change patient types and transfers in/out of the nurse station, giving today's patient days. The patient days are the same as the variance of the previous day's Nurse Station Statistic report.

Generating and Printing This Report

The following is an example of a Patient Day Balancing Report.

Figure 6.29 FSRDPB - Patient Day Balancing Report

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```
Date: 03/15/96                                General Hospital                                Page  : 1
Time: 13:18P                        Patient Day Balancing Report for - 03/14/96              Report: FSRDPBA


Nurse Station              Occ    Outpat  One Day  Cancel  Cancel  Bkdate  Bkdate  Change  Trans   Today's
                           Beds   In Bed  Stays    Admits  Disch   Admits  disch   Pat     In/Out  Pat
                                                                                   types           Days


1E 1 EAST                   25       2       0       0       0       0       0       0       0        23
CCU CORONARY CARE UNIT      10       0       0       0       0       0       0       0       0        10
ICU INTENSIVE CARE UNIT      9       1       0       0       0       0       0     -12       0        -4
LAA LABORATORY NSA          27       5       1       5       0       5       0      12       1        35
LD LABOR AND DELIVERY        2       1       0       0       0       0       0       0      -1         1
LS1 FIRST STATION            7       1       0       0       0      -4       0       0       0         2
LS2 SECOND STATION           7       4       0       0       0       0      -5       0       0         8
MH MENTAL HEALTH            11       2       0       0       0       0       3       0       0         6
NSY NURSERY                 10       1       0       0       0       3       0     -11       0         1
OB OBSTETRICS                6       0       0       0       0       0       0       0       0         6
OPA OUTPATIENT/BED NSA       6       6       0       0       0       0       0      -1       0        -1
PED PEDIATRICS               9       0       0       0       0       0       0       0       0         9
PTA PATIENT CARE NSA         3       0       0       0       0       0       0       0       0         3
RAA RADIOLOGY NSA            3       0       0       0       0       0       0       0       0         3
RXA PHARMACY NSA             1       0       0       0       0       0       0       0       0         1
SFA STAR FIN NSA             1       0       0       0       0       0       0      -1       0         0


Totals                     137      23       1       5       0       4      -2     -13       0       103


                                              End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

NURSE STATION
This column contains the name of the nurse station.

OCC BEDS
This column contains the number of occupied beds that Patient Care has as of midnight.

OUTPAT IN BED
This column contains the number of Outpatients in Bed for the Nurse Station.

ONE DAY STAYS
This Column contains the number of patients who were admitted and discharged with today's date.

CANCEL ADMITS
This column contains the number of days credited for accounts who were in this nurse station at the time that the admit was canceled.

CANCEL DISCH
This column contains the number of days added due to canceling the discharge.

BKDATE ADMITS
This column contains the number of days added or subtracted due to revising the admit date.

BKDATE DISCH
This column contains the number of days added or subtracted due to revising the discharge date.

CHANGE PATIENT TYPE
This column contains the net patient days due to patients being changed from an Inpatient to Outpatient or Outpatient to Inpatient. This field is signed if the figure is negative.

TRANS IN/OUT
This column is for informational purposes only and is not needed to calculate Patient Days. It contains the number of accounts that were transferred into or out of this nurse station during the day. This field is signed and reflects the Net amount for the day. This information currently prints on Patient Care's Census Summary report (FCSC).

TODAY'S PAT DAYS
This column is a calculation of the other fields on this report. Following is the calculation for this field:

Occ Beds - Outpat in bed + One Day Stays - Cancel Admits + Cancel Disch + Bkdate Admits - Bkdate Disch +/- Change Patient Types.

This report can be verified in two ways. First, look at the Statistic Audit Detail Report. Second, look at today's Nurse Station Statistic report (FSR330) and subtract yesterday's Nurse Station Statistic report (FSR330).

STATISTIC AUDIT DETAIL REPORT - FSRDSP

Description/Purpose

The Statistic Audit Detail report is created nightly as part of Midnight Processing. There are seven sections on this report, Admissions, Deaths, Discharges, Outpatients in Bed, Patient Days, Outpatient Visits, and Registrations.

Generating and Printing This Report

The following is an example of a Statistic Audit Detail Report.

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Figure 6.30 FSRDSP - Statistic Audit Detail Report

```
Date: 03/15/96                  General Hospital                Page  : 1
Time: 13:19P        Statistic Audit Detail Report for - 03/14/96  Report: FSRDSPA


                               Admissions

Nurse Station  :  1E - 1 EAST
Acct Number   Patient Name                    Count   Reason  Pat Type  FC  Med Svc
-----------   ------------                    -----   ------  --------  --  -------
A9607200004   PAK,IIC                           1               LIC     S   SIC
A9607200004   PAK,IIC                          -1   Can Admit   LIR     S   SIC


          Total Nurse Station 1 EAST  :  0


Nurse Station  :  ICU - INTENSIVE CARE UNIT
Acct Number   Patient Name                    Count   Reason  Pat Type  FC  Med Svc
-----------   ------------                    -----   ------  --------  --  -------
A9607200009   PAK,IOPBC                        -1   Can Admit   LIR     S   OBS


          Total Nurse Station INTENSIVE CARE UNIT  :  -1


Nurse Station  :  LAA - LABORATORY NSA
Acct Number   Patient Name                    Count   Reason  Pat Type  FC  Med Svc
-----------   ------------                    -----   ------  --------  --  -------
A9607400002   KIM,ODS                           1               LIR     S   THR
A9607400005   MOON,FULL                         1               LIR     S   MIC
A9607400005   MOON,FULL                        -1   Can Admit   LIR     S   MIC
A9607200014   OH,IPC;ONE                        1               LIR     L   LIM
A9607200019   OH,OP;TWO                         1               LIR     S   LEM
A9607200007   PAK,OIC                           1               LIC     S   SIC
A9607200011   PAK,OPBIC                         1               LIC     S   PED
A9607400003   STANLEY,TOOLS;R                   1               I/P     S   ERS
A9607400001   TREE,JC                           1               I/P     S   MED
A9607400014   UNK,FIVE                          1               LTC     S   REN
A9607400013   UNK,FOUR                          1               LTC     S   NUR
A9607400010   UNK,ONE                           1               LTC     S   ERS
A9607400012   UNK,THREE                         1               LTC     S   LEM
A9607400011   UNK,TWO                           1               LTC     S   MED


          Total Nurse Station LABORATORY NSA  :  12


          Total Nurse Station NURSERY  :  -1
```

This report is sorted as follows:

Admissions

The primary sort is by nurse station with a secondary sort by patient name. The normal count is one. Counts less than one reflect Cancel Admissions or Change Patient Type (IE I/P to O/P patient type). Patients who have patient information revised also appear in this section.

Deaths

The sort for this section is by Patient name. The normal count in this section is one. Counts less then one reflect patients who were dispositioned incorrectly with a death classification that was later changed.

Discharges

The primary sort is by Patient Type with a secondary sort by patient name. The normal count is one. Counts less then one reflect Cancel Discharges.

Outpatients in Bed

The primary sort is by nurse station with a secondary sort by the patient name. The normal count is one. Counts greater than one reflect Backdated Registrations or Change Patient Types. Counts less than one reflect Revised Registration Date or Change Patient Types.

Patient Days

The primary sort is by nurse station, with a secondary sort of patient name. Each nurse station subtotals with a facility total after the last nurse station has printed. If the nurse station needs to print on more than one page, the next page shows the nurse station followed by "Cont." The normal count is one. One day stays have a reason code of One Day with a count of one. Counts greater than one reflect Canceled Discharges, Backdated Admissions, Patient Type Changes, Revise Admit or Discharge Date. Counts less than one reflect Canceled Admissions, Backdated Discharges, Patient Type changes, Revise Admit, or Discharge dates.

Outpatient Visits

This section only sorts by account number. The normal count in this section is one. A count less than one reflect a Cancel Registration or Change Patient Types.

Registrations

The primary sort is by patient type with a secondary sort by patient name. The normal count is one. Counts less than one reflect Cancel Registrations or Change Patient Types.

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

ACCOUNT NUMBER
This column contains the patient account number.

PATIENT NAME
This column contains the patient's name, last name first.

COUNT
This column contains the number that the statistic was adjusted for this patient. Normal counts are always one and do not have a reason code.

REASON
This column displays exception type reasons as to why this account adjusted the statistic.

Valid reason codes are:

Can Admit - Canceled Admission
Can Disch - Canceled Discharge
Chg Pt - Patient Type Changes
Can Reg - Canceled Registration
One Day - One Day Stay
Rev Adm - Revised Admit Date
Rev Dis - Revised Discharge Date
Rev Disp - Dispositioned Modified
Rev Pat - Revised Patient information; Medical Service, and Financial Class.

PATIENT TYPE
This column contains the patient type for this patient, at time the event occurred.

FC
This column contains the patients Financial Class, at time the event occurred.

MED SVC
This column contains the patient's medical service, at time the event occurred.

STATISTIC AUDIT SUMMARY REPORT - FSRDSS

Description/Purpose

The Statistic Audit Summary report is created nightly as part of Midnight Processing. It is created at the same time that the Statistic Detail Audit report is being created.

This report has the same totals as the Statistic Audit Detail report. If there is a primary and a secondary sort on the detail report then this report only uses the primary sort.

Generating and Printing This Report

The following is an example of a Statistic Audit Summary Report.

Figure 6.31 FSRDSS - Statistic Audit Summary Report

```
Date: 03/15/96                  General Hospital              Page  : 1
Time: 13:19P        Statistic Audit Summary Report for 03/14/96   Report: FSRDSSA

Admissions
        Nurse Station 1E    0
        Nurse Station ICU   -1
        Nurse Station LAA   12
        Nurse Station LS1   1
        Nurse Station NSY   -1
        Nurse Station OPA   -1
                Total Admissions  10
Deaths
                Total Deaths  1
Discharges
        Patient Type I/P    0
        Patient Type LIC    0
        Patient Type LIR    1
        Patient Type LTC    1
                Total Discharges  2
Out Patient in Bed
        Nurse Station 1E    2
        Nurse Station ICU   1
        Nurse Station LAA   28
        Nurse Station LD    1
        Nurse Station LS1   1
        Nurse Station LS2   4
        Nurse Station MH    -1
        Nurse Station NSY   1
        Nurse Station OPA   6
        Nurse Station PED   -5
        Nurse Station RXA   -1
                Total Out Patient in Bed  37
Patient Days
        Nurse Station 1E    23
        Nurse Station CCU   10
        Nurse Station ICU   -4
        Nurse Station LAA   35
        Nurse Station LD    1
        Nurse Station LS1   2
        Nurse Station LS2   8
        Nurse Station MH    6
        Nurse Station NSY   1
        Nurse Station OB    6
        Nurse Station OPA   -1
                            End of Report
```

Chapter 7 - THIRD PARTY LOG REPORTS

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Illustrations

NEW ACCOUNTS LOG REPORT - FLR100

Description/Purpose

The New Accounts Log Report provides a list of accounts added to the log system as part of the claim process. Accounts are added to the log when this report is run. As such, this report displays log records created as a result of batch processing as well as from manually released claims.

The top part of this report displays patient demographic information, insurance plan information, billing dates, and discharge dates. The second half of the report displays summary charge information.

Generating and Printing This Report

The New Accounts Log Report is a demand report created using the demand print procedure. The report is sorted by log number and subsorted by patient account number. Pages break by patient.

The following is an example of the New Accounts Log Report.

Figure 7.1 FLR100 - New Accounts Log Report

```
Date: 06/24/92                          General Hospital                             Page  : 1
Time: 01:03am                         New Accounts Log Report                        Report: FLR100A


Log ID: Commercial                  Type        : Final              Primary Payor  : Yes


Account No      : 01001-74929       HIC No      : 3439049            Claim Type     : UB82
Patient         : WHITE,KNOX        Patient Type : IP                Claim Seq      : 3
Birthdate       : 08/07/24  Age: 64Y  Aged Ind    :
Attending Phys  : BECKER,BRUCE H    Medical Srvc  : MEDICAL
Prim Diagnosis  : INTESTINAL ADHES  Prim Procedure: PERITONEAL ADHESIOLYSIS
Admission Date  : 04/20/92          Discharge Date: 04/22/92        Discharge Status : H
Bill From       : 04/20/92          Bill Through  : 04/22/92        Bill Date      : 05/15/92


Billed Days: 3          Outlier:       Amount:          0.00    DRG:
Paid Days:              Outlier:       Amount:          0.00    DRG:
Plan     : 21004
Plan Name : MEDICARE PART A          COB Excess   :        $0.00
Remit Date  :                        1-Time Deduct:      $540.00
Blood Units : 0                      Blood Deduct :        $0.00
# Late Chgs :                        Daily Coins  :        $0.00
Anc Coins   :         $0.00

                   HCPCS Procedures
        ----------------------------------------------------------------

Group Nbr:                  UB82/92 Revenue:


                                    Covered          Total
Summary Code                Qty     Amount           Amount
        ----------------------------------------------------------------
270    MEDICAL & SURGICAL S               $46.00         $46.00

440    SPEECH-LANGUAGE THER            $1,114.40      $1,114.40

480    CARDIOLOGY                      $4,703.60      $4,703.60

Ancillary Chgs:   $5,864.00   Non-Cvrd Anc Chgs:          $0.00    Cov Anc Chgs  :      $5,864.00

Room/Bed Chgs:        $0.00   Non-Cvrd Rm/Bd Chgs:        $0.00    Cov Rm/Bd Chgs :         $0.00
Total Chgs:       $5,864.00   Total Non-Cvrd Chgs:        $0.00    Total Cov Chgs :     $5,864.00
Adjustments:          $0.00   Billed Amount:         $5,864.00
Late Chgs:            $0.00   Paid Amount:               $0.00
                              Est. Liability:        $1,160.40    Unreconciled Amt :       $0.00

                           End of Report
```

A full page of the report is provided for each patient account selected. Each page contains a header including the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

LOG ID
This field contains the description of the log to which the patient is assigned, for example, Medicare Log.

TYPE
This field displays the bill type.

PRIMARY PAYOR
This field indicates whether the carrier is the primary payor for this account.

ACCOUNT NO
This field displays the account number.

HIC NO
This field displays the policy number, if applicable.

CLAIM TYPE
This field displays the claim type for this claim.

PATIENT
This field displays the patient name.

PATIENT TYPE
This field displays the patient type.

CLAIM SEQ
This field displays the claim sequence number.

BIRTHDATE
This field displays the patient's date of birth.

AGED IND
The aged indicator *D* prints in this field if this log is labeled as a Medicare log and the patient is under 65 years of age.

ATTENDING PHYS
This field displays the attending physician.

MEDICAL SRVC
This field displays the medical service.

PRIM DIAGNOSIS
This field displays the primary diagnosis.

PRIM PROCEDURE
This field displays the primary procedure.

ADMISSION DATE
This field displays the date the patient was admitted.

DISCHARGE DATE
This field displays the date the patient was discharged.

DISCHARGE STATUS
This field displays the discharge status for this account.

BILL FROM
This field displays the beginning charge date for this bill.

BILL THROUGH
This field displays the ending charge date for this bill.

BILL DATE
This field displays the date on which this bill was generated.

BILLED DAYS
This field displays the number of days included on the bill.

OUTLIER
This field displays the DRG outlier for this bill.

AMOUNT
This field displays the DRG reimbursement amount for the billed DRG.

DRG
This field displays the billed DRG.

PAID DAYS
This field displays number of days paid on this bill by the carrier.

OUTLIER
This field displays the outlier paid on this bill by the carrier.

AMOUNT
This field displays the amount paid on this bill by the carrier.

DRG
This field displays the DRG paid on this bill by the carrier.

PLAN
This field displays the number of the insurance carrier and plan for this log.

PLAN NAME
This field contains the description of the insurance plan causing the log record to be created.

COB EXCESS
This field displays the amount of charges that are covered by another carrier.

LAST PAY DATE
This field displays the last date on which a carrier payment was posted to this claim record.

1-TIME DEDUCT
This field displays the deductible for this bill. This field is calculated by proration when the bill is produced.

BLOOD UNITS
This field displays the number of units of blood supplied.

BLOOD DEDUCT
This field displays the blood deductible.

 # LATE CHARGES
This field displays the number of late charges. This field is manually maintained.

DAILY COINS
This field displays the daily coinsurance amount. This field is calculated by proration when the bill is produced.

ANC COINS
This field displays the amount of coinsurance for ancillary charges. This field is calculated by proration when the bill is produced.

HCPCS PROCEDURES
This portion of the report displays information about the HCPCS procedures performed on this patient. The report displays the HCPCS code, group number, and associated UB-82/92 revenue code. Even if a range of HCPCS is specified in Report Selection, all HCPCS codes associated with the account print.

SUMMARY CODES
This portion of the report displays information about the charges on the claim. For each summary code, the report displays the quantity, covered amount, and total amount.

ANCILLARY CHGS
This field displays the total amount of all ancillary department charges for this account.

NON-CVRD ANC CHGS
This field displays the amount of all non-covered ancillary department charges for this account.

COV ANC CHGS
This field displays the amount of all covered ancillary department charges for this account.

ROOM/BED CHGS
This field displays the total amount of all room/bed charges for this account.

NON-CVRD RM/BD CHGS
This field displays the amount of all non-covered room/bed charges for this account.

COV RM/BD CHGS
This field displays the total amount of all covered room/bed charges for this account.

TOTAL CHGS
This field displays the total amount of all ancillary department and room/bed charges for this account.

TOTAL NON-CVRD CHGS
This field displays the amount of all non-covered ancillary department and room/bed charges for this account.

TOTAL COV CHGS
This field displays the amount of all covered ancillary department and room/bed charges for this account.

ADJUSTMENTS
This field displays the amount of all adjustments posted for this account.

BILLED AMOUNT
This field displays the total amount billed on this claim.

LATE CHGS
This field displays the amount of all late charges included on this bill. This field is manually maintained.

PAID AMOUNT
This field displays the total amount paid to the facility for this account.

EST LIABILITY
This field displays the amount calculated by proration to be the responsibility of the carrier.

UNRECONCILED AMOUNT
This field displays the carrier liability remaining on this claim record.

SELECTED LOG ACCOUNTS REPORT - FLR

Description/Purpose

The Selected Log Accounts Report enables the hospital to create and generate log reports using a wide range of log selection criteria. The selection criteria are entered using the Log Reports-Create Report Selection menu option. Totals are generated for all logs selected and include covered charges, adjustments, non-covered charges, billed amounts, paid amounts, billed and paid outlier amounts (if the DRG billed or paid amount is associated with an outlier code), late charges, and estimated liability. Totals only can be selected when the report definition is entered.

The Selected Log Accounts Report is also available in a summary format, which provides two lines of information per patient, and a totals format, which displays only the report totals.

Generating and Printing This Report

The Selected Log Accounts Report is requested via the Log Reports option in Third Party Logs. It is printed through the demand print feature and sorted by log number with a subsort by patient name. For the detail version of the report, pages break by patient.

The following provide samples of both the detail, summary, and totals versions of the Selected Log Accounts Report.

Figure 7.2 FLR - Detail Selected Log Accounts Report - Page 1

```
Date: 06/24/92                  GENERAL HOSPITAL              Page  : 1
Time: 09:58am              SELECTED LOG ACCOUNT REPORT        Report: FLRA
                                 Selection Criteria


INCLUDE PATIENT INDICATORS     : Inpatient
REPORT FORMAT?                 : DETAIL
REPORT ON HCPCS?               : YES
HCPCS RANGE:                   : Beginning thru End
PAID/UNPAID LOGS               : BOTH
BILL TYPE                      : ALL
PRIMARY PAYOR                  : ALL
BILLED vs PAID DRG             : BOTH
BILLED vs PAID OUTLIER         : BOTH
BILLED vs PAID DRG AMOUNT      : BOTH
BILLED vs PAID DAYS            : BOTH
BILLED vs PAID AMOUNT          : BOTH
BILL THRU DATES                : 01/01/91 thru Latest
REMITTANCE DATES               : 01/01/91 thru Latest
DISCHARGE DATES                : 01/01/91 thru Latest
LATE CHARGE LOGS               : NO
PURGE                          : NO
```

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Figure 7.3 FLR - Detail Selected Log Accounts Report - Page 2

```
Date: 06/24/92                         General Hospital                              Page  : 2
Time: 11:49am                     Selected Log Account Report                        Report: FLRA
                                    Log ID : MEDICAID LOG


Log ID: MEDICAID LOG                    Type        : Final               Primary Payor   : Yes


Account No      : 91711-91823           HIC No      : 45465               Claim Type      : UB82
Patient         : SMITH,WARREN D        Patient Type : INPATIENT          Claim Seq       : 7
Birthdate       : 05/05/57  Age: 35Y    Aged Ind    :
Attending Phys  : BECKER,BRUCE H        Medical Srvc : Emergency
Prim Diagnosis  : CONCUSSION            Prim Procedure: PERITONEAL ADHESIOLYSIS
Admission Date  : 10/25/91              Discharge Date: 12/01/91          Discharge Status : H
Bill From       : 11/22/91              Bill Through  : 12/01/91          Bill Date       : 12/03/91


Billed Days: 9           Outlier:            Amount:    22,000.00    DRG: 320
Paid Days:               Outlier:            Amount:         0.00    DRG:
Plan        : 020010
Plan Name   : CIGNA - PERCENTAGE       COB Excess   :      $0.00
Last Pay Date:                         1-Time Deduct:    $250.00
Blood Units : 0                        Blood Deduct :      $0.00
# Late Chgs :                          Daily Coins  :      $0.00
Anc Coins   :          $0.00


                         HCPCS Procedures
--------------------------------------------------------------------------------
00140 Anesthesia
Group Nbr: 0                    UB82/92 Revenue: 370


                                     Covered        Total
Summary Code                Qty      Amount         Amount
--------------------------------------------------------------------------------
170    INTENSIVE CARE        9     $15,540.00    $15,540.00


730    EKG AND ECG           1        $560.00       $560.00

Ancillary Chgs:  $5,760.00     Non-Cvrd Anc Chgs:       $0.00    Cov Anc Chgs:        $5,760.00
Room/Bed Chgs: $15,540.00      Non-Cvrd Rm/Bd Chgs:     $0.00    Cov Rm/Bd Chgs:     $15,540.00
Total Chgs:    $21,300.00      Total Non-Cvrd Chgs:     $0.00    Total Cov Chgs:     $21,300.00
Adjustments:        $0.00      Billed Amount:      $21,300.00
Late Chgs:          $0.00      Paid Amount:             0.00
                               Est. Liability:     $21,300.00    Unreconciled Amt  :      $0.00
```

Figure 7.4 FLR - Detail Selected Log Accounts Report - Page 3

```
Date: 01/30/92                        General Hospital                    Page  : 3
Time: 09:58am                     Selected Log Account Report             Report: FLR
                                    Log ID : MEDICARE I/P

                        TOTALS

                                  Covered              Total
Summary/Procedure Code       Qty   Amount              Amount
--------------------------------------------------------------------------------
     CHARGES WITHOUT CODES     0    $0.00               $0.00
170  INTENSIVE CARE            9   $15,540.00          $15,540.00
300  LABORATORY GENERAL C      3    $320.00             $320.00
360  OR SERVICES               1   $4,080.00           $4,080.00
370  ANESTHESIA                1    $800.00             $800.00
730  EKG AND ECG               1    $560.00             $560.00
Total number of accounts selected:    1

Ancillary Chgs:      $5,760.00   Non-Cvrd Anc Chgs:       $0.00   Cov Anc Chgs    :    $5,760.00
Room/Bed Chgs:      $15,540.00   Non-Cvrd Rm/Bd Chgs:     $0.00   Cov Rm/Bd Chgs  :   $15,540.00
Total Chgs:         $21,300.00   Total Non-Cvrd Chgs:     $0.00   Total Cov Chgs  :   $21,300.00
Adjustments:             $0.00   Billed Amount:      $21,300.00
Late Chgs:               $0.00   Billed Outlier:          $0.00
Deductible:            $250.00   Paid Amount:         $8,300.00
Anc Coins:               $0.00   Paid Outlier:            $0.00
Billed Days:                 9   Est. Liability      $13,000.00   Unreconciled Amt:    $5,983.80
Paid Days:                   0   # Late Chgs:                 0

                                  End of Report
```

A full page of the report is provided for each patient account selected. Each page contains a header including the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

The Selection Criteria page displays the settings that the system used in creating this report. You define these settings using the Report Selection processor. For more information about this function, refer to the Third Party Logs section in the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide.*

The report header on the remaining pages of the report contain the following information:

LOG ID
This field contains the description of the log to which the patient is assigned; for example, Medicare Log.

TYPE
This field displays the bill type (cycle, final, adjustment, or late) for this claim.

PRIMARY PAYOR
This field indicates whether the carrier is the primary payor for this account.

For each account selected, the report displays the following account-specific information (as in the second page of this example report):

ACCOUNT
This field displays the account number.

HIC NO
This field displays the policy number, if applicable.

PATIENT
This field displays the patient name.

PATIENT TYPE
This field displays the patient type.

BIRTHDATE
This field displays the patient's date of birth.

AGE
This field displays the system-calculated patient age.

AGED IND
The aged indicator D prints in this field if this log is labeled as a Medicare log and the patient is under 65 years of age.

ATTENDING PHYS
This field displays the attending physician.

MEDICAL SRVC
This field displays the medical service.

PRIM DIAGNOSIS
This field displays the primary diagnosis.

PRIM PROCEDURE
This field displays the primary procedure.

ADMISSION DATE
This field displays the date the patient was admitted.

DISCHARGE DATE
This field displays the date the patient was discharged.

DISCHARGE STATUS
This field displays the discharge status for this account.

BILL FROM
This field displays the beginning charge date for this bill.

BILL THROUGH
This field displays the ending charge date for this bill.

BILL DATE
This field displays the date on which this bill was generated.

BILLED DAYS
This field displays the number of days included on the bill.

OUTLIER
This field displays the DRG outlier for this bill.

AMOUNT
This field displays the DRG reimbursement amount for the billed DRG.

DRG
This field displays the billed DRG.

PAID DAYS
This field displays number of days paid on this bill by the carrier.

OUTLIER
This field displays the outlier paid on this bill by the carrier.

AMOUNT
This field displays the amount paid on this bill by the carrier.

DRG
This field displays the DRG paid on this bill by the carrier.

PLAN
This field displays the number of the insurance carrier and plan for this log.

PLAN NAME
This field contains the description of the insurance plan causing the log record to be created.

COB EXCESS
This field displays the amount of charges that are covered by another carrier.

LAST PAY DATE
This field displays the last date on which a carrier payment was posted to this claim record.

1-TIME DEDUCT
This field displays the deductible for this bill. This field is calculated by proration when the bill is produced.

BLOOD UNITS
This field displays the number of units of blood supplied.

BLOOD DEDUCT
This field displays the blood deductible.

 # LATE CHARGES
This field displays the number of late charges. This field is manually maintained.

DAILY COINS
This field displays the daily coinsurance amount. This field is calculated by proration when the bill is produced.

ANC COINS
This field displays the amount of coinsurance for ancillary charges. This field is calculated by proration when the bill is produced.

HCPCS PROCEDURES
This portion of the report displays information about the HCPCS procedures performed on this patient. The report displays the HCPCS code, group number, and associated UB-82/92 revenue code. Even if a range of HCPCS is specified in Report Selection, all HCPCS codes associated with the account print.

SUMMARY CODES
This portion of the report displays information about the charges on the claim. For each summary code, the report displays the quantity, covered amount, and total amount.

ANCILLARY CHGS
This field displays the total amount of all ancillary department charges for this account.

NON-CVRD ANC CHGS
This field displays the amount of all non-covered ancillary department charges for this account.

COV ANC CHGS
This field displays the amount of all covered ancillary department charges for this account.

ROOM/BED CHGS
This field displays the total amount of all room/bed charges for this account.

NON-CVRD RM/BD CHGS
This field displays the amount of all non-covered room/bed charges for this account.

COV RM/BD CHGS
This field displays the total amount of all covered room/bed charges for this account.

TOTAL CHGS
This field displays the total amount of all ancillary department and room/bed charges for this account.

TOTAL NON-CVRD CHGS
This field displays the amount of all non-covered ancillary department and room/bed charges for this account.

TOTAL COV CHGS
This field displays the amount of all covered ancillary department and room/bed charges for this account.

ADJUSTMENTS
This field displays the amount of all adjustments posted for this account.

BILLED AMOUNT
This field displays the total amount billed on this claim.

LATE CHGS
This field displays the amount of all late charges included on this bill. This field is manually maintained.

PAID AMOUNT
This field displays the total amount paid to the facility for this account.

EST LIABILITY
This field displays the amount calculated by proration to be the responsibility of the carrier.

UNRECONCILED AMOUNT
This field displays the carrier liability remaining on this claim record.

The final page of the report displays totals for all accounts displayed.

NOTE: More than one carrier/plan can be assigned to the same log ID. In this case, all totals are all carriers/plans on the report.

The information on this page of the report includes:

SUMMARY/PROCEDURE CODE
This area of the report contains charge information in a format based on how the claim form has been designed for charges. Charges are summarized by UB-82/92 revenue code, HCPCS procedure code, or summary code. For each code, the report displays the quantity, covered amount, and total amount.

CHARGES WITHOUT CODES
This line of the report displays information about charges not associated with a UB-82/92 revenue code, HCPCS procedure code, or service code.

TOTAL NUMBER OF ACCOUNTS SELECTED
This field displays the total number of accounts included in the report.

ANCILLARY CHGS
This field displays the total amount of all ancillary department charges for all accounts on the report.

NON-CVRD ANC CHGS
This field displays the amount of all non-covered ancillary department charges for all accounts on the report.

COV ANC CHGS
This field displays the amount of all covered ancillary department charges for all accounts on the report.

ROOM/BED CHGS
This field displays the total amount of all room/bed charges for all accounts on the report.

NON-CVRD RM/BD CHGS
This field displays the amount of all non-covered room/bed charges for all accounts on the report.

COV RM/BD CHGS
This field displays the total amount of all covered room/bed charges for all accounts on the report.

TOTAL CHGS
This field displays the total amount of all ancillary department and room/bed charges for all accounts on the report.

TOTAL NON-CVRD CHGS
This field displays the amount of all non-covered ancillary department and room/bed charges for all accounts on the report.

TOTAL COV CHGS
This field displays the amount of all covered ancillary department and room/bed charges for all accounts on the report.

ADJUSTMENTS
This field contains the total amount of all adjustments posted to claims in the selected log ID.

BILLED AMOUNT
This field contains the total dollar amount actually billed to the carriers/plans.

LATE CHGS
This field contains the amount of all late charges included on this log report. Late charges are entered manually into the patient log record.

BILLED OUTLIER
This field contains the amount billed to the carrier/plan that is defined as either a day or stay outlier for the billed DRG.

DEDUCTIBLE
This field contains the total deductible amount.

PAID AMOUNT
This field contains the amount paid by all carriers/plans for the selected log.

ANC COINS
This field contains the amount of ancillary charges covered by a different carrier/plan.

PAID OUTLIER
This field contains the amount paid by the carrier/plan that is defined as either a day or stay outlier for the paid DRG.

BILLED DAYS
This field contains the total number of patient days included in the selected log ID.

EST LIABILITY
This field contains the amount due from all carriers/plans.

UNRECONCILED AMOUNT
This field displays the total carrier amount outstanding.

PAID DAYS

This field contains the number of patient days that have been paid by all carriers/plans.

 # LATE CHGS

This field contains the number of late charges included in the report for the selected log ID. Late charges are manually entered into the patient log record.

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Figure 7.5 FLR - Summary Selected Log Accounts Report - Page 1

```
Date: 06/24/92                    General Hospital              Page  : 1
Time: 09:58am               Selected Log Account Report         Report: FLRA
                                 Selection Criteria


INCLUDE PATIENT INDICATORS     : Inpatient
REPORT FORMAT?                 : SUMMARY
REPORT ON HCPCS?               : YES
HCPCS RANGE:                   : Beginning thru End
PAID/UNPAID LOGS               : BOTH
BILL TYPE                      : ALL
PRIMARY PAYOR                  : ALL
BILLED vs PAID DRG             : BOTH
BILLED vs PAID OUTLIER         : BOTH
BILLED vs PAID DRG AMOUNT      : BOTH
BILLED vs PAID DAYS            : BOTH
BILLED vs PAID AMOUNT          : BOTH
BILL THRU DATES                : 01/01/91 thru Latest
REMITTANCE DATES               : 01/01/91 thru Latest
DISCHARGE DATES                : 01/01/91 thru Latest
LATE CHARGE LOGS               : NO
PURGE                          : NO
```

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Figure 7.6 FLR - Summary Selected Log Accounts Report - Page 2

```
Date: 01/30/92                              GENERAL HOSPITAL                              Page  : 2
Time: 09:58am                          SELECTED LOG ACCOUNT REPORT                        Report: FLR
                                          Log ID : MEDICARE I/P


                                                                        Non     Non
Account #  ADM Dt   DSCH Dt  Bill Frm Bill Thru Total Chgs Bill Dt     Cov Room  Cov Ancill Total CVD  CVD Rm COV Anc  Late Chgs
Pat Name            LOS  Age  InsPln FC Pay Dt   Pay Amt   Adj Dt   Adj Amt   Ded    Co Ins    HCPCS Cd  DRG
---------------------------------------------------------------------------------------------------------------------------------
9019000001 08/09/90 08/09/90 08/09/90 08/09/90  $1,913.70 08/13/90    $246.00 $1,667.70  $1,913.70 $0.00    $0.00   $100.00
CLARKE,ROBERT       001  33Y  201001 M  09/13/90 $1,000.00 09/13/90 -$321.70 $592.00    $0.00

9020500001 08/24/90 08/24/90 08/24/90 08/24/90  $4,376.75 08/24/90    $246.00 $4,130.75  $4,376.75 $0.00    $0.00    $0.00
GLUECK,NORMA        001  42Y  201001 M  08/24/90 $3,000.00 08/24/90 -$774.75 $592.00    $0.00

9020100001 08/20/90 08/20/90 08/20/90 08/24/90  $3,488.72 08/20/90    $246.00 $3,242.72  $3,488.72 $0.00    $0.00    $0.00
GLUECK,PAT          001  34Y  201001 M  10/01/90 $2,000.00 08/20/90 -$881.72 $592.00    $0.00

9017700001 07/25/90 07/25/90 07/25/90 07/25/90   $616.75 08/03/90    $0.00 $616.75    $616.75 $0.00    $0.00    $0.00
HOLLAND,DAVID       001  39Y  201001 M           $0.00            $0.00 $592.00    $0.00                466

9017700001 07/25/90 07/25/90 07/25/90 07/25/90    $26.75 08/05/90    $0.00 $26.75     $26.75 $0.00    $0.00    $0.00
HOLLAND,DAVID       001  39Y  201001 M           $0.00            $0.00 $0.00     $0.00

9017700001 07/25/90 07/25/90 07/25/90 07/25/90   $618.05 08/06/90    $0.00 $618.05    $618.05 $0.00    $0.00    $0.00
HOLLAND,DAVID       001  39Y  201001 M           $0.00            $0.00 $0.00     $0.00                466

9016600001 05/26/90 07/31/90 05/26/90 05/31/90    $26.75 06/20/90    $0.00 $26.75     $26.75 $0.00    $0.00    $0.00
HOLLAND,JOHN        030  80Y  201001 M           $0.00            $0.00 $26.75     $0.00

9016600001 05/26/90 07/31/90 06/01/90 06/30/90   $590.00 07/14/90    $0.00 $590.00    $590.00 $0.00    $0.00    $0.00
HOLLAND,JOHN        030  80Y  201001 M  07/31/90 $0.00            $0.00 $23.25     $0.00

9016600001 05/31/90 06/13/90 05/31/90 05/31/90    $26.75 06/13/90    $0.00 $26.75     $26.75 $0.00    $0.00    $0.00
HOLLINGS,SUSAN      013  56Y  201001 M           $0.00 06/19/90    $0.00 $26.75     $0.00

9021100001 07/26/90 07/30/90 07/26/90 07/30/90  $3,106.71 07/30/90  $2,452.00 $654.71  $3,106.71 $0.00    $0.00    $0.00
JACKSON,CLAIRE      004  67Y  201001 M           $0.00            $0.00 $592.00    $0.00                080

9019400001 07/13/90 07/13/90 07/13/90 07/13/90  $3,423.50 07/13/90    $246.00 $3,177.50  $3,423.50 $0.00    $0.00    $0.00
KEELER,JAMES        001  44Y  201001 M  07/13/90 $2,000.00 07/13/90 -$831.50 $592.00    $0.00
```

Figure 7.7 FLR - Summary Selected Log Accounts Report - Page 3

```
Date: 06/25/92                      GENERAL HOSPITAL                       Page  : 3
Time: 09:58am                  SELECTED LOG ACCOUNT REPORT                 Report: FLRA
                                  Log ID : MEDICARE I/P


                       TOTALS


                                     Covered                Total
Summary/Procedure Code         Qty    Amount                Amount
---------------------------------------------------------------------------------
      CHARGES WITHOUT CODES     0     $9,108.43            $9,108.43
120   ROOM & BED SEMIPRIVAT     9     $3,436.00            $3,436.00
300   LABORATORY GENERAL C      3       $320.00              $320.00
360   OR SERVICES               1     $4,080.00            $4,080.00
370   ANESTHESIA                1       $800.00              $800.00
730   EKG AND ECG               1       $560.00              $560.00
Total number of accounts selected:   1


Ancillary Chgs:      $14,778.43   Non-Cvrd Anc Chgs:       $0.00   Cov Anc Chgs    :   $14,778.43
Room/Bed Chgs:        $3,436.00   Non-Cvrd Rm/Bd Chgs:     $0.00   Cov Rm/Bed Chgs :    $3,436.00
Total Chgs:          $18,214.43   Total Non-Cvrd Chgs:     $0.00   Total Cov Chgs  :   $18,214.43
Adjustments:         -$2,809.67   Billed Amount:      $18,214.43
Late Chgs:              $100.00   Billed Outlier:              0
Deductible:           $3,628.75   Paid Amount:         $8,000.00
Anc Coins:                $0.00   Paid Outlier:                0
Billed Days:                 35   Est. Liability      $10,214.43   Unreconciled Amt :    $5,983.80
Paid Days:                    0   # Late Chgs:                 2

                                    End of Report
```

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SELECTED LOG ACCOUNTS REPORT - FLR

Chapter 7 - THIRD PARTY LOG REPORTS

Each page contains a header including the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system, and the description of the log to which the patients are assigned (for example, Medicare Log).

The Selection Criteria page displays the settings that the system used in creating this report. You define these settings using the Report Selection processor. For more information about this function, refer to the Third Party Logs section in the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide*.

Following the Selection Criteria page, the system displays summary information for each patient account selected. The report provides two lines of summary information for each log record. Log records are created when a claim assigned to the log ID is released.

ACCOUNT #
This field contains the patient's account number.

AD DT
This field contains the date the patient was admitted.

DSCH DT
This field contains the date the patient was discharged.

BILL FRM
This field contains the beginning date of charges included on this log record.

BILL THRU
This field contains the ending date of charges included on this log record.

TOTAL CHGS
This field contains the total charges for this log record.

BILL DT
This field contains the date the bill was generated for this account.

COV ROOM
This field contains the covered room charges for this log record.

COV ANCILL
This field contains the covered ancillary charges for this log record.

TOTAL CVD
This field contains the total covered charges for this log record.

NON CVD RM
This field contains the room charges for this log record that are not covered by insurance.

NON COV ANC
This field contains the ancillary charges for this log record that are not covered by insurance.

LATE CHGS
This field contains the amount of any late charges assessed to this log record.

PAT NAME
This field contains the patient name.

LOS
This field contains the patient's length of stay, in days, for this log record. The length of stay is calculated by adding covered days and non-covered days for this log record.

AGE
This field contains the patient's age, in years.

INSPLN
This field contains the code of the insurance carrier and plan causing the log record to be created.

FC
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes self pay, commercial insurance, Medicare, etc. Some examples of classes include S-self pay, C-commercial or M-Medicare.

PAY DT
This field contains the date the most recent payment was posted to the insurance carrier/plan for this log record.

PAY AMT
This field contains the total payment amount posted to this claim.

ADJ DT
This field contains the most recent date an adjustment was posted to the carrier/plan for this log record.

ADJ AMT
This field contains the net amount of any adjustment made to the carrier/plan for this log record.

DED
This field contains the amount of the insurance deductible for this log record.

CO INS
This field contains the amount of charges covered by another carrier.

HCPCS CD
This field contains the primary HCPCS code assigned to this account.

DRG
This field contains the billed DRG for this log record.

The final page of the report displays totals information.

Figure 7.8 FLR - Totals Selected Log Accounts Report - Page 1

```
Date: 01/30/92                  GENERAL HOSPITAL              Page  : 1
Time: 09:58am              SELECTED LOG ACCOUNT REPORT        Report: FLRA
                               Selection Criteria


INCLUDE PATIENT INDICATORS    : Inpatient
REPORT FORMAT?                : TOTALS
REPORT ON HCPCS?              : NO
HCPCS RANGE:                  : Beginning thru End
PAID/UNPAID LOGS              : BOTH
BILL TYPE                     : ALL
PRIMARY PAYOR                 : ALL
BILLED vs PAID DRG            : BOTH
BILLED vs PAID OUTLIER        : BOTH
BILLED vs PAID DRG AMOUNT     : BOTH
BILLED vs PAID DAYS           : BOTH
BILLED vs PAID AMOUNT         : BOTH
BILL THRU DATES               : 01/01/91 thru Latest
REMITTANCE DATES              : 01/01/91 thru Latest
DISCHARGE DATES               : 01/01/91 thru Latest
LATE CHARGE LOGS              : NO
PURGE                         : NO
```

Figure 7.9 FLR - Totals Selected Log Accounts Report - Page 2

```
Date: 01/30/92                        GENERAL HOSPITAL                      Page  : 2
Time: 09:58am                    SELECTED LOG ACCOUNT REPORT                Report: FLRA
                                   Log ID : MEDICARE I/P

                      TOTALS

                                  Covered                Total
Summary/Procedure Code       Qty  Amount                 Amount
--------------------------------------------------------------------------------

        CHARGES WITHOUT CODES   2    $1,000.00             $1,000.00
110     ROOM-BOARD/PVT         11   $12,010.00            $12,010.00
119     OTHER/PVT               6    $2,700.00             $2,700.00
120     ROOM-BOARD/SEMI         3    $8,850.00             $8,850.00
200     INTENSIVE CARE OR IC   47   $31,432.00            $31,432.00
210     CORONARY CARE OR CCU   34   $39,474.00            $39,474.00
250     PHARMACY                9      $267.75               $267.75
270     MED-SUR SUPPLIES       11      $430.35               $430.35
290     MED EQUIP/DURAB         1       $15.00                $15.00
300     LABORATORY OR LAB       1       $49.31                $49.31
320     DX X-RAY                1      $161.10               $161.10
409     OTHER IMAG SYS          1      $590.00               $590.00
420     PHYSICAL THERP          1    $1,200.00             $1,200.00
450     EMERG ROOM              1    $2,500.00             $2,500.00
480     CARDIOLOGY              2    $1,425.00             $1,425.00
730     EKG/ECG                10    $4,027.36             $4,027.36
740     EEG                    20    $4,666.00             $4,666.00
942     EDUC/TRAINING           1   $15,500.00            $15,500.00
Total number of accounts selected:  16


Ancillary Chgs:    $30,831.87    Non-Cvrd Anc Chgs:          0   Cov Anc Chgs   :   $30,831.87
Room/Bed Chgs:     $95,466.00    Non-Cvrd Rm/Bd Chgs:        0   Cov Rm/Bed Chgs :   $3,436.00
Total Chgs:       $126,297.87    Total Non-Cvrd Chgs:        0   Total Cov. Chgs :  $18,214.43
Adjustments:       $10,182.93    Billed Amount:     $106,851.94
Late Chgs:              $0.00    Billed Outlier:      $1,500.00
Deductible:         $9,263.00    Paid Amount:        $18,058.64
Anc Coins:              $0.00    Paid Outlier:        $1,850.00
Billed Days:               89    Est. Liability:     $88,793.30
Paid Days:                  0    # Late Chges:               0   Unreconciled Amt :  $5,983.80

                              End of Report
```

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SELECTED LOG ACCOUNTS REPORT - FLR

This report provides a recap of account totals based on the selection criteria. It displays a header including the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

The Selection Criteria page displays the settings that the system used in creating this report. You define these settings using the Report Selection processor. For more information about this function, refer to the Third Party Logs section in the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide.*

The second page of the report displays totals information.

LOG CASH REPORT - FLR101

Description/Purpose

The Log Cash Report provides a list of paid accounts having a log record. The report includes the log ID, patient account number, patient name, carrier plan, bill from and thru dates, amount billed, amount previously paid or adjusted, amount paid and unreconciled amounts. Totals for the log are provided for the amount paid and the unreconciled amount. Facility totals are provided by amount paid and unreconciled amounts.

Generating and Printing This Report

The Log Cash report is generated during midnight processing and is available through the demand print procedure. The report is sorted by patient name.

The following is an example of the Log Cash Report.

Figure 7.10 FLR101 - Log Cash Report

```
Date: 11/08/89                          General Hospital                          Page  : 1
Time: 08:41am                           Log Cash Report                           Report: FLR101

                                        Log ID: A MEDICARE LOG

Account       Patient                   Carr   Bill      Bill                    Amount Prev                 Unreconciled
Number        Name                      Plan   From      Thru     Amount Billed  Paid or Adj   Amount Paid   Amount
----------------------------------------------------------------------------------------------------------------------

01001-75066 ANDERSON,ELIZABETH          600040 10/26/89  10/27/89     515.00         0.00         10.00         505.00
01001-75173 BAILEY,ROBERT               600040 10/28/89  10/28/89     325.00         0.00         10.00         315.00
01001-75207 CLARKE,LINDA                600040 10/28/89  10/28/89     780.28         0.00         10.00         770.28

                     Totals for Log A MEDICARE LOG

                                   Amount Paid        :           30.00
                                   Unreconciled Amount:        1,590.28
```

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Chapter 7 - THIRD PARTY LOG REPORTS

A full page of the report is provided for each log ID. Each page contains a header including the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system. Entries on the report are sorted by patient name.

ACCOUNT NUMBER
This field contains the patient account number.

PATIENT NAME
This field contains the patient name.

CARR PLAN
This field contains the carrier/plan code.

BILL FROM
This field contains the bill from date.

BILL THRU
This field contains the bill through date.

AMOUNT BILLED
This field contains the prorated amount due from the carrier for the claim.

AMOUNT PREV PAID OR ADJ
This field contains the amount previously paid by the carrier. If an adjustment has been made to the account, this is the net amount.

AMOUNT PAID
This field contains the current payment amount.

UNRECONCILED AMOUNT
This field contains the difference between the amount billed and the amount paid.

LOG ADJUSTMENT REPORT - FLR102

Description/Purpose

The Log Adjustment Report provides a list of adjusted accounts having a log record. The report includes the log ID, patient account number, patient name, carrier plan, bill from and thru dates, amount billed, amount previously paid or adjusted, amount paid and unreconciled amounts. Totals for the log are provided for the amount paid and the unreconciled amount. Facility totals are provided by amount paid and unreconciled amounts.

Generating and Printing This Report

The Log Adjustment Report is generated during midnight processing and is available through the demand print procedure. The report is sorted by patient name.

The following is an example of the Log Adjustment Report.

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Figure 7.11 FLR102 - Log Adjustment Report

```
Date: 11/17/89                        GENERAL HOSPITAL                       Page  : 1
Time: 12:57 am                      Log Adjustment Report                    Report: FLR102

                                  Log ID: 1 MEDICARE LOG


Account     Patient                  Carr  Bill From Bill Thru              Amount Prev                 Unreconciled
Number      Name                     Plan  Date      Date     Amount Billed Paid or Adj  Amount Adj.    Amount
------------------------------------------------------------------------------------------------------------------


  88264-00009 DUNCAN,FREIDA          500001 09/20/89  09/26/89       110.00       57.00       10.00-        43.00
  88264-00113 EDWARDS,HERMANN        429101 09/20/89  09/27/89     1,790.20        2.00-       1.00-     1,787.20
  88918-01411 FITZGERALD,THOMAS S    119281 09/13/89  09/20/89     1,000.00        3.00-       1.00-       996.00

              Totals for Log 1 MEDICARE LOG

                              Amount Adjusted    :         12.00-
                              Unreconciled Amount:       2,826.20
```

A full page of the report is provided for each log ID. Each page contains a header including the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system. Entries on the report are sorted by patient name.

ACCOUNT NUMBER
This field contains the patient account number.

PATIENT NAME
This field contains the patient name.

CARR PLAN
This field contains the carrier/plan code.

BILL FROM
This field contains the bill from date.

BILL THRU
This field contains the bill through date.

AMOUNT BILLED
This field contains the prorated amount due from the carrier for the claim.

AMOUNT PREV PAID OR ADJ
This field contains the amount previously paid by the carrier. If an adjustment has been made to the account, this is the net amount.

AMOUNT ADJ
This field contains the adjustment amount.

UNRECONCILED AMOUNT
This field contains the difference between the amount billed and the amount adjusted.

DELETED LOGS REPORT - FLRDEL

Description/Purpose

The Deleted Logs Report provides a list of log records that have been deleted. The report includes the log ID, patient account number, patient name, carrier/plan, bill type, claim sequence number, and the reason the log was deleted.

Generating and Printing This Report

The Deleted Logs Report is generated during midnight processing and is available through the demand print procedure. The report is sorted by log ID.

The following is an example of the Deleted Logs Report.

Figure 7.12 FLRDEL - Deleted Logs Report

```
Date: 07/10/92                         GENERAL HOSPITAL                   Page  : 1
Time: 01:16am                       THIRD PARTY LOGS DELETED              Report: FLRDEL


Log ID: 1 COMMERCIAL REVENUE LOG

Account          Patient Name              Carrier     Bill  Claim     Claim    Selection
Number                                     Plan        Type  Type      Seq      Criteria


A9217900267      ANDERSON,HARRIET S        040027      C     UB82      7        Deleted Claim
A9218200011      HARPER,TYRONE J           440001      F     UB82      1        Adjustment Bill
A9218800121      MITCHELL,EDGAR            500023      L     1500      12       Adjustment Bill
A9219800083      SMITH,WENDY O             921002      F     UB82      4        Deleted Claim
A9218800258      TUCKER,MARY               500023      F     1500      8        Adjustment Bill
A9218800020      WATKINS,EUNICE            630021      L     UB82      9        Adjustment Bill

                                         End of Report
```

A full page of the report is provided for each log ID for which logs have been deleted. Each page contains a header including the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

ACCOUNT NUMBER
This field contains the patient account number.

PATIENT NAME
This field contains the patient name.

CARRIER PLAN
This field contains the carrier/plan code.

BILL TYPE
This field contains the type of bill.

CLAIM TYPE
This field contains the type of claim.

CLAIM SEQ
This field contains the claim sequence number of the log record deleted.

SELECTION CRITERIA
This field describes the reason that the system deleted the log record. These reasons include:

• The claim was deleted online.

• An adjustment bill produced adjustment claims replacing these claim and log records.

• The insurance and associated claims were deleted using the AR Insurance Management function.

LOG PURGE SUMMARY - FLRSLAP

Description/Purpose

The Log Purge Summary provides information about purged log records. The report displays the date range for which log information was purged, the ID and description of each log purged, the number of records in the log that were purged, and the total number of records for all logs that were purged.

NOTE: The system also creates a Selected Log Accounts report (FLR) when logs are purged. This FLR report contains detailed information on each account in the purged log. Remember to print this FLR report if you want to keep a record of the purged log.

Generating and Printing This Report

The Log Purge Summary is generated during midnight processing and is available through the demand print procedure. The report is sorted by log ID.

The following is an example of the Log Purge Summary.

Figure 7.13 FLRSLAP - Log Purge Summary

```
Date: 07/10/92                              GENERAL HOSPITAL                          Page  : 1
Time: 10:59am                               Log Purge Summary                         Report: FLRSLAP


Date Range : 06/25/92 to 06/25/92


Log ID     :  3    STATE ASSISTANCE LOG              records purged = 0004

                      Total Log Records Purged - 0004

                                         End of Report
```

Each page contains a header including the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system. The report then displays the date range for which log information was purged, the ID and description of each log purged, the number of records in the log that were purged, and the total number of records for all logs that were purged.

Chapter 8 - CONTRACT BILLING REPORTS

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Illustrations

CONTRACT ACCOUNTS REPORT - FDRAAR

Description/Purpose

The Contract Accounts Report is a listing of all active contract accounts in the system. It can be used to verify the subsidiary balance of contract accounts as well as to review the billing status of each contract.

Generating and Printing This Report

This report, which is sorted by contract name, is an optional batch job. It needs to run in downtime batch after all activity for the day has been processed. Refer to "Optional Batch Jobs" in Chapter 2: Financial System Management of the *General Information Volume* in the *STAR Financials Patient Accounting Reference Guide* for more information.

Totals are provided for all contracts in each location and all contracts for the facility.

The following is an example of the Contract Account Report.

Figure 8.1 FDRAAR - Contract Account Report

```
Date: 10/17/90                        PROVIDENCE MED CENTER                      Page  : 1
Time: 00:23                          Contract Accounts Report                   Report: FDRAARP

Contract                         Last       Last        Total      Unbilled   Current
Code       Name           ID     Bill       Payment     Payment    Charges    Balance    Loc
--------   ------------------------   ------------   --------   ---------   ---------  ---------  ---------  -----
DMF        DAVE'S SPECIAL LAB    22352653   09/10/90                  0.00       0.00     126.00   AR
DMFX       DMF CONGLOMERATE INC.  39729069  09/05/90                  0.00       0.00     715.55   AR
FBH        FRED'S BODY SHOP     66859493   09/11/90   08/22/90      16.82       0.00      72.11   AR

FBH1       FRED'S SALVAGE                  09/23/90                  0.00       0.00       0.00   AR
BWM        MASTER'S COMPANY     16732512   10/11/90   08/16/90      20.00     150.15     617.10   PA
NLW        WEISSMANN LAB INC.   12232234   10/15/90   08/22/90      35.50       0.00   6,588.49   PA
QWK        BRUNSTING WORKS, INC. 18563650                            0.00     109.55     109.55   PA
           Contract location totals            PA       3          55.50     259.70   7,315.14
                                               AR       4          16.82       0.00     913.66

           Facility Total                                          72.32     259.70   8,228.80

                                     END OF REPORT
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

CONTRACT CODE
This field contains the contract code number.

NAME
This field contains the contract name.

ID
This field contains the contract ID number.

LAST BILL
This field contains the date of the last cycle bill or the final bill date.

LAST PAYMENT
This field contains the date the last payment was made by the contract.

TOTAL PAYMENT
This field contains the amount of total payments made by the contract.

UNBILLED CHARGES
This field contains the dollar amount of unbilled charges.

CURRENT BALANCE
This field contains the current balance for the contract.

LOC
This field contains the location of the contract account (AR or PA).

CONTRACT ACTIVITY JOURNAL DETAIL REPORT - FDRAJR

Description/Purpose

The Contract Activity Journal Detail Report lists all charges posted for the day to contract accounts and their associated patient. It can be used as an audit trail to check detailed contract charges and is used in balancing.

This report provides subtotals of charges by contract, flags both late and automatic charge items, and lists the average number of days elapsed to post a charge for a facility. Facility totals are provided.

NOTE: The Facility Total on this report is used to balance to the Revenue Amount on the Administrative Operating Summary report (FSRAOS).

Generating and Printing This Report

This report is generated during midnight processing and can be set up and printed as a demand report. It is sorted by contract code.

The following is an example of the Contract Activity Journal Detail Report.

Figure 8.2 FDRAJR - Contract Activity Journal Detail Report

```
Date: 04/03/02                   Model Hospital A              Page  : 1
Time: 0:09          Contract Activity Journal Detail for 04/02/02 Report: FDRAJRA



Contract     Name                         ID
 Code    Item Description          Patient Name      Int Order  Qty   Chg Am
   Dept  FIM Code   RC    Srv Dte  P Day To/From#     R/B  Auto  Late
---------------------------------------------------------------------------

MLK1         MIKES CONTRACT ONE           40403382851
  6340  17-HYDROXY CORTICOSTEROID         MLK 000001   1     500.0
   LAB   7011-6375  7011  04/02/02  0
                                 Contract Total        1    1    500.00


                         Facility Average Days to Post     0
                         End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, the report name as used in the system, and the date the contract activity was posted.

CONTRACT
This field contains the contract code.

NAME
This field contains the contract name.

ID
This field contains the contract ID number.

CODE ITEM DESCRIPTION
This field contains the SIM (Service Item Master) code and description of the item ordered.

PATIENT NAME
This field contains the patient name if the contract charge is patient-related.

INT
This field contains the initials of the person entering the order.

ORDER
This field contains the order number.

QTY
This field contains the quantity of the item ordered.

CHG AMOUNT
This field contains the dollar amount charged for the item.

DEPT
This field contains the SIM (Service Item Master) department for this item.

FIM CODE
This field contains the FIM (Financial Item Master) code for the item ordered.

RC
This field contains the revenue center to which the charges are mapped.

SRV DTE
This field contains the date the service was performed.

P DAY
This field contains the number of days elapsed to post the charge.

R/B
This field contains R/B if this is a room/bed charge.

AUTO
This field contains the word Auto if this is an automatic charge, indicating this is an auto daily charge.

LATE
This field contains the word Late if this is a late charge/credit.

CONTRACT ACTIVITY JOURNAL SUMMARY REPORT - FDRAJR2

Description/Purpose

This report summarizes all daily revenue charges for contract accounts. Charges are summarized by room & bed; revenue charges and late charges/credits by revenue center; and charge counts by department. A total revenue center summary is provided that accumulates room & bed, late charges/credits and charges by department.

This report can be used as a management summary of contract revenue by revenue center.

NOTE: The Total Dollars on this report is used to balance to the Revenue Amount on the Administrative Operating Summary report (FSRAOS).

Generating and Printing This Report

This report, which is sorted by revenue center, is a daily batch report automatically generated as a result of midnight processing. It is set up as a demand report and printed through the Demand print function. Page breaks occur at the end of the page or after each revenue center summary.

The following is an example of a Contract Activity Journal Summary Report.

Figure 8.3 FDRAJR2 - Contract Activity Journal Summary Report

```
Date: 10/17/90                  GENERAL HOSPITAL                 Page  : 1
Time: 00:14        Contract Activity Journal Summary for 10/16/90 Report: FDRAJR2P


            Revenue Center Summary - Room & Bed Charges

                    Total  Total     Charge Charge    Credit Credit   Zero
Department          Dollars Count     Dollars Count    Dollars Count  Count
----------------------------------------------------------------------------

            Revenue Center Summary - Late Charges/Credits

                    Total  Total     Charge Charge    Credit Credit   Zero
Department          Dollars Count     Dollars Count    Dollars Count  Count
----------------------------------------------------------------------------

            Revenue Center Summary - Revenue Department

                    Total  Total     Charge Charge    Credit Credit   Zero
Department          Dollars Count     Dollars Count    Dollars Count  Count
----------------------------------------------------------------------------

7131 CTT SCANNER     15.00     5      555.20     3     540.20-    2      0

     Total           15.00     5      555.20     3     540.20-    2      0


                          End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

The following fields are represented for room & bed charges, revenue charges, and late charges/credits by department.

TOTAL DOLLARS
This field is the sum of charge dollars less credit dollars for this revenue center.

TOTAL COUNT
This field is the sum of the charge count, credit count and zero count for this revenue center.

CHARGE DOLLARS
This field contains the total charges for this revenue center.

CREDIT DOLLARS
This field contains the total credit dollars for this revenue center.

CREDIT COUNT
This field contains the total credit charges count for this revenue center.

ZERO COUNT
This field contains the number of SIM items charged with a price of $00.00.

CONTRACT AR BALANCE CONTROL REPORT - FARBAL12

Description/Purpose

The Contract AR Balance Control Report provides a daily AR balance summary and reconciliation for contract billing. It lists the opening AR balance, a total for all final billed accounts, the total of all AR cash, and the ending unapplied subsidiary balance and GL control balance (for comparison). If the ending AR balance, subsidiary balance and the GL control balance are not the same, the balance (Bal) field is filled with a Y indicating the AR must be reconciled for that day. This report serves as a daily auditing tool for the balancing and reconciliation of AR for contract billing.

Generating and Printing This Report

This report is sorted by day of the month from the Daily Balancing functions from Contract AR with the desired reporting period selected using the online screen. It set up as a demand report and printed through the Demand Print function.

The following is an example of the Contract AR Balance Control Report.

Figure 8.4 FARBAL12 - Contract AR Balance Control Report

```
Date: 10/17/90                          GENERAL HOSPITAL                             Page  : 1
Time: 00:23                     Contract AR Balance Control Report                   Report: FARBAL12
                                      MO:  09  YEAR:  90


        OPENING                                          LATE       ENDING       SUBSIDIARY    G/L CONTROL
DAY   AR BALANCE     F/B TOTAL    AR CASH    AR ADJUST.   CHG/CR   AR BALANCE      BALANCE        BALANCE       BAL
---   ----------    ---------    -------    ----------   ------   ----------    ----------    -----------     ---
01          0.00         0.00       0.00          0.00     0.00         0.00          0.00           0.00       Y
09          0.00         0.00       0.00          0.00     0.00         0.00          0.00           0.00       Y
10          0.00         0.00       0.00          0.00     0.00         0.00          0.00           0.00       Y
11          0.00         0.00       0.00          0.00     0.00         0.00          0.00           0.00       Y
12          0.00       178.00       0.00          0.00     0.00       178.00        178.00         178.00       Y
13        178.00         0.00       0.00         10.00     0.00       188.00        188.00         188.00       Y
14        188.00       765.50       5.00          0.00     0.00       948.50        948.50         948.50       Y
15        948.50         0.00       0.00          0.00     0.00       948.50        948.50         948.50       Y
16        948.50         0.00       0.00          0.00     0.00       948.50        948.50         948.50       Y
17        948.50    13,048.20       5.32         -6.12     0.00    13,985.26     13,985.26      13,985.26       Y
18     13,985.26     3,077.35      -8.03         -5.06     0.00    17,065.58     17,065.58      17,065.58       Y
19     17,065.58         0.00       0.00          0.00     0.00    17,065.58     17,065.58      17,065.58       Y
20     17,065.58         0.00       0.00          0.00     0.00    17,065.58     17,065.58      17,065.58       Y
21     17,065.58       811.61       0.00          0.00     0.00    17,877.19     17,877.19      17,877.19       Y
22     17,877.19     2,302.70       0.00          0.00     0.00    20,179.89     20,179.89      20,179.89       Y
23     20,179.89    13,572.49       0.00          0.00     0.00    33,752.38     33,752.38      33,752.38       Y



                                         END OF REPORT
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, the report name as used in the system, and the month and year for the report.

DAY
This field contains the day of the month.

OPENING AR BALANCE
This field contains the previous day's subsidiary balance.

F/B TOTAL
This field contains the account balance of all contract accounts final billed for the day. This amount comes from the Contract Billed Accounts report (FDR200).

AR CASH
This field contains the daily total of cash posted to contract accounts in Accounts Receivable. This amount is the Contract AR Total on the Cash Posting Detail report (FAR130).

AR ADJUST.
This field contains the daily total of adjustments posted to contract accounts in Accounts Receivable. This amount is the Contract AR Total on the Adjustment Posting Detail report (FAR210).

LATE CHG/CR
This field contains the dollar amount of any late charges on contract accounts. Currently, late charges are not allowed on contract accounts.

ENDING AR BALANCE
This field contains the system-supplied ending balance which is calculated by adding and subtracting daily activity from the opening balance. The calculation follows:

```
    Opening Balance
  + Final Bill Amount
  -  Cash
+ or - Adjustments
    +  Late Charges
  -  Late Credits (if any)
_____
    Ending AR Balance
```

SUBSIDIARY BALANCE
This field contains the amount, calculated during Midnight Processing, representing the total of all contract accounts in account location AR. Tomorrow, this amount is used as the Opening Balance.

G/L CONTROL BALANCE
This field contains the General Ledger control balance for AR contract accounts. The General Ledger Control Balance should match the Subsidiary and Ending balances.

BAL
This field contains a Y if the daily balance is reconciled.

COMMENTS
This field displays the a line of comments (if any).

RECONCILED BY
This field displays the initials of the person who entered the comment (if any).

CONTRACT BILLED ACCOUNTS REPORT - FDR200

Description/Purpose

The Contract Billed Accounts Report lists all contract accounts that were billed for the business day.

The report lists the contract ID, contract name, amount billed, account balance and bill type. Subtotals are summarized and sorted by bill types. Facility totals are provided by bill type and bill totals.

This report provides a daily audit trail of all contract accounts billed and is used in the daily balancing of PA and AR. The account balance of bill type F indicates the PA to AR transfer amount.

Generating and Printing This Report

The Contract Billed Accounts Report is a daily batch report and is printed through the Demand Print function. The report is sorted by contract name and code.

The following is an example of the Contract Billed Accounts Report.

Figure 8.5 FDR200 - Contract Billed Accounts Report

```
Date: 10/17/90                              GENERAL HOSPITAL                          Page  : 1
Time: 00:22                             Contract Billed Accounts                       Report: FDR200P
                                      Contract Accounts Billed on 10/16/90

Code      Contract ID     Contract Name          Amount Billed     Account Balance     Bill Type
----      -------------   --------------------    -------------     ---------------     ---------
NLW       1429-5462       Webster Lab, Inc.            180.00              180.00            F

                          Bill type totals
                                F Final       1         180.00              180.00

                          Facility Total      1         180.00              180.00

                                          End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, the report name as used in the system, and the date the contract accounts were billed.

CODE
This field contains the contract code.

CONTRACT ID
This field contains the contract ID number.

CONTRACT NAME
This field contains the vendor name.

AMOUNT BILLED
This field displays the amount billed for either the final bill or cycle bill.

ACCOUNT BALANCE
This field displays the current contract account balance.

BILL TYPE
This field contains the bill type assigned to this contract account. Valid bill types are C-cycle and F-final.

CONTRACT DEPARTMENT LOG REPORT - FDRDLR

Description/Purpose

This report is produced in a detail and a summary format. The detail format of the report lists, by department, all charges placed on contract accounts for the day. It includes automatic and late charge items, the number of days elapsed to post a charge, and the department average. Department totals are provided by contract code. The summary version of the report lists the total quantity and price for each item. In addition to totals by item, the summary report provides totals by facility.

Generating and Printing This Report

This report, which is sorted by department and subsorted by contract code, is generated during midnight processing as an optional batch report. Totals are provided by department.

Following is an example of the detail and summary versions of the Contract Department Log Report.

Figure 8.6 FDRDLR - Contract Department Log Report - Detail

```
Date: 11/08/90                GENERAL HOSPITAL                Page  : 1
Time: 08:13              Financial Contract Department Log     Report: FDRDLRP
              LABORATORY Department Contract Log Detail for 11/07/90


Contract      Name
 Code  Item Description                        Int Order#    Qty         Price
  FIM Code     RC    Srv Dte  P Day   Charge Location         Auto     Late
-------------------------------------------------------------------------------


BWM       MATEER'S COMPANY
  2460 HEMOGLOBIN SERUM FREE                   KCA 000001     1         20.25
   409-0606-7 6075  11/07/90     0    DEFAULT
  3501 LAB STAT CHARGE                         KCA 000001     1         28.00
   403-8888-6 7073  11/07/90     0    DEFAULT
                                     Totals           2        2         48.25

NLW       WEBSTER LAB INC
  0001    GIVE 25% S ALB 12.5GM-50ML 1U 1    S B 000015       1          .00
   999-9999-7 7073  11/07/90     0    DEFAULT
  0021    GIVE AUTOLOGOUS BLOOD 1U 1         S B 000003       1         91.25
   407-0481-9 7077  11/07/90     0    DEFAULT
  1922 VDRL (CSF)                   86592    S B 000002       1          9.10
   488-0910-7 3107  11/07/90     0    DEFAULT
  9421 VANCOMYCIN 80031                      S B 000001       1         46.75
   409-0959-0 7078  11/07/90     0    DEFAULT
                                     Totals           4        4        147.10

                              Dept Average Days to Post        0

                              Department Totals                195.35
```

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CONTRACT DEPARTMENT LOG REPORT - FDRDLR

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Figure 8.7 FDRDLR - Contract Department Log Report - Summary

```
Date: 11/08/90               GENERAL HOSPITAL            Page  : 2
Time: 08:13            Financial Contract Department Log    Report: FDRDLRP
             LABORATORY Department Contract Log Summary for 11/07/90


Item Description                          ------Total-------
--------------------------------------------------------------------------------
0001   GIVE 25% S ALB 12.5GM-50           1        .00
0021   GIVE AUTOLOGOUS BLOOD 1U           1       91.25
1922 VDRL (CSF)                           1        9.10
2460 HEMOGLOBIN SERUM FREE                1       20.25
3501 LAB STAT CHARGE                      1       28.00
9421 VANCOMYCIN 80031                     1       46.75


              Facility Totals   # Contracts    Quantity       Amount
                                    2              6           195.35

                     End of Report
```

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Each report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system. The department name is included in the header.

The Contract Department Log Report consists of a detail report and a summary report.

Contract Log Detail Report Fields

CONTRACT
This field contains the contract code.

NAME
This field contains the contract name.

CODE ITEM DESCRIPTION
This field contains the SIM (Service Item Master) code and description of the item ordered.

INT
This field contains the initials of the person entering the order.

ORDER#
This field contains the order number.

QTY
This field contains the quantity of the item ordered.

PRICE
This field contains the price charged for the item.

FIM CODE
This field contains the FIM (Financial Item Master) code for the item ordered.

RC
This field contains the revenue center to which the charges are mapped.

SRV DTE
This field contains the date the service was performed.

P DAY
This field contains the number of days required to post the charge, comparing the service date and the posting date.

CHARGE LOCATION
This field contains the location (nursing station, etc.) from which the charge was placed.

AUTO
This field contains the word Auto if this is an automatic charge, indicating this is an auto daily charge.

LATE
This field contains the word Late if this is a late charge/credit.

Contract Log Summary Report Fields

ITEM DESCRIPTION
This field contains the SIM (Service Item Master) code and description of the item ordered.

------TOTAL------
This field consists of two columns. The first column represents the total quantity of the item ordered. The second column represents the total price charged for the item ordered.

 # CONTRACTS
This facility total field contains the number of contracts that had charge activity for the department.

QUANTITY
This facility total field contains the total number of items ordered.

AMOUNT
This facility total field contains the total dollar amount charged for the items ordered.

CONTRACT AGED TRIAL BALANCE REPORT - FDRATB

Description/Purpose

The Contract Aged Trial Balance Report lists all information for all contract bills with a nonzero balance. The report can be generated at month end through midnight processing, a specific date through midnight processing, or online.

Generating and Printing This Report

The report can be sorted by bill date, contract code by bill date, descending balance, and follow up collector. The system allows you to page break by sort key when the contract code by bill date or follow up collector sort options are used. The aging criteria and reserve percentages parameters are located in the Report Aging Code table within the Financial Table Maintenance menu option.

The following is an example of the Contract Aged Trial Balance Report.

Figure 8.8 FDRATB - Contract Aged Trial Balance Report - Detail

```
Date: 01/16/06                                    Model Hospital A                              Page  : 1
Time: 13:51                                  Contract Aged Trial Balance                        Report: FDRATBA
                                     SORTED BY DESCENDING BALANCE - CURRENT BALANCE


CONT   CONTRACT                       CONTRACT      BILL   BILL      LAST       LAST       BILL            AGING CATEGORY
CODE   DESCRIPTION                    ID #          TYPE   DATE      PAYMENT    ADJUST     BALANCE     1 2 3 4 5 6 7 8 9 0 1 2 +

MLKA   A432 TEST CONTRACT             A25425234     C      09/29/04  11/11/02   09/29/04   1,084.39                  X
MLKA   A432 TEST CONTRACT             A25425234     C      10/01/05             10/01/05      80.97            X
MLKA   A432 TEST CONTRACT             A25425234     C      11/01/05             11/01/05      80.97          X
1      TEST CONTRACT ACCT             A87           C      09/17/04             09/17/04      32.48-                     X
```

Figure 8.9 FDRATB - Contract Aged Trial Balance Report - Summarization By Aging Category

```
Date: 03/02/06                              Model Hospital A                            Page  : 2
Time: 9:09                              Contract Aged Trial Balance                     Report: FDRATBA
                                SORTED BY DESCENDING BALANCE - CURRENT BALANCE

TOTALS BY CONTRACT
CODE    UNBILLED    30 DAYS     60 DAYS     90 DAYS    120 DAYS    150 DAYS    180 DAYS    210 DAYS    240 DAYS    270 DAYS
                       300 DAYS     330 DAYS     360 DAYS

1     30263400.65                                                 1230.40-

MLKA                                                              1246.33
```

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Figure 8.10 FDRATB - Contract Aged Trial Balance Report -
Summarization By Aging Category

```
Date: 01/16/06                            Model Hospital A                          Page  : 3
Time: 13:51                          Contract Aged Trial Balance                    Report: FDRATBA
                               SORTED BY DESCENDING BALANCE - CURRENT BALANCE


TOTALS: UNBILLED CHARGES              1                  1,683.14
   Cat 1     1 -  30 DAYS            0                       .00
   Cat 2    31 -  60 DAYS            0                       .00
   Cat 3    61 -  90 DAYS            1                     80.97
   Cat 4    91 - 120 DAYS
   Cat 5   121 - 150 DAYS
   Cat 6   151 - 180 DAYS
   Cat 7   181 - 210 DAYS
   Cat 8   211 - 240 DAYS
   Cat 9   241 - 270 DAYS
   Cat 10  271 - 300 DAYS
   Cat 11  301 - 330 DAYS
   Cat 12  331 - 360 DAYS
   Cat 13  OVER 361 DAYS             1                     80.97


   GRAND TOTAL                       7                 $1,699.07
```

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This report consists of three sections: detail balance information, aging summarization by contract code, and summarization by aging category. The report combines AR and PA location contract information. The summary by aging category page (last page of report) identifies unbilled charges so the total dollar amount agrees with the General Ledger balances.

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number and the report name as used in the system.

CONT CODE
The contract code is pulled from the Contract Names table.

CONTRACT DESCRIPTION
The contract description is pulled from the Contract Names table.

CONTRACT ID #
The contract ID# is pulled from the Contract Names table.

BILL TYPE
The bill type is either a C for a cycle bill or a F for a final bill.

BILL DATE
The bill date is pulled from the billing information for the specific bill

LAST PAYMENT
The last payment date for the specific bill is printed. If no payment was posted to this bill, the field is blank.

LAST ADJUST
The last adjustment date for the specific bill is printed. If no adjustment was posted to the specific bill, the field is blank.

BILL BALANCE
The balance reflected for the specific bill is either the current balance or the balance as of midnight. This is a user controlled parameter. This balance is *not* the contract balance cumulating all specific bill balances.

AGING CATEGORY
An X is placed in the appropriate column based on the Report Aging Code table definition. Thirteen aging categories are displayed on this report. A single number in each column heading coincides with a category number: 1=1, 2=2, 3=3, 4=4, 5=5, 6=6, 7=7, 8=8, 9=9, 10=0, 11=1, 12=2, and 13=3.

CONTRACT LATE CHARGE/CREDIT REPORT - FDRAJR1

Description/Purpose

The Contract Late Charge/Credit Report lists all charges/credits posted to contract accounts in Accounts Receivable (AR). A transaction is late if it is posted to an account after that account is final billed (transferred from PA to AR).

Since late charges are not allowed on contract accounts, this report is not currently used.

Generating and Printing This Report

This report, which is sorted by contract ID, is generated during midnight processing. It is set up and printed as a demand report.

The following is an example of a Contract Late Charge/Credit Report.

Figure 8.11 FDRAJR1 - Contract Late Charge/Credit Report

```
Date: 10/17/90                              GENERAL HOSPITAL                        Page  : 1
Time: 00:13                    Contract Late Charge/Credit Report for 10/16/90      Report: FDRAJR1P


       Contract    Name                         Pat Type  F/C  Srv Date   Dept  Sim Code  Qty      Amount
       ------------------------------------------------------------------------------------------------------

                                            Facility Contract Late Charges/Credits  0     0         .00
                                            Total by Location                AR                     .00
                                                                             BD                     .00

                       End of Report
```

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The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

CONTRACT
This field contains the contract account number.

NAME
This field contains the contract name.

PAT TYPE
This field contains the patient type code used to categorize the patient. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same-day surgery, and series patients.

F/C
This field contains the hospital-defined financial class code assigned to this patient's account.

SRV DATE
This field contains the date the service was received.

DEPT
This field contains the SIM (Service Item Master) department for this item.

SIM CODE
This field contains the Service Item Master code assigned to the charge/credit.

QTY
This field contains the quantity of the item ordered.

AMOUNT
This field contains the amount charged for the item.

CONTRACT PA BALANCE CONTROL REPORT - FARBAL11

Description/Purpose

There are separate balancing reports for contract PA and contract AR accounts. The format and frequency of these reports is identical to the daily PA and AR patient balancing reports currently produced in midnight processing. The data included on the report is loaded from the daily balancing screens.

The Contract PA Balance Control Report provides a daily PA balance summary and reconciliation for contract billing. It lists the beginning daily balance, daily PA transactions and calculates a new PA daily balance. The daily subsidiary balance and GL control balance are listed for comparison.

If the Ending PA Balance, Subsidiary Balance and the GL Control Balance are not the same, the balance (Bal) field contains an N, indicating the AR needs to be reconciled for that day.

This report serves as a daily auditing tool for the balancing and reconciliation of Patient Accounting (PA) contract billing.

Generating and Printing This Report

This report is sorted by day of the month from the Daily Balancing functions for Contract PA with the desired reporting period selected using the online screen. It is set up as a demand report and printed through the Demand Print function.

The following is an example of the Contract PA Balance Control Report.

Figure 8.12 FARBAL11 - Contract PA Balance Control Report

```
Date: 10/17/90                              GENERAL HOSPITAL                              Page  : 1
Time: 00:23                          Contract PA Balance Control Report                   Report: FARBAL11
                                            MO:  09  YEAR:  90

        OPENING                                                  LATE      ENDING     SUBSIDIARY   G/L CONTROL
DAY    PA BALANCE    PA REVENUE   F/B TOTAL   PA CASH   PA ADJUST.  CHG/CR   PA BALANCE   BALANCE     BALANCE     BAL
---    ----------    ----------   ---------   -------   ----------  ------   ----------   ----------  -----------  ---

01        0.00          0.00        0.00       0.00        0.00     0.00       0.00        0.00         0.00       Y

06        0.00          0.00        0.00       0.00        0.00     0.00       0.00        0.00         0.00       Y

09        0.00          0.00        0.00       0.00        0.00     0.00       0.00        0.00         0.00       Y

10        0.00          0.00        0.00       0.00        0.00     0.00       0.00        0.00         0.00       Y

11        0.00       1,468.40       0.00       0.00        0.00     0.00    1,468.40     1,468.40     1,468.40     N

12     1,468.40      1,054.10      178.00      35.00       15.00    0.00    2,324.50     2,324.50     7,551.44     N

13     2,324.50       110.50        0.00       0.00        0.00     0.00    2,435.00     2,435.00     7,661.94     N

14     2,435.00       178.00       765.50      17.00       18.00    0.00    1,848.50     1,848.50     7,039.44     N

15     1,848.50       283.10        0.00       0.00        0.00     0.00    2,131.60     2,131.60     7,322.54     N

16     2,131.60         0.00        0.00       0.00        0.00     0.00    2,131.60     2,131.60     7,322.54     N

17     2,131.60     27,168.33    13,048.20    118.57      14.02-    0.00   16,119.14    16,119.14    21,338.12     N
       This is an example of a comment                           Reconciled by: Douglas,Cliff
18    16,119.14     3,771.05     3,077.35      10.24      86.80-    0.00   16,715.80    16,715.80    22,108.38     N

19    16,715.80       50.00        0.00       0.00        0.00     0.00   16,765.80    16,765.80    22,158.38     N

                                           End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, the report name as used in the system, and the month and year of the report.

DAY
This field contains the day of the month.

OPENING PA BALANCE
This field contains the previous day's subsidiary balance.

PA REVENUE
This field contains the total revenue posted to contract accounts for the day.

F/B TOTAL
This field contains the account balance of all accounts final billed for the day. This amount comes from the Contract Billed Accounts report (FDR200).

PA CASH
This field contains the daily total of cash posted to contract accounts in Patient Accounting. This amount is the PA Contract Total on the Cash Posting Detail report (FAR130).

PA ADJUST.
This field contains the daily total of adjustments posted to contract accounts in Patient Accounting. This amount is the PA Contract Total on the Adjustment Posting Detail report (FAR210).

LATE CHG/CR
This field contains the dollar amount of any late charges posted to contract accounts. Currently, late charges are not allowed on contract accounts.

ENDING PA BALANCE
This field contains the system-supplied ending balance which is calculated by adding and subtracting daily activity from the opening PA balance. The calculation follows:

    Opening PA Balance
  + Revenue
  - Final Bill Amount
  - Cash
  + or - Adjustments
  + Late Charges
  - Late Credits (if any)
  _____

    Ending PA Balance

SUBSIDIARY BALANCE
This field contains the amount, calculated during Midnight Processing, representing the total of all contract accounts in account location PA. Tomorrow, this amount is used as the Opening PA Balance.

G/L CONTROL BALANCE
This field contains the General Ledger control balance for contract accounts. The General Ledger Control Balance should match the Subsidiary and Ending PA balances.

BAL
This field contains a Y if the daily balance is reconciled.

COMMENTS
This field displays the a line of comments (if any).

RECONCILED BY
This field displays the initials of the person who entered the comment (if any).

UNBILLED CONTRACT ACCOUNTS - FDR110

Description/Purpose

The Unbilled Contract Accounts report lists all contract accounts that have been marked inactive but have not yet been final billed. The future release of contract billing allows for suspense days and billing edits which results in more accounts being included on this report.

The total number of contracts and the total balance prints for each facility.

Generating and Printing This Report

This report, which is sorted by contract ID number, is generated daily during midnight processing.

The following is an example of the Unbilled Contract Accounts Report.

Figure 8.13 FDR110 - Unbilled Contract Accounts Report

```
Date: 10/17/90                              GENERAL HOSPITAL                        Page  : 1
Time: 00:23                              Unbilled Contracts Report                  Report: FDR110P
                                    Unbilled Contract Accounts For 10/16/90


                                                 Active    Inactive   Unbilled   Act
Code    Contract ID    Contract Name             Date       Date      Amount  Hold Days    Balance
----    -------------  --------------------------  --------   --------   ---------- ----  ----   ----------
AGII    82746-1938462  General Contract          09/07/90   09/09/90     31.50          2      31.50


                                            Total                        31.50                 31.50

                                       End of Report
```

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Chapter 8 - CONTRACT BILLING REPORTS

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, the report name as used in the system, and the month and year of the report.

CODE
This field contains the contract code.

CONTRACT ID
This field contains the contract ID number.

CONTRACT NAME
This field contains the contract name for this ID.

ACTIVE DATE
This field contains the date this contract was created.

INACTIVE DATE
This field contains the date that the contract was flagged as inactive. Inactive flags are set when the contract meets the number of inactivity days specified in the contract table, or when the user requests a final bill.

UNBILLED AMOUNT
This field contains the amount of unbilled charges for the contract.

HOLD
This field indicates if the contract is on billing hold. If so, Yes prints.

This field is not used currently.

ACT DAYS
This field contains the number of days the contract was active.

BALANCE
This field contains the total balance of the contract.

CONTRACT AUTOMATIC W/O REPORT - FDR300

Description/Purpose

The Contract Automatic Write-Off (W/O) report is an audit trail for the adjustment posted to the General Ledger for the Automatic Contractual Write off process. The report shows detail by charge how the write off amount was calculated. The report summarizes the write-off by department within a contract code and also summarizes the write off by contract code.

Generating and Printing This Report

This report is generated automatically through midnight processing.

The following is an example of the Contract Automatic Write-Off Report.

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Figure 8.14 FDR300 - Contract Automatic Write-Off Report

```
Date: 03/12/96                              General Hospital                           Page  : 1
Time: 00:24A                             Automatic Writeoff Report                     Report: FDR300A


Code Contract Name           SIM Department       Patient    Charge              Charge   Type Writeoff Writeoff
                                                  Account    Description          Amount       Percent  Amount


MDK  MDK CONTRACT MGT
                              CSR   CENTRAL SERVICES
                                                            BANDAGE, ELASTIC 2"     75.00  O            8.99%          6.74
            0112300123/ Karney, Mike
                                                 9607100001 CONNECTOR, "Y"--------------    5.40  O            8.99%           .49
            0112300123/ Karney, Mike

                                                 9607100001 UROL IRRI, Y-TYPE TUR     12.60  O    8.99%       1.13
                              Subtotal                                                                        8.36

                              EEG   EEG
                                                            24 HOUR AMBULATORY EEG / SCAN   607.00  S  20.00%    121.40
                                                            24 HOUR AMBULATORY EEG / SCAN   607.00- S  20.00%    121.40-
                                                            24 HR EEG / VIDEO------------   682.50  S  20.00%    136.50
                                                            24 HR EEG / VIDEO------------   682.50- S  20.00%    136.50-
                                                            24 HR EEG / VIDEO------------   682.50- S  20.00%    136.50-
                                                 9607100001 24 HOUR AMBULATORY EEG / SCAN   607.00  S  20.00%    121.40

                              Subtotal                                                                          15.10-

                              OT    OCCUPATIONAL THERAPY
                                                            HYDROCOLLATOR STEAM PACK     14.30  D              .30
                                                 9607100001 ADAPTIVE EQUIP/10 MIN      50.00  D            40.00
                                                 9607100001 THERAPEUTIC MASSAGE        13.30  D             1.70-
                              Subtotal                                                                    38.60

                              RT    RESPIRATORY THERAPY                             DISP I.S. UNIT
54.50    S    25.00%    13.63
                              Subtotal                                                                    13.63

   MDK-MDK CONTRACT MGT Total                                                                             45.49

 Date: 03/12/96                              General Hospital                           Page  : 2
   Time: 00:24A                           Automatic Writeoff Report                     Report: FDR300A


Code Contract Name              Total Charges    Total Writeoff   Net Charges


MDK  MDK CONTRACT MGT TEST          149.60           45.49           104.11

   Grand Totals                     149.60           45.49           104.11

                                         End of Report
```

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, the report name as used in the system, and the month and year of the report.

CODE
The field contains the contract code.

CONTRACT NAME
 This field contains the name of the contract.

SIM DEPARTMENT
This field contains the SIM department which has charges billed to the contract.

PATIENT ACCOUNT
This field identifies the patient account number which received the charge. If this field is blank, the charge applies to the contract and not a specific contract patient account number.

CHARGE DESCRIPTION
This field displays the description of the charge.

CHARGE AMOUNT
This field displays the gross charge amount as received from Patient Care.

TYPE
This identifies how the contractual adjustment was calculated. The values are O for overall percentage as defined in the Contract Financial Information table. The value of S represents a SIM department exception as identified in the Contract Financial Information table. A value of D represents a charge level exception as defined in the Contract Financial Information table.

WRITE OFF PERCENT
This field identifies the write off percentage as defined for either the O for Overall percentage or S for SIM department level exception. This field is blank if the calculation method is C for Charge level exception.

WRITE OFF AMOUNT
This field is calculated by taking the Charge Amount field multiplied by the percentage in the Write Off Percent field if the Type field contains a O for Overall or S for SIM department level exception. If the calculation method is C for Charge, the system calculated the write off amount as the Charge Amount field less the Charge exception dollar amount.

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▪ 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 *Reports 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.

_____

_____

_____

_____

_____

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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