McKESSON
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STAR 2000™

STAR PATIENT CARE REFERENCE GUIDE
DRG Assignment Module

Release 17.0
October 2011

C17000041

Publication date

October 2011

Produced in Cork, Ireland

Product and version

STAR 2000 Release 17.0

Publication number

C17000041

Reader comments

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

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Preface

This volume of the *STAR Patient Care Reference Guide* provides a detailed explanation of the DRG Assignment Module, including information on DRG Simulation, DRG Assignment, DRG Attestation, DRG Maintenance functions, and DRG reports.

Documentation Conventions

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

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

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

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

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

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

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

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

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

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

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

Enter patient name--

Field Characteristics

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

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

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

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

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

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Introduction

In 1983, Medicare implemented a prospective payment system (PPS) based on diagnostic-related groups (DRGs), whereby the healthcare provider could anticipate the amount that would be reimbursed on a cost-per-case basis. The goal of PPS is to eliminate reimbursement abuses and to slow the rapid growth of healthcare costs burdening the Medicare program.

DRGs are a classification system that categorizes inpatients who are medically related in terms of diagnoses and treatments and who are statistically similar in their length-of-stay (LOS). Upon discharge, information on a patient is reviewed and a DRG is assigned. The appropriate payment (reimbursement) for that case is then calculated from the DRG assignment.

Reimbursement based on DRG assignment is fixed per DRG in that, should cost exceed reimbursement, the hospital incurs that cost. Conversely, should costs be less than reimbursement, a portion of the surplus may be kept by the hospital.

Although final assignment of a DRG may not be submitted for reimbursement until the patient has been discharged (discharge status is required), it is common practice that admitting and provisional DRGs are assigned throughout the patient's hospital stay for the purpose of concurrent monitoring.

Concurrent monitoring enables the hospital to evaluate the costs associated with a patient's particular DRG and the patient's performance as it relates to length of stay. This process allows problem cases to be identified and addressed to ensure quality care and favorable reimbursement for that case.

Through the DRG Assignment/Concurrent Monitoring functions and TRENDSTAR®, McKesson provides healthcare facilities with the mechanism for accurately tracking and monitoring a patient's costs and length-of-stay while in the hospital. The hospital staff assigned to monitor DRGs can utilize the on-line data entry and reporting capabilities as a means to maintain up to the day awareness of potentially costly cases.

To assist the hospital in processing the abstract, McKesson developed an interface between the STAR Patient Care DRG Assignment Module and the 3M® Coding and Reimbursement System, an encoding system.

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

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

Information on using the interface can be found in the *STAR Patient Care, STAR/3M Coding and Reimbursement Interface Guide.* The interface can be accessed from both the Diagnosis and Procedure screens in the DRG Assignment module.

This reference guide contains the following chapters:

Chapter 1: DRG Simulation

This chapter describes how to simulate calculation of a DRG without selecting a patient from the MPI.

Chapter 2: DRG Assignment

This chapter describes the DRG Assignment function, which allows you to enter a patient's diagnosis and procedure information and calculate working and final DRGs for billing.

Chapter 3: Attestation and Abstract Summary Forms

This chapter describes how to print attestation and abstract summary forms from the Medical Record main menu.

Chapter 4: DRG Maintenance Functions

This chapter contains information on DRG maintenance. Topics include ICD-9-CM maintenance, HCPCS Table maintenance, DRG Rate Table generation, the DRG Rate Master, M/R Abstract and DRG census criteria, budget maintenance, electronic signature maintenance, and the encoder interface.

Chapter 5: DRG Reports

This chapter contains information on and examples of various DRG and concurrent monitoring reports.

Appendix A: Tables

This chapter contains a list of tables used by the DRG Assignment module.

Chapter 1 - DRG SIMULATION

DRG SIMULATION

The DRG Simulation function provides the ability to calculate a DRG without having to select a patient from the MPI. This function requires you to enter the skeleton information necessary for the grouper to calculate a DRG. This function is useful in answering inquiries regarding information on a DRG. Since the data is not linked to a patient in the MPI, the information is not retained once you exit the function.

When you select the DRG Simulation function, you are prompted to select a facility and then the following screen is displayed:

```
                General Hospital DRG Simulation Processor
                                              Mon Aug 06, 2007 12:42 pm

 1 Financial class          2 DRG Payor             3 Age
   M MEDICARE                 M MEDICARE              65Y
 4 Sex                      5 Current LOS           6 Dischg Disposition
   FEMALE                     6




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

Field Explanations

1. FINANCIAL CLASS (2-AN-R)
Enter the financial class for the DRG payor on whom you wish to calculate. If you do not know the code, press hyphen (-) followed by ENTER to display the financial class code table for selection.

2. DRG PAYOR (DISPLAY ONLY)
The DRG Payor that is associated with the financial class entered in Field 1 displays in this field. If the financial class selected is not associated with aDRG Payor, this field is blank.

3. AGE (3-N-R)
Enter the age of the patient using a number between 0 and 124.

4. SEX (1-A-R)
Enter the sex of the patient using **M** for Male or **F** for Female.

5. CURRENT LOS (10-N-O)
Enter the LOS for use in the calculation of the DRG.

6. DISCHG DISPOSITION (1-N-O)
Enter the discharge disposition for use in calculating a DRG. Enter the table code if you know it, or press hyphen (-) followed by ENTER to display the code table for selection. If a discharge disposition is not entered, the system assumes a disposition of HOME - SELF CARE.

After you accept this screen, the Diagnosis Processor screen displays.

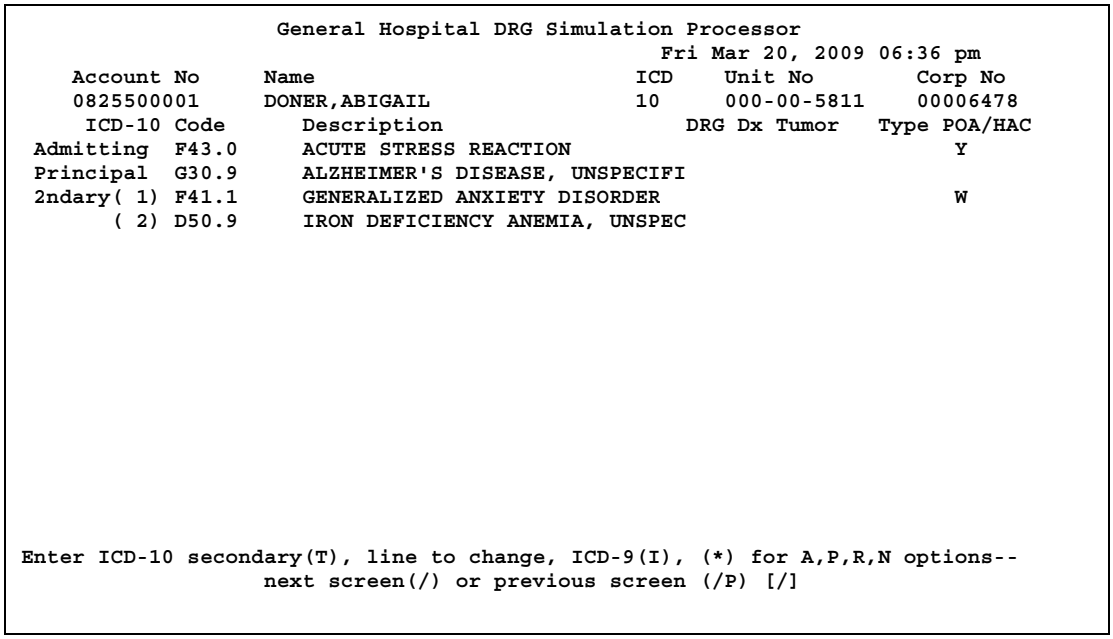
Diagnoses Screen

The system accepts entry of an Admitting, Reason, Nosocomial, Principal, and up to 14 ICD Secondary diagnosis codes.

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

Following are examples of the ICD-10 and ICD-9 Diagnoses Processor screens. The ICD-10 Diagnoses Processor is the primary screen. The ICD-9 Diagnoses Processor is the secondary screen, and is accessed through the ICD-10 Diagnoses Processor.

ICD-10 Diagnoses Processor



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




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

ICD-9 Diagnoses Processor

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









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

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

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

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

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

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

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

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

Field Explanations

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

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

Select one of the following entry options:

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

The following conditions may impact your Admitting diagnosis code entry:

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

  You have entered a code that requires an E-code

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

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

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

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

WARNING: ICD code is inactive

Then the following prompt is displayed:

Do you accept the XXX diagnosis? (Y/N)

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

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

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

  where [sex] is male or female.

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

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

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

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

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

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

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

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

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

Select one of the following entry options:

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

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

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

Select one of the following entry options:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Delete? (N) --

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

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

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

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

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

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

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

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

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

Delete? (N)--

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

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

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

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

Procedures Screen

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

ICD-10 Procedure Summary

```
                  General Hospital DRG Simulation Processor
                                                Tue Mar 24, 2009 01:48 pm
    Account No     Name                        ICD    Unit No        Corp No
    0904200002     TONEY,TEN                   10     000-00-5885    00006552
ICD-10-PCS Code  Description                   Date/Time        Surgeon      AC
P  (1) HZ80ZZZ MEDICATION MANAGEMENT OF NICOTIN 02/11/09 07:00   ADAIR,CAR
   (2) 00160K0 0 Medical and Surgical|0 Central 02/11/09 07:00   TONGEN,LYLE
Select procedure to revise, View Charges(C), ICD-9(I), or add(A)--
                     next screen (/) or previous (/P) [/]
```

Field Explanations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Impact

After you accept this screen, the following takes place:

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

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

ICD-9 Procedure Summary

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




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

Field Explanations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Impact

After you accept this screen, the following takes place:

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

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

Procedure Detail Screen

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

ICD-10 Procedure Detail

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

 9 Anesth Start Time         10 Anesth End Time           11 Anesth Duration

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

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

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



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

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

Delete? [N]--

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

Field Explanations

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

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

You have the following entry options:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ICD-9 Procedure Detail

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

12 ASA-PS Class             13 Other Institution

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

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

20 Procedure Team Information


Enter procedure suffix--  |
```

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

Delete? [N]--

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

Field Explanations

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

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

You have the following entry options:

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

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

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

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

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

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

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

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

2. PROCEDURE CODE (34-AN-R)

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

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

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

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

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

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

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

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

- Enter the physician code.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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









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

Subscreen Field Explanations

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

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

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

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

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

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

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

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

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

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

This prompt gives you these entry options:

- Enter **Y** or press ENTER for Yes to accept the screen. If you enter **Y**, the system stores your additions or changes and redisplays the Procedures Summary screen, where you can select another procedure to revise or delete, or add another procedure.
- Enter **N** for No to return to the Procedure Detail screen for additional revisions.
- Press **D** for Delete to delete the procedure. If you enter **D**, the system removes the procedure from the system and redisplays the Procedures Summary screen, where you can select another procedure to revise or delete, or add another procedure.

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

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

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

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

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

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

DRG Assignment Results Screen

The DRG Assignment Results screen displays output from the Medicare Grouper for inpatients. None of the fields on this screen can be edited. The admitting diagnosis, entered during the admission sequence or on the Diagnosis screen, is displayed on this screen. When the Principal diagnosis is entered, a Provisional DRG is calculated and displayed in the DRG 'Provisional' (highlighted) and Provisional DRG fields. At the time of discharge, the Provisional DRG changes to Final DRG, indicating this DRG can now be accepted for billing purposes.

If any changes are made to the diagnoses, procedures, age, sex, or disposition of the patient during the abstracting sequence, the DRG is recalculated and any changes are reflected on this screen and throughout the system.

The following is an example of a DRG Assignment Results screen:

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

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



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

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

Field Explanations

1. DRG PAYOR (DISPLAY ONLY)
This field displays the party responsible for paying the DRG; for example, Medicare. This is determined by the patient's Financial Class (see the *STAR Patient Care Reference Guide, Tables Volume*).

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

3. AGE (DISPLAY ONLY)
This field displays the patient's age at the time of admission as entered during the admission sequence or reflects changes made to the birthdate while editing the MPI or abstract.

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

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

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

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

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

9. LOS (DISPLAY ONLY)
This field contains the patient's actual length of stay in the facility.

10. STD LOS (DISPLAY ONLY)
This field contains the standard length of stay associated with this particular DRG.

11. LOS THRESHOLD (DISPLAY ONLY)
The number in this field indicates the number of days at which the DRG becomes a Day Outlier. For example, for the DRG shown on the screen above, when an LOS of 35 days is reached, the DRG becomes a Stay Outlier indicating the hospital may receive additional reimbursement on this case.

NOTE: Beginning with Grouper Version 15.0, effective October 1, 1997, CMS eliminated high stay outlier reimbursement; therefore, this field displays a value of zero.

12. DRG WEIGHT (DISPLAY ONLY)
This is the weight of the DRG as assigned by CMS. This weight is a value that is used as a multiplier in calculating a hospital's reimbursement for a particular DRG.

13. REIMB. (DISPLAY ONLY)
This is the dollar amount of the calculated payment for this DRG for your facility.

14. COST THRESHOLD (DISPLAY ONLY)
The number that is displayed in this field indicates the dollar amount that the system uses in determining whether this case should be considered as a possible cost outlier.

If a patient's standardized costs are greater than the cost outlier threshold, the patient is passed through the calculations to determine if this is in fact a cost outlier.

15. CHARGES (DISPLAY ONLY)
This field contains the current total amount of all charges ordered for this patient, including any Room and Bed Charges ordered, pharmacy, and late charges. This information is updated online as charge information changes.

16. VARIANCE (DISPLAY ONLY)
The number that displays in this field is the dollar difference between the accumulated total charges and the expected reimbursement. For example, Reimbursement minus Charges equals Variance.

17. PRINCIPAL DIAGNOSIS (DISPLAY ONLY)
The Principal diagnosis that displays in this field is the current principal diagnosis entered on either the Diagnosis screen in the abstracting sequence or the DRG Assignment function.

18. COMPLICATION/COMORBIDITY (DISPLAY ONLY)
A complication is any condition that arises while the patient is in the hospital. A comorbidity is any condition that existed prior to the patient's admission to the hospital. If there is a complication/comorbidity (C/C) affecting this DRG, it displays in this field.

19. GROUPER DIAGNOSIS 1 (DISPLAY ONLY)
This diagnosis is only seen when a coronary DRG is involved with three conditions rather than just the primary and secondary.

20. GROUPER DIAGNOSIS 2 (DISPLAY ONLY)
This diagnosis is only seen when a coronary DRG is involved with three conditions rather than just the primary and secondary.

21. GROUPER MAJOR PROCEDURE (DISPLAY ONLY)
The procedure that displays in this field is the procedure the grouper has determined to be the most resource intensive, and is being used in the calculation of the DRG.

22. OUTLIER INDICATION (DISPLAY ONLY)
If the DRG surpasses the LOS Threshold, High Stay displays in this field. If the DRG surpasses Cost Threshold, Cost displays in this field. If both the LOS and the Charge Thresholds are surpassed, the one that pays the highest reimbursement is what displays in this field.

NOTE: Beginning with Grouper Version 15.0, effective October 1, 1997, CMS eliminated high stay outlier reimbursement.

23. ADMIT DRG (DISPLAY ONLY)
This field contains the DRG calculated based on the admitting diagnosis. If the admit diagnosis is updated, the Admit DRG is updated accordingly.

24. PROVISIONAL DRG (DISPLAY ONLY)
This field displays the same DRG displayed in the DRG 'Provisional' field until a change is made to the diagnosis or procedure, which in turn changes the DRG. If the DRG is changed, the previous DRG moves to this field and remains a Provisional DRG, while the new DRG is displayed in the DRG 'Provisional' field as Provisional until the patient is discharged and the DRG is accepted as Final.

You are prompted to choose one of the following actions:

- press **A** if you want the Alternate DRGs screen to display
- press **S** if you want the DRG Standards screen to display
- press **R** if you want to view additional reimbursement information
- press **H** if you want to view Hospital Acquired Condition (HAC) details.

NOTE: It is not necessary to press ENTER after the A or the S.

DRG ALTERNATES

If you enter **A**, the DRG Alternates screen displays as follows:

```
                General Hospital DRG Simulation Processor
                                                Wed Jul 10, 1996 05:40 pm
 Account No   Name                             Age  Sex    Dischg Dispositn
 89046-00001  DOE,JOHN R                       38Y  MALE
 DRG Payor: MEDICARE                LOS: 21
              Diagnosis                    DRG  Weight  StdLOS  Reimbursement
  (1) 540.0 *AC APPEND W PERITONITIS       164  2.4065  11.20      7586.05
  (2) 401.0 *MALIGNANT HYPERTENSION        468  3.3045  12.50     10416.82
  (3) 574.11 *CHOLELIT/GB INF NEC-OBS      201  2.4875   9.00      7841.38









Select new Principal Diagnosis--
```

This screen displays the DRG, Weight, Standard Length of Stay (LOS), and the Reimbursement amount of all diagnoses entered as if they were the Principal diagnosis. You are prompted to select a new principal diagnosis. If you choose to enter a new principal diagnosis, the system automatically changes the display on the Diagnosis screen and recalculates the patient's DRG. This screen enables you to optimize the DRG reimbursement, when appropriate.

Press ENTER after viewing this screen to return to the DRG Assignment screen.

Impact

After you accept this screen, the following takes place:

- Selection of a new principal diagnosis could affect the DRG assignment.
- Selection of a new principal diagnosis displays on the diagnosis processor screen.

DRG STANDARDS

If you enter **S**, the DRG Standards screen displays as follows:

```
                General Hospital DRG Simulation Processor
              DRG Results          Page  4 of  4 Thu Apr 09, 2009 06:31 pm
   Account No     Name                          ICD    Unit No        Corp No
   0824600003     DONER,ABIGAIL                 9      000-00-5811    00006478
                             Hospital Comparisons

 1 Budget LOS      2 Total LOS       3 LOS Variance
     10.0              9.0               1.0
 4 Budget Charges  5 Total Charges   6 Charge Variance
     2947.74           4120.65             -1172.91
 7 Budget Cost     8 Total Cost      9 Cost Variance
     2358.19           3296.52             -1172.91

                               Payor Comparisons

10 LOS Threshold           11 Total LOS           12 LOS Variance
    26.00                       9.0                   17.00
13 Charge Threshold        14 Total Charges       15 Charge Variance
     19646.50                   4120.65               15525.85
16 DRG Cost Threshold      17 Total Cost          18 Cost Variance
     12129.75                   3296.52               8833.23

Press NL--
```

NOTE: If this patient's payor uses the 3M Coding System's RCS, you do not have the option to view DRG Standards.

This screen displays the Hospital and DRG Payor comparisons for the patient's DRG.

The payor comparisons are derived by comparing the patient's charges and LOS information against the reimbursement and LOS information held in the rate master for the patient's payor (see Rate Master Maintenance in the DRG Maintenance Functions chapter of this manual).

The Hospital Comparisons provide you with a mechanism to compare the patient's charge, cost, and length of stay information with hospital-specific standards. This budgeted information can be based on figures entered manually by the hospital or by averages accumulated by the system and averaged over a hospital-defined length of

time. The patient's actual data is compared with these figures, and the variances are calculated (see Budget Maintenance in the DRG Maintenance Functions chapter of this manual).

Field Explanations

All fields on this screen are display only. Fields 2, 5, and 8 represent the length of stay, total charges, and total costs associated with this episode of care. The length of stay increments by one day each night during processing and represents the current length of stay up until discharge. The Patient Charges and Cost fields are updated on-line and reflect all charge activity for the patient. The total charges in Field 5 are identical to the charge summary for the patient when accessed via the Patient Care Charge Inquiry function. Total costs are derived using the Charge/Cost Ratios determined for each department.

Fields 11, 14, and 17 are identical to Fields 2, 5, and 8, and are repeated for your convenience.

Fields 1, 4, and 7 are the budget or standard length of stay, charges, and cost information determined by the hospital for this particular DRG.

Fields 10, 13, and 16 are the length of stay, charge and cost thresholds set by Medicare for stay or cost outlier determinations for this particular DRG.

The six variance fields (3, 6, 9, 12, 15, and 18) are the mathematical differences between the respective two preceding fields. A negative number indicates that the patient has exceeded the standard or threshold for this DRG.

Pressing ENTER after viewing this screen returns you to the DRG Assignment screen.

REIMBURSEMENT INFORMATION

If you press **R** to enter reimbursement information, the following screen displays:

```
                 General Hospital DRG Simulation Processor
              DRG Results          Page  4 of  4 Thu Apr 09, 2009 06:31 pm
    Account No     Name                          ICD    Unit No        Corp No
    0824600003     DONER,ABIGAIL                 9      000-00-5811    00006478
                       DETAIL REIMBURSEMENT INFORMATION
( 1)Operating DRG Reimb      :  $2062.72
( 2)Capital DRG Reimb        :  $203.38
( 3)Operating Outlier Reimb. :  $14918.15
( 4)Capital Outlier Reimb.   :  $1538.59
( 5)Add-On Technology Reimb. :

( 6)Total                    :  $18722.84









Press NL--
```

NOTE: If the patient's payor uses 3M's Coding and Reimbursement System, you do not have the option to view Reimbursement Information.

This screen is for informational purposes only. The Reimbursement field on the DRG Results screen displays the total reimbursement for this patient (including outlier payments). For detailed information on what comprises this total, you can view this Detail Reimbursement Information screen. To determine if the outlier reimbursement is for Cost or Stay, refer to the Outlier Indication field on the DRG Results screen.

HOSPITAL ACQUIRED CONDITION (HAC) INFORMATION

If you press **H** to view Hospital Acquired Condition (HAC) details, the following screen is displayed:

```
                General Hospital DRG Simulation Processor
              DRG Results          Page  4 of  4 Thu Apr 09, 2009 06:31 pm
    Account No     Name                          ICD    Unit No        Corp No
    0824600003     DONER,ABIGAIL                 9      000-00-5811    00006478
                          DETAIL OF HAC PROCESSING
( 1)HAC Required : Yes
( 2)HAC Status   : No HACs
( 3)Initial DRG  : 221 CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CAT
( 4)Initial Reimb: 20076.35









Press NL--
```

This screen displays the HAC details, including:

- HAC Processing Required indicator
  - If indicator is **Yes**, DRG was calculated *with* HAC processing.
  - If indicator is **No**, the DRG was grouped by a third party grouper *without* HAC processing.
- Status of HAC Processing (demotions, DRG change)
- Initial DRG (DRG prior to HAC Processing), and
- Initial Reimb (reimbursement prior to HAC Processing).

  All the fields on this screen are display only.

Press ENTER after viewing this screen to return to the DRG Assignment screen.

Chapter 2 - DRG ASSIGNMENT

DRG ASSIGNMENT

The principal use of the DRG Assignment function is to enter current diagnosis and procedure information on a patient in order to calculate both a working and final DRG for billing. To initiate the process, a patient must be selected from the MPI using the MPI Search function of the STAR Patient Care system.

Once the appropriate patient account is selected, the DRG Calculation screen is displayed:

```
              General Hospital DRG Assignment Processor
               DRG Calculation      Page  1 of  4 Mon Aug 06, 2007 12:55 pm
    Account No     Name                                Unit No        Corp No
    0715900009     SMITH,CAROLEE                       000-00-4461    00004972
 1 Financial class        2 DRG Payor              3 Attending Physician
   S SELF PAY               S SELF PAY               100 DOCTOR,ADMITTING ONEX
 4 Service                5 Admission Date         6 Birthdate  Admit Age
   MED MEDICALXX            06/08/07                 07/18/60      46Y
 7 Sex       8 Discharge Date     9 Current LOS   10 Dsch Disposition
   FEMALE      07/07/07             29              *HOME(OUTPATIENT)
11 Date Attestation Signed









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

Field Explanations

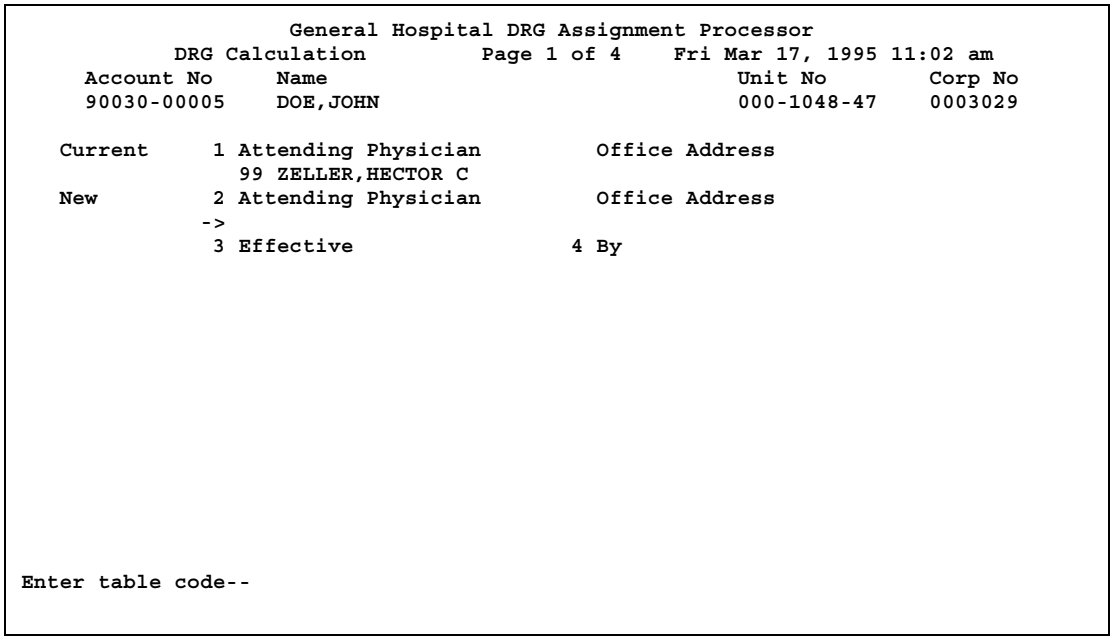
1. FINANCIAL CLASS (2-AN-R)
The financial class of the selected patient displays in this field. You can update the financial class by entering the code if you know it, or press hyphen (-) followed by ENTER to display the financial class table for selection. Updating the Financial Class here does not update the Insurance information or MPI. It is suggested that if the wrong financial class displays, the business office or appropriate area be contacted.

2. DRG PAYOR (DISPLAY ONLY)
The DRG Payor that is associated with the financial class entered in field 1 displays in this field. If the financial class selected is not associated with a DRG Payor, this field is blank.

3. ATTENDING PHYSICIAN (TABLE LOOKUP)
This field can initiate two different response sequences by the system depending on whether or not the patient was assigned to a bed during the selected visit. If the patient was not in a bed, this field displays the name and address of the attending physician entered during the admission sequence. When you access this field in the STAR

Financials environment, the system displays a subscreen on which you can enter the name and address of the new attending physician:

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



Subscreen Field Explanations

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

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

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

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

If the selected patient was assigned to a bed during the selected visit, the Attending Physician field displays the name of the physician responsible for the patient's care during this visit. When you access this field to update the information already in it, the system automatically displays the Physician Tracker subscreen. This subscreen enables you to track all changes made to the attending physician for this patient. The following screen is a sample of the Physician Tracker subscreen.

```
            General Hospital Episode Information-1 Processor
              Physician             Page 3 of 16 Tue Apr 25, 2000 10:23 am
  No.         Name             Sex    BD    Room    Physician     SVC   Status
00116-00001   TEST,AARON        M  10/10/31 2103-02 CARVER,JOHN   MED   1E  1
EPISODE ATTENDING PHYSICIAN  (CODE) (SPEC)      START DATE              LOS
                                                MM/DD/YY
   1    CARVER,JOHN (13) (CAR)                  04/25/00                  0









Enter Start Date in the format MM/DD/YY or use a 'T' for today.
    F1Prev Page F2Next Page F3 Insert  F4 Delete  F6 Reset  F7  Exit   ?
```

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

This screen uses the scrolling screen processor. Use the function keys at the bottom of the screen to page through multiple screens (if there are any), insert a new entry between existing ones, delete an entry, reset a line entry, or exit from the Physician Tracker.

Subscreen Field Explanations

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

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

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

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

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

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

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

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

You must enter both a date and time.

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

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

You must enter a date only.

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

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

Once you complete the subscreen you are returned to the DRG Assignment screen where the code and name of the new attending physician displays.

Field Explanations for DRG Calculation cont.

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

Information-1 screen, where the most recent entry in the Service Tracker is displayed in the Service field.

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

```
        General Hospital  Episode Information-1 Processor
                                              Mon Mar 18, 1996 11:02 am
     Account No     Name                            Unit No        Corp No
     9332600002     KING,ADAM                       000000220      00000301
 NO  SERVICE  (CODE)            START    LOS SUB PHYSICIAN      (SPC) DIAGNOSIS
  1  ADULT PSYCHIATRIC (PSY)   10/18/95   26
  2  MEDICINE, GENERAL (MED)   11/13/95    4
  3  ADULT PSYCHIATRIC (PSY)   11/17/95    3  1  LEES,JACK R         304.62 0 2
  4  NEUROLOGY (NEU)           11/20/95    0  2  THOMPSON,DOCTOR     800.12   2









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

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

This screen uses the scrolling screen processor. Use the function keys at the bottom of the screen to page through multiple screens (if there are any), insert a new entry between existing ones, delete an entry, reset a line entry, or exit from the Service Tracker. You can delete all but one service episode entry, since you must have at least one service associated with the patient's visit. The most recent entry in the tracker becomes the new and current service that displays in the Service field on the Episode Information-1 screen.

Subscreen Field Explanations

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

SERVICE (TABLE LOOKUP)
This column enables you to enter the new service, or correct the current service of the patient. You can overwrite the service using the same line number on which the service is listed. To indicate that the patient was transferred to a new service, press ENTER or the down arrow key to access the next sequential episode number. Select the new service by entering the code, if you know it, or enter a hyphen (-) to display the Hospital Services code table for selection.

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

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

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

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

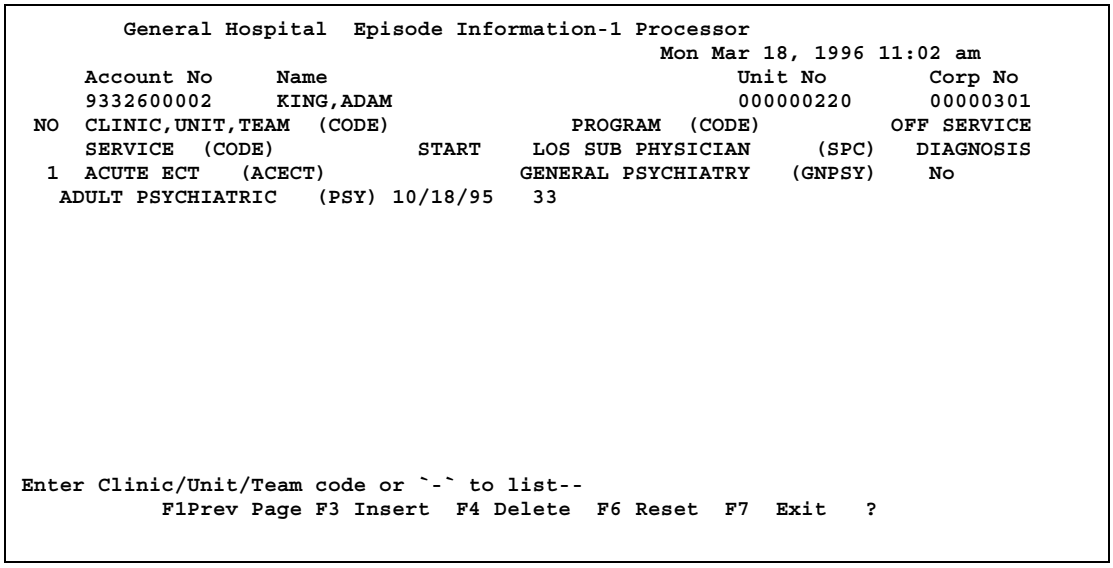
PHYSICIAN (TABLE LOOKUP)
This column enables you to associate a physician with the change of service. You only need to enter physicians in the Service Tracker if they are different from the Most Responsible Physician. Once you enter a physician, you are prompted to complete the next column, (SPC).

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

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

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

When you access the Service field on the Episode Information screen and your system is live on Program Management, a more detailed Service Tracker subscreen is displayed. After you accept the Service Tracker screen, you are returned to the Episode Information-1 screen, where the updated service (if applicable) displays. The following screen is a sample of the Service Tracker subscreen:



Subscreen Field Explanations

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

CLINIC,UNIT,TEAM (TABLE LOOKUP)
Enter the Clinic,Unit,Team (CUT) code, or press hyphen (-) to display the CUT code table for selection. To override the existing CUT code, enter a new CUT code at the

appropriate column number. To add a new service episode, press ENTER or the down arrow key to access the next sequential episode number.

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

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

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

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

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

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

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

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

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

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

Field Explanations for DRG Calculation cont.

5. ADMISSION DATE (DISPLAY ONLY)
The date of admission for this patient displays in this field. This field cannot be edited via the DRG Assignment function.

6. BIRTHDATE & AGE (10-N-R)
The patient's date of birth and age at the time of admission display in this field. You can edit the patient's birthdate, and the age is updated accordingly.

7. SEX (1-A-R)
The sex of the patient displays in this field. You can edit this field by entering **M** for Male or **F** for Female.

8. DISCHARGE DATE (DISPLAY ONLY)
The date of discharge for this patient displays in this field. If the patient has not been discharged, this field is blank. This field cannot be edited via the DRG Assignment function.

9. CURRENT LOS (DISPLAY ONLY)
The patient's LOS displays in this field. This field cannot be edited.

10. DSCH DISPOSITION (1-N-O)
The discharge disposition of the patient displays. Once you enter the field to edit it, the discharge disposition code table displays for selection. If the patient has not been discharged, the system assumes a disposition of Home - Self Care in the calculation of the DRG. You cannot enter a disposition on a patient who has not been discharged.

11. DATE ATTESTATION SIGNED (DISPLAY ONLY)
This field displays the date when the attestation form was electronically signed. After you accept this screen, the Diagnoses Processor screen displays.

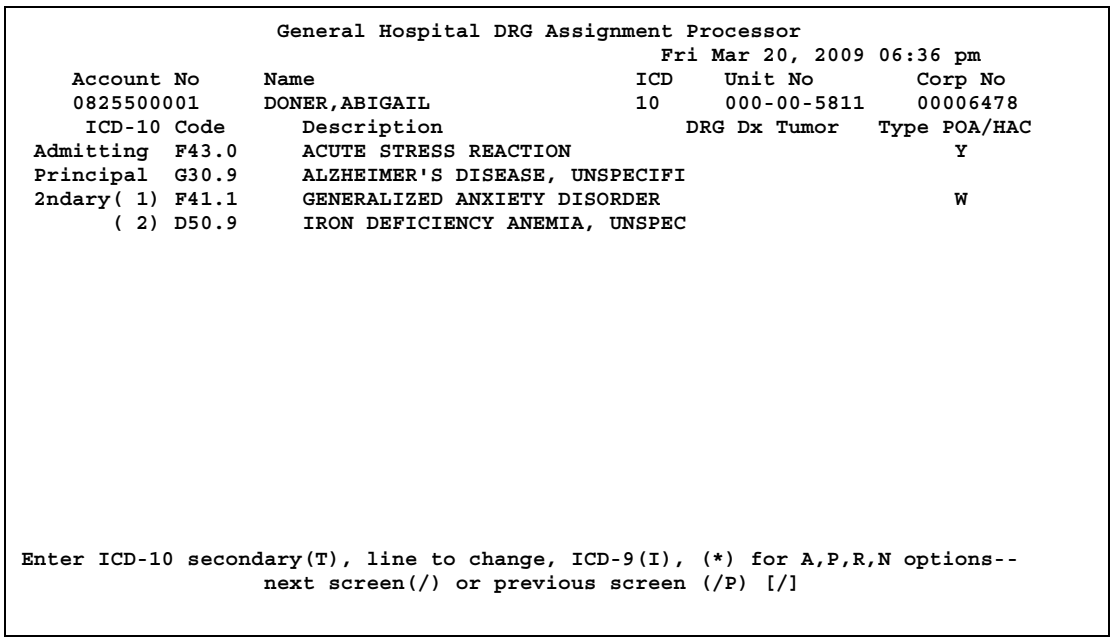
Diagnoses Screen

The system accepts entry of an Admitting, Reason, Nosocomial, Principal, and up to 14 ICD Secondary diagnosis codes.

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

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

ICD-10 Diagnoses Processor



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









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

ICD-9 Diagnoses Processor

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









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

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

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

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

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

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

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

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

Field Explanations

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

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

Select one of the following entry options:

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

The following conditions may impact your Admitting diagnosis code entry:

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

  You have entered a code that requires an E-code

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

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

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

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

WARNING: ICD code is inactive

Then the following prompt is displayed:

Do you accept the XXX diagnosis? (Y/N)

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

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

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

  where [sex] is male or female.

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

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

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

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

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

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

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

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

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

Select one of the following entry options:

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

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

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

Select one of the following entry options:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Delete? (N) --

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

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

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

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

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

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

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

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

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

Delete? (N)--

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

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

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

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

Impact

After you accept this screen, the following takes place:

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

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

Procedures Screen

The Procedures screen enables you to enter up to 15 ICD-9-CM procedure codes. (You can enter an unlimited number of codes in the GUI product.) The information entered in this screen is updated throughout the system.

NOTE: If ICD-9-CM procedure codes have been entered for the patient through Outpatient Dispositioning before any entries have been made in the Abstract, those codes from Outpatient Dispositioning will automatically display on the Procedures screen. However, future changes to the codes on the Outpatient Dispositioning screen will not update the abstract, nor will changes to the codes in the abstract update Outpatient Dispositioning.

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

ICD-10 Procedure Summary

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

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

Field Explanations

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

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

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

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

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

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

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

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

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

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

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

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

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

Once the codes are processed through the grouper (on STAR), they are resequenced so that those procedure codes affecting the DRG are all placed at the top of the list

under the principal procedure, provided the Resequencing Parameter is defined in MR Abstract and DRG Census Criteria option.

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

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

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

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

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

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

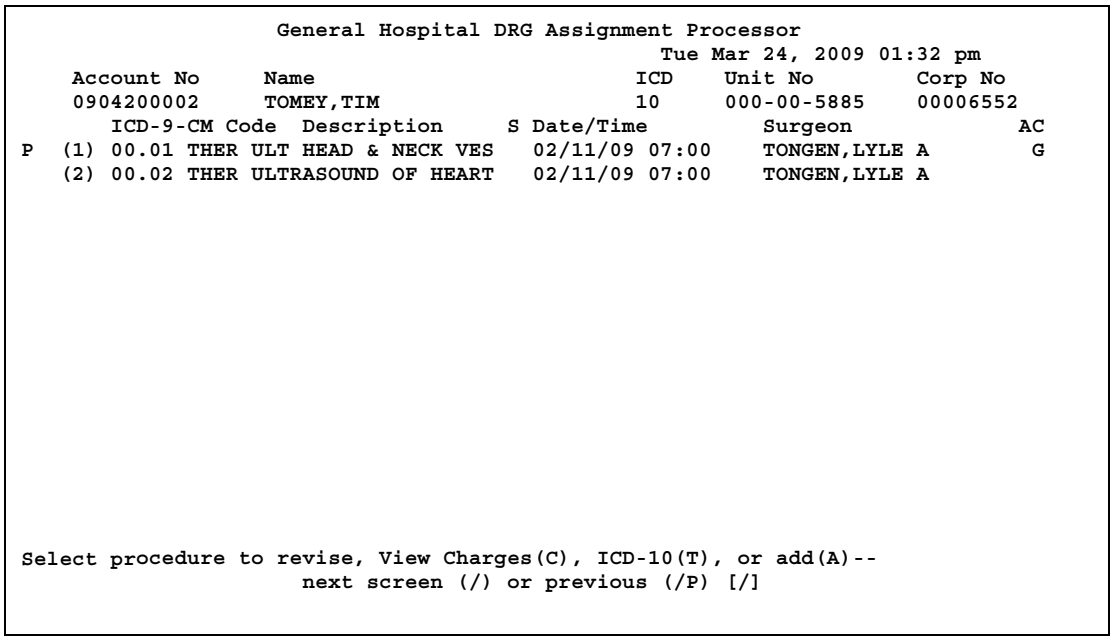
Impact

After you accept this screen, the following takes place:

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

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

ICD-9 Procedure Summary



Field Explanations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

from the Procedures screen or HCPCS Procedures screen.

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

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

Impact

After you accept this screen, the following takes place:

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

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

Procedure Detail Screen

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

ICD-10 Procedure Detail

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

 9 Anesth Start Time         10 Anesth End Time           11 Anesth Duration

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

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

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



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

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

Delete? [N]--

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

Field Explanations

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

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

You have the following entry options:

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

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

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

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

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

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

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

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

- Enter the ICD-10-PCS procedure code if you know it.
- Enter **U** followed by a hyphen (**-**) to display the entire procedure pointer table in alphabetic order. Make your selection from this table.
- Enter **U,** followed by an alpha character or characters, then a hyphen (for example, **UA-** or **UB-**) to display the pointer table that begins with the specific alpha character. For example, entering **UAN-** might cause the codes for anastomosis, anesthesia, or angioplasty to display if they have been built into the pointer table. Make your selection from this table.
- Enter a number (or numbers) and a hyphen to display the table by specific numeric range of codes. For example, if you know that the code you are searching for begins with 22, enter **22-** and all the codes beginning with 22.0 are displayed. Make your selection from this table.
- Enter a hyphen (**-**) to display the entire table in numeric code order, starting with 01.0. Make your selection from this table.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ICD-9 Procedure Detail

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

12 ASA-PS Class             13 Other Institution

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

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

20 Procedure Team Information


Enter procedure suffix--
```

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

Delete? [N]--

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

Field Explanations

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

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

You have the following entry options:

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

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

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

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

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

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

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

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

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

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

2. PROCEDURE CODE (34-AN-R)
If you are revising a procedure, this field displays the code selected from the Procedure Summary screen. To add to or revise this field, enter an ICD-9-CM procedure code using one of the following entry options:

- Enter the ICD-9-CM procedure code if you know it.

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

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

- Enter a number (or numbers) and a hyphen to display the table by specific numeric range of codes. For example, if you know that the code you are searching for

begins with 22, enter **22-** and all the codes beginning with 22.0 are displayed. Make your selection from this table.

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

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

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

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

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

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

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

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

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

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

- Enter the physician code.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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









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

Subscreen Field Explanations

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

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

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

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

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

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

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

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

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

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

This prompt gives you these entry options:

- Enter **Y** or press ENTER for Yes to accept the screen. If you enter **Y**, the system stores your additions or changes and redisplays the Procedures Summary screen, where you can select another procedure to revise or delete, or add another procedure.
- Enter **N** for No to return to the Procedure Detail screen for additional revisions.

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

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

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

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

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

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

- Enter **Y** or press ENTER for Yes to accept the screen and process the additions or changes you entered on the Procedure Detail screen. The DRG Assignment Results screen is displayed.

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

DRG Assignment Results Screen

The DRG Assignment Results screen displays output from the Medicare Grouper for inpatients. None of the fields on this screen can be edited. The admitting diagnosis, entered during the admission sequence or on the Diagnosis screen, is displayed on this screen. When the Principal diagnosis is entered, a Provisional DRG is calculated and displayed in the DRG 'Provisional' (highlighted) and Provisional DRG fields. At the time of discharge, the Provisional DRG changes to Final DRG, indicating this DRG can now be accepted for billing purposes.

If any changes are made to the diagnoses, procedures, age, sex, or disposition of the patient during the abstracting sequence, the DRG is recalculated and any changes are reflected on this screen and throughout the system.

The following is an example of a DRG Assignment Results screen:

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

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



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

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

Field Explanations

1. DRG PAYOR (DISPLAY ONLY)
This field displays the party responsible for paying the DRG; for example, Medicare. This is determined by the patient's Financial Class (see the *STAR Patient Care Reference Guide, Tables Volume*).

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

3. AGE (DISPLAY ONLY)
This field displays the patient's age at the time of admission as entered during the admission sequence or reflects changes made to the birthdate while editing the MPI or abstract.

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

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

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

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

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

9. LOS (DISPLAY ONLY)
This field contains the patient's actual length of stay in the facility.

10. STD LOS (DISPLAY ONLY)
This field contains the standard length of stay associated with this particular DRG.

11. LOS THRESHOLD (DISPLAY ONLY)
The number in this field indicates the number of days at which the DRG becomes a Day Outlier. For example, for the DRG shown on the screen above, when an LOS of 35 days is reached, the DRG becomes a Stay Outlier indicating the hospital may receive additional reimbursement on this case.

NOTE: Beginning with Grouper Version 15.0, effective October 1, 1997, CMS eliminated high stay outlier reimbursement; therefore, this field displays a value of zero.

12. DRG WEIGHT (DISPLAY ONLY)
This is the weight of the DRG as assigned by CMS. This weight is a value that is used as a multiplier in calculating a hospital's reimbursement for a particular DRG.

13. REIMB. (DISPLAY ONLY)
This is the dollar amount of the calculated payment for this DRG for your facility.

14. COST THRESHOLD (DISPLAY ONLY)
The number that is displayed in this field indicates the dollar amount that the system uses in determining whether this case should be considered as a possible cost outlier. If a patient's standardized costs are greater than the cost outlier threshold, the patient is passed through the calculations to determine if this is in fact a cost outlier.

15. CHARGES (DISPLAY ONLY)
This field contains the current total amount of all charges ordered for this patient, including any Room and Bed Charges ordered, pharmacy, and late charges. This information is updated online as charge information changes.

16. VARIANCE (DISPLAY ONLY)
The number that displays in this field is the dollar difference between the accumulated total charges and the expected reimbursement. For example, Reimbursement minus Charges equals Variance.

17. PRINCIPAL DIAGNOSIS (DISPLAY ONLY)
The Principal diagnosis that displays in this field is the current principal diagnosis entered on either the Diagnosis screen in the abstracting sequence or the DRG Assignment function.

18. COMPLICATION/COMORBIDITY (DISPLAY ONLY)
A complication is any condition that arises while the patient is in the hospital. A comorbidity is any condition that existed prior to the patient's admission to the hospital. If there is a complication/comorbidity (C/C) affecting this DRG, it displays in this field.

19. GROUPER DIAGNOSIS 1 (DISPLAY ONLY)
This diagnosis is only seen when a coronary DRG is involved with three conditions rather than just the primary and secondary.

20. GROUPER DIAGNOSIS 2 (DISPLAY ONLY)
This diagnosis is only seen when a coronary DRG is involved with three conditions rather than just the primary and secondary.

21. GROUPER MAJOR PROCEDURE (DISPLAY ONLY)
The procedure that displays in this field is the procedure the grouper has determined to be the most resource intensive, and is being used in the calculation of the DRG.

22. OUTLIER INDICATION (DISPLAY ONLY)
If the DRG surpasses the LOS Threshold, High Stay displays in this field. If the DRG surpasses Cost Threshold, Cost displays in this field. If both the LOS and the Charge Thresholds are surpassed, the one that pays the highest reimbursement is what displays in this field.

NOTE: Beginning with Grouper Version 15.0, effective October 1, 1997, CMS eliminated high stay outlier reimbursement.

23. ADMIT DRG (DISPLAY ONLY)
This field contains the DRG calculated based on the admitting diagnosis. If the admit diagnosis is updated, the Admit DRG is updated accordingly.

24. PROVISIONAL DRG (DISPLAY ONLY)
This field displays the same DRG displayed in the DRG 'Provisional' field until a change is made to the diagnosis or procedure, which in turn changes the DRG. If the DRG is changed, the previous DRG moves to this field and remains a Provisional

DRG, while the new DRG is displayed in the DRG 'Provisional' field as Provisional until the patient is discharged and the DRG is accepted as Final.

You are prompted to choose one of the following actions:

- press **A** if you want the Alternate DRGs screen to display
- press **S** if you want the DRG Standards screen to display
- press **R** if you want to view additional reimbursement information
- press **H** if you want to view Hospital Acquired Condition (HAC) details.

NOTE: It is not necessary to press ENTER after the A or the S.

DRG ALTERNATES

If you enter **A**, the DRG Alternates screen displays as follows:

```
                General Hospital DRG Assignment Processor
                                                Wed Jul 10, 1996 05:40 pm
 Account No   Name                              Age  Sex    Dischg Dispositn
 89046-00001  DOE,JOHN R                        38Y  MALE
 DRG Payor: MEDICARE                LOS: 21
              Diagnosis                     DRG  Weight  StdLOS  Reimbursement
  (1) 540.0 *AC APPEND W PERITONITIS        164  2.4065  11.20      7586.05
  (2) 401.0 *MALIGNANT HYPERTENSION         468  3.3045  12.50     10416.82
  (3) 574.11 *CHOLELIT/GB INF NEC-OBS       201  2.4875   9.00      7841.38









Select new Principal Diagnosis--
```

This screen displays the DRG, Weight, Standard Length of Stay (LOS), and the Reimbursement amount of all diagnoses entered as if they were the Principal diagnosis. You are prompted to select a new principal diagnosis. If you choose to enter a new principal diagnosis, the system automatically changes the display on the Diagnosis screen and recalculates the patient's DRG. This screen enables you to optimize the DRG reimbursement, when appropriate.

Press ENTER after viewing this screen to return to the DRG Assignment screen.

Impact

After you accept this screen, the following takes place:

- Selection of a new principal diagnosis could affect the DRG assignment.
- Selection of a new principal diagnosis displays on the diagnosis processor screen.

DRG STANDARDS

If you enter **S**, the DRG Standards screen displays as follows:

```
                General Hospital DRG Assignment Processor
              DRG Results          Page  4 of  4 Thu Apr 09, 2009 06:31 pm
   Account No     Name                          ICD    Unit No        Corp No
   0824600003     DONER,ABIGAIL                 9      000-00-5811    00006478
                             Hospital Comparisons

 1 Budget LOS      2 Total LOS       3 LOS Variance
     10.0              9.0               1.0
 4 Budget Charges  5 Total Charges   6 Charge Variance
     2947.74           4120.65           -1172.91
 7 Budget Cost     8 Total Cost      9 Cost Variance
     2358.19           3296.52           -1172.91

                              Payor Comparisons

10 LOS Threshold           11 Total LOS           12 LOS Variance
    26.00                       9.0                   17.00
13 Charge Threshold        14 Total Charges       15 Charge Variance
     19646.50                   4120.65               15525.85
16 DRG Cost Threshold      17 Total Cost          18 Cost Variance
     12129.75                   3296.52               8833.23

Press NL--
```

NOTE: If this patient's payor uses the 3M Coding System's RCS, you do not have the option to view DRG Standards.

This screen displays the Hospital and DRG Payor comparisons for the patient's DRG.

The payor comparisons are derived by comparing the patient's charges and LOS information against the reimbursement and LOS information held in the rate master for the patient's payor (see Rate Master Maintenance in the DRG Maintenance Functions chapter of this manual).

The Hospital Comparisons provide you with a mechanism to compare the patient's charge, cost, and length of stay information with hospital-specific standards. This budgeted information can be based on figures entered manually by the hospital or by averages accumulated by the system and averaged over a hospital-defined length of time. The patient's actual data is compared with these figures, and the variances are calculated (see Budget Maintenance in the DRG Maintenance Functions chapter of this manual).

Field Explanations

All fields on this screen are display only. Fields 2, 5, and 8 represent the length of stay, total charges, and total costs associated with this episode of care. The length of stay increments by one day each night during processing and represents the current length of stay up until discharge. The Patient Charges and Cost fields are updated on-line and reflect all charge activity for the patient. The total charges in Field 5 are identical to the charge summary for the patient when accessed via the Patient Care Charge Inquiry function. Total costs are derived using the Charge/Cost Ratios determined for each department.

Fields 11, 14, and 17 are identical to Fields 2, 5, and 8, and are repeated for your convenience.

Fields 1, 4, and 7 are the budget or standard length of stay, charges, and cost information determined by the hospital for this particular DRG.

Fields 10, 13, and 16 are the length of stay, charge and cost thresholds set by Medicare for stay or cost outlier determinations for this particular DRG.

The six variance fields (3, 6, 9, 12, 15, and 18) are the mathematical differences between the respective two preceding fields. A negative number indicates that the patient has exceeded the standard or threshold for this DRG.

Pressing ENTER after viewing this screen returns you to the DRG Assignment screen.

REIMBURSEMENT INFORMATION

If you press **R** to enter reimbursement information, the following screen displays:

```
                  General Hospital DRG Assignment Processor
               DRG Results          Page  4 of  4 Thu Apr 09, 2009 06:31 pm
    Account No     Name                          ICD    Unit No        Corp No
    0824600003     DONER,ABIGAIL                 9      000-00-5811    00006478
                       DETAIL REIMBURSEMENT INFORMATION
( 1)Operating DRG Reimb      :  $2062.72
( 2)Capital DRG Reimb        :  $203.38
( 3)Operating Outlier Reimb. :  $14918.15
( 4)Capital Outlier Reimb.   :  $1538.59
( 5)Add-On Technology Reimb. :

( 6)Total                    :  $18722.84









Press NL--
```

NOTE: If the patient's payor uses 3M's Coding and Reimbursement System, you do not have the option to view Reimbursement Information.

This screen is for informational purposes only. The Reimbursement field on the DRG Results screen displays the total reimbursement for this patient (including outlier payments). For detailed information on what comprises this total, you can view this Detail Reimbursement Information screen. To determine if the outlier reimbursement is for Cost or Stay, refer to the Outlier Indication field on the DRG Results screen.

HOSPITAL ACQUIRED CONDITION (HAC) INFORMATION

If you press **H** to view Hospital Acquired Condition (HAC) details, the following screen is displayed:

```
                General Hospital DRG Assignment Processor
              DRG Results          Page  4 of  4 Thu Apr 09, 2009 06:31 pm
    Account No     Name                          ICD    Unit No        Corp No
    0824600003     DONER,ABIGAIL                 9      000-00-5811    00006478
                          DETAIL OF HAC PROCESSING
( 1)HAC Required : Yes
( 2)HAC Status   : No HACs
( 3)Initial DRG  : 221 CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CAT
( 4)Initial Reimb: 20076.35









Press NL--
```

This screen displays the HAC details, including:

- HAC Processing Required indicator
  - If indicator is **Yes**, DRG was calculated *with* HAC processing.
  - If indicator is **No**, the DRG was grouped by a third party grouper *without* HAC processing.
- Status of HAC Processing (demotions, DRG change)
- Initial DRG (DRG prior to HAC Processing), and
- Initial Reimb (reimbursement prior to HAC Processing).

  All the fields on this screen are display only.

Press ENTER after viewing this screen to return to the DRG Assignment screen.

If the patient has been discharged and changes were made to the information that affect DRG assignment (for example, diagnosis, procedure, sex age, disposition), when you exit the DRG Assignment screen, this prompt is displayed:

Accept Final DRG Assignment? (Y/N) [N]--

To accept the DRG as final, enter **Y** for Yes (do not press ENTER). This indicates to the system that this DRG is acceptable for the bill. It also causes the date of the acceptance to display in the Final Accept Date field on the DRG Assignment screen.

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

If you use the 3M's Coding and Reimbursement System for reimbursement calculation, the system does not allow you to accept the DRG as final if the field that displays the DRG is blank. If you enter **Y** at the prompt when this field is blank, the system displays one of two messages:

- For visits that have DRGs calculated:

  Error: Final DRG is missing. Recalculate using a valid Code 3 product option.

  The system then displays the acceptance prompt again, and you must enter **N** or press ENTER. You must then reaccess 3M's Coding and Reimbursement System and select a 3M product option that calculates a DRG, then return to this screen and accept the DRG as final. If you are using multiple groupers, you must select a 3M product option that calculates a DRG both times STAR Patient Care accesses 3M's Coding and Reimbursement System.

  For more information on the 3M Coding and Reimbursement System, refer to the *STAR Patient Care, STAR/3M Coding and Reimbursement Interface Guide.*

- For visits that have APCs calculated:

  It is not necessary to mark the DRG as final when using APCfinder.

  The system then displays the acceptance prompt again, and you must enter **N** or press ENTER.

Whether or not you accept the DRG as final, after you respond to the previous prompt, the following prompt displays:

Enter Alternate Description for Diagnoses and/or Procedures? (Y/N) [N]--

An alternate description for the ICD-9-CM code is one that may be more acceptable to the physician responsible for completing the attestation form. The alternate description does not print on or affect any other reports, bills, or department functions. The alternate description only prints on the attestation and abstract summary forms for this patient. Once an alternate description is set up for a patient's episode, it remains there until it is removed or changed. Entering an alternate description on a patient's abstract does not change the ICD-9-CM description found in the maintenance function.

To enter an alternate description(s), press **Y** (do not press ENTER) to access the diagnosis processor screen. The system displays this prompt:

Select principal (P), or number (n), to enter alternate description--

Enter **P** or the number of the secondary diagnosis (to the left of the ICD-9-CM code). The system now displays this prompt:

Enter alternate description--

Enter the new description which is posted in place of the previous ICD-9-CM code description. You are then returned to this prompt:

Select principal (P), or number (n), to enter alternate description--

You can continue entering alternate descriptions or press ENTER to display this prompt:

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

Enter **N** for No to return to the prompt to select the principal diagnosis or code number for an alternate description. Once the screen is accepted, this message displays:

Filed!

The message displays briefly, then you are taken to the procedure processor screen.

To enter alternate descriptions for procedures, select the number to the left of the ICD-9-CM procedure code, and this prompt displays:

Enter alternate description for procedure--

Enter the new description which is posted in place of the previous ICD-9-CM code description and you are returned to this prompt:

Select number (n) to enter alternate description--

You can continue entering alternate descriptions or press ENTER and this prompt displays:

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

Press ENTER to accept the default of **N** for No to continue processing, and this prompt displays:

Print an (A)ttestation, an Abstract (S)ummary, or (B)oth forms? --

You have the following entry options:

- Enter **A** to print an attestation form. The following prompt displays:

  Indicate # of Primary copies, followed by # of Secondary copies (eg 1,2), or one copy of each [B]--

  For example, to print two copies for the primary payor and two copies for the secondary payor, enter **2,2**. If you want only one copy of each, press ENTER to accept the default of **B** for both.

  NOTE: The maximum number of primary or secondary attestation forms that can be requested at one time is 99.

  The following message displays:

  Printing Attestation Form!

- Enter **S** to print an abstract summary form. The following message displays:

  Printing Abstract Summary form!

- Enter **B** to print both an attestation and an abstract summary form. The system displays the following prompt:

  Indicate # of Primary copies, followed by # of Secondary copies (eg 1,2), or one copy of each [B]--

  For example, to print two copies of the attestation form for the primary payor and two copies for the secondary payor, enter **2,2**. If you want only one copy of each, press ENTER to accept the default of **B** for both.

  NOTE: The maximum number of primary or secondary attestation forms that can be requested at one time is 99.

  The following messages display:

  Printing Attestation Form!

  Printing Abstract Summary form!

The system displays the *Printing* message, then displays this prompt:

Send an Attestation message? (Y/N) [N]--

This message is not displayed if the Medical Record Maintenance Option Electronic Signature parameter is set to No.

Press ENTER to accept the default of **N** for No and an electronic attestation is not sent. To send an electronic attestation, enter **Y** for Yes (do not press ENTER), and this prompt displays:

Enter physician code to send Attestation message--

Enter the code number of the physician to whom the attestation should be sent. If the selected physician does not have a secret code on file, or the secret code has expired, this message displays:

Error: Physician not available for Electronic Signature

Physicians are set up for electronic attestation in the Medical Records Maintenance option, Assign Phys Electronic Signature function.

The message displays briefly then returns you to the prompt to enter another physician code. You can enter a period (.) followed by ENTER to terminate this process.

Once you select a physician whose code is on file, this screen displays:

```
                  General Hospital DRG Assignment Processor
             DRG Results          Page  4 of  4   Thu Jul 11, 1996 10:49 am
      Account No    Name                              Unit No        Corp No
      90106-00003   ROGERS,ELLEN T                    0000-0000-67   00003191
1 DRG Payor            2 Table No  3 Age    4 Sex     5 Dischg Disposition
  MEDICARE               14          31Y      FEMALE    HOME - SELF CARE
6 Major Diagnostic Category                             7 FINAL ACCEPT DATE
  6  DISEASES/DISORDERS OF THE DIGESTIVE SYSTEM
           1         2         3         4         5         6         7
  12345678901234567890123456789012345678901234567890123456789012345678901234
01|                                                                          |
02|                                                                          |
03|                                                                          |
04|                                                                          |
05|                                                                          |
06|                                                                          |
07|                                                                          |
08|                                                                          |
09|                                                                          |
10|                                                                          |
11|                                                                          |
12|                                                                          |
`E`dit/`C`reate/`D`elete notes to the physician or `S`end message? (ECDS)--  |
```

This screen is used by the Medical Record Department to send notes or messages to the physician regarding the attestation. These notes display when the physician views the attestation via STAR Clinical Browser or Horizon*WP*® Physician Portal.

The prompt associated with this screen asks you to select one of the following entry options. (It is not necessary to press ENTER after you enter an option.)

- Enter **E** to edit notes
- Enter **C** to create notes
- Enter **D** to delete the notes
- Enter **S** to send the notes and/or attestation

If you enter **E** or **C** to edit or create notes, this screen displays:

```
                    General Hospital DRG Assignment Processor
              DRG Results          Page  4 of  4 Thu Jul 11, 1996 10:49 am
    Account No     Name                              Unit No         Corp No
    90106-00003    ROGERS,ELLEN T                    0000-0000-67    00003191
 1 DRG Payor            2 Table No  3 Age    4 Sex     5 Dischg Disposition
   MEDICARE               14          31Y      FEMALE    HOME - SELF CARE
 6 Major Diagnostic Category                          7 FINAL ACCEPT DATE
   6  DISEASES/DISORDERS OF THE DIGESTIVE SYSTEM
            1         2         3         4         5         6         7
   12345678901234567890123456789012345678901234567890123456789012345678901234
01|Please sign attestation by Friday.                                          |
02|                                                                            |
03|                                                                            |
04|                                                                            |
05|                                                                            |
06|                                                                            |
07|                                                                            |
08|                                                                            |
09|                                                                            |
10|                                                                            |
11|                                                                            |
12|                                                                            |
   F1           F2           F3      F4    F5          F6            F7    F10
   Delete Line  Insert Line  Center  Exit  Store Line  Restore Line  Pack  Help
```

This screen enables you to enter 12 lines of free-form text to send additional instructions or information to the receiving physician. The function keys at the bottom of the screen assist you with the various word processing functions available.

If you enter **D** for delete, the following prompt displays:

Are you sure you want to delete current notes? (Y/N) [N]--

Press ENTER to accept the default of **N** for No. If you enter **Y** for Yes, the notes are deleted.

If you enter **S** for send, the following prompt displays:

Are you sure you want to send this Attestation message to XXXX? (Y/N) [Y]--

where XXXX is the name of the selected physician.

Enter **Y** for Yes or press default to send the message. Enter **N** for No to skip sending the attestation message. If you accept the default, this message displays:

Sending Attestation Message!

The message displays briefly, then you are returned to the function where you started.

If an attestation is electronically signed and the diagnoses and/or procedures pertaining to that attestation are subsequently updated, the electronic signature and date are automatically removed from the file, and must either be electronically sent again and signed, or the physician can manually sign the attestation.

The message displays briefly, then you are returned to the abstracting process.

Impact

After you accept this screen, the following takes place:

- Alternate descriptions display on the Diagnosis Processor screen and always print on the attestation and abstract summary forms for this episode for this patient until changed or removed.
- If the DRG is accepted as final (which can only take place if the patient is discharged), the system completes Field 7 on the DRG Assignment screen with the date of acceptance.
- When the DRG is accepted as final, an internal flag is set and/or a set of interface records are created.
- Patients whose DRGs are accepted as final are no longer included on the Unaccepted DRG Discharges Report.
- Patients whose DRGs are accepted as final are included on the Final DRGs Accepted Report.
- Electronically transmitted attestation forms are now available for processing by the physician via STAR Clinical Browser or Horizon^{WP} Physician Portal.

Output

- An attestation form is printed to the spooler or the default printer linked to the user's CRT, depending on the setting of the Abstract Facility Options parameter.
- An abstract summary form is printed to the spooler or the default printer linked to the user's CRT, depending on the setting of the Abstract Facility Options parameter.

- When the physician returns an electronic attestation, either signed or unaccepted, the attestation form prints in the Medical Record Department. If the attestation is electronically signed, the form contains the signature and date and time of signing.

- If the attestation is not signed but is electronically returned as unaccepted, the unsigned attestation form prints in the Medical Record Department along with the medical record messages sent to the physician (if any), the Physician DRG unaccepted reasons (if any), and the physician message (if any).

Chapter 3 - ATTESTATION AND ABSTRACT SUMMARY FORMS

Illustrations

ATTESTATION FORM

This function enables you to print, at your CRT's default printer, an attestation form for a patient's visit without having to go through the screens in either DRG Assignment or Medical Record Abstracting.

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

To print an attestation form, select this option from the Medical Record main menu. The next prompt that displays is the MPI Patient Lookup, which is used to select a patient. Once a patient and associated visit have been selected, the following screen is displayed:

```
                General Hospital Attestation Form Processor
                                                Thu Jun 20, 2002 06:49 pm
  Account No     Name                                Unit No        Corp No
  0203200001     FITCHETT,AUBRY                      000-00-2612    00003051









Enter alternate description for diagnoses and/or procedures? (Y/N) [N]--
```

The following prompt displays at the bottom of the screen:

Enter alternate description for diagnoses and/or procedures? (Y/N) [N]--

An alternate description for the ICD-9-CM code is one that may be more acceptable to the physician responsible for completing the attestation form. The alternate description does not print on or affect any other reports, bills, or department functions. The alternate description only prints on the attestation form for this patient. Once an alternate description is set up for a patient's episode, it remains there until it is removed or changed. Entering an alternate description for an ICD-9-CM code does not change the ICD-9-CM description found in the maintenance function.

To enter an alternate description(s), enter **Y** (do not press ENTER) to access the Diagnosis Processor screen that follows:

```
                General Hospital Attestation Form Processor
                                              Thu Jun 20, 2002 06:49 pm
   Account No     Name                            Unit No        Corp No
    0203200001     FITCHETT,AUBRY                  000-00-2612    00003051
                              Diagnosis

         Code   Description                  Alternate Description
Prin.    005.0  STAPH FOOD POISONING
Sec.( 1) 900.82 INJ MLT HEAD/NECK VESSEL     DIFFERENT DESCRIPTION 2
    ( 2) 250.01 DMI WO CMP NT ST UNCNTRL
    ( 3) 003.1  SALMONELLA SEPTICEMIA
    ( 4) 001.0  CHOLERA D/T VIB CHOLERAE
    ( 5) 001.1  CHOLERA D/T VIB EL TOR
    ( 6) 001.9  CHOLERA NOS
    ( 7) 002.0  TYPHOID FEVER
    ( 8) 401.9  HYPERTENSION NOS
    ( 9) 002.2  PARATYPHOID FEVER B
    (10) 002.3  PARATYPHOID FEVER C
    (11) 002.9  PARATYPHOID FEVER NOS
    (12) 003.0  SALMONELLA ENTERITIS
    (13) 003.20 LOCAL SALMONELLA INF NOS
    (14) 003.21 SALMONELLA MENINGITIS

Select principal(P) or number(n) to enter alternate description--
```

The following prompt displays at the bottom of the screen:

Select principal (P), or number (n), to enter alternate description--

Enter **P** or the number of the secondary diagnosis (to the left of the ICD-9-CM code) and press ENTER. This prompt then displays:

Enter alternate description for principal--

Enter the new description which is posted in place of the previous ICD-9-CM code description. You are then returned to this prompt:

Select principal (P), or number (n), to enter alternate description--

You can continue entering alternate descriptions or press ENTER to display this prompt:

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

Enter **N** for No to return to the prompt to select the principal diagnosis or code number for an alternate description. Once the screen is accepted, this message displays:

Filed!

The message displays briefly, then you are taken to the procedure processor screen. To enter alternate descriptions for procedures, select the number to the left of the ICD-9-CM code, and this prompt displays:

Enter alternate description for procedure--

Enter the new description which is posted in place of the previous ICD-9-CM code description and you are returned to this prompt:

Select number (n) to enter alternate description--

You can continue entering alternate descriptions or press ENTER and this prompt displays:

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

Press ENTER to accept the default of **Y** for Yes. The system displays the following message:

Filed!

If alternate descriptions are not to be entered for procedures, press ENTER. The following prompt displays:

Print an (A)ttestation, an Abstract (S)ummary, or (B)oth forms? --

You have the following entry options:

- Enter **A** to print an attestation form. The following prompt displays:

  Indicate # of Primary copies, followed by # of Secondary copies (eg 1,2), or one copy of each [B]--

  For example, to print two copies for the primary payor and two copies for the secondary payor, enter **2,2**. If you want only one copy of each, press ENTER to accept the default of **B** for both.

  NOTE: The maximum number of primary or secondary attestation forms that can be requested at one time is 99.

  The following message displays:

  Printing Attestation Form!

- Enter **S** to print an abstract summary form. The following message displays:

  Printing Abstract Summary form!

- Enter **B** to print both an attestation and an abstract summary form. The system displays the following prompt:

Indicate # of Primary copies, followed by # of Secondary copies (eg 1,2), or one copy of each [B]--

For example, to print two copies of the attestation form for the primary payor and one copy for the secondary payor, enter **2,1**. If you want only one copy of each, press ENTER to accept the default of **B** for both.

NOTE: The maximum number of primary or secondary attestation forms that can be requested at one time is 99.

The following messages display:

Printing Attestation Form!

Printing Abstract Summary form!

The system displays the *Printing* message, then displays this prompt:

Send an Attestation message? (Y/N) [N]--

Enter **N** for No or press ENTER, and the system returns to the MPI Patient Lookup screen for selection of another patient.

To send an electronic attestation, enter **Y** for Yes. The following prompt displays:

Enter physician code to send Attestation message--

Enter the code number of the physician to whom you want to send an attestation. If the selected physician does not have a secret code on file, or the secret code has expired, this message displays:

Error: Physician not available for Electronic Signature

The message displays briefly, and then you are returned to the prompt to enter another physician code. Press period (.) followed by ENTER to terminate this process.

If you do not know the code, enter a hyphen (-) to select from a table listing of physicians. Once you select a physician whose code is on file, this screen displays:

```
                  General Hospital Attestation Form Processor
                                                 Thu Jun 20, 2002 06:58 pm
    Account No     Name                              Unit No        Corp No
    0203200001     FITCHETT,AUBRY                    000-00-2612    00003051
                                  Procedures
         Code   Description                  Alternate Description
P  (1)   44.29  OTHER PYLOROPLASTY
   (2)   50.21  MARSUPIALIZAT LIVER LES
            1         2         3         4         5         6         7
   12345678901234567890123456789012345678901234567890123456789012345678901234
01|h                                                                          |
02|                                                                           |
03|                                                                           |
04|                                                                           |
05|                                                                           |
06|                                                                           |
07|                                                                           |
08|                                                                           |
09|                                                                           |
10|                                                                           |
11|                                                                           |
12|                                                                           |
`E`dit/`C`reate/`D`elete notes to the physician or `S`end message? (ECDS)--  |
```

This screen is used by the Medical Record Department to send notes or messages to the physician regarding the attestation. These notes display when the physician views the attestation via STAR Clinical Browser or Horizon^{WP} Physician Portal.

The prompt associated with this screen asks you to select one of the following entry options. (It is not necessary to press ENTER after you enter an option.)

- Enter **E** to edit notes
- Enter **C** to create notes
- Enter **D** to delete the notes
- Enter **S** to send the notes and/or attestation

If you enter **E** or **C** to edit or create notes, this screen displays:

```
                General Hospital Attestation Form Processor
                                                Thu Jun 20, 2002 06:58 pm
    Account No     Name                              Unit No        Corp No
    0203200001     FITCHETT,AUBRY                    000-00-2612    00003051
                                 Procedures
         Code   Description                  Alternate Description
P  (1)   44.29  OTHER PYLOROPLASTY
   (2)   50.21  MARSUPIALIZAT LIVER LES
           1         2         3         4         5         6         7
  12345678901234567890123456789012345678901234567890123456789012345678901234
01|Please sign attestation by Friday.                                        |
02|                                                                          |
03|                                                                          |
04|                                                                          |
05|                                                                          |
06|                                                                          |
07|                                                                          |
08|                                                                          |
09|                                                                          |
10|                                                                          |
11|                                                                          |
12|                                                                          |
  F1           F2           F3      F4    F5          F6            F7    F10
  Delete Line  Insert Line  Center  Exit  Store Line  Restore Line  Pack  Help
```

This screen enables you to enter 12 lines of free-form text to send additional instructions or information to the receiving physician. The function keys at the bottom of the screen assist you with the various word processing functions available.

If you enter **D** for delete, the following prompt displays:

Are you sure you want to delete current notes? (Y/N) [N]--

Press ENTER to accept the default of **N**. If you enter **Y**, the notes are deleted.

If you enter **S** for send, the following prompt displays:

Are you sure you want to send this Attestation message to XXX? (Y/N) [Y]--

where XXX is the name of the physician previously selected.

The default is **Y** for Yes, or you can enter **N** for No and the attestation message is not sent. If the default is accepted, this message displays:

Sending Attestation Message!

The message displays briefly, then you are returned to the function where you started.

If an attestation is electronically signed and the diagnoses and/or procedures pertaining to that attestation are subsequently updated, the electronic signature and date are automatically removed from the file, and must either be electronically re-sent and signed, or the physician can manually sign the attestation.

Impact

- Once this screen is accepted, alternate descriptions always print on the attestation and abstract summary forms for this episode for this patient until changed or removed.

Output

- An attestation form is printed to the spooler or the default printer linked to the user's CRT, depending on the setting of the Abstract Facility Options parameter.

- An abstract summary form is printed to the spooler or the default printer linked to the user's CRT, depending on the setting of the Abstract Facility Options parameter.

- When the physician returns a signed electronic attestation, the attestation form prints in the Medical Record Department at the default printer. If the attestation is electronically signed, the form contains the signature and the date and time of the signature.

- If the attestation is not signed but electronically returned as unaccepted, the medical record messages sent to the physician (if any), the Physician DRG unaccepted reasons (if any), and the physician message (if any) print in the Medical Record department at the default printer.

- The first attestation to print is always associated with the primary financial class. If the parameters in the Insurance Carrier and/or Insurance Plan table(s) are set to print an attestation form for secondary insurances, the forms include the following line in the header below the hospital identification information:

  FOR SECONDARY INSURANCE

The following is an example of an attestation form for the patient's primary insurance.

Figure 3.1 Attestation Form

```
                          Model Hospital A                        Page: 1
                  301 Perimeter Center North ATLANTA,NJ 30346



Date:       Name                              Acct. #        Financial Class
06/20/02    FITCHETT,AUBRY                    0203200001     M - MEDICARE
Sex         Birth Date  Age                   Adm Date       Dsch Date       LOS
M           01/01/92     10Y                  02/01/02       02/01/02        1

Attending Physician                           Discharge Status
AKER,TOM                                      021  - KARINAS DISPOSTION
Coder: djf

--------------------------------------------------------------------------------
MDC: 06   DISEASES/DISORDERS OF THE DIGESTIVE SYSTEM
DRG: 156   EGD PROC 0-17

OUTLIER STATUS: N/A
--------------------------------------------------------------------------------

   DIAGNOSIS  DESCRIPTION                    DIAGNOSIS DESCRIPTION
 1.(P) 005.0  STAPH FOOD POISONING       9.    401.9  HYPERTENSION NOS
 2.    900.82 DIFFERENT DESCRIPTION 2    10.   002.2  PARATYPHOID FEVER B
 3.    250.01 DMI WO CMP NT ST UNCNTRL   11.   002.3  PARATYPHOID FEVER C
 4.    003.1  SALMONELLA SEPTICEMIA      12.   002.9  PARATYPHOID FEVER NOS
 5.    001.0  CHOLERA D/T VIB CHOLERAE   13.   003.0  SALMONELLA ENTERITIS
 6.    001.1  CHOLERA D/T VIB EL TOR     14.   003.20 LOCAL SALMONELLA INF NOS
 7.    001.9  CHOLERA NOS                15.   003.21 SALMONELLA MENINGITIS
 8.    002.0  TYPHOID FEVER

   PROCEDURE  DESCRIPTION                      DATE      SURGEON NAME
 1.(P) 44.29  OTHER PYLOROPLASTY              02/01/02  COLEMAN,MICHAEL G
 2.    50.21  MARSUPIALIZAT LIVER LES         02/01/02  COLEMAN,MICHAEL G
 3.    42.99  ESOPHAGEAL OPERATION NEC        02/01/02  COLEMAN,MICHAEL G
 4.    88.74  DX ULTRASOUND-DIGESTIVE         02/01/02  COLEMAN,MICHAEL G
 5.    42.99  ESOPHAGEAL OPERATION NEC        02/01/02  COLEMAN,MICHAEL G
 6.    88.74  DX ULTRASOUND-DIGESTIVE         02/01/02  COLEMAN,MICHAEL G
 7.    42.99  ESOPHAGEAL OPERATION NEC        02/01/02  COLEMAN,MICHAEL G
 8.    88.74  DX ULTRASOUND-DIGESTIVE         02/01/02  COLEMAN,MICHAEL G
 9.    28.5   EXCISION LINGUAL TONSIL         02/01/02  COLEMAN,MICHAEL G
10.    50.29  DESTRUC HEPATIC LES NEC         02/01/02  COLEMAN,MICHAEL G
11.    50.99  LIVER OPERATION NEC             02/01/02  COLEMAN,MICHAEL G
12.    88.33  OTHER SKELETAL X-RAY            02/01/02  TONGEN,LYLE A
13.    01.02  VENTRICL SHUNT TUBE PUNC        02/01/02  COLEMAN,MICHAEL G
14.    01.02  VENTRICL SHUNT TUBE PUNC        02/01/02  COLEMAN,MICHAEL G
15.    28.5   EXCISION LINGUAL TONSIL         02/01/02  COLEMAN,MICHAEL G

   HCPCS  DESCRIPTION          MODIFIER(S)    DATE      SURGEON        PRE APC
 1. 0003T CERVICOGRAPHY        47,59,80,DP,82 02/01/02  COLEMAN,MICHAE
 2. 88172 CYTOPATHOLOGY EVAL O                02/01/02  COLEMAN,MICHAE
 3. 43232 ESOPH ENDOSCOPY W/US                02/01/02  COLEMAN,MICHAE
 4. 0001T ENDOVAS REPR ABDO AO                02/01/02  COLEMAN,MICHAE
 5. 33214 UPGRADE OF PACEMAKER                02/01/02  TONGEN,LYLE A
 6. 33216 REVISE ELTRD PACING-                02/01/02  TONGEN,LYLE A
 7. 33218 REVISE ELTRD PACING-                02/01/02  COLEMAN,MICHAE
 8. 33220 REVISE ELTRD PACING-                02/01/02  TONGEN,LYLE A
 9. 33233 REMOVAL OF PACEMAKER                02/01/02  COLEMAN,MICHAE
10. 33236 REMOVE ELECTRODE/THO                02/01/02  COLEMAN,MICHAE
11. 33243 REMOVE ELTRD/THORACO                02/01/02  COLEMAN,MICHAE
12. 33245 INSERT EPIC ELTRD PA                02/01/02  COLEMAN,MICHAE
13. 33246 INSERT EPIC ELTRD/GE                02/01/02  COLEMAN,MICHAE
```

Model Hospital A Page: 2
301 Perimeter Center North ATLANTA,NJ 30346

Date:	Name	Acct. #	Financial Class
06/20/02	FITCHETT,AUBRY	0203200001	M - MEDICARE

	HCPCS	DESCRIPTION	MODIFIER(S)	DATE	SURGEON	PRE APC
14.	33910	REMOVE LUNG ARTERY E		02/01/02	COLEMAN,MICHAE	
15.	45379	COLONOSCOPY W/FB REM		02/01/02	COLEMAN,MICHAE	
16.	45385	LESION REMOVAL COLON		02/01/02	COLEMAN,MICHAE	
17.	76020	X-RAYS FOR BONE AGE		02/01/02	COLEMAN,MICHAE	
18.	82370	X-RAY ASSAY, CALCULU		02/01/02	COLEMAN,MICHAE	
19.	75984	XRAY CONTROL CATHETE		02/01/02	COLEMAN,MICHAE	
20.	49423	EXCHANGE DRAINAGE CA		02/01/02	COLEMAN,MICHAE	

I CERTIFY THAT THE NARRATIVE DESCRIPTIONS OF THE PRINCIPAL AND SECONDARY DIAGNOSIS AND THE MAJOR PROCEDURES PERFORMED ARE ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

FITCHETT,AUBRY _____CODER _____DATE
000-00-2612 00003051
05/20/02 _____ _____DATE
AKER,TOM

Sample Attestation Form

Field Explanations

DATE
This is the date the attestation was printed. It is the current date.

NAME
This is the name of the patient and is displayed as LAST,FIRST MIDDLE.

ACCT #
This is the account number of the patient's episode of care.

FINANCIAL CLASS
This is the patient's financial class. The financial class is obtained from the Financial Class field located in the Medical Record Abstract and in the DRG Assignment function. This field displays the two-character financial class code and the description.

SEX
This field displays the patient's sex (M for male or F for female).

BIRTH DATE
This field displays the patient's birthdate.

AGE
This field displays the patient's age upon admission.

ADM DATE
This field displays the patient's admission date for this episode of care.

DSCH DATE
This field contains the patient's discharge date for this episode of care.

LOS
This field contains the total length of stay for this patient's episode of care.

ATTENDING PHYSICIAN
This field contains the patient's attending physician name.

DISCHARGE STATUS
This field contains the discharge status entered for this episode of care. This information is obtained from the Medical Record Abstract or the DRG Assignment function. The code and description print. Up to 27 characters of the description display.

CODER
This field contains the coder's initials obtained from the Coder field in the Medical Record Abstract on the Episode Detail 2 screen.

MDC
This field contains the Major Diagnostic Category number and the description of the category. This information is obtained from the grouper process.

DRG
This field contains the Diagnostic Related Group number and the description of the DRG. This information is obtained from the grouper process.

OUTLIER STATUS
If the financial class is Medicare, if applicable, an outlier status prints (ex: STAYOUTLIER) as a result of the grouper process. If it is not an outlier, *N/A* prints.

DIAGNOSIS
Up to fifteen ICD-9-CM diagnosis codes display with their corresponding description. The description is either the default description defined in ICD-9-CM Maintenance or an alternate description entered in the Medical Record Abstract, the DRG Assignment Function, or the Attestation Form function. Up to 24 characters of the description print. The principal diagnosis is identified with a (P) to the left of the code. A lowercase *c* identifies if a diagnosis is considered a C/C (Complication or Comorbidity) in the grouper process.

PROCEDURE
Up to fifteen ICD-9-CM procedure codes display with their corresponding description, date, and surgeon. The description is either the default description defined in ICD-9-CM Maintenance or an alternate description entered in the Medical Record Abstract, the DRG Assignment Function, or the Attestation Form function. Up to 24 characters of the description print. The principal procedure is identified with a (P) to the left of the code.

HCPCS
An unlimited number of HCPCS codes are displayed, along with their corresponding descriptions, modifiers (up to 5 per code), dates, surgeons, and preliminary APC codes. Preliminary APCs print only if you are using APCfinder software from 3M.

NOTE: HCPCS codes and related information print on the form only if the Print HCPCS parameter (in M/R Abstract & DRG Census Criteria) for the patient's abstract code is set to **Yes**. The HCPCS codes that are included are those from Medical Records, not those from Order Entry (Charges).

ATTESTATION STATEMENT
The patient's name, medical record number (unit number), and corporate number print in the bottom left corner of the form. You can also print the following elements at the bottom of the form, based on the Attestation Parameters settings in the DRG Payors table:

- User-defined Certification statement
- Signature line for physician, coder, or both

- Date line
- Form name

See the description of the DRG Payors table in the *STAR Patient Care Reference Guide, Tables Volume* for more information about how to set the parameters for these elements and where they appear on the printed form.

ABSTRACT SUMMARY FORM (EPABFX)

An example of an abstract summary form is on the following pages.

Figure 3.2 Abstract Summary Form (EPABFX)

```
Date: 06/21/02                  Model Hospital A                Page  : 1
Time: 11:57                   Abstract Summary Form             Report: MR

Patient:FITCHETT,AUBRY                          Address:900PEACHTREE RD
DOB:    01/01/92    Fin Class:MEDICARE                  WINDER
Sex:    MALE        Ins. Plan:BLUE CROSS                NC,30366
SS#:    227-77-9999 Guarantor:SELF            Phone #:(770)455-0101

Adm Date:02/01/02      Adm Source:ER                          Acct. #: 020320000
Adm Time:10:28         Adm Type:  ELECTIVE-PLANNED            Unit. #: 000002612
Dis Date:02/01/02      Trans From:                            Pt. Type:Regular I
Dis Time:11:17         Service:   PEDIATRICS                  Trans To:
LOS:     1             Dis Status:KARINAS DISPOSTION          Coder:   djf
Admitting DR:AKER,TOM                          Referring DR:COLEMAN,MICHAEL G
Attending DR:AKER,TOM                          Discharge DR:COLEMAN,MICHAEL G
ER Physician:ADAMS,JAY M                       Primary DR:  COLEMAN,MICHAEL G

DRG:   156   EGD PROC 0-17
Admit Diagnosis:     250.01   DMI WO CMP NT ST UNCNTRL
Principal Diagnosis: 005.0    STAPH FOOD POISONING
Secondary Diagnoses:
  900.82 DIFFERENT DESCRIPTION 2              002.9  PARATYPHOID FEVER NOS
  250.01 DMI WO CMP NT ST UNCNTRL             003.0  SALMONELLA ENTERITIS
  003.1  SALMONELLA SEPTICEMIA                003.20 LOCAL SALMONELLA INF NO
  001.0  CHOLERA D/T VIB CHOLERAE             003.21 SALMONELLA MENINGITIS
  001.1  CHOLERA D/T VIB EL TOR
  001.9  CHOLERA NOS
  002.0  TYPHOID FEVER
  401.9  HYPERTENSION NOS
  002.2  PARATYPHOID FEVER B
  002.3  PARATYPHOID FEVER C

Principal Procedure:                           Date:          Primary Surgeon:
  44.29  OTHER PYLOROPLASTY                    02/01/02       COLEMAN,MICHAEL G
Secondary Procedures:
  50.21  MARSUPIALIZAT LIVER LES               02/01/02       COLEMAN,MICHAEL G
  42.99  ESOPHAGEAL OPERATION NEC              02/01/02       COLEMAN,MICHAEL G
  88.74  DX ULTRASOUND-DIGESTIVE               02/01/02       COLEMAN,MICHAEL G
  42.99  ESOPHAGEAL OPERATION NEC              02/01/02       COLEMAN,MICHAEL G
  88.74  DX ULTRASOUND-DIGESTIVE               02/01/02       COLEMAN,MICHAEL G
  42.99  ESOPHAGEAL OPERATION NEC              02/01/02       COLEMAN,MICHAEL G
  88.74  DX ULTRASOUND-DIGESTIVE               02/01/02       COLEMAN,MICHAEL G
  28.5   EXCISION LINGUAL TONSIL               02/01/02       COLEMAN,MICHAEL G
  50.29  DESTRUC HEPATIC LES NEC               02/01/02       COLEMAN,MICHAEL G
  50.99  LIVER OPERATION NEC                   02/01/02       COLEMAN,MICHAEL G
  88.33  OTHER SKELETAL X-RAY                  02/01/02       TONGEN,LYLE A
  01.02  VENTRICL SHUNT TUBE PUNC             02/01/02       COLEMAN,MICHAEL G
  01.02  VENTRICL SHUNT TUBE PUNC             02/01/02       COLEMAN,MICHAEL G
  28.5   EXCISION LINGUAL TONSIL               02/01/02       COLEMAN,MICHAEL G
  40.19  LYMPHATIC DIAG PROC NEC               02/01/02       COLEMAN,MICHAEL G

HCPCS:                          Modifiers:     Date:      Surgeon:      Pre APC:
0003T CERVICOGRAPHY             47,59,80,DP,82 02/01/02   COLEMAN,MICHA
88172 CYTOPATHOLOGY EVAL OF FN                 02/01/02   COLEMAN,MICHA
43232 ESOPH ENDOSCOPY W/US FN                  02/01/02   COLEMAN,MICHA
0001T ENDOVAS REPR ABDO AO ANE                 02/01/02   COLEMAN,MICHA
33214 UPGRADE OF PACEMAKER SYS                 02/01/02   TONGEN,LYLE A
33216 REVISE ELTRD PACING-DEFI                 02/01/02   TONGEN,LYLE A
33218 REVISE ELTRD PACING-DEFI                 02/01/02   COLEMAN,MICHA
33220 REVISE ELTRD PACING-DEFI                 02/01/02   TONGEN,LYLE A
33233 REMOVAL OF PACEMAKER SYS                 02/01/02   COLEMAN,MICHA
33236 REMOVE ELECTRODE/THORACO                 02/01/02   COLEMAN,MICHA
33243 REMOVE ELTRD/THORACOTOMY                 02/01/02   COLEMAN,MICHA
```

```
Date: 06/21/02                  Model Hospital A                Page  : 2
Time: 11:57                   Abstract Summary Form             Report: MR

Patient:FITCHETT,AUBRY                          Acct. #:0203200001


HCPCS:                           Modifiers:     Date:      Surgeon:      Pre APC:
33245 INSERT EPIC ELTRD PACE-D                  02/01/02   COLEMAN,MICHA
33246 INSERT EPIC ELTRD/GENERA                  02/01/02   COLEMAN,MICHA
33910 REMOVE LUNG ARTERY EMBOL                  02/01/02   COLEMAN,MICHA
45379 COLONOSCOPY W/FB REMOVAL                  02/01/02   COLEMAN,MICHA
45385 LESION REMOVAL COLONOSCO                  02/01/02   COLEMAN,MICHA
76020 X-RAYS FOR BONE AGE                       02/01/02   COLEMAN,MICHA
82370 X-RAY ASSAY, CALCULUS                     02/01/02   COLEMAN,MICHA
75984 XRAY CONTROL CATHETER CH                  02/01/02   COLEMAN,MICHA
49423 EXCHANGE DRAINAGE CATHET                  02/01/02   COLEMAN,MICHA

Consultants:                                    Date:          Specialty:
BASS,STATE                                      02/01/02       FAMILY PRACTICE
AKER,TOM                                        02/01/02       CARDIOLOGY
GABRIEL,JOHN A                                  02/01/02       FAMILY PRACTICE
FREEMAN,ANNE                                    02/01/02       Medical Division
ADAMS,JAY M                                     02/01/02       Medical Division
LEES,JACK R                                     02/01/02       CARDIOLOGY
*BAAB,FREMSTAD ETAL                             02/01/02       CARDIOLOGY
DEBVDOC,WITHAV                                  02/01/02       Medical Division
KING,INGROUPTWO                                 02/01/02       NEPHROLOGY
KING,INGROUPTHREE                               02/01/02       NEUROLOG - SURGERY



                              End of Report
```

NOTE: HCPCS codes and related information print on the form only if the Print HCPCS parameter (in M/R Abstract & DRG Census Criteria) for the patient's abstract code is set to **Yes**. The HCPCS codes that are included are those from Medical Records, not those from Order Entry (Charges).

Preliminary APC codes print for the HCPCS codes only if your facility is using 3M's APCfinder software.

Chapter 4 - DRG MAINTENANCE FUNCTIONS

Illustrations

ICD-9-CM MAINTENANCE

For information on this function, see ICD-9-CM Maintenance in Chapter 2: High Level Tables of the *STAR Patient Care Reference Guide, Tables Volume*.

ICD-10-CA MAINTENANCE (CN ONLY)

This option is not available in the United States. For a description of it, please refer to the *STAR Patient Care Reference Guide, Tables Volume*.

ICD-10-CCI MAINTENANCE (CN ONLY)

This option is not available in the United States. For a description of it, please refer to the *STAR Patient Care Reference Guide, Tables Volume*.

HCPCS TABLE MAINTENANCE

For information on this function, see HCPCS Table Maintenance in Chapter 2: High Level Tables of the *STAR Patient Care Reference Guide, Tables Volume*.

DRG RATE TABLE GENERATION

Since the inception of the Prospective Payment System (PPS) and Diagnosis Related Groups (DRGs) as a basis for Medicare reimbursement to hospitals, the federal government releases, on an annual basis, new calculations that affect grouping and reimbursement. There are various factors that go into the calculation that results in the hospital's base PPS rate. The base PPS rate is multiplied by the weight of a DRG which is used to determine the reimbursement rate for that DRG for your facility.

The DRG Rate Table Generation function is where these factors are entered and the base PPS rate is calculated. This function is located on the Maintenance Functions Input Options submenu. The DRG Rate Table Generation function is used to maintain the rate table that determines the base payment used in calculating a reimbursement amount for a DRG. You can set up as many rate tables as necessary for a DRG payor to implement reimbursement changes as they become available.

You can also regroup patients in a particular date range if necessary. See information on M/R Update Functions in the *STAR Patient Care Reference Guide, General Information Volume*, Chapter 8: System Management.

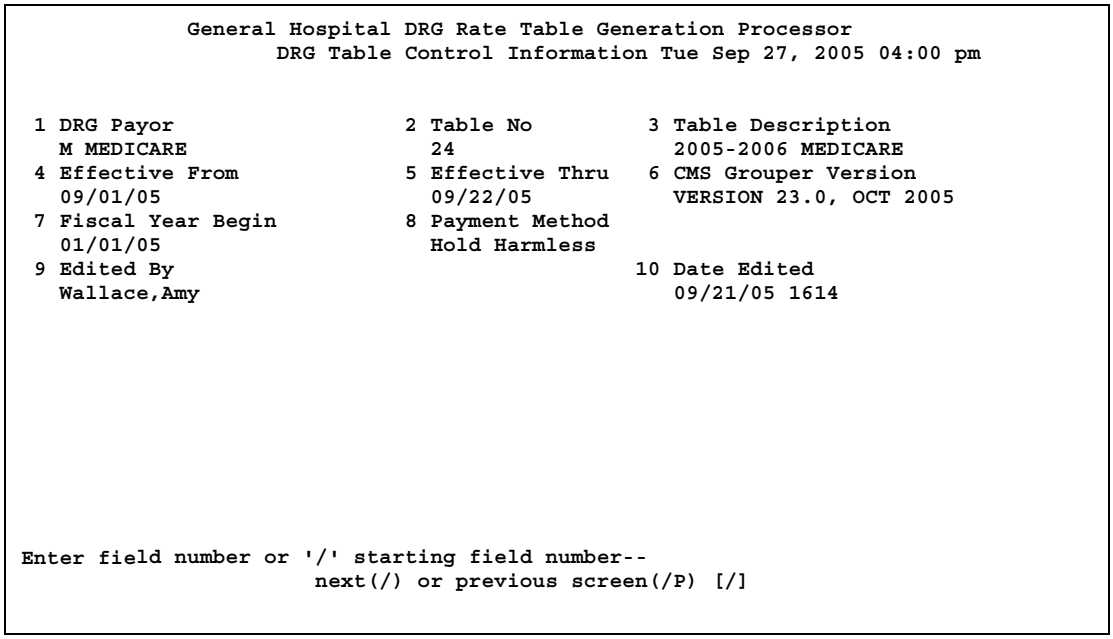
Once this option is selected, this screen displays:

```
                General Hospital Rate Table Generation Processor
                                                Tue Sep 27, 2005 04:00 pm


Page:01                   DRG RATE MASTER TABLE CONTROL
     DRG Payor          Table#      From       To     Description
( 1) CHAMPUS DRG PAYOR.X 01      10/01/90  09/30/91  CHAMPUS
( 2) CHAMPUS DRG PAYOR.X 02      10/01/91  09/30/95  CHAMPUS
( 3) CHAMPUS DRG PAYOR.X 03      10/01/95  09/04/96  champus
( 4) CHAMPUS DRG PAYOR.X 04      09/05/96  12/31/96  TEST
( 5) CHAMPUS DRG PAYOR.X 05      01/06/97  09/22/05  champus
( 6) LONG TERM CARE      01      10/01/04  09/30/05  TEST LTACH DRG
( 7) MEDICARE            01      10/01/90  09/30/91  MEDICARE
( 8) MEDICARE            02      10/01/91  12/31/91  MEDICARE
( 9) MEDICARE            03      01/01/92  09/30/92  1991-92 CAPITAL
(10) MEDICARE            04      10/01/92  09/30/93  1992-93 mcare update
(11) MEDICARE            05      10/01/93  12/31/93  1993-94 MCARE UPDATE
(12) MEDICARE            06      01/01/94  09/30/94  fully update
(13) MEDICARE            07      10/01/94  08/31/95  1994-95 mcare update
(14) MEDICARE            08      09/01/95  09/01/95  0995-96 MCARE UPDATE
(15) MEDICARE            09      09/02/95  09/02/95  12.0

Select DRG table to revise or add(A) new table
                       next pg(/ or PG DN)  Search(TAB)
```

This screen is a listing of all tables currently on file and the effective dates of each. You can select a DRG table to revise, or enter **A** to add a new table. Whether you are revising or adding a table, this screen displays:



Field Explanations

1. DRG PAYOR (1-N-R)
This field is used to indicate the DRG payor associated with this table. Enter the DRG payor code if you know it or press hyphen (-) followed by ENTER to display the DRG Payors table for selection. If this table is not being added, you cannot edit this field.

NOTE: If the Financial Class table is split in your facility, then the DRG Payors table should also be split.

2. TABLE NO (DISPLAY ONLY)
This field is automatically completed by the system when a DRG payor is selected. The system numbers the tables consecutively for each payor. For example, if this is the first table for this payor, the table number is 01. If this payor has five rate tables, the next table number assigned is 06.

3. TABLE DESCRIPTION (20-AN-R)
This is a free-form field used to describe the rate table. For example, MEDICARE 1989-90 indicates this table covers Medicare rate changes for the noted years.

4. EFFECTIVE FROM (DATE-R)
Enter the date this DRG rate table becomes effective. The date can be entered without slashes (01212000) or McKesson conventions can be used. For example, T-3, for today minus three days, can be entered. If you enter a date, you must enter a 4-digit year (mmddyyyy).

5. EFFECTIVE TO (DATE)
Enter the date this DRG rate table ceases to be in effect. It is not required that a date be entered here until necessary (for example, when you know the final effective date of the table).

The date can be entered without slashes (01212000) or McKesson conventions can be used. For example, T-3, for today minus three days, can be entered. If you enter a date, you must enter a 4-digit year (mmddyyyy).

6. CMS GROUPER VERSION
Select the appropriate grouper version that identifies the CMS Grouper Version used to group the DRG for patients assigned this payor and whose discharge date falls within the date range defined by the Effective From and Effective To fields. The grouper version is used to create the rate master using the CMS weights and LOS values for the selected grouper version.

If you selected a non-Medicare payor in the DRG Payor field, the following prompt displays:

Use Medicare calculations? (Y/N) [N]--

Enter **Y** for Yes if you are adding a rate master for a non-Medicare payor that uses Medicare calculations and CMS DRG weights to determine reimbursement. The system displays the hospital-specific DRG Rate Table Control screen for you to enter values. See the hospital-specific field explanations for the Medicare Payor DRG Table Control Information screen.

Enter **N** for No if you are adding a rate master for a non-Medicare payor that does not use Medicare calculations and CMS DRG weights to determine reimbursement. You must manually change the specific weight, LOS, trim points, and expected reimbursement values in the DRG Rate Master function for each DRG. See the DRG Rate Master section.

After you generate a rate master, you can edit this field. When you access this field for a non-Medicare payor, the following prompt displays:

Overlay existing Weights and LOS values in this rate master ? (Y/N)--

Enter **Y** for Yes to overlay the weights and LOS values in the corresponding rate master with the CMS rates associated with the selected grouper version. Enter **N** for No to change only the grouper version and not the weights and LOS values in the rate master. After you enter a response, the following prompt displays:

Use Medicare calculations? (Y/N) [N]--

If you entered Yes to overlay the existing weights and LOS values and entered No to not use Medicare calculations, the following warning prompt displays:

CAUTION: Existing reimbursement amounts will be erased! Continue? (Y/N)--

If you enter **Y** for Yes to overlay weights and you entered **N** to not use Medicare calculations, the rate master will be blank. The Rate Table Generation screens display for you to enter values.

NOTE: The option to overlay weights and LOS values is not available when the DRG Payor field contains the Medicare payor. For the Medicare payor, weights and LOS values in the corresponding rate master automatically overlay with the CMS rates for the new grouper version selected.

7. FISCAL YEAR BEGIN (DATE-C)
Enter the beginning date for your facility's fiscal year in the mm/dd/yyyy format. This field should be completed when you are creating a rate master for a Medicare payor with an effective From date that is 10/01/1991 or later and your facility is Fully Prospective for capital reimbursement. This date can be obtained from the financial department of your hospital. When creating a rate master for a non-Medicare payor, this field should be blank.

8. PAYMENT METHOD (1-A-C)
Enter the payment method indicator. This field is only required when you are creating a rate master for a Medicare payor. Enter either **F** (fully prospective method), **H** (hold harmless method), or **S** (sole community hospital) to describe your capital reimbursement scheme. If you do not enter one of these indicators, the system will not display any further rate master screens or allow generation of a rate master, thus assuming your facility is not reimbursed prospectively for capital costs. When creating a rate master for a non-Medicare payor, this field should be blank.

Impact

After you accept this screen, the following takes place:

- You can enter the information necessary to calculate the hospital's base PPS rate.
- A rate master can now be generated.

If you update or create a Rate Table associated with a Medicare payor, the following screen automatically displays for collecting **operating reimbursement information**. If you choose a Rate Table for another payor type, a prompt displays asking if you want to use the Medicare calculations. If you enter **Y**, this same screen displays.

```
            General Hospital DRG Rate Table Generation Processor
          Medicare Payor DRG Table Control Information Feb 20, 1994 10:41 am
    DRG Payor           Table No   From      Thru      Description
    BLUE CROSS             07     02/20/94             -

                        - HOSPITAL SPECIFIC PORTION -
 1 Base Year Cost     2 Case Mix Index   3 Update Factor  4 % of Total
   0.00                 0.00               0.00             0.00

                          - FEDERAL PORTIONS -
 5 MSA Wage Index     6 COLA
                        0.00
                - REGIONAL -                              - NATIONAL -
 7 % of Fed.   8 Labor      9 Non-Labor    10 % of Fed.  11 Labor     12 Non-Labor
   0.00          0.00         0.00            100.0
                    - COST FACTORS -
13 Operating RCC  14 Educational Adj.   15 Disp. Share Adj   16 Blended PPS Rate


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

NOTE: The information entered on this screen varies by facility and should be obtained from the financial department within your facility.

Field Explanations

HOSPITAL SPECIFIC PORTION

1. BASE YEAR COST, 2. CASE MIX INDEX, 3. UPDATE FACTOR, 4. % OF TOTAL
These fields are for use for those hospitals designated as Sole Community Hospitals or Medicare-Dependent Hospitals by CMS.

NOTE: McKesson cannot determine whether a facility qualifies as one of these types of hospitals. You must obtain this information from your financial department or fiscal intermediary. All other facilities should enter a value of 0.0 in these fields.

FEDERAL PORTIONS

5. MSA WAGE INDEX
This field indicates a facility's MSA Wage Index classification. The MSA Wage Index is facility-specific based on geographic location.

NOTE: McKesson cannot determine whether a facility is classified as urban, rural, or reclassified. You must obtain this information from your fiscal intermediary or the regional CMS office.

6. COLA
This field indicates the cost of living adjustment (COLA) for Alaska and Hawaii.

NOTE: Facilities not located in Alaska or Hawaii should enter a value of 0.0 in this field.

REGIONAL

7. % OF FED
CMS has eliminated the regional floor, so all facilities should enter a value of 0.0 in this field.

8. LABOR
Since the regional percentage has been eliminated, all facilities should enter a value of 0.0 in this field.

9. NON-LABOR
Since the regional percentage has been eliminated, all facilities should enter a value of 0.0 in this field.

NATIONAL

10. % OF FED
All facilities should enter a value of 100.0 in this field.

11. LABOR
This field indicates a value for the National Labor amount, based on whether the facility is considered to be in a Large Urban or Other area.

NOTE: McKesson cannot determine which category is appropriate for your facility. You must obtain this information from your fiscal intermediary or the regional CMS office.

12. NON-LABOR
This field indicates a value for the National Non-Labor amount, based on whether the facility is considered to be in a Large Urban or Other area by CMS.

NOTE: McKesson cannot determine which category is appropriate for your facility. You must obtain this information from your fiscal intermediary or the regional CMS office.

13. OPERATING RCC
This field indicates the national ratio of cost to charges. The value entered in this field is used to calculate cost outlier thresholds and payments to facilities.

NOTE: McKesson cannot determine the Operating RCC for your facility. You must obtain this information from your fiscal intermediary or the regional CMS office.

14. EDUCATIONAL ADJ
This field indicates the educational adjustment percentage. The Intermediate Medical Education (IME) adjustment factor applies to those hospitals that have a teaching or residency program per CMS. You must enter the value as a percentage.

NOTE: McKesson cannot determine the IME adjustment value for your facility. You must determine the value based on CMS's calculations or obtain it from your fiscal intermediary. Facilities that do not have an IME factor should enter a value of 0.0 in this field.

15. DISP SHARE ADJ
This field indicates the Disproportionate Share Hospital (DSH)adjustment percentage. The DSH value applies to those facilities that have met CMS's criteria for disproportionate share. You must enter the value as a percentage.

NOTE: McKesson cannot determine the DSH adjustment value for your facility. You must determine the value based on CMS's calculations or obtain it from your fiscal intermediary. Facilities that do not have a DSH factor should enter a value of 0.0 in this field.

16. BLENDED PPS RATE
This field displays the blended PPS rate, which is calculated based on information entered in other fields on this screen. When you access this field, the system prompts you for automatic calculation of the PPS rate, or you can enter the rate directly into the field. Enter **Y** for Yes to receive the automatic rate calculation.

If you change or add information to the screen and then accept the screen, this prompt displays:

Calc. Hosp. blended PPS rate? (Y/N) [N]--

If you are processing a Medicare rate master, the system displays the appropriate capital-related information screen explained in the following pages. If you are processing a non-Medicare rate master, the following prompt displays:

Generating Rate Master!

Once the rate master is generated, this prompt displays:

Print rate master? (Y/N) [N]--

To print the rate master, enter **Y**. If the rate master is not to be printed, press ENTER to accept the default of **N** for No. After you respond to this prompt, you are returned to the screen listing all the rate tables on file.

The following is an example of a printed rate master:

Figure 4.1 DRG Rate Master

```
Wed Sep 21, 1994 07:43 am         Model Hospital A                    Page 5
RATE MASTER REPORT

DRG PAYOR: M MEDICARE            TBL#: 07  EFFECTIVE FROM 09/14/94    TO

MDC DRG      WEIGHT   GLOS   ALOS   OTLR  OPER:REIMB   COST OTLR   STAY/DIEM
    DESCRIPTION                          CAP: REIMB   COST OTLR   STAY/DIEM
-------------------------------------------------------------------------------

3   065     0.50670   3.00   3.80   22.00    3025.14    26978.65     654.84
    DISEQUILIBRIUM,MED                        267.38     2305.55      70.36

3   066     0.50760   3.10   3.90   24.00    3030.51    26983.07     639.18
    EPISTAXIS, MEDICAL                        267.85     2305.99      68.68

3   067     0.83810   3.80   4.70   26.00    5003.70    28606.15     875.72
    EPIGLOTTITIS,MEDICAL                      442.25     2468.46      94.10

3   068     0.71000   4.40   5.40   26.00    4238.90    27977.06     645.70
    OTITIS MEDIA/URI >17 W/CC                 374.66     2405.49      69.38

3   069     0.51330   3.50   4.20   22.00    3064.55    27011.06     600.19
    OTITIS MED/URI,18+W0CC,MED                270.86     2308.80      64.49

3   070     0.58120   3.60   4.40   24.00    3469.93    27344.52     648.70
    OTITIS MED/URI,0-17,MED                   306.69     2342.17      69.70

3   071     0.65080   3.50   4.20   22.00    3885.46    27686.33     760.97
    LARYNGOTRACHEITIS,MED                     343.42     2376.39      81.77

3   072     0.61600   3.10   4.40   25.00    3677.69    27515.42     687.54
    NASAL TRAUMA/DEFORMITY,MED                325.05     2359.28      73.88

3   073     0.76160   4.10   5.50   26.00    4546.97    28230.46     680.04
    OTH ENT & MOUTH DX AGE >17                401.89     2430.85      73.07

3   074     0.35710   2.10   2.10   20.00    2131.99    26243.97     835.10
    OTH ENT MOUTH DX AGE 0-17                 188.44     2232.01      89.73

4   075     3.05510   9.90  12.40   32.00   18239.83    39493.82    1209.96
    MJ CHEST OR PROC                         1612.14     3558.28     130.01

4   076     2.51260  10.00  13.90   32.00   15000.95    36829.61     887.72
    OTHER RESP OR PROC,WCC                   1325.87     3291.60      95.39

4   077     1.06300   4.00   6.00   26.00    6346.41    29710.64     870.06
    OTHER RESP OR WO CC                       560.93     2579.01      93.49

4   078     1.42110   7.80   9.20   30.00    8484.37    31469.26     758.59
    PULMONARY EMBOLISM,MED                    749.90     2755.05      81.51

4   079     1.69550   8.30  10.70   30.00   10122.62    32816.84     778.19
    RSP INFEC/INFLAM,18+,WCC,M                894.69     2889.93      83.62

4   080     0.92590   5.90   7.40   28.00    5527.89    29037.34     614.47
    RSP INFEC/INFLAM,18+W0CC,M                488.58     2511.62      66.02
```

Impact

After you accept this screen, the following takes place:

- A rate master is now created for the payor; it displays the associated reimbursement when the payor is used.

Output

A Rate Master table can be printed.

Capital Reimbursement

FULLY PROSPECTIVE OR SOLE COMMUNITY METHODOLOGY

If your facility is using

- the Fully Prospective Method for calculating capital reimbursement and you entered **F** in the Payment Method field or

- the Sole Community Method for calculating capital reimbursement and you entered **S** in the Payment Method field,

you *must* complete this screen when creating a rate master at the beginning of each fiscal year.

```
            General Hospital DRG Rate Table Generation Processor
          Medicare Payor DRG Table Control Information Sep 23, 1991 05:14 pm
    DRG Payor           Table No   From      Thru      Description
    MEDICARE               17     10/01/91             MEDICARE 1991

 1 Standard Fed Rate   2 Fed. % of Cap     3 Hosp % of Cap    4 Hosp Spec Rate
   415.59                10.00               90.00            566.00

 5 Large Urban Add-on  6 Capital DSH Adj   7 Capital IME Adj  8 Capital RCC
   1.03                  0.05897             0.02139            0.06620

 9 Geographic Adj Factor  10 COLA (Alaska,Hawaii)     11 Hospital Adj Rate
   0.97270                   0.00000                     416.72









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

NOTE: The information entered on this screen varies by facility and should be obtained from the financial department within your facility.

Field Explanations

1. STANDARD FED RATE
Enter the standard federal rate for capital reimbursement. This rate is used in creating the hospital adjusted rate. CMS updates this field annually or as changes require.

NOTE: McKesson cannot determine the standard federal rate for your facility. You must obtain this information from your fiscal intermediary or the regional CMS office.

2. FED % OF CAP
Enter the federal percentage of capital reimbursement. The fully prospective payment methodology is a 10-year transition, and this number will change each year. The value in this field is used in the calculation of the capital reimbursement by DRG, and in the calculation of capital outlier payment.

NOTE: McKesson cannot determine the federal percentage of capital reimbursement for your facility. You must obtain this information from your fiscal intermediary or the regional CMS office.

3. HOSP % OF CAP
Enter the hospital percentage of capital reimbursement. The fully prospective payment methodology is a 10 year-transition, and this number will change each year.

NOTE: McKesson cannot determine the hospital percentage of capital reimbursement for your facility. You must obtain this information from your fiscal intermediary or the regional CMS office.

4. HOSP SPEC RATE
Enter the hospital-specific rate. This information is facility-specific and is obtained from the fiscal intermediary. McKesson does not have access to this information.

5. LARGE URBAN ADD-ON
Enter a value in this field if your facility qualifies as large urban by CMS. This information is facility-specific and is obtained from the fiscal intermediary. For those facilities that are not considered large urban, the value in this field is 0.0.

6. CAPITAL DSH ADJ
The Capital DSH (Disproportionate Share Hospital) adjustment factor is used for those facilities that have met CMS's criteria for disproportionate share. The value entered in this field must be determined by the facility based on CMS's calculations or must be obtained by the facility from their FI. This is a different value from that entered in the previous screen. McKesson does not have access to this information. If a facility does not have a DSH adjustment factor, the value in this field is 0.000.

7. CAPITAL IME ADJ
The Capital IME (Indirect Medical Education) adjustment factor is used for those facilities that have a teaching or residency program. The value entered in this field must be determined by the facility based on CMS's calculations or must be obtained by the facility from their FI. This is a different value from that entered in the previous screen. McKesson does not have access to this information. If a facility does not have an IME adjustment factor, the value in this field is 0.0000.

8. CAPITAL RCC
This field is used in determining outlier payments to facilities.

NOTE: McKesson cannot determine the Capital RCC for your facility. You must obtain this information from your fiscal intermediary or the regional CMS office.

9. GEOGRAPHIC ADJ FACTOR
Enter the geographic adjustment factor, which is facility-specific based on location.

NOTE: McKesson cannot determine the geographic adjustment factor for your facility. You must obtain this information from your fiscal intermediary or the regional CMS office.

10. COLA (Alaska & Hawaii)
CMS provides an additional payment to hospitals located in Alaska or Hawaii. Enter the COLA (cost of living adjustment) here. For hospitals not located in Alaska or Hawaii, the value in this field is 0.0.

11. HOSPITAL ADJ. RATE
The value in this field is calculated and completed by the system based on previously completed fields. The calculation being used is as follows:

Standard Federal Rate x Geographic Adj x Large Urban Add-on, or 1

x COLA, or 1 = Hospital Adjusted Rate

(If the value in either Large Urban Add-on or COLA is 0.0, the system substitutes a 1 in the calculation so the hospital adjusted rate is not zero.)

After you accept the capital screen, the system automatically generates the rate master and the following prompt displays:

Generating Rate Master!

Once the rate master is generated, this prompt displays:

Print rate master? (Y/N) [N]--

To print the rate master, enter **Y**. If the rate master is not to be printed, press ENTER to accept the default of **N** for No. After you respond to this prompt, you are returned to the screen listing all the rate tables on file.

Refer to Figure 4.1 on page 4-14 for an example of a printed rate master.

HOLD HARMLESS METHODOLOGY

If your facility is using the Hold Harmless Method for calculating capital reimbursement and you entered **H** in the Payment Method field, you must complete this screen when creating a Medicare rate master.

```
              General Hospital DRG Rate Table Generation Processor
          Medicare Payor DRG Table Control Information Sep 26, 1991 08:46 am
    DRG Payor           Table No   From      Thru      Description
    MEDICARE               17     09/01/91             1992

 1 Standard Fed Rate      2 Large Urban Add-on     3 Capital RCC
   415.59                   1.03                     0.06390

 4 Capital DSH Adj        5 Capital IME Adj        6 Geographic Adj Factor
   0.00231                  0.01230                  0.97270

 7 COLA (Alaska,Hawaii)   8 Hosp Ratio of New Cap  9 Remaining Old Cap
   0.00000                  0.1989                   2283000.00

10 Capital Discount      11 Medicare Discharges   12 1st Yr Transition Payment
   0.85                     1700                     1021.73

                         13 Hold Harmless Rate
                            1344.72


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

NOTE: The information entered on this screen varies by facility and should be obtained from the financial department within your facility.

Field Explanations

1. STANDARD FED RATE

Enter the standard federal rate for capital reimbursement. This rate is used in creating the hospital adjusted rate. CMS will update this field annually or as changes require.

NOTE: McKesson cannot determine the standard federal rate for your facility. You must obtain this information from your fiscal intermediary or the regional CMS office.

2. LARGE URBAN ADD-ON

Enter a value in this field if your facility qualifies as large urban. This information is facility-specific and is obtained from the fiscal intermediary. For those facilities that are not large urban, the value in this field is 0.0.

3. CAPITAL RCC

This field is used in determining cost outlier thresholds and outlier payments to facilities. Regardless of when your fiscal year begins, you should always enter the most recent value.

NOTE: McKesson cannot determine the capital RCC for your facility. You must obtain this information from your fiscal intermediary or the regional CMS office.

4. CAPITAL DSH ADJ
The Capital DSH (Disproportionate Share Hospital) adjustment factor is used for those facilities that have met CMS's criteria for disproportionate share. The value entered in this field must be determined by the facility based on CMS's calculations or must be obtained by the facility from their FI. This is a different value from that entered in the first screen for rate master. McKesson does not have access to this information. If a facility does not have a DSH adjustment factor, the value in this field is 0.000.

5. CAPITAL IME ADJ
The Capital IME (Indirect Medical Education) adjustment factor is used for those facilities that have a teaching or residency program. The value entered in this field must be determined by the facility based on CMS's calculations or must be obtained by the facility from their FI. This is a different value from that entered in the first screen for rate master. McKesson does not have access to this information. If a facility does not have an IME adjustment factor, the value in this field is 0.0000.

6. GEOGRAPHIC ADJ FACTOR
Enter the geographic adjustment factor, which is facility-specific based on location.

NOTE: McKesson cannot determine the geographic adjustment factor for your facility. You must obtain this information from your fiscal intermediary or the regional CMS office.

7. COLA (Alaska & Hawaii)
CMS provides an additional payment to hospitals located in Alaska or Hawaii. Enter the COLA (cost of living adjustment) here. For hospitals not located in Alaska or Hawaii, the value in this field is 0.0.

8. HOSP RATIO OF NEW CAP
The value in this field is determined by each facility. It is the ratio of new capital to total capital. This information can be obtained from the facility's financial department. McKesson does not have access to this information and it is not printed in the Federal Register.

9. REMAINING OLD CAP
The value in this field is determined by each facility. It is the dollar value of the first transition year of Medicare inpatient related old capital costs. This information can be obtained from the facility's financial department. McKesson does not have access to this information and it is not printed in the Federal Register.

10. CAPITAL DISCOUNT
Enter the value determined by CMS, which has been .85 for several years.

NOTE: McKesson cannot determine the capital discount for your facility. You must obtain this information from your fiscal intermediary or the regional CMS office.

11. MEDICARE DISCHARGES
Enter your facility's expected number of Medicare discharges. This information can be obtained from your facility's financial department. McKesson does not have access to this information, and it is not printed in the Federal Register.

12. 1ST YR TRANSITION PAYMENT
Enter your facility's dollar value of the first transition year payment based on 100% of the federal rate. This information can be obtained from your facility's financial department. McKesson does not have access to this information and it is not printed in the Federal Register.

13. HOLD HARMLESS RATE
This field is automatically calculated by the system as follows:

Standard Federal Rate x Geographic Adj Factor x
Large Urban Add-On, or 1 x COLA, or 1 = Hold Harmless Rate

After you accept the capital screen, the system automatically generates the rate master and the following prompt displays:

Generating Rate Master!

Once the rate master is generated, this prompt displays:

Print rate master? (Y/N) [N]--

To print the rate master, enter **Y**. If the rate master is not to be printed, press ENTER to accept the default of **N** for No. After you respond to this prompt, you are returned to the screen listing all the rate tables on file.

Refer to Figure 4.1 for an example of a printed rate master. The Rate Master Report name is DRMRX.

DRG RATE MASTER

The DRG Rate Master is a system file listing each DRG and its amount of reimbursement, standard length of stay, and stay and cost outlier trim points. It is created as a result of the DRG Rate Table Generation function. For each DRG Rate Table that is generated for a payor, a DRG Rate Master is created. Values for individual DRGs can be modified through the DRG Rate Master function.

The version of a rate table used in the reimbursement calculation of a patient's DRG is determined by the patient's discharge date and where it falls in relation to the effective dates of the table for that payor. When a patient is assigned a DRG, information from the Rate Master is tied to that patient's DRG payor and displays on the DRG Assignment and Standards and Comparisons screens of the Medical Record Abstracting and DRG Assignment functions.

For financial classes set up as Medicare payors, the rate master information is view-only and cannot be altered. For non-Medicare payors, the information for a particular DRG can be altered. To access the rate master, select this function from the menu, and this screen displays:

```
                General Hospital DRG Rate Master Processor
                                          Thu Feb 22, 1990 01:40 pm

DRG Rate Table Control
                                      Effective
        DRG payor           Table No    From      Thru    Description
   ( 1) CHAMPUS                01     10/01/87  05/15/88  1987-88 CHAMPUS
   ( 2) CHAMPUS                02     04/01/89  09/30/89  NEW CHAMPUS
   ( 3) CHAMPUS                03     10/01/89            10/89 CHAMPUS RATES
   ( 4) MEDICAID GEORGIA       01     02/26/86  03/28/86  TEST
   ( 5) MEDICAID GEORGIA       02     06/01/89  07/31/89  TEST FOR 2728
   ( 6) BLUE CROSS             01     10/01/89            BLUE CROSS 89-90
   ( 7) KAISER                 01     02/01/86  09/30/87  TESTER
   ( 8) KAISER                 02     10/01/87  09/30/88  NEW KAISER
   ( 9) KAISER                 03     10/01/88  10/31/88  NEW KAISER RM
   (10) KAISER                 04     06/01/89            TEST FOR 2728
   (11) PRUDENTIAL             01     02/25/86  03/17/86  TEST TABLE
   (12) PRUDENTIAL             02     10/01/87  04/30/88  OLD MEDICARE MODEL
   (13) PRUDENTIAL             03     05/01/88  01/17/90  TEST OF TABLE GENERA
   (14) PRUDENTIAL             04     01/18/90            TEST RATE MASTER
   (15) MEDICARE               01     10/31/85  05/01/86  MEDICARE 1986

Select DRG Table to revise, or `/` for next page--
```

This screen is a listing, by payor, of all rate masters generated and their effective dates. Select the DRG table to revise by entering the number to the left of the payor followed by ENTER. The next prompt requests you to enter the DRG number.

Once a DRG number is entered, this screen displays:

```
                General Hospital DRG Rate Master Processor
                                              Thu Feb 22, 1990 01:40 pm

 1 DRG Payor             2 DRG Table                3 From       4 Thru
   2 MEDICAID GEORGIA      01 TEST                    02/26/86     03/28/86
 5 Major Diagnostic Category
   1 DISEASES/DISORDERS OF THE NERVOUS SYSTEM
 6 DRG                                 7 C/C Ind.          8 Weight Factor
   008 PERIPH/CRAN/OTH OR WO70CC                             0.7466
 9 Geometric LOS        10 Arith LOS   11 Stay Trimpoint
   3.70                                  19.00
12 Operating Reimb Amount              13 Operating Cost Outlier Threshold
   60.02                                 22260.55
14 Transfer rate per diem              15 Oper Stay Outl per diem
   16.22                                 0.10
16 Capital Reimb Amount                17 Capital Cost Outlier Threshold

18 Capital Transfer Rate per diem      19 Capital Stay Outlier per diem



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

Since this example is a rate master for a Medicare payor, none of the fields on this screen can be edited.

Field Explanations

1. DRG PAYOR (DISPLAY ONLY)
This field displays the DRG payor code and description used in creating the rate master. In this case it should be the Medicare payor.

2. DRG TABLE (DISPLAY ONLY)
This field displays the rate master table number and description accessed.

3. FROM (DISPLAY ONLY)
This field displays the beginning effective date for this table.

4. THRU (DISPLAY ONLY)
This field displays the ending effective date for this table.

5. MAJOR DIAGNOSTIC CATEGORY (DISPLAY ONLY)
This field displays the number and description of the major diagnostic category (MDC) to which this DRG has been classified. There are a total of 25 MDCs to which 492 DRGs are classified.

6. DRG (DISPLAY ONLY)
This is the number and description of the DRG that was selected for viewing.

7. C/C IND (DISPLAY ONLY OR 1-A-O IF NON-MEDICARE)
This field displays Yes or No to indicate whether this DRG is affected by the presence of a complication or comorbidity (C/C). If the DRG is not affected by a C/C, this field is blank.

8. WEIGHT FACTOR (DISPLAY ONLY OR 6-N-O IF NON-MEDICARE) (99.9999)
This field displays the weighting factor of this DRG. CMS assigns a weight to each DRG. Generally, the higher the weight, the greater the reimbursement.

9. GEOMETRIC LOS (DISPLAY ONLY OR 5-N-O IF NON-MEDICARE) (999.99)
This field displays the geometric mean length of stay for this DRG as defined by CMS.

10. ARITH LOS (DISPLAY ONLY OR 5-N-O IF NON-MEDICARE) (999.99)
This field displays the arithmetic mean length of stay for this DRG as defined by CMS. As of 10/01/92, the arithmetic LOS is used in the calculation of high stay outlier per diem.

11. STAY TRIMPOINT (DISPLAY ONLY OR 5-N-O IF NON-MEDICARE) (999.99)
This field displays the day of stay at which a case grouped to this DRG becomes a stay outlier. The stay trim point for each DRG is defined by CMS.

12. OPERATING REIMB AMOUNT (DISPLAY ONLY OR 8-N-O IF NON-MEDICARE) (999999.99)
This field displays the operating portion of the expected reimbursement amount for this DRG. The value of this field is the Blended PPS Rate multiplied by the weight of this DRG.

13. OPERATING COST OUTLIER THRESHOLD (DISPLAY ONLY OR 8-N-O IF NON-MEDICARE) (999999.99)
This field displays the cost outlier threshold used in calculating the operating portion of outlier reimbursement. This field contains the higher of two times the operating reimbursement amount for the DRG or a calculation defined by CMS, whichever is greater.

For non-Medicare payors, enter the threshold amounts provided by the payor. If the payor does not provide a threshold amount and this field is left blank, the system interprets this threshold as $0.00. Because patient charges are more than $0.00, all patients would meet the threshold and be considered cost outliers; therefore, enter a large threshold amount in this field.

14. TRANSFER RATE PER DIEM (DISPLAY ONLY OR 8-N-O IF NON-MEDICARE) (999999.99)
This field displays the operating amount a facility will receive if a patient is transferred to a non-exempt facility.

15. OPER STAY OUTL PER DIEM (DISPLAY ONLY OR 8-N-O IF NON-MEDICARE) (999999.99)
This field displays the additional daily amount (for operating costs) a facility willreceive if a patient is classified as a stay outlier (for example, has a length of stay greater than the number in Field 12).

16. CAPITAL REIMB AMOUNT (DISPLAY ONLY)
This field displays the amount of capital reimbursement the facility will receive when this DRG is assigned to a patient. For non-Medicare rate masters, or those created prior to the beginning of capital reimbursement, this field is blank.

17. CAPITAL COST OUTLIER THRESHOLD (DISPLAY ONLY)
This field displays the cost outlier threshold used in calculating the capital portion of the outlier reimbursement. This field contains the higher of two times the capital reimbursement amount for the DRG or a calculation defined by CMS, whichever is greater. For non-Medicare rate masters, or those created prior to the beginning of capital reimbursement, this field is blank.

18. CAPITAL TRANSFER RATE PER DIEM (DISPLAY ONLY)
This field displays the additional daily amount (for capital costs) a facility will receive if a patient is classified as a stay outlier (for example, has a length of stay greater than the number in Field 12). For non-Medicare rate masters, or those created prior to capital reimbursement, this field is blank.

19. CAPITAL STAY OUTLIER PER DIEM (DISPLAY ONLY)
This field displays the capital amount a facility receives if a patient is transferred to a non-exempt facility.

If you have updated this screen (non-Medicare Rate Master only),the system prompts you to accept the changes. Once accepted, you can enter another DRG to view or update. If you do not enter another DRG and press ENTER, this prompt displays:

Do you wish to print rate master listing? (Y/N) [N]--

Press ENTER to accept the default of **N** for No, and a rate master is not printed. If you want to print a rate master, enter **Y** for Yes followed by ENTER, and the rate master prints. Please refer to the DRG Rate Table Generation function in this section for a sample of a DRG rate master report.

Impact

After you accept this screen, the selected DRG in the selected rate master utilizes the updated information when associated with a patient record.

Output

A Rate Master table can be printed. The report name is DRMRX.

M/R ABSTRACT & DRG CENSUS CRITERIA

Since patients for whom DRGs are calculated are always abstracted, there is *one* census for both Medical Record Abstracting and DRG. This census is created using the option M/R Abstract & DRG Census criteria, which is available on the Maintenance Functions menu in the character-based system. To determine which patients should display on DRG-related reports, the system checks the DRG Required parameter associated with the patient's abstract code. If a DRG is not required, then the patient does not display on the DRG-related reports.

Refer to the M/R Maintenance chapter of the *STAR Patient Care Reference Guide, Medical Record Abstracting Module* for a complete discussion of the M/R Abstract & DRG Census option, including the DRG Required parameter.

Concurrent Monitoring Parameters

The Concurrent Monitoring Parameters function is composed of two sections:

- Standards Basis - This section determines whether the concurrent monitoring reports use hospital averages for cost, charges and length-of-stay for patients treated at the hospital for a specific DRG, or use hospital-defined and maintained budget figures. If you choose to use the system-maintained averages, you must complete the field indicating the number of months for the averages to accumulate.

- Concurrent Monitoring Report Exceptions - Patients are flagged on concurrent monitoring reports according to the parameters set in this section. The hospital decides how many days before the patient reaches the standard length-of-stay that the patient should be included on the reports. For example, if this parameter is set to 2 and the standard length-of-stay for the DRG is 15 days, the patient is flagged on the report on day 13. The other reporting parameter is for percent of reimbursement. In this case, if the hospital sets this figure to 80.0, a patient whose charges reach 80% of the total charges budgeted for that DRG would be included on the reports.

NOTE: The Patient Accounting Billing Parameters can be defined to require a Final DRG before billing. Accounts must be included in the DRG Census and have their DRG marked as Final to pass this type of billing requirement.

When you select this function from the Maintenance Functions Input Options menu, the system displays this screen:

```
         General Hospital DRG Census Criteria/CM Parameters Processor
                                                 Tue Apr 02, 1996 01:41 pm



Standards Basis
 1 Average/Budget                          2 Number of months for average
   AVERAGE                                   6

Concurrent Monitoring Report Exceptions
 3 Days within StdLOS                      4 % of ReimAmount
   2                                         75.0









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

Field Explanations

1. AVERAGE/BUDGET (1-A-O)
Enter **A** for average or **B** for budget to determine how standards should be calculated. If **A** is entered, the field indicating the number of months for average must be completed.

2. NUMBER OF MONTHS FOR AVERAGE (2-N-O)
Enter a number from one to 18 to indicate the number of months used in calculating averages for a DRG. The averages used are cost, charges, and length-of-stay. If, for example, you enter 6, the six months of dataare not available until six months after the Implementation Date entered in the Medical Record Module Parameters in the HBO & Company tables (please consult your McKesson representative regarding these tables).

3. DAYS WITHIN STDLOS (2-N-O)
Enter the number of days within the standard length-of-stay that a patient should be flagged on the concurrent monitoring reports. If, for example, you enter 2, then two days before the patient reaches the standard length of stay for their assigned DRG they are flagged on the report.

4. % OF REIMBURSEMENT (2-C-O)
Enter the percent of reimbursement a patient must reach to be flagged on the concurrent monitoring reports. For example, if you enter 80, when the patient's charges reach 80% of the expected reimbursement for the assigned DRG, they are flagged on the report.

If you change or update any of the parameters on this screen, the system requests you accept the screen. Once the screen is accepted, you are returned to the Maintenance Functions Input Options menu.

Impact

After you accept this screen, the following takes place:

- The system uses the Standards Basis when displaying information on the Standards screen of DRG Assignment.
- The values placed in the Days within STDLOS, and % of Reimbursement fields determine when the associated message displays on the Concurrent Monitoring Reports.

CALCULATE BUDGET USING AVERAGES

Concurrent monitoring reports compare a patient's actual costs and charges against the hospital's standard budget figures. There are two methods of obtaining the standard figures:

1. The hospital can use averages maintained in the system.

2. Hospital personnel can enter, by payor, budget information for each day of stay for each major revenue center for each DRG.

The first option uses the Calculate Budget Using Averages function which calculates the system averages using actual patient data over a specified number of months. The number of months is specified in the DRG Census Criteria/CM Parameters function.

In order for the averages to be meaningful and useful, there must be enough data by DRG by payor. Therefore, it is possible that it may be several months before adequate data is available, depending on the activity of that DRG in your facility.

To set up a budget using averages, select this option from the Maintenance Functions Input Options menu, and this screen displays:

```
          General Hospital Calculate Budget Using Averages Processor
                                                  Thu Feb 22, 1990 01:42 pm
 DRG BUDGETS GENERAL HOSPITAL A

      Budget    Payors              Effective Date
( 4)    11      MEDICAID GEORGIA    06/01/89
                MEDICAID GEORGIA    06/01/90
( 5)    12      MEDICARE            06/28/89
( 6)    14      PIEDMONT            09/25/89
( 7)    15      MEDICARE            01/01/89
( 8)    16      MEDICARE            06/01/89
( 9)    17      BLUE CROSS          06/01/89
(10)    18      PIECE OF THE ROCK   06/01/89
(11)    19      NORTHWESTERN        06/01/89
(12)    20      MEDICARE            01/15/90
                MEDICARE            01/01/90
(13)    21      PIEDMONT            01/01/90
(14)    22      PIECE OF THE ROCK   01/01/90
(15)    23      CHAMPUS             01/01/90
(16)    24      BLUE CROSS          01/01/90

Select budget number or add(A) new budget--
```

This screen may or may not contain any budgets, depending on whether any have been established. To add a budget, press **A** followed by ENTER, and this screen displays:

```
          General Hospital Calculate Budget Using Averages Processor
                                                  Thu Feb 22, 1990 01:42 pm
 DRG BUDGETS GENERAL HOSPITAL A

Page:01                              DRG Payors                ##=Current Choices
( 1) BLUE CROSS
( 2) CHAMPUS
( 3) KAISER
( 4) MEDICAID GEORGIA
( 5) MEDICARE
( 6) NORTHWESTERN
( 7) PIECE OF THE ROCK
( 8) PIEDMONT









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

This screen displays a listing of the DRG Payors table. Select the payor(s) to be associated with this budget. Once the payor(s) is selected, the system prompts you to enter an effective date. The effective date is the date you want the data to be processed. For example, if you enter an effective date of 01-01-90 and in the CM parameters you entered the number of months as six, the data you are averaging includes six months back from 01-01-90.

NOTE: If the implementation date for the Medical Record Modules (in the HBO & Company tables) does not allow you to go back six months, the averaging does not include a complete six months.

Once you enter an effective date, the system prompts you to begin average calculation for the budget (the system also assigns the budget a number). If you enter **Y** for Yes, the system searches for cost and charge information for each DRG for the designated payor(s). If you accept the default of **N** for No, the system returns you to the screen listing of the DRG Budgets and the budget is not created.

After the budget has been calculated, the system prompts you to print a budget worksheet. Enter **Y** for Yes to print a worksheet, or press ENTER to accept the default of **N** for No and a worksheet is not printed. Once you respond to this prompt, you are returned to the screen listing the budgets.

To revise a budget, enter the budget number, and the system prompts you to replace the selected budget. If you enter **N** for No, the budget is not replaced and you are returned to the screen listing the budgets. Enter **Y** for Yes and the screen listing the DRG payors displays for selection. Once the payor(s) is selected, the system prompts you to enter an effective date. Follow the instructions regarding effective date as previously outlined.

Once you enter an effective date, the system prompts you to begin average calculation for the budget (the system retains the same budget number). If you enter **Y** for Yes, the system searches for cost and charge information for each DRG for the designated payor(s). If you accept the default of **N** for No, the system creates a skeleton budget without any amounts.

After the budget has been calculated, the system prompts you to print a budget worksheet. Enter **Y** for Yes to print a worksheet. If you press ENTER to accept the default of **N** for No, a worksheet is not printed. Once you respond to this prompt, you are returned to the screen listing the budgets.

To display a new budget, you must first exit the function. It then displays when you reenter the function.

BUDGET MAINTENANCE

When a patient's DRG is calculated by the system, one of the options on the DRG assignment results screen is to examine the Standards to which this patient is to be compared. On the top half of this screen, the set of Hospital Comparisons are based on historical information gathered over time by the system, or compiled manually and entered in the system. The method is determined by the entry made in the DRG Census Criteria/CM Parameters function in this manual.

Several budgets can be maintained on the system at the same time. Like the Rate Master, the budget used is determined by the effective date it is assigned. Each budget can also be linked to specific DRG payors so a patient on Medicare can have a different set of standards than a Medicaid or CHAMPUS patient. However, due to the complexity of the data matrix, when a new budget is generated based on historical data, it is generated for all patients and must be altered as outlined below if it is to be payor-specific.

After exiting the Budget Maintenance function, if a budget has been modified, a prompt displays asking you to print a DRG Budget Worksheet. Use this report to document the data base and assist in the budget refinement process.

When the averaging method is used to determine the hospital's standards, it is probable that inadequate information has been collected for several DRGs, and the data may not be accurate. The Budget Maintenance function is used to alter budget data so it is more accurate and reliable. When you select this option, the following screen displays:

```
                General Hospital Budget Maintenance Processor
                                                Thu Feb 22, 1990 01:43 pm

DRG Budgets for GENERAL HOSPITAL A

      Budget#   DRG Payor           Effective Date
 ( 4)   11      MEDICAID GEORGIA    06/01/89
                MEDICAID GEORGIA    06/01/90
 ( 5)   12      MEDICARE            06/28/89
 ( 6)   14      LINCOLN             09/25/89
 ( 7)   15      MEDICARE            01/01/89
 ( 8)   16      MEDICARE            06/01/89
 ( 9)   17      BLUE CROSS          06/01/89
 (10)   18      PRUDENTIAL          06/01/89
 (11)   19      NORTHWESTERN        06/01/89
 (12)   20      MEDICARE            01/15/90
                MEDICARE            01/01/90
 (13)   21      LINCOLN             01/01/90
 (14)   22      PRUDENTIAL          01/01/90
 (15)   23      CHAMPUS             01/01/90
 (16)   24      BLUE CROSS          01/01/90
Select DRG budget to revise or add(A) new budget--
```

This screen is a listing of all existing budgets. Select the budget to be revised, and this prompt displays:

Select DRG payor to revise, add payor(A) or modify budget(M)--

Revising a DRG payor is used to change the effective date for the budget. To revise a DRG payor, enter the number which displays to the left of the payor description and press ENTER. The system prompts you to enter a new effective date for the budget. Enter a new date or press period (.) followed by ENTER to abort the revision. If you enter a new effective date, this date displays with the payor.

Adding a payor is used to link another payor to a budget that is already established. It may be that you have two payors on whom you want to use the same budgeted information. This function enables you to accomplish that. To add a payor, press **A** followed by ENTER. The system prompts you to enter the new payor code (if you know it), or press hyphen (-) followed by ENTER to list the DRG Payors table for selection. Once a payor is selected, the system prompts you to enter an effective date. Once you enter an effective date for the new payor, both the payor and date display on the upper portion of the screen. Both payors have the same budget number and both are affected by any modifications made to a DRG budget.

Modifying a budget is used to add cost and charge information to 10 major revenue centers. This information is added by payor, by day, and by revenue center. It is used in Utilization Review and Concurrent Monitoring to compare the patient's actual charges to what has been entered via this function.

To modify a budget, press **M** followed by ENTER, and select the payor to be modified by entering the number to the left of the payor description followed by pressing ENTER. The system prompts you to enter the DRG for which the budgeted information is to be revised. Once the DRG is entered, this screen displays:

```
               General Hospital Budget Maintenance Processor
                                                    Thu Feb 22, 1990 01:43 pm
 1 Budget# 2 DRG
   11        001  CRANIOT, 18+,WO PRDX TRAUM
 3 Budget Charges & Costs                  4 Budget LOS
->                                           1
         Charges      Costs
( 1)     3000.00      2564.00

Total    3000.00      2564.00









Select day of stay to revise or add(A) day of stay--
```

Field Explanations

1. BUDGET # (DISPLAY ONLY)
This is the budget number associated with the selected payor and effective date.

2. DRG (DISPLAY ONLY)
This is the DRG number selected for budget modification.

3. BUDGET CHARGES & COSTS
This is the only field on this screen where information is entered. You are prompted to select the day of stay to revise or enter **A** to add a day of stay. If information has not been previously entered for this DRG, there will be no days to revise. To add information by day, press **A** followed by ENTER, and the screen displays as follows:

```
               General Hospital Budget Maintenance Processor
                                                  Thu Feb 22, 1990 01:43 pm
 1 Budget# 2 DRG
   11        001  CRANIOT, 18+,WO PRDX TRAUM
 3 Budget Charges & Costs                  4 Budget LOS
->                                           1
Day of Stay:   2
         Revenue Center          Charges       Cost
( 1) 01  NURSING SERVICES         0.00          0.00
( 2) 02  SURGERY-DELIVERY         0.00          0.00
( 3) 03  PHARMACY                 0.00          0.00
( 4) 04  PATHOLOGY-BLOOD          0.00          0.00
( 5) 05  RADIOLOGY SERVICES       0.00          0.00
( 6) 06  CENTRAL SUPPLY           0.00          0.00
( 7) 07  INHAL-PHYSICAL THY       0.00          0.00
( 8) 08  EMERGENCY SERVICES       0.00          0.00
( 9) 09  EKG-EEG-EMG              0.00          0.00
(10) 10  OTHERS                   0.00          0.00

Total                             0.00          0.00

Select revenue center to revise--
```

You are prompted to select the major revenue center to revise. To revise or add information for a revenue center, enter the number which displays to the left of the center description and press ENTER. The system now prompts you to enter the charges for the revenue center. The default is 0.00. Enter an amount up to 9999999.99, and press ENTER. The amount entered should reflect charges for that revenue center for one day. The charges entered do not display on the screen until you respond to the next prompt and enter cost information.

The system now prompts you to enter the cost for the revenue center. Again, the default is 0.00. Enter an amount up to 9999999.99, and press ENTER. The amount entered should reflect costs for that revenue center for one day. Once you press ENTER, both the charge and cost amounts display under the appropriate columns for the selected revenue center.

Continue this process until you have entered charge and cost information for all appropriate revenue centers for one day. When you have completed entering the information for one day, press ENTER. The system again prompts you to select a day

of stay to revise, or enter **A** to add a day of stay. Each day of stay added accumulates in the Budget LOS field.

4. BUDGET LOS (DISPLAY ONLY)
This field indicates the total number of days for which budget information has been entered. It automatically tracks the number of days entered and cannot be edited.

To revise budgeted information for a day of stay, enter the number of the day and press ENTER, and this prompt displays:

Enter manually (M) or system spread of revenue centers (S)--

Enter **M** to manually revise a day in the manner described above. If you enter **S**, the system displays the following prompt:

Enter the total charges for the day of stay (9999999.99) [0.00]--

Enter a dollar amount up to 9999999.99, and press ENTER, or press ENTER to accept the default of 0.00. The amount entered should reflect total charges of all major revenue centers for a day. The charges entered do not affect the information on the screen until you respond to the next prompt and enter cost information:

Enter the total cost for the day of stay (9999999.99) [0.00]--

Enter a dollar amount up to 9999999.99 and press ENTER, or press ENTER to accept the default of 0.00.

After you press ENTER, the system automatically spreads the amounts through the 10 major revenue centers.

NOTE: The system only spreads charge/cost information to revenue centers with previously entered amounts. You can only use the **M** or **S** when revising charge/cost information for a day of stay.

Press ENTER to exit the screen and return to the list of budgets. You can select another budget to revise, or press ENTER to return to the Maintenance menu.

Impact

After you accept this screen, the following takes place:

- The standard budget information established by payor by DRG displays on the Standard screen of the DRG assignment screen and on various concurrent monitoring reports.

Chapter 5 - DRG REPORTS

Illustrations

INTRODUCTION

This chapter contains information on the various DRG and Concurrent Monitoring Reports available as either demand reports or batch reports printed at Midnight Processing. Each example of a report is preceded by an explanation of the report and suggestions on how it might be used within your hospital.

DRG BUDGET WORKSHEET

The DRG Budget Worksheet (DCBWSX) is a printed report of the information entered for a DRG for a specific budget in the Budget Maintenance function. The purpose of printing the Budget Worksheet is to verify the budget information entered into the system and check for necessary modifications.

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*.

There are three options you can use to print the Budget Worksheet:

- A request can be made through the Calculate Budget Using Averages function.
- A request can be made through the Budget Maintenance function when a new budget is created.
- A request can be made through the Demand Reports function.

To print a Budget Worksheet from the Demand Reports function, select this option from the Demand Reports menu and this screen displays:

```
              General Hospital DRG Budget Worksheet Processor
                                                  Thu Feb 22, 1990 01:52 pm
 DRG BUDGETS GENERAL HOSPITAL A

      Budget    Payors              Effective Date
 ( 4)   11      MEDICAID GEORGIA    06/01/89
               MEDICAID GEORGIA    06/01/90
 ( 5)   12      MEDICARE            06/28/89
 ( 6)   14      LINCOLN             09/25/89
 ( 7)   15      MEDICARE            01/01/89
 ( 8)   16      MEDICARE            06/01/89
 ( 9)   17      BLUE CROSS          06/01/89
 (10)   18      PRUDENTIAL          06/01/89
 (11)   19      NORTHWESTERN        06/01/89
 (12)   20      MEDICARE            01/15/90
               MEDICARE            01/01/90
 (13)   21      LINCOLN             01/01/90
 (14)   22      PRUDENTIAL          01/01/90
 (15)   23      CHAMPUS             01/01/90
 (16)   24      BLUE CROSS          01/01/90

Select DRG Budget to print--
```

This screen is a listing of all budgets established via the appropriate functions. Select the budget to be printed by entering the number to the left of the budget. Once the budget is selected, the system prompts you to print the budget. You can enter Y for Yes to print the budget, or press ENTER to accept the default N for No.

The following is an example of a printed Budget Worksheet. The report is sorted by day and major revenue center, the charge and cost information that was entered in the budget maintenance function for each DRG. The last column of the report displays a total for the budgeted charges and costs for this DRG.

Figure 5.1 DRG Budget Worksheet (DCBWSX)

Thu Feb 22, 1990 02:53 pm — GENERAL HOSPITAL A — Page 6

DRG Budget 02 Worksheet

Day	(01) Charges/ Cost	(02) Charges/	(03) Charges/ Cost	(04) Charges/ Cost	(05) Charges/ Cost	(06) Charges/ Cost	(07) Charges/ Cost	(08) Charges/ Cost	(09) Charges/ Cost	(10) Charges/ Cost	Total Charges/
DRG: 466 AFTERCARE, WO HX MALIG MED	BUDGET LOS: 4.20		BUDGET CHARGES: 467864.40		BUDGET COST: 449687.20						
2	94184.40	0.00	12460.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	106644.40
	93825.60	0.00	5741.20	0.00	0.00	0.00	0.00	0.00	0.00	0.00	99566.80
3	93434.00	0.00	35286.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	128720.00
	93434.00	0.00	24186.40	0.00	0.00	0.00	0.00	0.00	0.00	0.00	117620.40
5	46440.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46440.00
	46440.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46440.00
6	46440.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46440.00
	46440.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46440.00
7	46440.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46440.00
	46440.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46440.00
8	46440.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46440.00
	46440.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46440.00
9	23520.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	23520.00
	23520.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	23520.00
10	23220.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	23220.00
	23220.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	23220.00
DRG: 466 TOTALS											
	420118.40	0.00	47746.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	467864.40
	419759.60	0.00	29927.60	0.00	0.00	0.00	0.00	0.00	0.00	0.00	449687.20

DRG ADMISSIONS REPORT

The DRG Admissions Report (DADMX) is a batch report that identifies patients admitted during the previous day who meet a M/R Abstract and DRG Census Code that requires a DRG. The report lists the patients for which the hospital may want to assign a provisional DRG for the purposes of concurrent monitoring.

Patients on the report are grouped by DRG payor. Within DRG payor, patients are grouped by inpatient or outpatient status, and the inpatient type of unit or outpatient type. For each patient, the report lists the following:

- Account number
- Patient name
- Unit number
- Corporate number
- Type of unit or outpatient type

The report also displays the total number of admissions and registrations for each payor and grand totals are provided.

The following is an example of the DRG Admissions Report.

Figure 5.2 DRG Admissions Report (DADMX)

```
 Thu Feb 22, 1990 05:05 am   GENERAL HOSPITAL A                          Page  1
                      DRG Admissions Report For 02/21/90

  Account No   Name                              Unit #        Pat Type - Sta
                                                 Corp #
 ------------------------------------------------------------------------------
DRG Payor:  OTHERS

  90-0520000-5 SMITH,ANDREA                      0000-0154-5   OTHERS
                                        00311113

                     Admissions    -      1
                     OP Admissions -      0
                                          _____

                                            1
 DRG Payor:  MEDICARE

  90-0520000-1 MORGAN,PAULETTE                   0000-0150-3   UR REQUIRED
                                        00311080

  90-0520000-2 HAMILTON,CHARLES                  0000-0151-1   UR REQUIRED
                                        00311130

 MEDICARE             Admissions    -      2
                      OP Admissions -      0
                                          _____
                                            2

          Total DRG Admissions    -      3
          OP Admissions           -      0
                                          _____
                                            3

               End of Report
```

DRG CASE ANALYSIS

The DRG Case Analysis (DCRCX) is a comparison of budgeted and actual charge or cost information for patients currently in the hospital. The report is not intended to provide data for case mix analysis, but rather serves as a bridge in identifying potentially high charges in treatment. The benefit of this early detection is to help prevent the case from becoming costly to the hospital.

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*.

For each patient meeting the selection criteria, this information is reported:

- Physician
- Nurse station, room and bed
- Unit Number
- Patient Name
- Account Number
- Medical Service
- DRG Payor
- Admitting and Provisional DRGs
- Standard length of stay, actual length of stay and the variance
- Standard cost or charges, actual cost or charges and the variance
- Total cost or charges, actual cost or charges and the variance

To print the DRG Case Analysis, select this option from the Demand Reports menu, and this screen displays:

```
                General Hospital DRG Case Analysis Processor
                                                    Thu Feb 22, 1990 01:52 pm
Report Definition
( 1)Charges/Cost             : Charges
( 2)Stay-to-Date/Day-by-Day  : Stay-To-Date
Selection Criteria
( 3)Physician                :
( 4)Station                  :
( 5)Medical Service          :
( 6)DRG Number               : 127
( 7)Account Number-1         :
( 8)Account Number-2         :
( 9)Account Number-3         :
(10)Account Number-4         :
(11)Account Number-5         :
(12)Account Number-6         :
(13)Account Number-7         :
(14)Account Number-8         :
(15)Account Number-9         :
(16)Account Number-10        :

Enter account number to report--
```

This screen enables you to define criteria for patient inclusion on the report. Note that the first two fields are required, while all others are optional. However, if you do not indicate some criteria (for example, only complete the first two fields), no data prints on the report. Therefore, in order to obtain data, you must indicate at least one of the optional criteria.

Field Explanations

1. CHARGES/COST (1-N-R)
Enter 1 in this field to indicate the report should compare charge data, or enter 2 if the report should compare cost data.

2. STAY-TO-DATE/DAY-BY-DAY (1-N-R)
Enter 1 in this field to indicate the report should include stay-to-date information, or enter 2 if the report should display day-by-day information. If you select stay-to-date, the report displays summary information by major revenue center. If you select day-by-day, the report displays information by major revenue center for each day of the patient's length of stay. The selection you choose depends on whether you are interested in viewing comparative data for the entire stay, or whether you need to see the data broken out for each day. The day-by-day report is longer.

3. PHYSICIAN (TABLE LOOKUP)
Enter the physician code if you know it, press hyphen (-) followed by ENTER to display the physician code table in alphabetic order, or enter a specific letter or letters followed by a hyphen (-) to display only the physician names that begin with those letters (for example, entering AD- displays all names that begin with those letters). This field enables you to indicate which physician's patients are to be included in the report. You can only identify one physician per report. This field is optional.

4. STATION (TABLE LOOKUP)
Enter the nursing station code if you know it, or press hyphen (-) followed by ENTER to display the nursing station code table for selection. This field enables you to identify which nursing station's patients are to be included in the report. You can only indicate one nursing station per report. This field is optional.

5. MEDICAL SERVICE (TABLE LOOKUP)
Enter the medical service code if you know it, or press hyphen (-) followed by ENTER to display the medical service code table for selection. This field enables you to identify which medical service's patients are to be included in the report. You can only indicate one medical service per report. This field is optional.

6. DRG NUMBER (3-N-O)
Enter the DRG number to be included on the report. This field enables you to identify which patient's with the specified DRG number are to be included on the report. You can indicate only one DRG number per report.

7. ACCOUNT NUMBER-1 (10-N-O)
Enter a specific patient account number to be included on this report.

8. ACCOUNT NUMBER-2 (10-N-O)
Enter a specific patient account number to be included on this report.

9. ACCOUNT NUMBER-3 (10-N-O)
Enter a specific patient account number to be included on this report.

10. ACCOUNT NUMBER-4 (10-N-O)
Enter a specific patient account number to be included on this report.

11. ACCOUNT NUMBER-5 (10-N-O)
Enter a specific patient account number to be included on this report.

12. ACCOUNT NUMBER-6 (10-N-O)
Enter a specific patient account number to be included on this report.

13. ACCOUNT NUMBER-7 (10-N-O)
Enter a specific patient account number to be included on this report.

14. ACCOUNT NUMBER-8 (10-N-O)
Enter a specific patient account number to be included on this report.

15. ACCOUNT NUMBER-9 (10-N-O)
Enter a specific patient account number to be included on this report.

16. ACCOUNT NUMBER-10 (10-N-O)
Enter a specific patient account number to be included on this report.

After you complete the necessary fields and accept the screen, the report prints.

The following is an example of a DRG Case Analysis by Major Revenue Center using stay-to-date and charges.

Figure 5.3 DRG Case Analysis (DCRCX)

```
Thu Feb 22, 1990 03:55 pm              GENERAL HOSPITAL A                  Page 1
                    Case Analysis By Major Revenue Center for 02/22/90

    Report Definition:

     Stay-To-Date Charges

    Selection Criteria:

           Physician:
             Station:
     Medical Service:
                 DRG: 127 HEART FAILURE/SHOCK MED
            Accounts:


             Case Analysis By Major Revenue Center for 02/22/90
                           STAY-TO-DATE - Charges
Physician
Station/Bed  Patient Name                Account #    Med Service
 DRG Payor       Admit DRG  Prov DRG    Standard LOS  Actual LOS  Variance LOS
-------------------------------------------------------------------------------

5L-5L01-2     WEISENTHAL,HAILEY          90-0310000-2  I-FAMILY MATERNITY
MEDICARE            423        127            2            23           -21

    (01)   (02)   (03)   (04)   (05)   (06)   (07)   (08)   (09)   (10)  Total

T S  5100    500      0      0   1000      0      0     0    200      0   6800
  A 15092     25   1204      0      0      0      0     0    218      0  16539
  V -9992    475  -1204      0   1000      0      0     0    -18      0  -9739

                                                                  Over Std LOS
*******************************************************************************

5G-5G24-5     SMITH,ANN                  90-0530000-3  I-MEDICINE
 MEDICARE                       127            2            1             1

    (01)   (02)   (03)   (04)   (05)   (06)   (07)   (08)   (09)   (10)  Total

T S     0      0      0      0      0      0      0      0      0      0      0
  A     0      0      0      0      0      0      0      0      0      0      0
  V     0      0      0      0      0      0      0      0      0      0      0

                                                                  Near Std LOS

End of Report
```

CONCURRENT MONITORING REPORT BY NURSE STATION

The Concurrent Monitoring Report by Nurse Station (DCMRNX) lists, by nursing station, information on patients currently in the hospital. The information provided can be used to monitor the length of stay and charge/cost on a patient. For each patient listed on the report, the following information is included:

- Doctor name
- Nursing station, room and bed
- Patient name
- Account number
- Medical service
- Exception message which indicates if the patient has exceeded either the length of stay outlier or cost outlier trim point
- DRG payor
- Admit DRG
- Provisional DRG
- Standard length of stay for the DRG
- Actual length of stay for the patient
- Variance length of stay (that is, standard LOS minus the actual LOS)
- Standard charges for the DRG
- Actual charges for the patient
- Variance charges (that is, standard charges minus the actual charges)
- Standard costs for the DRG
- Actual costs for the patient
- Variance costs (that is, standard costs minus the actual costs)

The report also contains, for each station, the total number of cases, the number of exceptions (cost or stay outliers), the average LOS variance, the average charge variance, and the average cost variance. The final page of the report displays the

grand totals for all stations. The following is a sample of the Concurrent Monitoring Report by Nurse Station.

Figure 5.4 Concurrent Monitoring Report by Nurse Station (DCMRNX)

```
Tue Jun 25, 1996 05:06 am            GENERAL HOSPITAL A                    Page 1
           Concurrent Monitoring Report by Nurse Station for 06/24/96
Doctor
Station/Bed   Patient Name               Account #   Med Service  Exception Msg
 DRG Payor        Admit DRG  Prov DRG  Standard LOS  Actual LOS  Variance LOS
                                       Standard Chg  Actual Chg  Variance Chg
                                       Standard Cst  Actual Cst  Variance Cst
--------------------------------------------------------------------------------

HALL,JULIA F
CCU-CCU 1   HALL,RAYMOND               90-0510000-1 I-MEDICINE    OverStdCost
  MEDICARE                    127           4.20          5.00         -1.00
                                       1,547.50       3,231.70     -1,683.50
                                       1,334.91       2,638.66     -1,303.75

MEDICAL,RECORDS D
CCU-CCU 10  EDWARDS,FREDDY             90-0510000-2 I-MEDICINE    OverStdCost
  OTHERS                      127           8.50          8.00          0.50
                                       3,781.68       3,985,35       -203.67
                                       3,071.68       3,265.35       -193.67

WAGNER,CH COLLEEN
CCU-CCU 2   ABBOTT,ROSE                90-0370000-1 I-DIGESTIVE   OverStdCost
  OTHERS                      127           5.40          7.00         -1.60
                                       1,973.25       1,875.25         98.00
                                       1,508.65       1,456.65         52.00


Station Totals: Number of Cases:       3  Average LOS Variance         -0.70
                Number of exceptions:  3  Average Chg Variance       -576.39
                                          Average Cst Variance        281.87
```

NOTE: Information displays only if the patient has been assigned a DRG through DRG Assignment of Medical Record Abstracting.

CONCURRENT MONITORING REPORT BY PHYSICIAN

The Concurrent Monitoring Report by Physician (DCMRDX) lists, by physician, information on patients currently in the hospital. The information provided can be used to monitor the length of stay and charge/cost on a patient. For each patient listed on the report, the following information is included:

- Doctor name
- Nursing station, room and bed
- Patient name
- Account number
- Medical service
- Exception message which indicates if the patient has exceeded either the length of stay outlier or cost outlier trim point
- DRG payor
- Admit DRG
- Provisional DRG
- Standard length of stay for the DRG
- Actual length of stay for the patient
- Variance length of stay (that is, standard LOS minus the actual LOS)
- Standard charges for the DRG
- Actual charges for the patient
- Variance charges (for example, standard charges minus the actual charges)
- Standard costs for the DRG
- Actual costs for the patient
- Variance costs (for example, standard costs minus the actual costs)

The report also displays, for each doctor, the total number of cases, the number of exceptions (cost or stay outliers), the average LOS variance, the average charge variance, and the average cost variance. The final page of the report displays the

grand totals for all physicians. The following is a sample of the Concurrent Monitoring Report by Physician.

Figure 5.5 Concurrent Monitoring Report by Physician (DCMRDX)

```
 Tue Jun 25, 1996 05:06 am                GENERAL HOSPITAL A                Page  1
                     Concurrent Monitoring Report by Physician for 06/24/96
Doctor
Station/Bed   Patient Name                Account #   Med Service  Exception Msg
  DRG Payor         Admit DRG  Prov DRG  Standard LOS  Actual LOS  Variance LOS
                                         Standard Chg  Actual Chg  Variance Chg
                                         Standard Cst  Actual Cst  Variance Cst
--------------------------------------------------------------------------------

ACHTERMAN,CHRISTOPHER
2G-2G02 5   MORGAN,PAULETTE             90-0520000-1 I-MEDICINE    OverStdCost
   MEDICARE                                   0.00           0.00         0.00
                                              0.00         249.15       -249.15
                                              0.00         249.15       -249.15

ACHTERMAN,CHRISTOPHER
2G-2G02 6   SISNEY,GARY ANDREW           90-0230000-5 I-MEDICINE    OverStdCost
   MEDICARE           020       468           0.00          29.00        -29.00
                                              0.00      13,843.27    -13,843.27
                                              0.00      18,283.68    -18,283.68

ACHTERMAN,CHRISTOPHER
2G-2G04 3   VELVET,RON                   90-0370000-3 I-MEDICINE    OverStdCost
   OTHERS                                     0.00          15.00        -15.00
                                              0.00       6,000.80     -6,000.80
                                              0.00       5,600.80     -5,600.80

ACHTERMAN,CHRISTOPHER
2G-2G04 6   HAMILTON,CHARLES             90-0520000-2 I-MEDICINE    OverStdCost
   MEDICARE                                   0.00           0.00         0.00
                                              0.00       2,117.95     -2,117.95
                                              0.00       1,450.28     -1,450.28

Doctor Totals: Number of Cases:         5  Average LOS Variance        -13.20
               Number of exceptions:    5  Average Chg Variance     -4,597.47
                                           Average Cst Variance     -5,198.73

  Grand Totals: Number of Cases:       34  Average LOS Variance        -17.85
                Number of Exceptions:  34  Average Chg Variance     -6,553.57
                                           Average Cst Variance     -6,220.64

               End of Report
```

FINAL DRGS ACCEPTED REPORT

The Final DRGs Accepted Report (DFDAX) is a midnight processing report that lists those patients whose DRG was accepted as final the previous day. It is a daily audit listing, sorted by DRG payor. For each patient, the following information is listed on the report:

- Account number
- Patient name
- Unit number
- Discharge date
- Corporate number
- Doctor name
- DRG and description

  NOTE: For DRG 470, only 470 prints and not the word "Ungroupable."

  If the 3M Interface is used with RCS, the description printed is the description sent from 3M, not from the STAR DRG Rate Master.

- Total charges

The report also displays the total number of cases for each payor and grand totals for all payors.

The following is a sample of the Final DRGs Accepted Report.

Figure 5.6 Final DRGs Accepted Report (DFDAX)

```
Thu Mar 22, 1990 12:08 am     GENERAL HOSPITAL A                        Page  1
                        Final DRG's Accepted For 03/21/90
  Account No   Name                     Unit No                    Discharge Date
Corp No        Doctor                   DRG                        Total Charge
-------------------------------------------------------------------------------

DRG Payor:   LAKESIDE

               WILSON,ROBERT L          0000-1048-84               02/09/90
00003067       ADAMS,HAROLD R           183 GI DIS 18+WO CC MED             .00

               RONDERS,VIOLET           0000-1048-99               02/12/90
00003082       CHUNG,TERRY              182 GI DIS 18+W CC MED              .00

               CERDERIO,TESS            0000-0000-09               03/16/90
00003135       SANDERS,RICHARD K        182 GI DIS 18+W CC MED              .00

   LAKESIDE          Number of Cases -     3      Total Charges:           .00
```

UNACCEPTED DRG DISCHARGES REPORT

The Unaccepted DRG Discharges Report (DUADX) is a batch report that lists those patients who are in the abstract census and have been discharged, but whose DRGs have not been accepted as final. This report can be used to identify patients on whom additional information should be entered to pass to the billing system. Patients remain on this report until their DRGs are accepted as final.

The Unaccepted DRG Discharges Report has a primary sort by DRG payor; then patients are listed alphabetically according to their last name.

The *DRG Payor: Unknown* section of the report includes patient accounts that have no financial class assigned or that have a financial class that is not attached to a DRG payor in the DRG Payors table. The *DRG Payor: Unknown Current Financial Class = x* (where *x* is the account's financial class) contains accounts that have a financial class assigned, but the DRG Assignment screens for these accounts have not been viewed.

For each patient, the following information is displayed:

- Account number
- Patient name
- Unit number
- Type of unit or outpatient type
- Corporate number
- Doctor name
- Discharge date
- Total charges

The report also includes the total number of cases for the payor and the total charges for the listed cases.

The following is an example of the Unaccepted DRG Discharges Report.

Figure 5.7 Unaccepted DRG Discharges Report (DUADX)

```
Thu Feb 22, 1990 05:06 am              GENERAL HOSPITAL A                    Page  1
                          Unaccepted DRG Discharges For 02/21/90

  Account No   Name/                            Unit No/          Unit/O/P Type
Corp No        Doctor                           Discharge Date    Total Charge
-------------------------------------------------------------------------------
 DRG Payor:  OTHERS

  90-0160001-2 BOOTH,LEONARD                    0000-0127-1       UR REQUIRED
 00311089       ACKER,ROBERT L                  01/22/90                2,078.85

  90-0170000-2 SMITH,EDWARD                     0000-0039-8
 00311095       ANDREWS,RICHARD P               02/16/90                    6.05

  90-0230000-1 SMITH,LAMAR                      0000-0058-8       UR APPLICABLE
 00311112       GAIL,ANNA H                     01/23/90                  435.60

  90-0230000-6 WEISENTHAL,HAILEY                0000-0095-0
 00311085       ANDREWS,RICHARD P               01/23/90                1,110.29

  90-0290000-6 WEISENTHAL,HAILEY                0000-0095-0       UR REQUIRED
 00311085       ACKER,ROBERT L                  01/29/90                  860.82

          Total Number of Cases    -      24

               End of Report
```

DRG RATE MASTER REPORT

The DRG Rate Master Report (DRMRX) is a listing of the rate master of a selected DRG payor. Since it lists pertinent information for each DRG, it is useful as a reference. It is not necessary to print the rate master, but it could be helpful in trying to locate omissions that need to be corrected (for non-Medicare payors).

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

The report includes the following information for the selected payor and effective date:

- Major diagnostic category (MDC) group number
- DRG number
- DRG description
- Weight of the DRG
- Standard length of stay (GLOS, geometric length of stay, and ALOS, arithmetic length of stay) for the DRG
- Day outlier trim point for the DRG
- Expected reimbursement amount for your facility for this DRG
- Cost outlier trim point for the DRG
- The expected per diem amount for stay outliers
- Complication/comorbidity (C/C) flag which indicates whether this DRG is affected by a C/C

To print the DRG Rate Master Report, select this option from the Demand Reports menu and the following screen is displayed:

```
              General Hospital DRG Rate Master Report Processor
                                                 Thu Feb 22, 1990 01:53 pm

DRG Rate Table Control
                                          Effective
        DRG payor           Table No    From      Thru    Description
   ( 1) CHAMPUS                01      10/01/87  05/15/88  1987-88 CHAMPUS
   ( 2) CHAMPUS                02      04/01/89  09/30/89  NEW CHAMPUS
   ( 3) CHAMPUS                03      10/01/89            10/89 CHAMPUS RATES
   ( 4) MEDICAID GEORGIA       01      02/26/86  03/28/86  TEST
   ( 5) MEDICAID GEORGIA       02      06/01/89  07/31/89  TEST FOR 2728
   ( 6) BLUE CROSS             01      10/01/89            BLUE CROSS 89-90
   ( 7) KAISER                 01      02/01/86  09/30/87  TESTER
   ( 8) KAISER                 02      10/01/87  09/30/88  NEW KAISER
   ( 9) KAISER                 03      10/01/88  10/31/88  NEW KAISER RM
   (10) KAISER                 04      06/01/89            TEST FOR 2728
   (11) PRUDENTIAL             01      02/25/86  03/17/86  TEST TABLE
   (12) PRUDENTIAL             02      10/01/87  04/30/88  OLD MEDICARE MODEL
   (13) PRUDENTIAL             03      05/01/88  01/17/90  TEST OF TABLE GENERA
   (14) PRUDENTIAL             04      01/18/90            TEST RATE MASTER
   (15) MEDICARE               01      10/31/85  05/01/86  MEDICARE 1986

Select DRG Table to print, or `/` for next page--
```

This screen is a listing of all rate masters set up for your hospital via the Abstracting, DRG, and UM Maintenance Functions. Select a rate master to print by entering the number to the left of the DRG payor. Once you select the rate master, the system prompts you to print the listing. The default is **Y** for Yes, or you can enter **N** for No (do not press ENTER) and the report does not print.

Following is an example of a DRG Rate Master Report.

Figure 5.8 DRG Rate Master Report (DRMRX)

```
Wed Sep 21, 1994 07:43 am         Model Hospital A                    Page 5
RATE MASTER REPORT

DRG PAYOR: M MEDICARE            TBL#: 07  EFFECTIVE FROM 09/14/94    TO

MDC DRG      WEIGHT   GLOS   ALOS   OTLR  OPER:REIMB   COST OTLR   STAY/DIEM
    DESCRIPTION                          CAP: REIMB   COST OTLR   STAY/DIEM
-------------------------------------------------------------------------------

3   065     0.50670   3.00   3.80   22.00    3025.14    26978.65     654.84
    DISEQUILIBRIUM,MED                         267.38     2305.55      70.36

3   066     0.50760   3.10   3.90   24.00    3030.51    26983.07     639.18
    EPISTAXIS, MEDICAL                         267.85     2305.99      68.68

3   067     0.83810   3.80   4.70   26.00    5003.70    28606.15     875.72
    EPIGLOTTITIS,MEDICAL                       442.25     2468.46      94.10

3   068     0.71000   4.40   5.40   26.00    4238.90    27977.06     645.70
    OTITIS MEDIA/URI >17 W/CC                  374.66     2405.49      69.38

3   069     0.51330   3.50   4.20   22.00    3064.55    27011.06     600.19
    OTITIS MED/URI,18+W0CC,MED                 270.86     2308.80      64.49

3   070     0.58120   3.60   4.40   24.00    3469.93    27344.52     648.70
    OTITIS MED/URI,0-17,MED                    306.69     2342.17      69.70

3   071     0.65080   3.50   4.20   22.00    3885.46    27686.33     760.97
    LARYNGOTRACHEITIS,MED                      343.42     2376.39      81.77

3   072     0.61600   3.10   4.40   25.00    3677.69    27515.42     687.54
    NASAL TRAUMA/DEFORMITY,MED                 325.05     2359.28      73.88

3   073     0.76160   4.10   5.50   26.00    4546.97    28230.46     680.04
    OTH ENT & MOUTH DX AGE >17                 401.89     2430.85      73.07

3   074     0.35710   2.10   2.10   20.00    2131.99    26243.97     835.10
    OTH ENT MOUTH DX AGE 0-17                  188.44     2232.01      89.73

4   075     3.05510   9.90  12.40   32.00   18239.83    39493.82    1209.96
    MJ CHEST OR PROC                          1612.14     3558.28     130.01

4   076     2.51260  10.00  13.90   32.00   15000.95    36829.61     887.72
    OTHER RESP OR PROC,WCC                    1325.87     3291.60      95.39

4   077     1.06300   4.00   6.00   26.00    6346.41    29710.64     870.06
    OTHER RESP OR WO CC                        560.93     2579.01      93.49

4   078     1.42110   7.80   9.20   30.00    8484.37    31469.26     758.59
    PULMONARY EMBOLISM,MED                     749.90     2755.05      81.51

4   079     1.69550   8.30  10.70   30.00   10122.62    32816.84     778.19
    RSP INFEC/INFLAM,18+,WCC,M                 894.69     2889.93      83.62

4   080     0.92590   5.90   7.40   28.00    5527.89    29037.34     614.47
    RSP INFEC/INFLAM,18+W0CC,M                 488.58     2511.62      66.02
```

REGROUPING CONVERSION REPORT

STAR automatically compiles the Regrouping Conversion Report (ECDRGX) after DRG regrouping is performed. DRG regrouping re-runs patients through the appropriate grouper and rate master to calculate the correct DRG and reimbursement and sends this updated data to Financials. Patient Accounting adjustment bills will be created for each account on the report if the Diagnosis, Procedure, or DRG Produce Adjustment Bill PA parameters are defined. The option to regroup is on the System Management menu for IS personnel to access.

For more information on performing DRG Regrouping, see the System Management chapter of the *STAR Patient Care Reference Guide, General Information Volume*.

The report contains the following information for all accounts on the report:

- Patient's name
- Account number
- Discharge date
- DRG Rate Table number
- Old and new DRGs

  NOTE: If the Rate Table/Master was not changed to calculate a different DRG, the DRG will not change.

- Old and new reimbursements

  NOTE: If the Rate Table/Master was not changed to calculate a different reimbursement, the reimbursement will not change.

- Old and new DRG weights

  NOTE: If the Rate Table/Master was not changed to calculate a different DRG weight, the DRG weight will not change.

- The date the previous DRG was accepted as final

The following is an example of the Regrouping Conversion Report.

Figure 5.9 Regrouping Conversion Report (ECDRGX)

General Hospital View Reports Processor

Fri Oct 30, 1998 02:12 pm

Report : ECDRGA REGROUPING CONVERSION REPORT
Spooled: 10/30/98 0000 Last Printed: Not Printed
Fri Oct 30, 1998 10:47 am Model Hospital A Page: 1
Regrouped Accounts Discharged 10/01/98 through 10/15/98
Payor MEDICARE

NAME	ACCOUNT #	DISCH	TBL	DRG OLD	DRG NEW	REIMBURSEMENT OLD	REIMBURSEMENT NEW	WEIGHT OLD	WEIGHT NEW	OLD DATE
KAIN,TOSHA	A9805400018	10/02/98	12	305	306	5744.92	4744.92	1.42500	1.21680	10/11/98
BASS,SAM	A9814700002	10/10/98	12	127	126	9876.50	7250.00	2.98500	2.48790	10/13/98

Total Accounts Re-grouped: 2

End of Report

ELECTRONIC ATTESTATION PENDING SIGNATURE

This report, which prints at the default printer, includes all patients on whom an attestation was electronically sent, but has not been sent back as signed or as unaccepted. Once the attestation for the account has been signed or returned, the patient is automatically removed from this report.

When this report option is selected from the menu, the following prompt displays:

Sort by physician name(P), disch date(D), fin class(F), patient name(N), transmission date(T), or total charges(C)? [D]--

Select one of the sort options by entering the appropriate letter. The default is **D** for discharge date. The other sort options are as follows:

- Enter **P** to sort alphabetically by the physician's last name
- Enter **D** to sort by the patient's discharge date
- Enter **F** to sort by the patient's financial class as found in the Medical Record Abstract and/or DRG Assignment function
- Enter **N** to sort alphabetically by the patient's last name
- Enter **T** to sort by the date the attestation was sent to the physician
- Enter **C** to sort by the patient's total charges (in descending order)

Once a sort option is selected, this prompt displays:

Display or Print? (D/P) [D]--

This prompt enables you to choose whether to display the report on the screen or print the report at the default printer. To display the report on the screen, press ENTER to accept the default of **D** for display. The report begins processing.

The following is an example of the Electronic Attestation Pending Signature Report that displays on the screen:

Figure 5.10 Electronic Attestation Pending Signature Report (screen)

```
Thu May 24, 1990 10:51 am                                          Page 1

                          GENERAL HOSPITAL A
                 Electronic Attestation Pending Signature Report
                          Sort: Discharge Date

#  Account #      Patient Name                    FC  Final DRG  Discharge Date
    Unit #          Physician Name                Trans Date     Total Charges
-------------------------------------------------------------------------------
1  90106-00007    TOST,LYNETTE                    M       no     04/16/90
    0000-0000-72    WOODBURN,ROBERT LOUIS         05/22/90        $.00

2  90115-00005    BISALLE,JOHN                    S       no     04/25/90
    0000-0001-08    LEES,JACK R                   05/22/90        $.00

3  90106-00003    ROGERS,ELLEN T                  18      no     05/15/90
    0000-0000-67    LEES,JACK R                   05/22/90        $1959983.50

4  90106-00003    ROGERS,ELLEN T                  18      no     05/15/90
    0000-0000-67    WOODBURN,ROBERT LOUIS         05/22/90        $1959983.50

Enter # to delete from report or Press NL for next screen [NL]--
```

Field Explanations

All fields are display only.

ACCOUNT #
This is the account number associated with this episode of care for this patient.

PATIENT NAME
This is the name of the patient on whom this attestation was sent.

FC
This is the financial class of the patient as found in either the Medical Record Abstracting and/or DRG Assignment function. If this was changed by the Medical Record Department, it may differ from the financial class stored in the MPI and business office.

FINAL DRG
No in this field indicates the DRG for this account has not yet been accepted as final. Yes in this field indicates the DRG has been accepted as final.

DISCHARGE DATE
The discharge date of this patient for this episode of care displays in this field.

UNIT #
This is the unit number (medical record number) for this patient.

PHYSICIAN NAME
This is the name of the physician to whom the electronic attestation was sent.

TRANS DATE
This is the date the electronic attestation was sent to the physician for signature.

TOTAL CHARGES
This is the total charges for this patient.

You can enter the number to delete from the report or press ENTER to display the next screen. If you select a number to delete, the following prompt is displayed:

Are you sure you want to delete #XX from this report? (Y/N) [N]--

where XX is the number to the left of the patient's name.

Press ENTER for the default **N** for No and the entry is not deleted. Press **Y** for Yes followed by ENTER, and the patient entry is deleted.

The following is an example of a printed Electronic Attestation Pending Signature Report.

Figure 5.11 Electronic Attestation Pending Signature Report (print)

```
Thu May 24, 1990 10:51 am                                          Page 1

                          GENERAL HOSPITAL A
                Electronic Attestation Pending Signature Report
                          Sort: Discharge Date

#  Account #      Patient Name                    FC  Final DRG  Discharge Date
    Unit #          Physician Name                Trans Date     Total Charges
-------------------------------------------------------------------------------
1  90106-00007    TOST,LYNETTE                    M       no     04/16/90
    0000-0000-72    WOODBURN,ROBERT LOUIS         05/22/90        $.00

2  90115-00005    BISALLE,JOHN                    S       no     04/25/90
    0000-0001-08    LEES,JACK R                   05/22/90        $.00

3  90106-00003    ROGERS,ELLEN T                  18      no     05/15/90
    0000-0000-67    LEES,JACK R                   05/22/90        $1959983.50

4  90106-00003    ROGERS,ELLEN T                  18      no     05/15/90
    0000-0000-67    WOODBURN,ROBERT LOUIS         05/22/90        $1959983.50

End of Report
```

UNACCEPTED ELECTRONIC ATTESTATION

This report, which prints at the default printer, includes all patients on whom an attestation was electronically sent, and then electronically sent back by the physician as unaccepted. When a new attestation message is sent to the physician for this account, the patient is automatically removed from this report.

When this report option is selected from the menu, the following prompt displays:

Sort by physician name(P), disch date(D), fin class(F), patient name(N), transmission date(T), or total charges(C)? [D]--

Select one of the sort options by entering the appropriate letter. The default is **D** for discharge date. The other sort options are as follows:

- Enter **P** to sort alphabetically by the physician's last name
- Enter **D** to sort by the patient's discharge date
- Enter **F** to sort by the patient's financial class as found in the Medical Record Abstract and/or DRG Assignment function
- Enter **N** to sort alphabetically by the patient's last name
- Enter **T** to sort by the date the attestation was sent back as unaccepted
- Enter **C** to sort by the patient's total charges (in descending order)

Once a sort option is selected, this prompt displays:

Display or Print? (D/P) [D]--

This prompts enables you to choose whether to display the report on the screen or print the report at the default printer. If **P** is entered to print the report, this prompt displays:

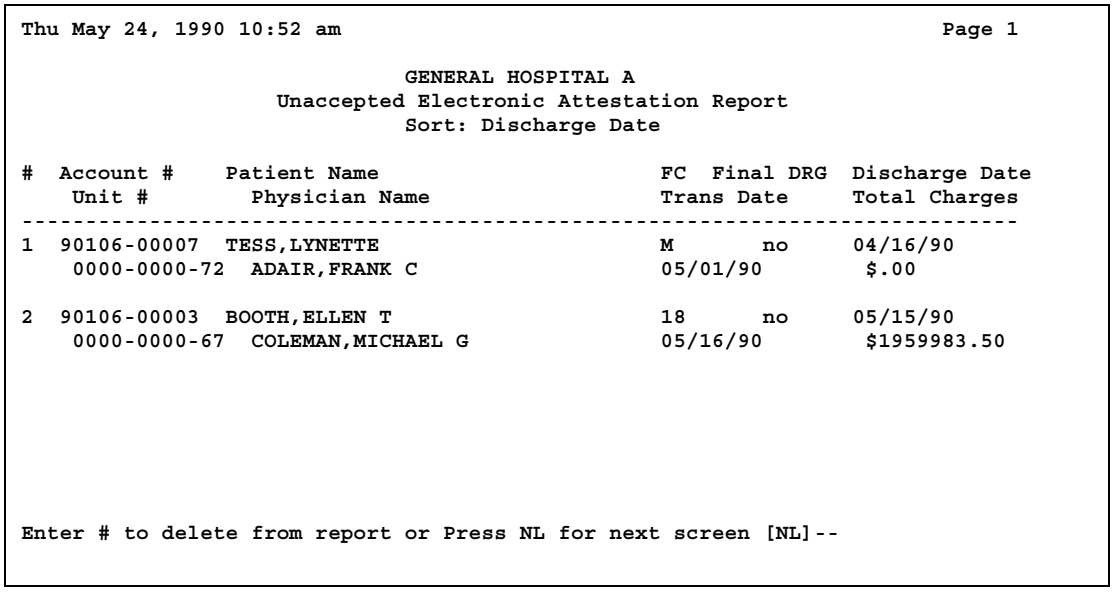
Print associated messages on report? (Y/N) [N]--

Press ENTER to accept the default **N** for No, and the messages are not printed. Enter **Y** for Yes, and the messages are included on the report. When the messages are included, the report prints one page per patient entry.

To display the report on the screen, press ENTER to accept the default **D** for display. The report begins processing.

The following is an example of the Unaccepted Electronic Signature Report that displays on the screen:

Figure 5.12 Unaccepted Electronic Attestation Report (screen)



```
Thu May 24, 1990 10:52 am                                          Page 1

                          GENERAL HOSPITAL A
                  Unaccepted Electronic Attestation Report
                          Sort: Discharge Date

#  Account #    Patient Name                    FC  Final DRG  Discharge Date
    Unit #        Physician Name                 Trans Date     Total Charges
-------------------------------------------------------------------------------
1  90106-00007  TESS,LYNETTE                    M       no     04/16/90
    0000-0000-72  ADAIR,FRANK C                 05/01/90        $.00

2  90106-00003  BOOTH,ELLEN T                   18      no     05/15/90
    0000-0000-67  COLEMAN,MICHAEL G             05/16/90        $1959983.50




Enter # to delete from report or Press NL for next screen [NL]--
```

Field Explanations

All fields are display only.

ACCOUNT #
This is the account number associated with this episode of care for this patient.

PATIENT NAME
This is the name of the patient on whom this attestation was sent.

FC
This is the financial class of the patient as found in either the Medical Record Abstracting and/or DRG Assignment function. If this was changed by the Medical Record Department, it may differ from the financial class stored in the MPI and business office.

FINAL DRG
No in this field indicates the DRG for this account has not yet been accepted as final. Yes in this field indicates the DRG has been accepted as final.

DISCHARGE DATE
The discharge date of this patient for this episode of care displays in this field.

UNIT #
This is the unit number for this patient.

PHYSICIAN NAME
This is the name of the physician who returned the electronic attestation as unaccepted.

TRANS DATE
This is the date the electronic attestation was returned by the physician as unaccepted.

TOTAL CHARGES
This is the total charges for this patient.

You can enter the number to delete from the report or press ENTER to display the next screen. If you select a number to delete, the following prompt is displayed:

Are you sure you want to delete #XX from this report? (Y/N) [N]--

where XX is the number to the left of the patient's name.

Press ENTER for the default **N** for No and the entry is not deleted. Enter **Y** for Yes followed by ENTER and the patient entry is deleted.

The field explanations for the printed report are the same as the field explanations previously described for the report that displays on the screen, with the exception of the following 3 items that display when the report is printed with messages included.

MEDICAL RECORD MESSAGE
This is the message sent by the Medical Record Department to the physician. If a message was not sent, *NONE* displays here.

PHYSICIAN DRG UNACCEPTED REASONS
This is the reason(s) the physician selected from the code table to explain why the attestation was not signed.

PHYSICIAN MESSAGE
This is the message sent by the physician to the Medical Record Department. If a message was not sent, *NONE* displays here.

The following is an example of an Unaccepted Electronic Attestation Report.

Figure 5.13 Unaccepted Electronic Attestation Report (print)

```
Thu May 24, 1990 10:52 am                                          Page 1

                          GENERAL HOSPITAL A
                  Unaccepted Electronic Attestation Report
                          Sort: Discharge Date

#  Account #    Patient Name                      FC  Final DRG  Discharge Date
    Unit #        Physician Name                  Trans Date     Total Charges
-------------------------------------------------------------------------------
1  90106-00007  TESS,LYNETTE                      M       no     04/16/90
    0000-0000-72  ADAIR,FRANK C                   05/01/90        $.00

2  90106-00003  BOOTH,ELLEN T                     18      no     05/15/90
    0000-0000-67  COLEMAN,MICHAEL G               05/16/90        $1959983.50

Medical Record Message:

PLEASE SIGN BY FRIDAY




Physician DRG Unaccepted Reasons:

DATA NOT COMPLETE

Physician Message:

NONE
```

SIGNED ELECTRONIC ATTESTATIONS PENDING FINAL DRG

This report, which prints at the default printer, includes all patients on whom an attestation was electronically signed by the physician, but the DRG has not been accepted as final. Once the DRG is accepted as final, the patient is automatically removed from this report.

When this report option is selected from the menu, the following prompt displays:

Sort by physician name(P), disch date(D), fin class(F), patient name(N), signed date(T), or total charges(C)? [D]--

Select one of the sort options by entering the appropriate letter. The default is **D** for discharge date. The other sort options are as follows:

- Enter **P** to sort alphabetically by the physician's last name
- Enter **D** to sort by patient's discharge date
- Enter **F** to sort by the patient's financial class as found in the Medical Record Abstract and/or DRG Assignment functions
- Enter **N** to sort alphabetically by the patient's last name
- Enter **T** to sort by the date the attestation was signed
- Enter **C** to sort by the patient's total charges (in descending order)

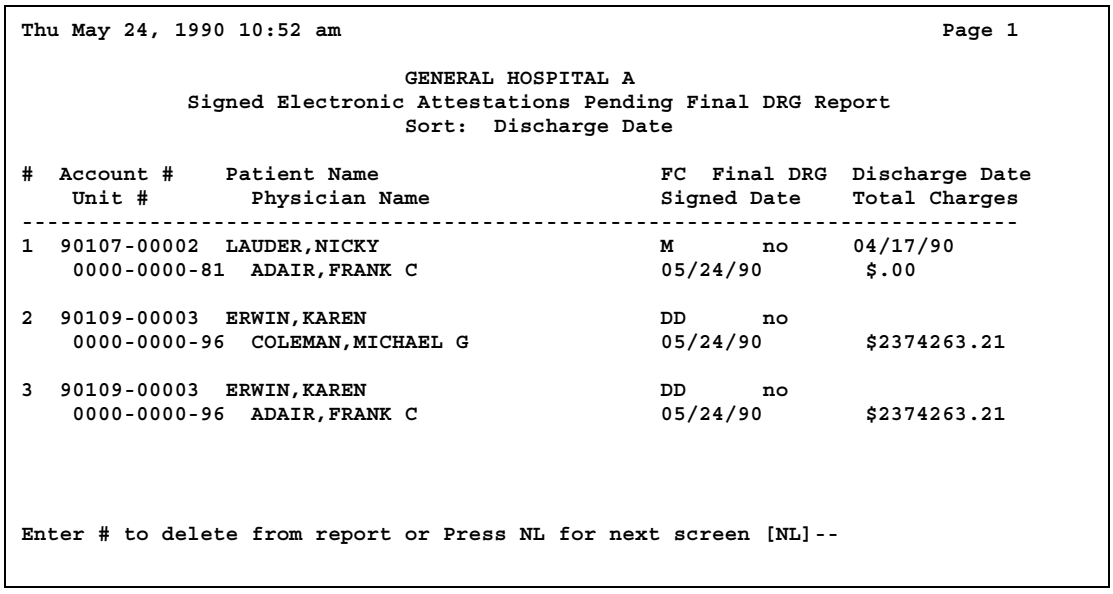
Once a sort option is selected, this prompt displays:

Display or Print? (D/P) [D]--

This prompts enables you to choose whether to display the report on the screen or print the report at the default printer. To display the report on the screen, press ENTER to accept the default **D** for display. The report begins processing.

The following is an example of the Signed Electronic Attestations Pending Final DRG Report that displays on the screen:

Figure 5.14 Signed Electronic Attestations Pending Final DRG Report (screen)



```
Thu May 24, 1990 10:52 am                                          Page 1

                          GENERAL HOSPITAL A
            Signed Electronic Attestations Pending Final DRG Report
                          Sort:  Discharge Date

#  Account #    Patient Name                    FC  Final DRG  Discharge Date
    Unit #        Physician Name                 Signed Date    Total Charges
-------------------------------------------------------------------------------
1  90107-00002  LAUDER,NICKY                    M       no     04/17/90
    0000-0000-81  ADAIR,FRANK C                 05/24/90        $.00

2  90109-00003  ERWIN,KAREN                     DD      no
    0000-0000-96  COLEMAN,MICHAEL G             05/24/90        $2374263.21

3  90109-00003  ERWIN,KAREN                     DD      no
    0000-0000-96  ADAIR,FRANK C                 05/24/90        $2374263.21



Enter # to delete from report or Press NL for next screen [NL]--
```

Field Explanations

All fields are display only.

ACCOUNT #
This is the account number associated with this episode of care for this patient.

PATIENT NAME
This is the name of the patient on whom this attestation was sent.

FC
This is the financial class of the patient as found in either the Medical Record Abstracting and/or DRG Assignment function. If this was changed by the Medical Record Department, it may differ from the financial class stored in the MPI and business office.

FINAL DRG
No in this field indicates the DRG for this account has not yet been accepted as final. Yes in this field indicates the DRG has been accepted as final.

DISCHARGE DATE
The discharge date of this patient for this episode of care displays in this field.

UNIT #
This is the unit number (medical record number) for this patient.

PHYSICIAN NAME
This is the name of the physician who returned the electronic attestation as unaccepted.

SIGNED DATE
This is the date the electronic attestation was signed by the physician.

TOTAL CHARGES
This is the total charges for this patient.

You can enter the number to delete from the report or press ENTER to display the next screen. If you select a number to delete, the following prompt is displayed:

Are you sure you want to delete #XX from this report? (Y/N) [N]--

where XX is the number to the left of the patient's name.

Press ENTER for the default **N** for No and the entry is not deleted. Press **Y** for Yes followed by ENTER and the patient entry is deleted.

The following is an example of a Signed Electronic Attestations Pending Final DRG Report.

Figure 5.15 Signed Electronic Attestations Pending Final DRG Report (print)

```
Thu May 24, 1990 10:52 am                                          Page 1

                          GENERAL HOSPITAL A
            Signed Electronic Attestations Pending Final DRG Report
                          Sort:  Discharge Date

#  Account #    Patient Name                    FC  Final DRG  Discharge Date
    Unit #        Physician Name                 Signed Date    Total Charges
-------------------------------------------------------------------------------
1  90107-00002  LAUDER,NICKY                    M       no     04/17/90
    0000-0000-81  ADAIR,FRANK C                 05/24/90        $.00

2  90109-00003  ERWIN,KAREN                     DD      no
    0000-0000-96  COLEMAN,MICHAEL G             05/24/90        $2374263.21

3  90109-00003  ERWIN,KAREN                     DD      no
    0000-0000-96  ADAIR,FRANK C                 05/24/90        $2374263.21









End of Report
```

RETURNED ATTESTATION MESSAGE

When a physician returns an attestation as unaccepted, the following message page prints at the default printer in the Medical Record Department (or designated area) on 8 1/2 X 11 paper.

The following data elements are included on this report:

- Patient name
- Account number
- Unit number
- Financial class
- Sex
- Birthdate
- Admission date
- Discharge date
- Length of stay
- Attending physician
- Date sent
- Date returned
- Medical record message
- Physician DRG unaccepted reason
- Physician message

If the physician electronically signs and accepts the attestation, the signed attestation prints in the Medical Record Department.

Figure 5.16 Returned Attestation Message

```
                          GENERAL HOSPITAL

                     Returned Attestation Message
Patient Name              Acct Number    Unit Number      Financial Class
THOMAS,MARY P.            92057-00002    0000-0223-6      80 - SELF PAY

Sex    Birthdate          Adm Date     D/C Date   LOS
 F     05/05/05  86Y      02/26/92                 1

Attending Physician          Date Sent       Date Returned
ADAIR,CHARLES K.             02/27/92        02/27/92

Medical Record Message:



Physician DRG Unaccepted Reason:



Physician Message:
```

POINTER TABLE INACTIVE CROSS REFERENCE REPORT

This report lists Pointer Table codes that are linked to inactive ICD codes (diagnosis or procedure) or inactive HCPCS codes. You can print this report at anytime. It prints to the default printer for the CRT.

Listed in the report are the pointer code, the pointer code description, and the attached inactive ICD indicator and ICD code or HCPCS code. The report is sorted alphabetically by the pointer code description.

The following is an example of a Pointer Table Inactive Cross Reference Report.

Figure 5.17 Pointer Table Inactive Cross Reference Report

```
Wed Mar 05, 2008 10:26 am     Model Hospital A                    Page 1
                    Pointer Table Inactive Cross Reference
                        ICD Diagnosis Pointer Table

Pointer Code       Pointer Description        ICD Ind       ICD Code
_____________________________________________________________________

947                *ACUTE ERYTHREMIA            9           07.0
                                               10          XXXXXXX

951                *ACUTE LEUKEMIA NOS                     208.0

931                *ACUTE LYMPHOID LEUKEMIA                204.0

942                *ACUTE MONOCYTIC LEUKEMI                206.0

936                *ACUTE MYELOID LEUKEMIA                 205.0

932                *CHR LYMPHOID LEUKEMIA                  204.1
```

Appendix A - TABLES

TABLES

Many of the tables defined in theSTAR Patient Care Maintenance function are utilized within the DRG Assignment Module. Rather than review the specifics of each of these individual tables, we have provided a list of all the tables utilized within the *STAR Patient Care Reference Guide, DRG Assignment Module* that have been referenced in this volume of documentation. For specific table information, please refer to the corresponding entry in the *STAR Patient Care Reference Guide, Tables Volume.*

- Discharge Status/Disposition
- DRG Payors
- Financial Classes
- Hospital Service
- ICD Diagnosis Pointer
- ICD Procedure Pointer
- Physician

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■ Reader Comment Form ■

We value your suggestions for improving our documentation. Please use this form to evaluate the *DRG Assignment Module* of the *STAR Patient Care Reference Guide* for Release 17.0.

Topic	Poor	Fair	Good	Excellent
Organization of information	❑	❑	❑	❑
Accuracy of information	❑	❑	❑	❑
Completeness of information	❑	❑	❑	❑
Clarity of information	❑	❑	❑	❑
Amount of overview information	❑	❑	❑	❑
Explanation of processes	❑	❑	❑	❑

Are there parts of this manual that could be made more helpful to you? Please explain.

Other Comments:

Thanks for your help in improving the documentation.

Your Name and Position _____

Hospital/Organization Name _____

Telephone Number _____

May we contact you? Yes or No (circle one)

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