McKESSON
Empowering Healthcare

STAR 2000™

STAR FINANCIALS PATIENT ACCOUNTING REFERENCE GUIDE
Nova Scotia Claims Processing Volume

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Reader comments

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

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Preface

The *STAR Financials Patient Accounting Reference Guide* is a multi-volume document written for all users of the system. The *Nova Scotia Claims Processing Volume* provides detailed information about claims processing.

Documentation Conventions

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

Revisions

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

Canadian Documentation

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

Key Names

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

Key Chords

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

ENTER

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

Data Entries

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

Selecting an Entry

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

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

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

Prompts

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

Enter patient name--

Field Characteristics

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

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

      NOTE: Facilities can designate that certain fields be Required. STAR product documentation does not display R for fields designated as Required by a facility.
    - O if an entry is Optional to complete the function
    - C if an entry is Conditionally required or optional
  - For YY-Z field types, where YY is:
    - TABLE LOOKUP for a field that enables you to select from a displayed table. See the *General Information Volume* for more information regarding this entry technique.
    - SPECIAL FORMAT for a field having data entry requirements not conforming to standard format. The field definition contains the specific data entry requirements for the field.
    - DATE for a field subject to the date entry conventions described in the *General Information Volume*.
    - TIME for a field subject to the time entry conventions described in the *General Information Volume*.

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

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Introduction

This document contains a detailed explanation of the Nova Scotia claims processing. The book contains the following chapters:

Chapter 1: Parameters

This chapter provides the claim load and edit parameters for the Canadian claim types.

Chapter 2: Claims Processing

This chapter enables you to review and edit a claim's status, the claim carrier status, claim demographic/visit information, claim attachments, and claim charge data.

Chapter 3: Reports

This chapter provides information on the claims reports for Nova Scotia.

Chapter 4: Automatic Repricing by Financial Class

This chapter provides information on automatic repricing by financial class.

Chapter 5: Outpatient Out of Province Diskette

This chapter provides the file layout for the diskette.

Chapter 1 - PARAMETERS

INTRODUCTION

Claim Types

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

- 3-Comm NS

  This claim form is used for inpatient Nova Scotia commercial, workman's compensation and CFB insurances. It should be attached to all commercial and CFB insurance carrier/plans. Charges associated with this insurance are printed in detail by SIM code and Service Date, since there is no quantity associated with the charge line.

- 4-OP Comm NS

  This claim form is used for outpatient Nova Scotia commercial, workman's compensation, and CFB insurances. It is not attached to insurance carrier/plans, but automatically loads claim type 4 if the patient type is not an inpatient Claim load and edit (CL&E) parameters associated with this claim type are available for outpatient CL&E fields for plans associated with claim type 3. Charges associated with insurances identified as CFB can cause up to three claims to be created - lab, rad and other.

- 5-OutPrv NS

  This claim form is used for out of province outpatients, to create a diskette and report to submit to the Department of Health. The DoH then bills the appropriate province for reimbursement.

  Accounts are selected for diskette inclusion based on their unit number and date of service. Therefore, if multiple accounts with the same unit number have the same date of service, all accounts must be evaluated. As a result, a billing requirement should be associated with these accounts to hold bills so all may be evaluated at the same time. Currently, there are two billing requirements available: one to hold bills until the 7th day of the month after the account was discharged, and a second one to hold bills until the end of the month during which the account was discharged.

  All charges are evaluated unless they are identified in the NS Misc Parameters as excluded charges. This would be used for items such as eye lens replacements, where the lens should not be considered, but also should not be written off. See "NS MISC CLAIM PARAMETERS" on page 1-16 for further information regarding these parameters.

  In order to write off charges, reimbursement type N - NS out of province should be attached to the insurance carrier/plan. In addition, transaction code *ZZZZ* should

be attached in the reimbursement section of the insurance carrier/plan. This transaction code, which does not need to be built in the Transaction code table, allows the hospital to calculate and post separate contractual adjustments for each revenue center with non-high dollar charges for out of province outpatients.

The hospital needs to build one TRANA code for each revenue center defined. If an adjustment transaction code was defined and the TRANA mapping to GL wasn't built, the contractual adjustment is posted to the DFTRANSA account.

- 6-InPrv NS

  This claim form is used for out of province inpatients, to create a report to submit to the Department of Health. ICD-10 information is not currently available on STAR Patient Accounting to allow creation of the inpatient diskette. A report is created for all inpatients with non-zero dollar charges, who meet the date and hospital code criteria at the time that the outpatient out of province diskette is created.

Demographic Information

Demographic information for claims is determined by the claim load and edit parameters assigned to the insurance.

Assignment of Charges

Charge Control Parameters are not used in Canada. Charges are assigned as either insurance or patient responsibility based on the coverage and proration summary code exceptions established on each insurance plan. During the billing and claims process, the charges are assigned to the appropriate insurance carrier or to the patient if the charge is not covered by any insurance. This segregation of charges is often referred to as *charge piles*. Each non-zero charge is evaluated and assigned to only one charge pile. Therefore, a charge will appear on only one claim. The charges are assigned in COB order, in other words, beginning with the primary insurance. For more information on Charge Piles, please refer to “Patient Billing” on page 1-4.

Patient Billing

When patient billing is run, the system reads through the charges to be billed for the account and assigns them to charge piles. A separate charge pile is created for each COB as well as for the patient. To determine where to put the charges, the system looks at the proration summary code exceptions for each insurance plan assigned to the account. If all insurance plans assigned to the account exclude the proration summary code, then the charge is the responsibility of the patient and prints on the bill. At this time, partial coverage is assumed to be the responsibility of the insurance plan. The same charge cannot be in multiple COB charge piles or in both a COB and patient charge pile.

Proration is not impacted by the charge pile logic. Charge piles are only applicable for the actual charges that are insurance responsibility and included on individual insurance claim forms and patient responsibility. The type of charge field in the Billing Parameter screen indicates whether a patient bill should include only those charges that are the responsibility of the patient, or if all charges should be included. The Canadian patient bill format will only include payment, adjustment, and refund activity from the patient.

The format selected in the Patient Bill Format of the Facility Information should be as follows:

- Detail, Summary, Prorated Bill Header -12-Canada Patient Bill Header
- Detail Bill Body - 29-Canada Patient Bill Detail
- Summary Bill Body - 38-Canada Patient Bill Summary
- Prorated Bill Body - 39-Canada Patient Prorated Bill

Using the bill formats specified above, the system first prints the charges followed by the transaction information. Again, the charges that print (Patient or Patient and Insurance) are determined by the Type of Charge field in the Billing Parameter screen. Detail transactions are not printed for payments and refunds. The Print Adj Detail field in the Billing Parameter screen determines whether adjustment detail is printed, or if a summary line is produced. A separate total line prints for payments, adjustments, and refunds. Balance transfers are included in the adjustment totals. If there is not activity for the transaction type, then the line is suppressed. For example, if there are no refunds on the bill, then the line Total Refunds is suppressed from printing. Accounts whose patient balance is zero or a credit are suppressed from printing unless the Print Bills with Zero Chg field in the Patient Bill Format of Facility Options is set to Yes.

PROVIDER MASTER

The Provider Master must be updated in order to provide inpatient and outpatient commercial insurance information to the system.The Alt Provider Code 3 field should contain the provider number for inpatient CFB commercial claims. For more information on the Provider Master, refer to the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

CLAIM GENERATION PARAMETERS

Claim Generation Parameters indicate the transaction codes used when a claim is loaded, produced, and submitted. This parameter also defines the number of days that a claim remains in *suspense* before being released. After you select the Claim Generation Parameters option from the Claim Parameters menu, the following screen is displayed:

```
            General Hospital Claim Generation Parameters Processor
                                                  Wed Oct 22, 2003 11:37 am
Claim Generation Parameters
 1 Code           2 Description                          3 Status
   IP               NS INPROVINCE                          Active
 4 Edit by                                               5 Edit date
   Brash, Mike                                            02/10/31 11:42
 6 Suspense Days
   3
 7 Cycle Claim Transaction Code          8 Final Claim Transaction Code
   Z1000-NS IN PROVINCE CYCLE CLAIM        Z0002-NS IN PROVINCE FINAL CLAIM
 9 Adjustment Claim Transaction Code    10 Reprint Claim Transaction Code
   Z0003-NS IN PROVINCE ADJUSTMENT         Z0004-NS INPROVINCE REPRINT
11 Late Claim Transaction Code
   Z0005-NS INPROVINCE LATE CLAIM




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

Field Explanations

1. CODE (DISPLAY ONLY)
This field displays the code of the generation parameter.

2. DESCRIPTION (30-A-R)
This field contains the description of the generation parameter.

3. STATUS (DISPLAY ONLY)
The system displays whether this parameter is active or inactive.

4. EDIT BY (DISPLAY ONLY)
This field contains the name of the person who last edited this screen.

5. EDIT DATE (DISPLAY ONLY)
This field contains the date and time that this screen was last edited.

6. SUSPENSE DAYS (2-N-R)
This field enables you to define the number of days to hold before printing. Enter a number from 0 to 99 or U for Unlimited.

7. CYCLE CLAIM TRANSACTION CODE (TABLE LOOKUP)
This field contains the transaction code. Enter the code or a hyphen (-) to select from a list of valid codes.

8. FINAL CLAIM TRANSACTION CODE (TABLE LOOKUP)
This field contains the transaction code for the final claim. Enter the code or a hyphen (-) to select from a list of valid codes.

9. ADJUSTMENT CLAIM TRANSACTION CODE (TABLE LOOKUP)
This field contains the transaction code for the adjustment claim. Enter the code or a hyphen (-) to select from a list of valid codes.

10. REPRINT CLAIM TRANSACTION CODE (TABLE LOOKUP)
This field contains the transaction code for the reprint claim. Enter the code or a hyphen (-) to select from a list of valid codes.

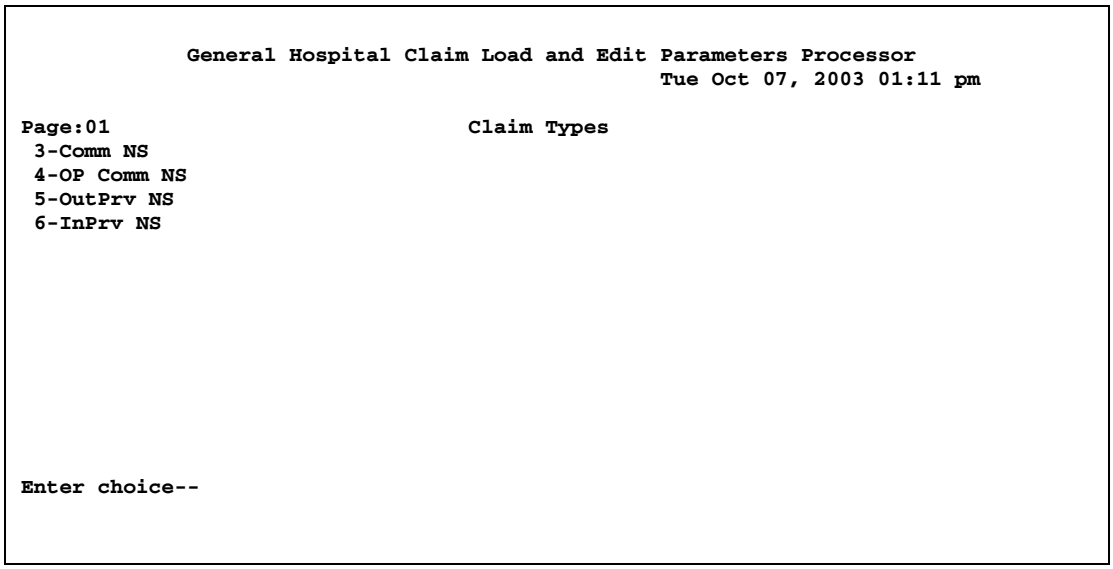
11. LATE CLAIM TRANSACTION CODE (TABLE LOOKUP)
This field contains the transaction code for the late claim. Enter the code or a hyphen (-) to select from a list of valid codes.

CLAIM LOAD AND EDIT PARAMETERS

Claim load and edit parameters allow the hospital to set up claim form edit criteriaused in loading the demographic information to claim forms. The parameters allow the hospital to define different variations of the claim forms, if needed, to accommodate specific carrier requirements or claim forms that need to differ depending on the type of patient. A master set of parameters that can be used as the basis for creating facility-specific parameters was developed by McKesson.

This parameter is not split by facility.

After this parameter is selected, the system prompts you to select a claim type. Claim types are defined by McKesson. The current choices for Nova Scotia customers are outlined in “INTRODUCTION” on page 1-3.



After you select a claim type, the system prompts you to enter a claim parameter. A claim parameter defines the basic format of a claim and how it is transmitted to the insurance. You can enter a claim parameter code or a hyphen (-) to display a list of valid codes. To add a code, enter the code. The system displays the following prompt:

Parameters do not exist for selection XXX. Add? (Y/N) [N]-

To return to the preceding screen and select another code, enter **N** or press ENTER. To add this code, enter **Y** and the system displays the following prompt:

Enter code to copy from or '=' to copy from HBOC masters-

To make building a newcode easier, the system enables you to copy the settings from an existing code or to copy from the McKesson setting for the selected claim type.

NOTE: Upon exiting a claim load and edit parameter, the system prompts you to determine whether you want a printed list. Enter **Y** to print a hardcopy of the parameter you exited from. All claim load and edit parameter reports spool to FCRCP without a facility indicator.

Enter the claim parameter or enter a hyphen (-) to select from the list of claim parameters. After you select an option, a screen similar to the following is displayed:

```
            General Hospital Claim Load and Edit Parameters Processor
                                                          Thu Oct 09, 2003 11:20 am


 1 Code      2 Claim Form   3 1500 Format      4 Description
   2           4 OP Comm                       OP COMMERCIAL
 5 Begin Date           6 End Date            7 Claim Media
   2001/01/01          ->                     B Paper and Electronic
 8 Electronic Types     9 Start Detail   10 Stop Detail    11 Load $0.00 Claim
                          42                57
12 Generation Pending? 13 Last Generated      14 Out of Province Hospital Code
                          2003/04/28 13:40
15 Edit Date           16 Edit By
   2003/04/28 13:40       Bane, Gail


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

Field Explanations

1. CODE (DISPLAY ONLY)
The system displays the letter representing the claim parameter.

2. CLAIM FORM (DISPLAY ONLY)
The system displays the type of claim form based on your selection of claimparameter.

3. 1500 FORMAT (DISPLAY ONLY)
This field contains the 1500 claim format and is not applicable to Canadian Claims.

4. DESCRIPTION (30-C-R)
This field contains the description of the claim parameter code.

5. BEGIN DATE (8-N-R)
This field contains the date on which this parameter becomes effective in the system. This field defaults to the current date.

6. END DATE (8-N-O)
This field contains the date on which this parameter becomes inactive.

7. CLAIM MEDIA (1-A-R)
This field contains the code and description of the claim media. Enter **P** for Paper, **E** for Electronic, **D** for Diskette, or **B** for Both (Paper and Electronic). The default is **B**.

You must enter B or E in this field to access the Electronic Types field. If you enter P or D in this field, the system does not permit you to access the Electronic Types field.

8. ELECTRONIC TYPES (TABLE LOOKUP)
This field contains the claim types that can be spooled to the electronic spool file if the Insurance Plan Master specifies that electronic claims should be generated. The options are Adjustment Claims, Cycle Claims, Final Claims, Late Claims, Reprint Claims, and Tracer Claims. This field is not required.

NOTE: If the Claim Media field is set to E or B and the Insurance Plan Master specifies that electronic claims should be generated, any claim types not specified here go to the paper, not the electronic spoolfile. To generate a hardcopy of your electronic claims, print your electronic spoolfile.

Reprint and Tracer claims can only spool to the electronic spoolfile if the original claim went electronically. If the original claim went to the electronic spoolfile, a reprint or tracer for the claim looks to the Claim Load and Edit Parameter to check if Reprints or Tracers are defined as an Electronic Type. If the claims are defined as an electronic type, the reprint or tracer spools to the electronic spoolfile. If Reprints or Tracers are not defined as an Electronic Type, the claims are spooled to the paper spoolfile.

If the original claim went to the paper spoolfile, the reprints and tracers go to the paper spoolfile regardless of the Electronic Types field in the Claim Load and Edit parameter. If the original claim was not sent electronically, it is not reprinted electronically.

9. START DETAIL (3-N-O)
This field indicates to the system where to start printing the detail charge information.

Enter a number from 0 to 999. You can also press ENTER to start printing.

10. STOP DETAIL (3-N-O)
This field indicates where to stop printing detail charge information. The end line must be greater than or equal to the start line in the previous field. Enter a number from 0 to 999. You can also press ENTER to stop printing.

11. LOAD $0.00 CLAIM (TABLE LOOKUP-O)
This field indicates whether a claim should load even if there are no charges for the insurance. This field is not used for Nova Scotia claims.

12. GENERATION PENDING? (1-A-R)
This field indicates whether changes have been made to this claim parameter or a new parameter has been added but the resulting program changes have not been generated. This enables you to modify the claim parameter but not generate the programs until all changes have been made. The claim parameter must be generated if a new parameter is added or changes to an existing parameter are made. To do this, enter Y when the system displays the following prompt at the end of this process:

Regenerate claim programs and screens (Y/N) [N] --

13. LAST GENERATED (DISPLAY ONLY)
This field contains the date and time a changed or new parameter was last generated.

14. OUT OF PROVINCE HOSPITAL CODE (3-A-O)
This field can only be accessed if the Claim Type is a V. The value in this field is used within the out of province download datafile and as the extension in the filename.

15. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this claim parameter was last edited.

16. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this claim parameter.

After you complete this screen, press ENTER, and the system displays the following prompt:

Delete? (N)-

If you do not want to delete this parameter, press ENTER to accept the default of **N** for No.

Editing Claim Form Fields

When these fields are completed, you have the option of accepting or editing the information on the screen. Accepting the screen establishes this claim parameter in the system. The system then prompts you to enter a claim form locator code or a hyphen (-) to display a list of valid form locators for the selected claim parameter. The form locators identify the information that is loaded in the demographic portion of the claim.

After a form locator is entered or selected, the system gives you the option to change the form locator description. The claim form locator and description appear on the top part of the screen along with the claim parameter code and description. If you change the locator description, the description you currently see is changed. If you enter N, the description remains unchanged and a list of field definitions relevant to the selected claim form locator appears. Claim form locators can contain single or multiple field definitions which are used to update the boxes on the claim forms or data within the downloaded files. When you select one of the field definitions, the following screen is displayed:

```
            General Hospital Claim Load and Edit Parameters Processor
                                                Thu Oct 09, 2003 01:05 pm
Claim Parameters: 1 CFB IP COMM
Claim Locator   : 6 INVOICE NUMBER
 1 Field #      2 Description                        3 Required?     4 Print?
   1              Invoice Number                       Yes             Yes
 5 Form Row     6 Form Column            7 Form Length        8 Field Type
   6              72                       19                   X Alphanumeric
 9 Valid Entries                        10 Default Value

11 Internal Element                     12 Set Up Routine
   ACCOUNT NUMBER
13 Print Routine                        14 Online Edit Routine
   ACCOUNT NUMBER (NO FACILITY)
15 Display Routine                      16 Batch Edit Routine
   ACCOUNT NUMBER (NO FACILITY)
17 Insurance UDF Code




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

Field Explanations

1. FIELD # (DISPLAY ONLY)
This field displays the number of this field definition in the claim locator. This field is set up by McKesson and cannot be edited.

2. DESCRIPTION (30-C-O)
This field displays the description of this field definition. The hospital may change it if necessary.

3. REQUIRED (1-A-R)
This field indicates whether the field definition is required to complete the claim form. Entry options are **Y** for Yes or **N** for No; the default is Y. If you enter Y, the system edits all patient claims for this field definition to ensure the appropriate information exists. The system holds the claim until the information is entered in the claims process or the maximum suspense days have been reached for the patient account. If you enter N, the system does not edit the claims.

4. PRINT (1-A-R)
This field indicates whether the field definition should be included on the claim form.

Entry options are **Y** for Yes or **N** for No; the default is Y. If you enter Y, the system includes this field definition, if it is present, on the claim form. If you enter N, the field definition is not printed on the form but is still loaded if present.

5. FORM ROW (3-N-O)
This field sets the vertical position on the claim form at which this field definition begins printing. You identify this position to the system as a line number on the claim form. Claims are based on printing six lines per inch. The range is 0 to 999.

NOTE: This field is defined in the claim master supplied by McKesson and should not have to be modified.

6. FORM COLUMN (3-N-O)
This field sets the horizontal position on the claim form at which this field definition begins printing. You identify this position to the system as a column number on the claim form. Claims are based on printing 10 columns per inch. The range is 0 to 999.

NOTE: This field is set up in the claim master supplied by McKesson and should not have to be modified.

7. FORM LENGTH (3-N-O)
This field defines the maximum number of characters that the field can contain. The range is 0 to 999 characters.

NOTE: This field is set up in the claim master supplied by McKesson and should not have to be modified.

8. FIELD TYPE (1-A-R)
This field contains the type of characters or information entered in this field definition. Entry options are **A** (alpha), **D** (date), **M** (money), **N** (numeric), **T** (time), **X** (alphanumeric), or **Y** (yes/no flag). What you enter here depends on the element you select. For example, if M (money) is entered, only the field definitions pertaining to dollars can be selected as elements for this field definition. The Y (yes/no flag) entry is used on the 1500 form for the boxes requiring X - either yes or no.

9. VALID ENTRIES (2-A-O)
This field enables the hospital to indicate the values accepted by the carrier for this form locator. The system edits a claim having valid values set up against these fields and, if a match is not found, an error is generated for the patient's claim. Entries must coincide with the Field Type field. For example, if you entered N for Numeric for the field type, valid entries might be 5, 56, 112, etc. Separate each valid entry with a comma.

10. DEFAULT VALUE (1-C-O)
This field contains the default value for this form locator. If a value is entered in this field, it is used on the claim form if the internal element does not exist for the patient. It can also be used in any claim when the hospital always wants a certain value loaded.

11. INTERNAL ELEMENT (35-C-O)
This field contains the internal element associated with this field definition. All internal elements are set up by McKesson. This field enables the hospital to choose what loads and prints on the claim form for this field definition.

It is important to remember that the elements that are displayed are those whose field types match the entry in the Field Type field.

You can enter a description of the element or a hyphen (-) to display a list of elements. If you enter a description, the internal elements table is searched.

12. SET UP ROUTINE (TABLE LOOKUP)
This field contains the setup routine for the field definition. The system prompts you to select a setup routine only if it is necessary because the selected internal element has more than one choice. For example, if Insurance Carrier/Plan name is entered in the Internal Element field, the system prompts you to select which insurance plan's name to include. You can enter a hyphen (-) to display a list of your choices.

13. PRINT ROUTINE (TABLE LOOKUP)
This field indicates the format that is used when the data is printed on the claim form. For example, field definitions that have dollar field types provide you with multiple choices regarding how the dollars should print. You can enter a hyphen (-) to display a list of choices.

14. ONLINE EDIT ROUTINE (DISPLAY ONLY)
This field is defined and maintained by McKesson and cannot be edited.

15. DISPLAY ROUTINE (TABLE LOOKUP)
This field indicates the format that is used when the data is displayed. For example, field definitions that have dollar field types provide you with multiple choices regarding how the dollars should display. You can enter a hyphen (-) to display a list of choices.

16. BATCH EDIT ROUTINE (DISPLAY ONLY)
This field is defined and maintained by McKesson and cannot be edited.

17. INSURANCE UDF CODE (3-AN-O)
This field allows entry of a valid insurance UDF code that is contained in the Patient Processing Insurance User-Defined Field table when an internal element for an Insurance UDF is selected. The format of the selected UDF code must match that of the Internal Element.

NS MISC CLAIM PARAMETERS

There are several miscellaneous parameters that need to be defined for Nova Scotia claims to work correctly.

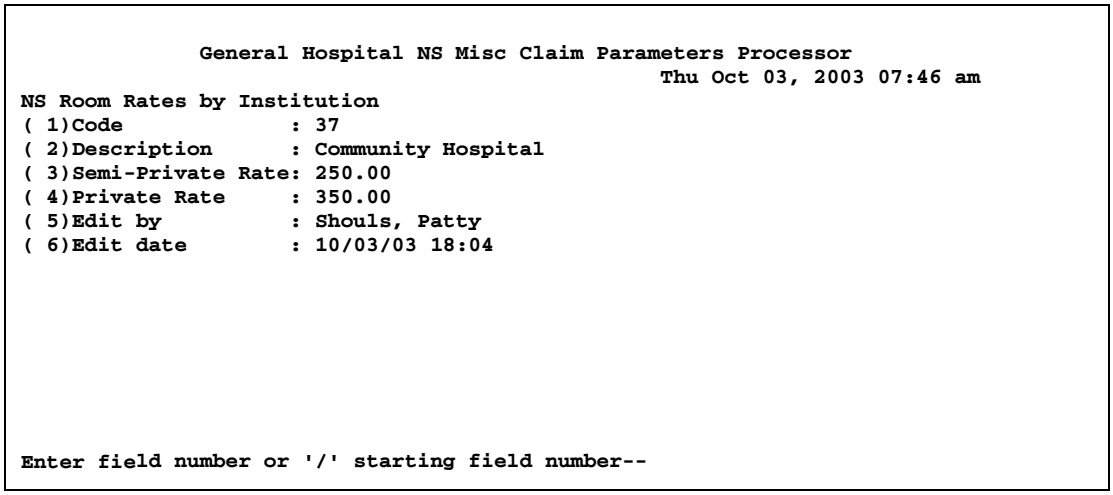
- For the system to pull the room rate information to the Nova Scotia Commercial IP claim form, define both semi-private and private room rates by Institution code.
- For the system to determine if the carrier/plan is a CFB type, enter carrier/plan codes that can produce split claims for CFB processing.

```
            General Hospital NS Misc Claim Parameters Processor
                                                Thu Oct 09, 2003 01:21 pm



 1 NS Room Rates by Institution
   See Entries Defined

 2 NS CFB Insurance Plans
   130100,130300,500100









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

Field Explanations

1. NS ROOM RATES BY INSTITUTION (4-N-R)

This field contains the Institution Code from the Institution table. The field displays the value No Entries Defined if no institution codes are set up; if codes are set up, the field displays the value See Entries Defined. Enter a valid Institution Code or hyphen (-) to select a code from the Institution table. If you access the table, the following screen is displayed:



This screen allows you to view and edit the semi-private and private room rates for an institution. The value that is stored in this table are the values that print in form locators 39 and 40 on the form.

Field Explanations

CODE (DISPLAY ONLY)
This field contains the institution code.

DESCRIPTION (DISPLAY ONLY)
This field contains a description of the institution code.

SEMI-PRIVATE RATE (DISPLAY ONLY)
This field contains the semi-private room rate used on the inpatient commercial claim form in locator 33.

PRIVATE RATE (DISPLAY ONLY)
This field contains the private room rate used on the inpatient commercial claim form in locator 34.

EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited the table.

EDIT DATE (DISPLAY ONLY)
This field contains the date and time the table was last updated.

NS Misc Claim Parameters Screen Fields Continued

2. NS CFB CARRIER/PLANS (3-N-R)
This field contains the carrier/plans that are CFB plans. These plans produce split claims based on the type of charges placed on the account. Because the CFB

insurances also use the commercial claim forms, this is used to identify those CFB plans that should produce split claims based on the charges on the account.

Enter a valid carrier/plan code or a hyphen (-) to select a code from the Insurance Plan Coverage table. For more information on that table, refer to the *Tables, Masters, and Parameters Volume* of the *STAR FInancials Patient Accounting Reference Guide*.

As you exit the screen, the system prompts you to identify, for both inpatients and outpatients, those FIM items which should be excluded from the Out of Province High Dollar calculations. These would be items for which the Ministry does not reimburse, but should not be written off. They should be billed to the patient. The following prompt is displayed:

Do you wish to revise items excluded from the Out of Province High Dollar Calculation for Inpatients (Y/N)-

You can enter **Y** for Yes to revise excluded items for inpatients or **N** for No to exit the screen. If you enter Y, the following screen is displayed:

```
        Inpatient FIM Items for Exclusion from Out of Province Write Off
Seq#  FIM Dept  FIM Code     FIM Description
1        EYC   350600002    ORTHOPTIC ASSESSMENT




                    Enter FIM Department or `-` for table--
   F1Prev Page F2Next Page F3 Insert  F4 Delete  F6 Reset  F7  Exit   ?
```

You can select FIM items to exclude by entering a hyphen (-) to select the item from a list of FIM items.

When you exit this screen, the system prompts you accept the screen. You are then prompted to identify, for outpatients, the FIM items to be excluded from the Out of Province High Dollar calculations. The following prompt is displayed:

Do you wish to revise items excluded from the Out of Province High Dollar Calculation for Outpatients (Y/N)-

You can enter **Y** for Yes to revise excluded items for outpatients or **N** for No to exit the screen. If you enter Y, the screen shown above (for inpatients) is displayed.

Chapter 2 - CLAIMS PROCESSING

INTRODUCTION

The Claims functions enable you to review and edit a claim's status, the claim carrier status, claim demographic/visit information, claim attachments, and claim charge data. You can reload a claim's demographic data and reprint a selected claim. Claim information can be accessed by either account or by biller. The system enables billers and their supervisors to review claims in a biller's workfile that passed edits, failed edits, are not yet submitted,have already been submitted to the carrier, and have been replaced.

Billers are assigned to claims based on the Facility Options of the Insurance Plan Coverage Master. The billing parameters of an account's primary insurance determine the biller who is responsible for the actual bill as well as the insurance claim. Billers for secondary claims can be different from the biller on the primary insurance, depending on the information entered on the Facility Options of the Insurance Plan Coverage Master.

Billers can access only the accounts in their workfiles. Billing supervisors can access the same information only for the billers in their billing group. Billing managers can access the workfiles of all billers.

THE CLAIMS PROCESS

This section discusses loading, editing, reviewing, and releasing claims.

Claim Load and Edit

If any carrier/plans are assigned to an account when it is billed, the system produces claims to be used for filing with each of the appropriate carriers. Claims can be produced for each carrier or shared by more than one carrier. The claim processing codes previously assigned to each carrier/plan define the demographic and charge information included on the claim form. These parameters tell the system which data fields need to be reported, indicate which charge types should be reported or excluded from the claim, specify any additional requirements, and determine how transaction history is updated by the claims process.

The claims process, which determines what is included and excluded on a claim, is as follows:

- Claim Load and Edit Parameters

  This parameter determines the information that prints in each field of a claim form and whether it is required. For example, if you want the biller name to print on the unproduced claim, you specify this in the claim load and edit parameter. The system may present you with format options on certain fields. If the field is marked required and the data is not available, the claim fails the edits when it is loaded.

  Each insurance plan has its own claim load and edit parameters. The parameters can be different for primary and secondary insurance coverage and for inpatients and outpatients.

- Claim Generation Parameters

  This parameter controls the transaction codes that are used to update the account's transaction history when claims are loaded, generated, and submitted. This parameter also contains the suspense days for claims. The suspense days control how long failed paper claims remain in the workfile before the system automatically releases them.

The Insurance Plan Coverage Master includes these parameters, as well as several other fields that control claim production. For more detailed information regarding these parameters and the Insurance Plan Coverage Master, refer to the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

You can submit claims by paper, tape, diskette, or electronic means. The claim media code defined for each carrier plan indicates the claim's actual submission media. Claims that are submitted electronically and on tape are spooled into a separate file for processing. To support claim follow-up, you can generate a paper reference copy of

each claim that is submitted by tape or electronic media by printing the electronic spoolfile. Claims submitted by diskette do not create pages or spooled files, and therefore these can not be printed.

When bills are produced, the system loads the associated claims into a claim review file. Based on the requirements specified in each carrier's claim processing code for each carrier plan, the system edits each claim. To assist the biller in claim review and correction, the system identifies any incomplete or invalid fields on each claim.

Claim Review and Release

As the system processes claims, it loads them into a claim review file. Billers can access this file to review, edit, and approve the claims prior to submission. The Pending Claims Report captures the contents of this file. As claims are loaded, the system edits each claim against the edit requirements defined in that carrier's claim load and edit parameters. Any errors appear on the Failed Claims Requirement report (generated as a result of Midnight Processing), which billers can use when reviewing claims. Errors also appear online within the biller workfile.

If the claim requires attachments, you can identify these with attachment codes and tie them into the insurance plan. If attachment codes are charge-related, you can also associate the attachments with an item in the Service Item Master. If not completed, the Failed Claims Released report provides a list of all attachments required for each claim. Updating the receipt of the attachment is accomplished through online claim review.

Claim Status

If the user enters the biller workfile by account, the system displays all claims for the particular account. Two claim status codes are displayed when the account's claims are displayed: Production Status and Work Status.

PRODUCTION STATUS CODES

Production status codes indicate whether the claim has been:

- Produced (P) - printed or sent electronically.
- Not Produced (NP) - not yet printed or not sent to third party, if electronic claim.
- Archived (AR) - already produced, denied claim, or paid claim that has been archived to microfiche or paper and is ready to be purged.
- Purged (P) - claim data has been archived, and data no longer exists on the system.

WORK STATUS CODES

Work status codes indicate the current status of the claim. There are several work status codes:

- **Awaiting Payment from Prior Payor (A)**

  This status indicates that a claim is waiting for payment from the primary carrier. A claim can be held for a payment from the primary carrier.

- **Delete (D)**

  If a claim has not yet been produced, it may be marked for deletion. The system deletes the claim online. Claims that have already been produced can only be deleted if the claim has been denied and the carrier balance is equal to zero.

  NOTE: When a shared claim is deleted, any remaining carrier balance is transferred to the patient.

- **Edit (E)**

  If you want the claim to be edited by the system in the next midnight processing, you should set the status to **E** (edit). When a claim is first loaded, the system edits the claim. The claim is also edited as changes are made to the claim by the biller. A claim awaiting prior payment is edited if the status is fail following a full carrier payment. All claims with this status are edited during midnight processing, and the status is changed as a result of the processing. A claim that had been previously suppressed and is later unsuppressed is assigned a work status of edit.

- **Fail (F)**

  This status indicates that a claim has errors that have not been corrected. This status does not appear on claims awaiting payment. Only one work status is valid at a time.

  Claims also fail if attachments are required.

- **Hold (H)**

  Prior to printing, a claim can be put on hold by the biller. A claim that is on hold is automatically removed from the claim review file. A claim may have passed all edits but is put on hold for internal reasons. Once a claim is put on hold, no further action is taken by the system. The hold status can be removed manually at any time by the biller.

- **Manually Released (M)**

  When you interact with a claim to cause its release, the work status is changed to Manually Released. This includes claims that have been on hold, claims released as a result of correcting edits, and claims released by the biller that have errors remaining.

- **System Released (R)**

  This work status is used for claims that have passed all of the claim requirements and have been generated.

- **System Released Forced (S)**

  When a claim has failed edits for the number of days beyond the maximum hold days specified on the Claim Generation Parameters, the claim is automatically generated with this work status.

- **Suppressed (P)**

  If a payment, adjustment, or balance transfer causes a carrier or account balance to be zero, any remaining claims can be suppressed. This is controlled by the insurance plan.

- **Claim Disposition**

  Refer to the Claim Disposition field for additional information.

CLAIMS PROCESSING

Access to a claim is different for claims by account and claims by biller. Once a patient and claim have been selected, the submenu is identical for both options (claim by account and claim by biller). The following topics discuss claim access by either method and provide a detailed explanation of the actual claim record. Claims Processing provides the following functions:

- Maintain Claims by Account
- Maintain Claims by Biller
- Add Claim to Insurance
- Archive Claims
- Purge Archived Claims
- Print Pending Claims Report
- Out of Province Diskette
- Recreate Out of Province diskette/report
- Purge Out of Province diskette

Accessing Claims By Account

This function enables you to access claims on a single patient account. After you select this menu option, the system prompts you to select a facility (if this is a multi-facility installation) and then a patient account using the FPI Lookup procedure.

The system displays the following information for the selected account: patient account number, patient name, financial class, patient type, admission and discharge dates, account balance, and account location/sub location.

All claims associated with this account are displayed in this format:

```
            General Hospital Maintain Claims by Account Processor
                                                 Wed Mar 15, 2006 10:10 am
Account      Name                      FC Typ Admit    Disch        Balance Loc
J4-0000102   BARENS,DALE               OP DIP 03/01/13 03/01/14     1720.00 AR/FCRV

     Clm Adj   Bill     Bill   Clm   Prd Wk  OPPS Clm
     Seq Clm   From     Thru   Type  Sts Sts Sts  Dsp Carrier/Plan(*Shared)
Page:01                            All Claims
( 1)   1     01/13/03 01/14/03 OutPr P    R           555100,NS OUT OF PROVI









Enter choice or (I)ncomplete, (C)omplete, (L)ist All, or (O)ther --
```

Replaced (adjusted) claims are displayed in reverse video indicating the claim has been replaced by a subsequent claim. If a claim has been replaced, the system displays the sequence number of the adjusting claim in the Adj. Clm column. The Biller/Collector Worklist Control parameters determine whether adjusted claims are included in the claim lookup.

Field Explanations

CLM SEQ (DISPLAY ONLY)
This field contains the sequence number for the claim record. This sequence number is assigned sequentially by the system to each claim as it is loaded and is separate from the bill sequence number.

ADJ. CLM (DISPLAY ONLY)
If this claim has been replaced by a subsequent claim, the claim sequence number of the claim that replaced it is displayed in this field.

BILL FROM (DISPLAY ONLY)
This field contains the beginning date covered by this claim.

BILL THRU (DISPLAY ONLY)
This field contains the ending date covered by this claim.

CLM TYPE (DISPLAY ONLY)
This field contains the type of claim form for this claim. If the insurance is outpatient CFB, there is also an indication if this is a physio, radiology, or other outpatient type claim.

PRD STS (DISPLAY ONLY)
This field indicates whether the claim has been produced (P), not produced (NP), purged (Pu), or archived (AR).

WK STS (DISPLAY ONLY)
This field indicates the current work status of the claim.

The work statuses include awaiting payment from prior carrier (A), delete (D), edit (E), fail (F), hold (H), manually released (M), system released (R), system released forced (S), and suppressed (P). Possible entries are explained in the Work Status Codes topic.

OPPS STS (DISPLAY ONLY)
This field is not applicable for Canada.

CLM DSP (DISPLAY ONLY)
This field indicates the current claim disposition. The valid claim dispositions are F (Final Payment), A (Adjusted to Zero), P (Partial Payment), T (Transfer), C (Clear), or R (Replaced).

CARRIER/PLAN (DISPLAY ONLY)
This field contains the carrier and plan code and description for this claim record. If the claim is shared by more than one carrier, the carrier/plan is displayed with an asterisk preceding it.

The following prompt is displayed at the bottom of the screen and allows you to select the claim(s) you want the system to display:

Enter choice or (I)ncomplete, (C)omplete, (L)ist All, or (O)ther --

The options are:

Choice - Enter the number of the claim you want to view.

I (Incomplete) - Display only complete claims.

C (Complete) - Display only completed claims.

L (List All) - Display all claims.

O (Other)- If you select O, the following prompt is displayed:

Limit claims by Claim (T)ype, (D)isp, (B)ill Dt, (S)ubm Dt, or (C)OB [D] –

If you select **T** (type), the system displays the list of claim type codes from the Claim Type table. You can select one or more claim types to be displayed for the account. The display is limited to claims valid for the facility.

```
                  General Hospital Maintain Claims by Account Processor
                                                  Wed Mar 15, 2006 10:10 am
Account      Name                     FC Typ Admit    Disch        Balance Loc
J4-0000102   BARNES, JILL             OP DIP 03/01/13 03/01/14     1720.00 AR/FCRV

Page:01                             Claim Types                ##=Current Choices
( 3) 3-Comm NS
( 4) 4-OP Comm NS
( 5) 5-OutPrv NS
( 6) 6-InPrv NS









Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
                                 end select(NL)
```

If you select **D** (Disp), the system displays the Claim Disposition Codes as follows:

```
            General Hospital Maintain Claims by Account Processor
                                                  Wed Mar 15, 2006 10:10 am
Account      Name                     FC Typ Admit    Disch        Balance Loc
C01000001    BERRY, MARTHA            OH XRC 02/01/22 02/01/22     30.44   AR/FCRV

Page:01                       Claim Disposition Codes          ##=Current Choices
( 1) A-Adjusted to zero
( 2) F-Final Payment
( 3) D-Denied
( 4) P-Partial Payment
( 5) R-Replaced by adjustment claim
( 6) T-Transfer
( 7) C-Clear disposition
( 8) N-No disposition




Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
                                 end select(NL)
```

You can select one or more Claim Disposition codes for claims to be displayed for the account. Notice that you can select claims with no disposition and claims with a clear disposition. For shared claims, the disposition used for selection matches the disposition displayed on the claims list screen which is the disposition for the first COB in the shared claim. For shared claims, the submission date for the first COB in the shared claim is used for selection.

If you select **B** (bill date), the system displays the following prompt:

Enter earliest bill thru date [Earliest] –

You can accept the default of Earliest, enter a specific date, or enter **T** - # to indicate the number of days prior to today to be used as the earliest bill date. For example, T-100 would include all claims with a bill through date 100 days prior to today or later. After entering the earliest bill through date, the following prompt is displayed:

Enter latest bill thru date [Latest] –

You can accept the default of Latest, enter a specific date, or enter **T - #** to indicate the number of days prior to today to be used as the latest bill through date. Claims will be included in the list of claims on the account if the bill through date on the claim falls within the range of bill through dates specified.

If you select **S** (submission date), the system displays the following prompt:

Enter earliest submission date or (N)ot Submitted [Earliest] –

You may accept the default of Earliest, enter a specific date, enter **T - #** to indicate the number of days prior to today to be used as the earliest submission date, or enter **N** for claims not submitted. If you choose N, then the system displays all claims not submitted for the account. If the default of earliest is accepted or if the earliest submission date is entered, then the following prompt is displayed:

Enter latest submission date [Latest] –

You may accept the default of Latest, enter a specific date, or enter **T - #** to indicate the number of days prior to today to be used as the latest submission date. Claims are included in the list of claims on the account if the submission date on the claim falls within the range of submission dates specified.

If you select **C** (COB), you can select from the insurance plans on the account. One or more COBs may be selected.

After entering the additional limits in each of the above options, the system displays the claims list screen for the account. Only the claims meeting the selection criteria are included in the claims list. Selecting a claim that has a production status of Produced or Suppressed for detail review presents you with the options shown on the following screen:

```
            General Hospital Maintain Claims by Account Processor
                                                    Wed Mar 15, 2006 10:10 am
Account      Name                      FC Typ Admit    Disch        Balance Loc
J1-0000202   ARNES, CALEB              OH I/P 02/11/04 02/11/04     2159.49 AR/FCRV
     Clm Adj   Bill     Bill   Clm    Prd Wk  OPPS Clm
     Seq Clm   From     Thru   Type   Sts Sts Sts  Dsp Carrier/Plan(*Shared)
       2     11/04/02 11/04/02 InPrv P    M           666100,NS IN PROVINCE
             Option No.  Option
             ---------------------------------------
                 1       Claim Status Information
                 2       Carrier Status Information
                 3       Claim Demographic/Visit Data - Errors Only
                 4       Claim Demographic/Visit Data - All Screens
                 5       Claim Demographic/Visit Data - Select Screens
                 6       Claim Attachments
                 7       Claim Charge Data
                 8       Claim Disposition
                 9       Re-Print Claim
                10       Account Inquiry
                11       Account Revision
                12       Claim Charge Reconciliation

Enter option number--
```

NOTE: The above screen is for a claim that has already been produced or manually released. If this claim had not been produced or manually released, the Reload Claim Demographic/Visit Errors option would display rather than the Re-Print Claim option. The Reload Claim Demographic/Visit Errors option is only available until the claim is produced or manually released. Following one of these events, the Re-Print Claim option becomes available. If you select archived or purged claims, the system presents the first two menu options only.

For details on the options on this screen, see “CLAIM FUNCTIONS” on page 2-19.

Accessing Claims by Biller

This option is used to access claims in a particular biller's workfile. If you are a biller, you can access only those accounts in your biller workfile. If you are a billing supervisor, you can enter a hyphen (-) to display a list of billers in your billing group. If you are a billing manager, you can enter a hyphen (-) to display a list of all the billers in the system.

After this option is selected, the system prompts the supervisor or manager to select a biller. Billers are immediately presented with the workfile options by the system. You can enter the biller code or a hyphen (-) to display a list of available billers or all billers

in the system, depending on your position (supervisor or manager). When a biller code is entered or selected, the system displays this screen and presents these options:

```
                General Hospital Claims by Biller Processor
                                                Tue Oct 16, 2003 10:24 pm
Biller:ASHLAND,MARY
Page:01                          Claim Types                ##=Current Choices
( 1) Claims that Failed Edits
( 2) Claims that Passed Edits
( 3) Generated Claims Not Yet Submitted
( 4) Claims Already Submitted
( 5) Claims Replaced by Adjustment Claims
( 6) Completed Claims









Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
                                end selection(NL)
```

- **Claims that Failed Edits**

  This option displays claims within the specified date range that have failed the edits established in the Claim Load and Edit Parameters. A claim that is awaiting prior payment with failed edits is included in this option. Only claims that have not been produced are included. If a claim has been replaced by an adjustment claim, the replaced claim is displayed in reverse dim video by the system.

- **Claims that Passed Edits**

  This option displays claims that have passed the edits but have not been produced. For example, claims awaiting prior payment with no failed edits are included in this option.

- **Generated Claims not Yet Submitted**

  This option includes all claims that have been produced but not yet submitted. You can submit claims individually or as a group by day.

  The system then prompts you to submit (**S**) or edit (**E**) the generated claims. If you enter **E**, the system displays each claim and enables you to select specific claim records for submission. If you enter **S**, the system displays each claim and enables you to select multiple claims to submit as a group. After you enter your choices, the system prompts you to enter the submission date; the default is the current system

date. In either case, you specify the submission date. It is important to submit a claim for several reasons:

- Biller statistics are updated when claims are submitted.

- Insurance follow-up is scheduled based on the claim submission date.

Submission indicates the mail date for paper claims or the transmission date for electronic claims. Claims that are never submitted never receive any insurance follow-up. This can hinder collection efforts and leave an account in limbo for an unspecified period of time since time-out does not occur and subsequent claims are not released.

NOTE: If your selection includes a claim that has a claim load date that is later than the claim submission date, the system displays the message Claims Excluded. If you try to enter a future date as the claim submission date, the system displays the message *Error: Entry out of Range!*

- **Claims Already Submitted**

  This option displays accounts with claims that have been submitted previously.

- **Claim Replaced by Adjustment Claims**

  This option is used to review claims that have been replaced by adjustment claims and provides an accurate before and after picture of claims generated by the system.

- **Completed Claims**

  This option displays accounts with claims that have been completed. Claims are completed when a disposition of **F** (final payment), **D** (denied), or **A** (adjusted to zero) is assigned.

You can select individual options or any combinations of options. The system highlights the selected options.

NOTE: The Biller table, not the Billing Group table, is used to identify billing supervisors.

The next step is to enter a range of search dates for the claims you want to review. You are asked to enter a Begin Search Date and an End Search Date. You can enter each date in the format MMDDYY or MM/DD/YY or use the default options. The default for the begin date is **F** (the date of the oldest claim in this biller's workfile). The default for the end date is **L** (the date of the most recent claim in this biller's workfile). After accepting the dates entered, the system displays either sort options (these are documented below) or the claims selected (by the sort options where applicable) within date for each account.

If you access Claims by Biller and then request Claims that Failed Edits, Claims that Passed Edits, Generated Claims Not Yet Submitted, Claims Already Submitted, Claims Replaced by Adjustment Claims, or Completed Claims, if the claim data does not match the biller data for the claim, this claim does not appear and is marked to be fixed during midnight processing.

SORT OPTIONS

If you select the Claims that Failed Edits or Claims that Passed Edits option, the system displays the following prompt after you enter the range of search dates:

Display in Alpha Sequence (A), Numeric (N), or Date (D)? [D]--

Enter **A** if you want to sort the claims in the workfile by name; enter **N** if you want to sort the claims by numeric sequence; press ENTER if you want to sort the claims by date.

NOTE: If you select both the Claims that Failed Edits and Claims that Passed Edits options, the system does not present any sort options and displays the claims in the workfile by date.

If you select the Generated Claims Not Yet Submitted option, the system displays the following prompt:

Display in Print Sequence (Y/N)? [N]--

If you enter **Y**, the workfile is sorted to dsplay the claims in the order in which they were printed.

Once the search and sort criteria are entered, the system displays the following screen:

```
                General Hospital Claims by Biller Processor
                                                Tue Oct 16, 2003 10:27 am
Biller:ASHLAND,MARY
                                                                      Page:01
     Clm Adj Bill Date  Account   Type Status Carrier/Plan(*Shared) Name
( 1)   6     03/10/22 89234-00007 Gen    Rel   ADJUSTCO/W.C.       SCHALLIP,
( 2)   1     03/11/01 89299-00003 Comp   Rel   EBI/W.C.            ROHDE,C L
( 3)   6     03/11/02 89268-00001 Fail  Wait   ADJUSTCO/W.C.       LOWENSTEI
( 4)   9     03/11/02 89234-00007 Gen    Rel   ADJUSTCO/W.C.       SCHALLIP,
( 5)   1     03/11/05 89305-00001 Gen    Rel   ALEXSIS RISK MGMT/W ROHDE,J A
( 6)  11     03/11/13 89270-00003 Fail  Wait   ADJUSTCO/W.C.       CURNICK,T
( 7)   3     03/11/28 80332-00007 Fail  Wait   EBI/W.C.            HALL,F B
( 8)   6     03/11/29 89332-00007 Fail  Wait   EBI/W.C.            HALL,F B
( 9)  12     03/12/03 89234-00007 Fail  Wait   ADJUSTCO/W.C.       SCHALLIP,









Enter choice--
```

Field Explanations

CLM (DISPLAY ONLY)
This field contains the claim sequence number of the selected claim record.

ADJ (DISPLAY ONLY)
This field contains the claim sequence number of the replacement claim if this claim has been adjusted by an additional claim.

BILL DATE (DISPLAY ONLY)
This field contains the claim load date associated with this claim.

ACCOUNT (DISPLAY ONLY)
This field contains the patient account number pertaining to this claim.

TYPE (DISPLAY ONLY)
This field contains a value that lets the biller know whether the claim has been sent to the carrier. The type field matches the selection type choices presented to the biller when the biller workfile is entered by the biller. This type can be one of the following:

- Claims that Failed Edits - Fail
- Claims that Passed Edits - Pass
- Claims that have been Generated - Gen

- Claims that have been Submitted - Sub
- Claims Replaced by Adjustment Claim - Repl
- Completed Claims - Comp

STATUS (DISPLAY ONLY)
This field contains the work status of this claim. The work statuses include awaiting payment from prior payment (A), delete (D), edit (E), fail (F), hold (H), manually released (M), system released (R), system released forced (S), and suppressed (P).

CARRIER/PLAN (DISPLAY ONLY)
This field contains the carrier and plan description for this claim record. If more than one carrier shares the same claim record, the first carrier/plan is displayed with an asterisk preceding it.

NAME (DISPLAY ONLY)
This field contains the name of the patient pertaining to this claim record.

CLAIM FUNCTIONS

The system provides the claim functions listed on the screen below:

```
             General Hospital Maintain Claims by Account Processor
                                                  Wed Mar 15, 2006 10:10 am
Account      Name                    FC Typ Admit    Disch        Balance Loc
J0-0001562   MERRT,OUTOF PROVINCE    OP O/P 03/06/27 03/06/27     195.35  AR/FCRV
     Clm Adj   Bill     Bill   Clm   Prd Wk  OPPS Clm
     Seq Clm   From     Thru   Type  Sts Sts Sts  Dsp Carrier/Plan(*Shared)
       1     06/27/03 06/27/03 OutPr P    R           150900,NS OUTPATIENT O
           Option No.  Option
           ----------------------------------------
               1       Claim Status Information
               2       Carrier Status Information
               3       Claim Demographic/Visit Data - Errors Only
               4       Claim Demographic/Visit Data - All Screens
               5       Claim Demographic/Visit Data - Select Screens
               6       Claim Attachments
               7       Claim Charge Data
               8       Claim Disposition
               9       Re-Print Claim
              10       Account Inquiry
              11       Account Revision
              12       Claim Charge Reconciliation

Enter option number--
```

NOTE: If you select a claim that has not been produced or manually released, option 9 would be Reload Claim Demographic/Visit Errors instead of Re-Print Claim.

Claims that have been archived and purged only display Claim Status and Carrier Status Information. Detail claim information is not available for archived and purged claims.

Claim Status Information

This transaction allows you to review basic information on a claim. The account number, name, financial class, patient type, admission date, discharge date, account balance, and account location/sub location are displayed for each selected account.

If the claim has not been produced, you can edit the following fields: Claim Work Status, Claim Amount, Produce Claim, and Electronic Media.

If the claim has been produced, the system displays the following prompt:

Claim produced -- Edit for resubmission? (Y/N) [N]--

If the claim has been suppressed, the system displays the following prompt:

Claim suppressed -- Edit for resubmission? (Y/N) [N]—

For both of these prompts, if you enter **Y** for Yes, the Claim Work Status is changed to Hold and the production indicator is changed to Not Produced. You can then update the Claim Demographics and/or the Claim Charge Data. The claim appears on the Hold report (FCR320) and the Pending Claims report (FCR260) with a Hold status.

If the claim was manually released with errors originally, and then the claim is later marked for resubmission, the Reload Claim Demographic/Visit Errors function cannot be used to reload fields in error. The system generates the following message:

Reload function not valid for claims marked for resubmission

If you want to correct the errors on the claim, you must use the Claim Demographic Visit Data - Errors Only, the Claim Demographic/Visit Data - All Screens, or the Claim Demographic/Visit Data - Select Screens. You are not required to correct the errors on the claim when resubmitting a claim. Claims resubmitted do not appear on the Failed Claims report. The claim contains the status that it had when marked for resubmission (generated or submitted).

In order for the claim to spool to the paper or to the electronic spool file or to be eligible for downloading to diskette again, the Claim Work Status must be changed to Manually Released.

If a claim is edited for resubmission, the system writes to Transaction History “xxxx Claim Edited Resubmission” where xxxx is the claim type.

```
          General Hospital Maintain Claims by Account Processor

                                                    Wed Mar 15, 2006 10:10 am
Account      Name                    FC Typ Admit    Disch       Balance Loc
J1-0000702   MERON, MICHAEL          FG I/P 02/11/15 02/11/20    1681.30 AR/FCRV
 1 Bill Seq #    2 Claim Seq #       3 Claim Type     4 Load/Edit Parameter
   11              39                  3 Comm NS        20 SUSAN'S COPY ON SEPT
 5 Bill Date     6 Bill From         7 Bill Through   8 Chg Control Parameter
   09/30/03        11/15/02            11/20/02
 9 Biller                              10 Last System Edit Date
   1 - AGRE, MARK                         03/09/30 13:15
11 Last Editing User                   12 Last User Edit Date/Time
   Brown, Susan                           03/09/30 13:15
13 Edit Failures                       14 Claim Production Status
                                          P Produced

15 Claim Work Status         16 Claim Amount   17 Archive Date  18 Purge Date
   M Manually Released          $1,225.00
19 Produce Claim?  20 Electronic Media      21 Claim Split Indicator
   Yes



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

Field Explanations

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

2. CLAIM SEQ # (DISPLAY ONLY)
This field contains the number identifying this claim. For example, if an account has three claims associated with it, the sequence numbers (based on when they were loaded) would be claim #1, claim #2, and claim #3.

3. CLAIM TYPE (DISPLAY ONLY)
This field contains this claim's type code and description.

4. LOAD/EDIT PARAMETER (DISPLAY ONLY)
This field contains the claim load and edit parameter code and description used for this claim. The claim load and edit parameters are assigned through the Insurance Plan Coverage master file.

5. BILL DATE (DISPLAY ONLY)
This field contains the bill load date for the bill that loaded the claim.

6. BILL FROM (DISPLAY ONLY)
This field contains the date on which charges began accruing on this bill and claim.

7. BILL THROUGH (DISPLAY ONLY)
This field contains the billing cut-off date for this bill and claim.

8. CHG CONTROL PARAMETER (DISPLAY ONLY)
This field is not used by Canadian Claims.

9. BILLER (3-N-O)
This field contains the name of the biller assigned to completing this claim. The name of the biller comes from the Biller table, which includes all billers and billing supervisors using the system. The biller is assigned based on the account's insurance.

This biller can be updated for the claim. Enter the biller code, or perform a table lookup to view the valid billers from the Biller Table. A change to the biller only affects this claim. Claims that load in the future for the insurance assign the biller according to the Biller Group assigned to the insurance.

10. LAST SYSTEM EDIT DATE (DISPLAY ONLY)
This field contains the date and time this claim was last edited. Claim edits are established and maintained using the Claim Load and Edit Parameter function. Claims are initially edited when they are loaded. Claims are edited again when:

- The biller enters a new date on the claim.

- A payment is made on a carrier and secondary carriers are waiting for payment.
- The reload option is used.

Failed claims are edited during midnight processing based on the optional batch job claim reload.

11. LAST EDITING USER (DISPLAY ONLY)
This field contains the name of the user who last edited this claim.

12. LAST USER EDIT DATE/TIME (DISPLAY ONLY)
This field contains the date and time this claim was last edited by a system user.

13. EDIT FAILURES (DISPLAY ONLY)
This field contains the number of times this claim failed a system edit. This is not the number of errors on the claim itself.

14. CLAIM PRODUCTION STATUS (DISPLAY ONLY)
This field contains this claim's status code and description. The claim is either N (not produced) or P (produced). Claims that have been archived or purged are displayed as P (produced).

15. CLAIM WORK STATUS (1-A-C)
This field contains the claim work status code and description. It can be changed if the claim has not been produced.

- Claims that have a work status of Awaiting Payment can be changed to M (manually released). If you change the status from Awaiting Payment to Manually Released, you cannot change the status back to Awaiting Payment.
- If you try to change the work status from Awaiting Payment to any work status other than Manually Released, the system displays the following error:

  Error: Status can only be changed to Manually Released

  Claims that have a work status of Awaiting Payment can be deleted in a two-step process. First, change the status to **M** (manually released). This updates the primary claim so it no longer attempts to release this claim when payment is received. After the status has changed to manually released, you can change the status to **D** (delete).
- Claims that have a work status of Edit can be changed to **M** (manually released), **H** (hold), or **D** (delete).
- Claims that have a work status of Failed can be changed to **H** (hold), **D** (delete), or **E** (edit). Some failed claims may also be changed to **M** (manually released). Claims that have a work status of Hold that are in a failed or passed status can be changed to **M** (manually release), **D** (delete), or **E** (edit). Claims that have a work

status of Hold because they were edited for resubmission can only be changed to **M** (manually release).

- Claims that have a work status of Manually Release can be changed to **D** (delete), **E** (edit), or **H** (hold).

16. CLAIM AMOUNT (7-N-O)
This field contains the amount of this claim. This figure represents the amount of charges on the claim. This field can only be edited if the claim has not been produced.

17. ARCHIVE DATE (DISPLAY ONLY)
This field contains the date on which this claim was archived. Once a claim has been archived, only the claim status and carrier status information is available. Payments, adjustments and balance transfers can be posted to an archived claim. Follow-up does not occur for archived or purged claims.

18. PURGE DATE (DISPLAY ONLY)
This field contains the date on which this claim was purged from the system. Claims that have been archived are purged when verification of the archive media (for example, microfiche) is received. Payments, adjustments and balance transfers can be posted to a purged claim.

19. PRODUCE CLAIM (1-A-O)
This field indicates whether a claim should be produced, either electronically through one of the electronic media spoolfiles, by diskette, or as a printed paper claim. Entry options are **Y** for Yes or **N** for No; the default is Y. The entry in this field is determined by information for this claim in the Insurance Plan Coverage master. If this field contains Y, the claim is spooled to either the paper or electronic spoolfile or to a temporary holding file for future claim download when it is released. If this field contains N, the claim does not spool when released. Copies of suppressed claims can always be generated using the Reprint Claim option.

20. ELECTRONIC MEDIA (1-A-O)
This field indicates what electronic media should be used to communicate a claim to the carrier. Entry options are:

- A, for Electronic Media A
- B, for Electronic Media B
- C, for Electronic Media C (formerly CPU-to-CPU)
- D, for Electronic Media D
- E, for Electronic Media E
- T, for Electronic Media T (formerly Magnetic Tape)

If you leave this field blank, the system spools the claim to the paper spoolfile.

The system creates a separate spool file for each type of claim communication. For a list of claim spoolfiles, refer to the Billing and Claims Reports chapter in the *Reports Volume* of the *STAR Financials Patient Accounting Reference Guide*.

The system automatically marks electronically submitted claims as being submitted when spooled.

To send claims electronically, the Claim Media field in the Claim Load and Edit Parameters must be set to **B** (for Both Paper and Electronic), or **E** (for Electronic). Also, the Electronic Types field in the Claim Load and Edit Parameters must be set to the claims (Final, Cycle, Adjustment, Late, or Reprint) that are to be sent electronically.

The system sends claims to the paper spoolfile if they are not marked to send electronically in the Electronic types field.

If a claim is submitted using electronic media, no paper claim is produced. For example, a claim in a spool file for tape submission is excluded from the spool file for paper submission. This is true even if the Print Paper Claim field contains Y.

NOTE: Claims that are sent either by diskette or where diskettes are created for download/upload into other software for transmission to the carrier do not use the electronic media indicators. The claim media in the claim load and edit parameters for these claims are set to D for diskette, and the claims are marked as submitted when the diskettes are created.

21. CLAIM SPLIT INDICATOR (DISPLAY ONLY)
For outpatient CFB claims, the type of claim, lab, radiology, or outpatient is displayed.

When these fields are completed, you have the option of editing or accepting the information displayed. Accepting the screen completes the transaction.

If the claim has been produced and the claim disposition is changed to Denied, the system displays the following prompt when you access this screen:

Delete Claim (Y/N)—

You must respond to the prompt. If you enter **Y** for Yes, the claim is marked for online deletion.

NOTE: If there are any payments or adjustments on a denied claim that have not been reversed, the Delete Claim prompt is not displayed.

Carrier Status Information

This function enables you to review basic claim information relating to the carrier(s) associated with this claim. If this is a shared claim, the system prompts you to select a

carrier to review. If thisis not a shared claim, the following screen is bypassed, and you are taken directly to the next screen. After you select this option, the system displays the following screen:

```
             General Hospital Maintain Claims by Account Processor
                                                  Wed Mar 15, 2006 10:10 am
Account      Name                     FC Typ Admit    Disch        Balance Loc
J1-0000702   BROWN, MARK              FG I/P 02/11/15 02/11/20     1681.30 AR/FCRV

    COB        Carriers                                                Page:01
( 1) 2  100100 JOHN INGLE VISITORS TO CANADA
```

After you select a carrier, the system displays the following screen:

```
              General Hospital Maintain Claims by Account Processor
                                                  Wed Mar 15, 2006 10:10 am
Account      Name                     FC Typ Admit    Disch        Balance Loc
J1-0000702   BROWN, MARK                 I/P 02/11/15 02/11/20     1681.30 AR/FCRV

          COB: 2  Carrier/Plan: 100100 JOHN INGLE VISITORS TO CANADA
   Attn: Claims Department                      Phone: 8003632818
Mail To: INGLE, JOHN INSURANCE
         438 UNIVERSITY AVE.
         SUITE 1200
         TORONTO ON M5G2K-8

 1 Claim Type       2 Claim Loaded     3 Claim Generated  4 Est Amount Due
   3 Comm NS          03/09/30           03/09/30           $0.00
 5 Payment Amount   6 First Payment    7 Last Payment     8 Adjustment Amt

 9 Net Transfers   10 Ext Claim #     11 Claim Seq's Waiting On
   $0.00              CL1234

12 Claim Submitted 13 Paid In Full?   14 Disp Date       15 Claim Disposition




Enter choice--
```

NOTE: The contents of the Attn (attention) and Mail To fields are based on the mail-to information for this claim's insurance demographic data. It is the same address information that is printed on the claim label that accompanies the claim.

Field Explanations

1. CLAIM TYPE (DISPLAY ONLY)

This field contains this claim's type code and description.

2. CLAIM LOADED (DISPLAY ONLY)

This field contains the date on which this claim was loaded in the system.

3. CLAIM GENERATED (DISPLAY ONLY)
This field contains the date on which this claim was generated (that is, printed or spooled for electronic submission). If the claim has not been generated, this field is left blank.

4. EST AMOUNT DUE (10-N-O)
This field, which can be edited, contains the estimated amount due from the carrier for this claim. This amount is the result of the proration process. This field cannot be edited for an archived or purged claim.

5. PAYMENT AMOUNT (DISPLAY ONLY)
This field contains the amount of payments received for this claim from the carrier. If carrier payments have not been received for this claim, this field is blank.

6. FIRST PAYMENT (DISPLAY ONLY)
This field contains the date of the first payment received from the carrier for this claim. If payment has not yet been received, this field is blank.

7. LAST PAYMENT (DISPLAY ONLY)
This field contains the date of the most recent payment received from the carrier for this claim. If payment has not been received, this field is blank.

8. ADJUSTMENT AMT (DISPLAY ONLY)
This field contains the amount of any adjustments to this claim. If there are not any adjustments, this field is blank.

9. NET TRANSFERS (DISPLAY ONLY)
This field contains the total of any balance transfers to and from the carrier.

10. EXT CLAIM # (15-AN-O)
This field contains the hospital-defined number identifying this claim for external purposes. If this information was entered on the patient's insurance demographic screen, it displays here. This field can be used to store a number issued to this claim by the carrier. This field cannot be edited for an archived or purged claim.

11. CLAIM SEQ'S WAITING ON (DISPLAY ONLY)
This field contains the claim sequences that this claim is waiting for payment, if this claim's work status is Awaiting Payment. This field is updated as the claims it's waiting on are dispositioned as final payment, adjusted to zero, or denied.

12. CLAIM SUBMITTED (6-N-O)
This field contains the date on which the claim was submitted to the carrier. Enter the date in the format of YYMMDD or YY/MM/DD. Leave this field blank if the claim has not been submitted. The claim submission date must be equal to or greater than the claim load date. You can enter a claim submission date at any time. However, once you enter the date, you can change it but you cannot leave the field blank. If you change the date, the assigned follow-up schedule information is not altered. If the claim has not been produced and you enter a claim submission date, the system issues a warning but you can still submit the claim. The submission of the claim updates the

account's transaction history and initiates insurance follow-up for this carrier if the account is in AR. The system automatically generates submission dates for electronically submitted claims on the day the claim form is generated.

NOTE: If you try to submit a claim that has a future date, the following message displays *Cannot be future date!*. If you enter a claim submission date that is less than the date the claim was loaded, the following message is displayed:

Must be same or after claim load date!.

13. PAID IN FULL? (1-A-R)
This field indicates whether this claim has been paid in full. Enter Y for Yes or N for No. The default is N. If this claim has been final dispositioned (disposition of final payment, adjusted to zero, or denied), this field contains Y. If a partial or no payment has been posted, this field is blank. Claims with a final disposition are not included in insurance follow-up. This field cannot be edited for an archived or purged claim.

14. DISPOSITION DATE (DISPLAY ONLY)
This field displays the date on which the disposition of this claim was last changed.

15. CLAIM DISPOSITION (DISPLAY ONLY)
This field displays the current disposition of the claim. The disposition codes are defined as follows:

Final Payment - Final payment has been made via Insurance Cash Posting to this claim.

Partial Payment - Partial payment has been made via Insurance Cash Posting to this claim.

Denied - The claim has been denied by the carrier. This flag is set by the user and removes the account from Insurance Follow-up. It also requires the balance to be transferred to another carrier or the patient.

Transfer - The claim balance has been transferred to another carrier. Any balance transfer from this carrier to another carrier or to the patient causes the disposition of this claim to display as T (transfer). This includes balance transfers resulting from insurance time-out. If the insurance times out and the disposition is already set, the disposition is not changed to T.

Adjusted to Zero - The claim has been adjusted to a zero balance via Insurance Adjustment Posting for this claim.

Replaced - The claim has been replaced by a new claim. This is the result of an adjustment bill, which loads adjustment or replacement claims. This disposition is system assigned only.

Clear Disposition - This code enables you to clear the disposition field so a different code can be entered.

Claim Demographic/Visit Data

The information loaded for online editing is defined by the Claim Load and Edit Parameters. The screen requirements for each claim edit parameter can vary. Each box on the claim is available for online editing. Based on your claim load and edit parameters, the fields on each of your screens may be different from the examples provided here.

The Claim Load and Edit parameter determines whether each field is required, not required, or should print if available. The parameter also determines the specific data element that prints in each field. The field descriptions are also maintained in the Claim Load and Edit parameters. Where applicable, the Claim Load and Edit Parameters also control the format of a field (for example, whether date fields display as YY/MM/DD or YY/MM). Each field displays in the order in which it displays on the actual claim form. Since the fields on each screen are labeled separately, the field numbers do not correspond to the field numbers on the claim. The hospital can choose to insert the claim form field number into the field description on the Claim Load and Edit Parameters. For more information regarding the Claim Load and Edit parameters, refer to the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide* or to Chapter 1 in this manual.

To create a form on the system, copy the Claim Load and Edit Parameter from the McKesson masters. For more information, refer to the discussion of Claim Load and Edit Parameters in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide* and Chapter 1 of this manual. This function enables you to review and edit the information associated with the selected claim.

The screens that follow are examples of the Nova Scotia claim forms.

NOTE: Changes made on these screens do not update information anywhere else in the system.

You can review and edit all pages of the claim by selecting Claim Demographic/ Visit Data - All Screens. You can review and edit only the screens with errors by selecting Claim Demographic/Visit Data - Errors Only. In this case, the system presents only the screens that have failed edits. If there are no errors, the system displays the message No Errors to Display and you are returned to the Claim Selection Menu.

You can also review and edit only selected screens using the Demographic/Visit Data - Select Screens option. If you select this option, the system displays a screen similar to the following:

```
            General Hospital Maintain Claims by Account Processor
                                                  Wed Mar 15, 2006 10:10 am
Account      Name                      FC Typ Admit    Disch        Balance Loc
J1-0000702   BROWN, TOM                FG I/P 02/11/15 02/11/20     1681.30 AR/FCRV

Page:01                                                  ##=Current Choices
     From Field                          Thru Field                  Errors
( 1) 4-Financial Class                   17-Insurance Co Address
( 2) 18-Insurance Co City/Pr             26-Patient Address 1
( 3) 26-Admission Date                   30-Accident
( 4) 30-Date of Accident                 55-Biller Phone Number
```

This screen displays the names of the fields of information and their form locator for each screen of claim information. There can be multiple fields for the same form locator. Form locators are defined in the Claim Load and Edit Parameters, as discussed in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide* and Chapter 1 of this manual. The data contained on each screen may vary from these illustrations.

The screen also displays whether errors exist for the claim. If errors exist for the claim, the system displays Yes under Errors.

To access one or more selected screens, enter the option number(s) of the screen(s) you want to access. If you select multiple screens, the system displays each screen in order of its option number.

With any of these selections, any existing errors display at the bottom of the screen. You can correct any errors as long as the claim has not been produced. Once a claim has been produced, you must mark the claim for resubmission in the Claim Status Information screen in order to make additional changes. When all errors, including attachments, have been corrected, the claim is released. The system displays the message Claim Manually Released and the work status of the claim is changed from Fail to Mrel. The claim is then produced during the next midnight processing. Claims going to diskette can also be produced immediately using the Reprint Claim function.

NOTE: If you accept a screen with errors but do not correct the errors, the claim is not released.

Nova Scotia Outpatient Commercial Insurance Claim Form 1 of 4

```
          General Hospital Maintain Claims by Account Processor
                              Page  1 of 4       Wed Mar 15, 2006 10:10 am
Account      Name                   FC Typ Admit    Disch      Balance Loc
   J5-0260708  MEANS, TOM           FG EMD 02/11/20 02/11/20   431.46  AR/FCRV
 1 Financial Class      2 Provider Number       3 Invoice No.
   U                                            00001535
 4 Invoice Date         5 HUN                   6 Health Card Number
                          0000901300              HC23456666
 7 Institution/Site                8 Contact
   1234 Model Hospital               (111) 222-3333
 9 Insurance Company Name         10 Insurance Reference 1
   JOHN DEERE INSUR. BASIC PLA       POL349983
11 Insurance Co Address 1
   P.O.BOX 1000
12 Error Messages
```

Field Explanations

1. FINANCIAL CLASS (A-3-R)
This field contains the patient's financial class from the Financial Class table.The financial class is necessary for the creation of the workman's compensation claim.

2. PROVIDER NUMBER (A-13-N)
This field is required for CFB insurance plans. This field contains the provider number which loads from the Provider Master. Providers are assigned based on the O/P Provider Master field assigned to the insurance. CFB Lab claims use the Alt Provider Code 1 number. CFB Rad claims use the Alt Provider Code 2 number. Other CFB claims use the billing institution number. Non-CFB claims do not display anything in this field.

3. INVOICE NUMBER (N-8-R)
This field contains the patient's invoice number.

4. INVOICE DATE (DISPLAY ONLY)
This field does not display a value. It prints on the claim form only and contains the date the claim was released.

5. HUN (A-13-R)
This field contains the patient's Medical/Health Record Number used to audit the history of treatment for the patient. This entry is Loaded from medical records.

6. HEALTH CARD NUMBER (N-9-R)
This field contains the patient's health card number. This is necessary for the creation of workman's comp claims.

7. INSTITUTION/SITE (A-30-N)
This field contains the institution name associated with the institution code assigned based on the patient type. The code is associated with the name via the Site/Institution Code table.

8. CONTACT (N-13-R)
This field contains the biller phone number associated with the biller assigned to this insurance.

9. INSURANCE COMPANY NAME (A-28-R)
This field contains the description of the insurance associated with this claim.

10. INSURANCE REFERENCE 1 (A-10-N)
This field contains either the policy/group number, Certificate/ID # or Section/Div # from the Insurance Plan's Demographic Information. Information from the first field which is not blank is used. If the claim is for a CFB insurance, this field reflects the Regimental Number.

11. INSURANCE CO ADDRESS 1 (A-30-R)
This field contains the insurance plan's demographic information, Address Line 1 field.

12. ERROR MESSAGES (DISPLAY ONLY)
The system displays the error messages pertaining to the information displayed on this screen. For example, if the Provider Number is required but not completed, the error message *Provider Number Required* is displayed in this field.

Nova Scotia Outpatient Commercial Insurance Claim Form 2 of 4

```
        General Hospital Maintain Claims by Account Processor
                                Page  2 of 3        Wed Mar 15, 2006 10:10 am
Account      Name                FC Typ Admit    Disch     Balance Loc
5-0260708   MEANS, TOM           FG EMD 02/11/20 02/11/20  431.46  AR/FCRV
 1 Insurance Reference 2             2 Insurance Co Address 2
   CERT483838
 3 Insurance Reference 3             4 Insurance Co City/Province
   2                                   GRIMSBY, ON
 5 Claim Number          6 Ins Co Country, Postal Code
   POL349983               CA,  L3M4H5
 7 Patient Name                      8 Patient Date of Birth
   MEANS, TOM                          781212
 9 Patient Address 1
   COLLEGE ADDRESS
10 Error Messages
```

1. INSURANCE REFERENCE 2 (A-10-O)
This field contains the section/Div# information of the insurance, if it as not previously printed and if the insurance is not CFB.

2. INSURANCE CO ADDRESS 2 (A-30-N)
This field contains the 2nd line of the insurance address for the insurance's demographic information.

3. INSURANCE REFERENCE 3 (A-10-O)
This field contains the section/Div # information of the insurance, if it was not previously printed and if the insurance is not CFB.

4. INSURANCE CO CITY/PROVINCE (A-10-O)
This field contains the City and Province associated with the insurance's demographic information.

5. CLAIM NUMBER (DISPLAY ONLY)
This field contains the claim number. This is necessary for the creation of workman's comp claims.

6. INSURANCE CO COUNTY, POSTAL CODE (A-10-O)
This field contains the County and Postal Code associated with the Insurance's demographic information.

7. PATIENT NAME (A-10-O)
This field contains the name of the patient. The format is determined by the Claim Load and Edit parameters.

8. PATIENT DATE OF BIRTH (A-10-O)
This field contains the patient's date of birth.

9. PATIENT ADDRESS 1 (A-10-O)
This field contains the first line of the patient's address, which is loaded from the patients demographic file.

10. ERROR MESSAGES (DISPLAY ONLY)
The system displays the error messages pertaining to the information displayed on this screen. For example, if the Provider Number is required but not completed, the error message *Provider Number Required* is displayed in this field.

Nova Scotia Outpatient Commercial Insurance Claim Form 3 of 4

```
            General Hospital Maintain Claims by Account Processor
                              Page  3 of 3        Wed Mar 15, 2006 10:10 am
Account      Name               FC Typ Admit    Disch      Balance Loc
5-0260708   MEANS, TOM          FG EMD 02/11/20 02/11/20   431.46  AR/FCRV
 1 Patient Address 2                2 Patient City, Province
                                     HALIFAX, NS
 3 Patient Country                  4 Patient Postal Code
   CA                                X9X 9X9
 5 Patient Phone Number             6 Admitting Diagnosis Descriptio
   (919) 333-2222                    84001
 7 Accident                         8 Date of Accident
   Y, AUTO                           021211
 9 Patient Employer                10 Insured's Employer Address 1
                                     301 PERIMETER CENTER N
11 Error Messages

Press NL--
                  next screen(/) or previous screen(/P) [/]
```

Field Explanations

1. PATIENT ADDRESS 2 (A-10-O)
This field contains the 2nd line of the patient's address, which is loaded from the patient's demographic file.

2. PATIENT CITY, PROVINCE (A-10-O)
This field contains the patient's city and province which is loaded from the patient's demographic file.

3. PATIENT COUNTRY (A-10-O)
This field contains the patient's country which is loaded from the patient's demographic file.

4. PATIENT POSTAL CODE (DISPLAY ONLY)
This field contains the patient's post code which loads from the patient's demographic file.

5. PATIENT PHONE NUMBER (DISPLAY ONLY)
This field contains the patient’s phone number. This is necessary for the creation of workman’s comp claims.

6. ADMITTING DIAGNOSIS DESCRIPTION (DISPLAY ONLY)
This field contains the code for the admitting diagnosis.

7. ACCIDENT (DISPLAY ONLY)
This field contains Y for Yes or N for No from the Medical Information completed during admission. If the response is yes, the Nature of Accident field is printed also. This can be reviewed through the Medical Information, Accident Information page.

8. DATE OF ACCIDENT (DISPLAY ONLY)
This field contains the date the accident occurred.

9. PATIENT EMPLOYER (DISPLAY ONLY)
This field contains the name of the patient's employer, which is loaded from the Patient Employer information.

10. INSURED'S EMPLOYER ADDRESS 1 (DISPLAY ONLY)
This field contains the first line of the employer's address.

5. ERROR MESSAGES (DISPLAY ONLY)
The system displays the error messages pertaining to the information displayed on this screen. For example, if the Provider Number is required but not completed, the error message *Provider Number Required* is displayed in this field.

Nova Scotia Outpatient Commercial Insurance Claim Form 4 of 4

```
Page  4 of 4        Wed Mar 15, 2006 10:10 am
Account      Name                    FC Typ Admit    Disch        Balance Loc
J0-0001535   MEANS, TOM              U  O/P 02/12/11 02/12/11     37.50   AR/FCRV
 1 Insured's Employer Address 2                2 Total Charges
   ATLANTA, GA, 30346                            37.50
 3 Error Messages
```

Field Explanations

1. INSURED'S EMPLOYER ADDRESS 2 (DISPLAY ONLY)
This field contains the second line of the employer's address.

2 TOTAL CHARGES (DISPLAY ONLY)
This field contains the total of the charges associated with the claim.

3. ERROR MESSAGES (DISPLAY ONLY)
The system displays the error messages pertaining to the information displayed on this screen. For example, if the Provider Number is required but not completed, the error message *Provider Number Required* is displayed in this field.

Nova Scotia Inpatient Commercial Insurance Claim Form 1 of 4

```
          General Hospital Maintain Claims by Account Processor
                              Page  1 of 4        Wed Mar 15, 2006 10:10 am
Account      Name                    FC Typ Admit    Disch        Balance Loc
J1-0000702   BARRON, BOB             FG I/P 02/11/15 02/11/20     1681.30 AR/FCRV
1 Financial Class      2 Invoice Number        3 Invoice Date
   OH                     50000503
 4 HUN                  5 Health Card #
   0000901375             9999999990
 6 Institution/Site                7 Insurance Company Name
   1234 Model Hospital               JOHN DEERE INSUR. BASIC P
 8 Subscriber                      9 Insurance Co Address1
   JOENS, BO                         P.O.BOX 1000
10 Claim Number                   11 Insurance Co Address2
   PO48484848                        HERE'S ANOTHER ADDRESS 2
12 Error Messages
```

Field Explanations

1. FINANCIAL CLASS (A-3-R)
This field contains patient's financial class from the Financial Class table. This is necessary for the creation of workman's comp claims.

2. INVOICE NUMBER (N-8-R)
This field contains the patient's account number.

3. INVOICE DATE (DATE)
This field does not display a value. It prints on the claim form only, and contains the date the claim was released.

4. HUN (A-13-R)
This field contains the patient's Medical/Health Record Number used to audit the history of treatment for the patient. This entry is loaded from medical records.

5. HEALTH CARD NUMBER (A-30-N)
This field contains the patient's health card number. This is necessary for the creation of workman's comp claims.

6. INSTITUTION/SITE (A-30-N)
This field contains the institution name associated with the institution code assigned based on the patient type. The code is associated with the name via the Site/Institution Code table.

7. INSURANCE COMPANY NAME (A-28-R)
This field contains the description of the insurance associated with this claim.

8. SUBSCRIBER (A-30-R)
This field contains the name of the patient. The format is determined by the claim load & edit parameters.

9. INSURANCE CO ADDRESS 1 (A-30-R)
This field contains the insurance plan's demographic information, Address Line 1 field.

10. CLAIM NUMBER (A-30-N)
This field contains the patient's claim number. This is necessary for the creation of workman's comp claims.

11. INSURANCE CO ADDRESS 2 (A-30-N)
This field contains the second line of the insurance address for the insurance's demographic information.

12. ERROR MESSAGES (DISPLAY ONLY)
The system displays the error messages pertaining to the information displayed on this screen. For example, if the Provider Number is required but not completed, the error message *Provider Number Required* is displayed in this field.

Nova Scotia Inpatient Commercial Insurance Claim Form 2 of 4

```
          General Hospital Maintain Claims by Account Processor
                              Page  1 of 4        Wed Mar 15, 2006 10:10 am
Account      Name                    FC Typ Admit    Disch        Balance Loc
J1-0000702   BARRON, BOB             FG I/P 02/11/15 02/11/20     1681.30 AR/FCRV
 1 Insurance Co City/Province       2 Ins Co Country/Postal Code
   GRIMSBY, ON                        CA,  L3M4H5
 3 Relation                         4 Insurance Number 1
   CHILD                              PO48484848
 5 Insurance Number 2   6 Insurance Number 3    7 Provider Number
   CERT23456              2
 8 Patient Name                                  9 Patient Date of Birth
   BARRON, BOB                                     880504
10 Patient Address 1
   HOME HOME HOME
11 Error Messages
```

Field Explanations

1. INSURANCE CO CITY/PROVINCE (A-10-N)
This field prints the City and Province associated with the insurance's demographic information.

2. INSURANCE CO COUNTRY, POSTAL CODE (A-10-N)
This field prints the County and Postal Code associated with the Insurance's demographic information.

3. RELATION (A-10-N)
This field contains the Relation to Insured information associated with the insurance plan.

4. INSURANCE NUMBER 1 (A-10-N)
This field contains either the policy/group number, Certificate/ID # or Section/Div # from the Insurance Plan's Demographic Information. Information from the first field

which is not blank is used. If a CFB insurance, this field reflects the Regimental Number.

5. INSURANCE NUMBER 2 (A-10-N)
This field contains either the Certificate/ID # or Section/Div # field from the insurance plan's demographic information if the insurance is not CFB. Section/Div # appears if Certificae/ID # was used for Insurance Number 1.

6. INSURANCE NUMBER 3 (A-10-O)
This field contains the section/Div # information of the insurance, if it was not previously printed and if the insurance is not CFB.

7. PROVIDER NUMBER (A-13-N)
Required for CFB insurance plans. This field contains the provider number which loads from the Provider Master. Providers are assigned based on the I/P Provider Master field assigned to the insurance. Inpatient CFB insurances load the Billing Institute Number. Non-CFB insurances do not display a value in this field.

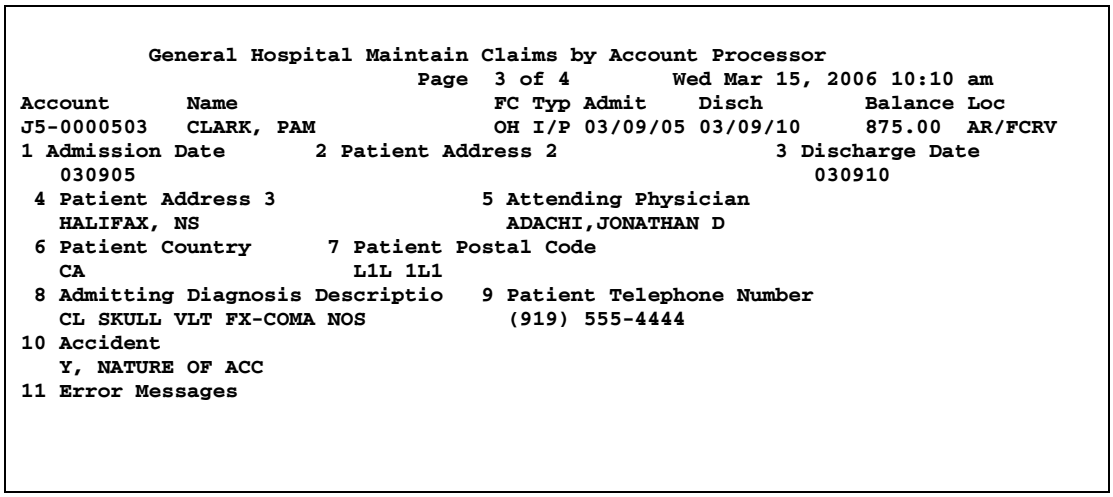
8. PATIENT NAME (A-10-O)
This field contains the name of the patient. The format is determined by the Claim Load and Edit Parameters.

9. PATIENT DATE OF BIRTH (A-10-N)
This field contains the patient's date of birth

10. PATIENT ADDRESS 1 (A-10-N)
This field contains the first line of the patient's address, which is loaded from the patient's demographic file.

11. ERROR MESSAGES (DISPLAY ONLY)
The system displays the error messages pertaining to the information displayed on this screen. For example, if the Provider Number is required but not completed, the error message *Provider Number Required* is displayed in this field.

Nova Scotia Inpatient Commercial Insurance Claim Form 3 of 4



```
          General Hospital Maintain Claims by Account Processor
                              Page  3 of 4        Wed Mar 15, 2006 10:10 am
Account      Name                    FC Typ Admit    Disch        Balance Loc
J5-0000503   CLARK, PAM              OH I/P 03/09/05 03/09/10     875.00  AR/FCRV
1 Admission Date       2 Patient Address 2                 3 Discharge Date
   030905                                                     030910
 4 Patient Address 3               5 Attending Physician
   HALIFAX, NS                       ADACHI,JONATHAN D
 6 Patient Country      7 Patient Postal Code
   CA                     L1L 1L1
 8 Admitting Diagnosis Descriptio   9 Patient Telephone Number
   CL SKULL VLT FX-COMA NOS           (919) 555-4444
10 Accident
   Y, NATURE OF ACC
11 Error Messages
```

Field Explanations

1. ADMISSION DATE (DISPLAY ONLY)
This field contain's the patient date of admission.

2. PATIENT ADDRESS 2 (DISPLAY ONLY)
This field contains the second line of the patient's address, which is loaded from the patient's demographic file.

3. DISCHARGE DATE (DISPLAY ONLY)
This field contains the patient's date of discharge

4. PATIENT ADDRESS 3 (DISPLAY ONLY)
This field contains the patient's city and province which is loaded from the patient's demographic file.

5. ATTENDING PHYSICIAN (DISPLAY ONLY)
This field contains the patient's attending physician name which is loaded from the Physician page of the Medical Information.

6. PATIENT COUNTRY (DISPLAY ONLY)
This field contains the patient's country which is loaded from the patient's demographic file.

7. PATIENT POSTAL CODE (DISPLAY ONLY)
This field contains the patient's post code which loads from the patient's demographic file.

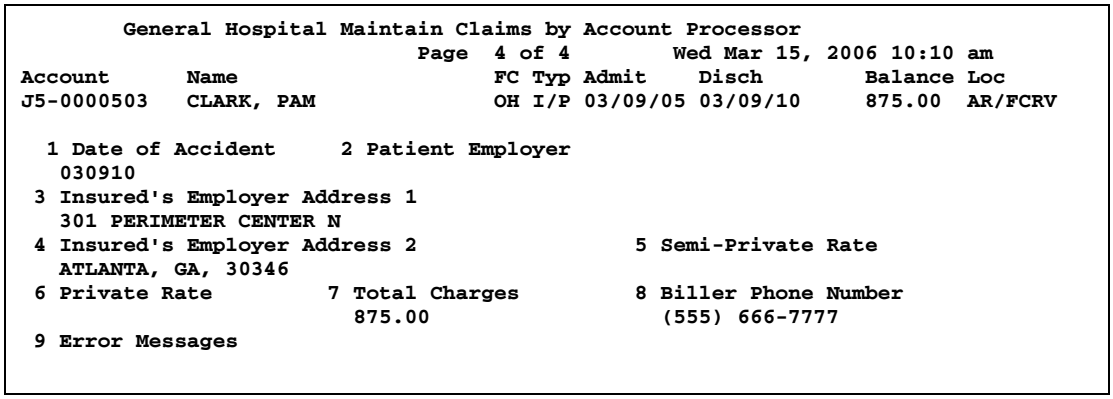
8. ADMITTING DIAGNOSIS DESCRIPTION (DISPLAY ONLY)
This field corresponds to the ICD-9-CM diagnosis code provided at the time of admission as stated by the physician. The entry in this field is loaded from the patient's medical information.

9. PATIENT TELEPHONE NUMBER (DISPLAY ONLY)
This field contains the patient's telephone number. This is necessary for the creation of workman's comp claims.

10. ACCIDENT (DISPLAY ONLY)
This field contains a Y for yes or N for no from the Medical Information completed during admission. If the response is yes, the Nature of Accident will also print. This can be reviewed through the Medical Information, Accident Information page.

11. ERROR MESSAGES (DISPLAY ONLY)
The system displays the error messages pertaining to the information displayed on this screen. For example, if the Provider Number is required but not completed, the error message *Provider Number Required* is displayed in this field.

Nova Scotia Inpatient Commercial Insurance Claim Form 4 of 4



Field Explanations

1. DATE OF ACCIDENT (DISPLAY ONLY)
This field contains the date an accident occurred. This is necessary for the creation of workman's comp claims.

2. PATIENT EMPLOYER (DISPLAY ONLY)
This field contains the name of the patient's employer.

3. INSURED'S EMPLOYER ADDRESS 1 (DISPLAY ONLY)
This field contains the first line of the employer's address.

4. INSURED'S EMPLOYER ADDRESS 2 (DISPLAY ONLY)
This field contains the second line of the employer's address.

5. SEMI-PRIVATE RATE (DISPLAY ONLY)
This field contains the Semi-Private rate associated with the patient's Institution, as set up in the NS Misc Claim Parameters.

6. PRIVATE RATE (DISPLAY ONLY)
This field contains the Private rate associated with the patient's Institution as set up in the NS Misc Claim Parameters. The institution is assigned by patient type.

7. TOTAL CHARGES (DISPLAY ONLY)
This field contains the total of the charges associated with the claim.

8. BILLER PHONE NUMBER (DISPLAY ONLY)
This field contains the telephone number of the biller assigned to this patient.

9. ERROR MESSAGES (DISPLAY ONLY)
The system displays the error messages pertaining to the information displayed on this screen. For example, if the Provider Number is required but not completed, the error message *Provider Number Required* is displayed in this field.

Nova Scotia Out of Province Claim Form Screen 1 of 1

```
          General Hospital Maintain Claims by Account Processor
                              Page  1 of 1        Wed Mar 15, 2006 10:10 am
Account      Name            FC Typ Admit    Disch        Balance Loc
J0-0001551   MILLS, PAM      OP O/P 03/01/25 03/01/25     15.00   AR/FCRV
 1 Patient Account Number           2 Province Code
   00001551                           99
 3 Health Card Number   4 Patient Last Name
   446688012              MILLS
 5 Patient First Name               6 Patient Middle Initial
   PAM                                H
 7 Patient Date of Birth            8 Patient Sex

9 Patient Indicator   10 Institution Code
   I                      0085
11 Error Messages









Press NL--
```

Field Explanations

1. PATIENT ACCOUNT NUMBER (9-A-R)
This field contains the patient's account number

2. PROVINCE CODE (2-N-R)
This field contains the last 2 digits of the insurance plan's reference number, which is found in the Patient Care Insurance Plan table, Reference Number field.

3. HEALTH CARD NUMBER (15-A-R)
This field contains the patient's health card number.

4. PATIENT LAST NAME (20-A-R)
This field contains the patient's last name from the demographic data

5. PATIENT FIRST NAME (19-A-R)
This field contains the patient's first name from the demographic data

6. PATIENT MIDDLE INITIAL (1-A-O)
This field contains the patient's middle initial from the demographic data

7. PATIENT BIRTHDATE (8-D-R)
This field contains the patient's date of birth

8. PATIENT SEX (1-A-R)
This field contains the patient's gender.

9. PATIENT INDICATOR (1-A-R)
This field contains an I for inpatient or O for outpatient

10. INSTITUTION CODE (4-A-R)
This field contains the clinical site/institution code. For inpatients, this field comes from either the current nursing station (for patients not yet discharged), the discharge nursing station (for discharged patients), or the patient type table, if there is no data in the other 2 places) in the Institution field. For outpatients it comes from the patient type table, Institution field.

11. ERROR MESSAGES (DISPLAY ONLY)
The system displays the error messages pertaining to the information displayed on this screen. For example, if the Provider Number is required but not completed, the error message *Provider Number Required* is displayed in this field.

Nova Scotia In Province Claim Form Screen 1 of 1

```
         General Hospital Maintain Claims by Account Processor
                                Page  1 of 1        Wed Mar 15, 2006 10:10 am
Account      Name                    FC Typ Admit    Disch        Balance Loc
J1-0000202   MEANS, TOM              OH I/P 02/11/04 02/11/04     2159.49 AR/FCRV
 1 Client Name                      2 Patient Account Number
   MEANS, TOM                         10000202
 3 Error Messages









Press NL--
```

Field Explanations

1. CLIENT NAME (DISPLAY ONLY)
This field contains the client's name.

2. PATIENT ACCOUNT NUMBER (9-A-R)
This field contains the patient's account number.

3. ERROR MESSAGES (DISPLAY ONLY)
The system displays the error messages pertaining to the information displayed on this screen. For example, if the Provider Number is required but not completed, the error message *Provider Number Required* is displayed in this field.

Claim Attachments

This function enables you to confirm that required attachments have been sent with the claim. The attachments are hospital-defined and entered into the system through the Insurance Plan Coverage master. Claim attachments can be charge specific; that is, they can be required only if a specific charge exists on the account. In addition, it is possible to have patient type exceptions for claim attachments. For more detailed information regarding attachments, refer to the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

When you use this function, you are indicating that the attachments have been received for a specific claim and not all claims.

After you select this option, the system displays this screen if required attachments are required for this carrier's claim:

```
                  General Hospital Edit Claims Processor
                                                Wed Mar 15, 2006 10:10 am
Account      Name                     FC Typ Admit    Disch        Balance Loc
A0-02000-019 JONES,ROBERT             15 I/P 03/09/25 95/10/31     7165.00 AR/FCRV

Page:01                        Completed Attachments           ##=Current Choices
( 1) DS-DISCHARGE SUMMARY









Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
                               end selection(NL)
```

If no attachments are required, the system displays the message *No Attachments Required* and returns you to the Claims menu.

Along with patient account information, the system displays a list of attachments required for this claim based on the patient's insurance plan, patient type, and certain services provided. You have the option of marking the attachments as received that must be sent with the claim for this account. The numbers identifying attachments received are displayed in blinking, reverse video. Once all edits are made, you have the option of editing or accepting the choices made. Required attachments that are incomplete print on the Failed Claims Requirements report.

After you press ENTER, the system prompts you to delete incomplete attachments. You select the attachments that you want to delete. You can also remove an attachment from a patient's insurance record if necessary. If a claim already exists and you delete the attachments from the patient's insurance, you are not deleting the attachments from the claim. The attachments would not, however, be required for subsequent claims. Otherwise, attachments are required for each claim generated for this insurance carrier/plan.

Accepting the screen completes the transaction.

Claim Charge Data

Charge data on a claim form is determined by the proration summary code exceptions for the specific carrier/plan. The format of the claim charge detail is determined by the type of claim that is loaded. This function enables you to add, edit, and delete claim charge information included on the claim form prior to the production of the claim. Once

the claim is produced, the screen is inquiry only and limited function keys are available unless the claim is edited for resubmission. After you select this option, the system displays Claim Charge Data screens that are applicable for the claim type accessed.

Outpatient Out of Province Claim Charge Data Screen

Charges are evaluated and only the high dollar charge appears on the claim.

```
            General Hospital Maintain Claims by Account Processor
                                                  Wed Mar 15, 2006 10:10 am
Account      Name                     FC Typ Admit    Disch        Balance Loc
J0-0001555   MILLS,PAM                OP  O/P 03/01/31 03/01/31    20.00   AR/FCRV


    Service  SIM   SIM   SIM                                        OOP  Download
Seq Date     Dept  Code  Description              Qty    Amount  Code Date
1   03/01/31 OT    546   PRISM PROJECT REVENUE      1     20.00   02  2003/01/31









                          F2Next Page F7  Exit
```

Field Explanations

SEQ (DISPLAY ONLY)
This field holds the sequential listing of the charge lines which appear on the claim.

SERVICE DATE (DISPLAY ONLY)
This field contains the date of service of the charge(s).

SIM DEPT (DISPLAY ONLY)
This field contains the SIM department for this line of information.

SIM CODE (DISPLAY ONLY)
This field contains the SIM code for this line of information. If you enter a SIM code, it is checked against the SIM to ensure that the code entered exists within the system.

SIM DESCRIPTION (DISPLAY ONLY)
This field contains the SIM item description. It is updated based on the SIM Code entered.

QTY (DISPLAY ONLY)
This field contains the quantity of the item associated with the patient.

AMOUNT (DISPLAY ONLY)
This field contains the amount of the charge.

OOP CODE (DISPLAY ONLY)
This field contains the province code.

DOWNLOAD DATE (DISPLAY ONLY)
This field contains the date the claim was downloaded to a diskette.

Outpatient Commercial Insurance Claim Charge Data

Charges print in detail by service dateand SIM number. For CFBinsurances, separate claims are loaded for Lab, Rad, and Other charge types. These charges are identified by the value or R, L, or O in the Alt Summary Code 3 field of the FIM.

```
          General Hospital Maintain Claims by Account Processor
                                                  Wed Mar 15, 2006 10:10 am
Account      Name                   FC Typ Admit    Disch        Balance Loc
J0-0001555   MILLS,PAM              OP O/P 03/01/31 03/01/31     20.00   AR/FCRV
Seq Date     SIM Dept SIM Code  SIM Description          Amount
1   02/11/20   LBJ     39050    ACETYL ISONIAZIDE        31.02
```

Field Explanations

SEQ (DISPLAY ONLY)
This field contains the sequential listing of the charge lines which appear on the claim.

DATE (DISPLAY ONLY)
The date of service of the charge(s) in YY/MM/DD format.

SIM DEPT (5-AN-O)
This field contains the SIM department for this line of information.

SIM CODE (5-AN-O)
This field contains the SIM code for this line of information. If you enter a SIM code, it is checked against the SIM to ensure that the code entered exists within the system.

SIM DESCRIPTION (DISPLAY ONLY)
This field contains the SIM item description. It is updated based on the SIM Code entered.

AMOUNT (DISPLAY ONLY)
This field contains the total charges for this line of information.

Inpatient Commercial Claim Charge Data

Room and Board charges are printed on this claim form.

```
          General Hospital Maintain Claims by Account Processor
                                                  Wed Mar 15, 2006 10:10 am
Account      Name                      FC Typ Admit    Disch        Balance Loc
J0-0001555   MILLS,PAM                 OP O/P 03/01/31 03/01/31     20.00   AR/FCRV

   Seq From/Serv Date Thru/Serv Date SIM Dept SIM Code  Accom  Qty Rate
   1   02/12/01       02/12/05       RB       105       P      5   175.00
```

Field Explanations

SEQ (DISPLAY ONLY)
This field contains the sequential number identifying the line items on the form.

FROM/SERV DATE (8-C-R)
This field contains the first date of service associated with the charge. Modifying this date changes the quantity field.

THRU/SERV DATE (8-C-R)
This field contains the last date of service associated with the charge. Modifying this field changes the quantity field.

SIM DEPARTMENT (DISPLAY ONLY)
This field contains the SIM department for this line of information.

SIM CODE (DISPLAY ONLY)
This field contains the SIM code for this lineof information. This field is checked against the SIM master; only SIM Codes associated with the SIM department can be entered.

ACCOM (DISPLAY ONLY)
This field contains the accommodation type associated with the charge line.

QTY (DISPLAY ONLY)
This field contains the quantity associated with the charge line. It cannot be edited. You must change the service date fields in order to modify the quantity.

RATE (DISPLAY ONLY)
This field contains the R&B rate associated with this charge. Note that the claim will contain the R&B rate per day plus a total determined by multiplying the rate by the number of days.

In Province Claim Charge Data

```
             General Hospital Maintain Claims by Account Processor
                                                  Wed Mar 15, 2006 10:10 am
Account      Name                    FC Typ Admit    Disch        Balance Loc
J1-0000202   MEANS, TO               OH I/P 02/11/04 02/11/04     2159.49 AR/FCRV


     Service   SIM    SIM   SIM
Seq  Date      Dept   Code  Description                          Qty      Amount
1    02/11/04    CD     15  ADVANCED TESTING-TECH                  1        7.80
2    02/11/04    CD     16  ADVANCED TESTING - PROF                1        5.50
```

Field Descriptions

SEQ (DISPLAY ONLY)
This field contains the sequential number identifying the line items on the form.

SERVICE DATE (8-C-R)
This field contains the first date of service associated with the charge. Modifying this date changes the quantity field.

SIM DEPARTMENT (DISPLAY ONLY)
This field contains the SIM department for this line of information.

SIM CODE (DISPLAY ONLY)
This field contains the SIM code for this lineof information. This field is checked against the SIM master; only SIM Codes associated with the SIM department can be entered.

SIM DESCRIPTION (DISPLAY ONLY)
This field contains the SIM item description. It is updated based on the SIM Code entered.

QTY (DISPLAY ONLY)
This field contains the quantity associated with the charge line. It cannot be edited. You must change the service date field in order to modify the quantity.

AMOUNT (DISPLAY ONLY)
This field contains the total charges for this line of information.

Claim Disposition

This function allows you to change the disposition of a claim.

```
              General Hospital Maintain Claims by Account Processor
                                                  Wed Mar 15, 2006 10:10 am
Account      Name                      FC Typ Admit    Disch        Balance Loc
A9-00134-95  BRWERRY,CRIS JASON      20 I/P 96/01/29 96/02/02     573.00  AR/FCRV

     Clm Adj   Bill     Bill   Claim    Prod    Work
     Seq Clm   From     Thru   Type    Status  Status  Carrier/Plan(*Shared)
       1     02/02/93 02/02/93 UNV     Produced Forced  PRUDENTIAL 100

           Option No.  Option
           ---------------------------------------
               1       Claim Status Information
               2       Carrier Status Information
               3       Claim Demographic/Visit Data - Errors Only
               4       Claim Demographic/Visit Data - All Screens
               5       Claim Demographic/Visit Data - Select Screens
               6       Claim Attachments
               7       Claim Charge Data
               8       Claim Disposition
               9       Re-Print Claim

Enter option number--
```

When you select the Claim Disposition option, the system displays the claim disposition balance transfer screen (displayed below).

```
              General Hospital Maintain Claims by Account Processor
                                                  Wed Mar 15, 2006 10:10 am
Account      Name                      FC Typ Admit    Disch        Balance Loc
J4-0000202   BAST, MIKE                OP INP 03/02/05 03/02/06     742.00  AR/FCRV

 1 C  2 Carrier/Plan          3 EP     4 Pd    5 Orig Balance   6 New Balance
   1    150150 ALBERTA          1                       0.00            0.00
   P                                                  742.00          742.00
                                                  =============    =============
        PC-           Total                          742.00          742.00




     From                                  To
COB CS  Dsp                       Amount Cmp COB CS  Tran Code/Description   Cmt
1   1                                    No




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

Field Explanations

The COB and claim sequence numbers are automatically displayed by the system. The disposition displays the current claim disposition. The disposition can be modified to any valid disposition code.

COB (DISPLAY ONLY)
This field displays the carrier of the selected claim.

CS (DISPLAY ONLY)
This field contains the claim sequence number of the claim.

CLAIM DISPOSITION (1-A-O)
This field displays the current disposition of the claim. The disposition codes are defined as follows:

Final Payment - Final payment has been made via Insurance Cash Posting to this claim.

Partial Payment - Partial payment has been made via Insurance Cash Posting to this claim.

Denied - The claim has been denied by the carrier. This flag is set by the user and will remove the account from Insurance Follow-up. It also requires the balance to be transferred to another carrier or the patient.

Transfer - The claim balance has been transferred to another carrier. Any balance transfer from this carrier to another carrier or to the patient will cause the disposition of this claim to display as T (transfer). This includes balance transfers resulting from insurance time-out. If the insurance times out and the disposition is already set, the disposition will not be changed to T.

Adjusted to Zero - The claim has been adjusted to a zero balance via Insurance Adjustment Posting for this claim.

Replaced - The claim has been replaced by a new claim. This is the result of an adjustment bill, which loads adjustment or replacement claims. This disposition is system assigned only.

Clear Disposition - This code enables you to clear the disposition field so a different code can be entered. If your claim has been previously completed, you see a message that informs you it is complete. You are also given the option to continue.

The hospital may wish to set up transaction codes to distinguish between different dispositions.

When you enter a valid disposition for the claim, you have the option to transfer the carrier balance. If you are entering a disposition which completes the claim (D, F, or A) and this is the last remaining claim for the carrier, you must transfer the entire balance.

If the claim disposition is changed to D (denied), the claim is removed from insurance follow-up. If the disposition is changed to F (final payment) or A (adjustment to zero), it is also removed from insurance follow-up. If you transfer the balance to another carrier, the claim and carrier record is added to insurance follow-up. Any other claim

disposition will not affect insurance follow-up for the claim. However, if you enter a balance transfer with the new disposition and leave the carrier with a zero balance, insurance follow-up will stop for that carrier.

This option does not exist for an archived or purged claim.

If you reset the claim disposition code, account transaction history will reflect Claim Disposition Cleared. If insurance follow-up had been halted, the claim is returned to insurance follow-up when you clear the claim disposition. If this is theonly claim for this carrier, insurance follow-up restarts from the first step. The original claim submission date is used to calculate the next follow-up date. If insurance follow-up is already in progress due to other claims for this carrier, this claim is simply added to the existing follow-up schedule.

AMOUNT (12-AN-O)
This field contains the amount being transferred from the carrier for this claim. Entries of whole dollar amounts do not require a decimal. Entries of dollars and cents require a decimal.

CMP (DISPLAY ONLY)
This field indicates if the disposition is complete. For dispositions of D (denied), A (adjusted to zero), or F (final payment), Yes displays in this field. For dispositions of T (transferred), C (clear disposition), or P (partial), No displays in this field. If the entry is No, the claim remains in the biller index and in follow-up. If the entry is Yes, the claims do not remain in the biller index and follow-up.

TO COB (1-AN-R)
This field indicates the portion of the account's liability dollars to which the transfer is being made. Entry options are 1, 2, 3, or 4 from the COB field, P for Patient, or T for Third Party excess. The COB field displays the eligible indicators that can have balance transferred to them.

CS (1-N-C)
This field contains the carrier of the selected claim. If the selected carrier has only one claim, this field defaults to that claim sequence number. If there are multiple claims, you are prompted to select the appropriate claim sequence to transfer the money. If you did not enter a carrier in the COB field, this field is blank.

TRANS CODE/DESCRIPTION (5-AN-R)
This field contains the transaction type and code that is used to record this balance transfer in the account's transaction history. The description of the selected transaction code also displays. You can enter the code or a hyphen (-) to display a list of valid codes under transaction type B (balance transfer).

CMT (1-A-R) and (60-C-C)
This field provides space for comments regarding this balance transfer. You must first respond to a prompt asking if you want to enter a comment concerning this balance transfer. Entry options are Y for Yes or N for No; the default is N. You can enter up to

60 characters of comment. Comments entered display in the account's transaction history under Comment.

When you complete these fields, this procedure can be repeated for another balance transfer for the carrier and claim, if necessary. Press F7 to accept your entries. After you press F7 and your selected account is in location AR or BD, thefollowing message is displayed:

Modify financial class 'X'? (Y/N) [N]--

The X represents the account's financial class. Responding to this message allows you to modify the account's financial class. Changing the financial class at this prompt is the same as changing the financial class through Account Revision. The financial class in the MPI does not change. Only the financial record is affected.

If you enter **N** for No, the system returns to the name lookup so that you can select another account. If you enter **Y** for Yes, you are prompted for the new financial class to be assigned. The message Enter new financial class or '-' for table lookup displays. After you make your selection, the transaction is complete and you are returned to the claim menu.

NOTE: You do not need to enter any balance transfer transactions to change the financial class or disposition the claim.

In general, you should not use this function for any claim where remittance posting is by individual claim charge detail line.

Reprinting a Claim

This function, which only displays if the claim has been released, enables you to reprint an individual claim. Claims that have been released but not produced can also be reprinted. One purpose for this function is the ability to send a claim to a carrier that has misplaced or lost the original copy.

After you select the reprint claim option, the following prompt is displayed:

How many copies of the claim should be reprinted? [1]--

The valid number of copies is 1 through 9; the default is 1. If you enter a valid number or accept the default, the system displays the following prompt:

Reprint Immediately or during tonight's Batch (I/B)? [I]--

If you enter **I** for immediately or press ENTER, the selected claim prints right away at the printer requested. When printing immediately, you can point the claim to any of the printers assigned to the claim form in Reports Maintenance. If you enter **B** for batch, the request is filed to print in midnight processing. The default is I. In either case, the

transaction history reflects the claim reprint activity. You repeat this procedure for each claim that you want to reprint.

NOTE: The reprinted claim is labeled with the word REPRINT on the top of the form and is directed to the printer specified, with the following exceptions:

- Claims that are produced by creating diskettes will place the claim in the appropriate temporary download file in preparation for creating the diskette.

Reprints that are printed immediately are not queued to separate spool files. The claims print immediately on the printer specified. Reprint requests that are processed during midnight processing are queued to separate spool files according to the setting of the Insurance Parameters and the Claim Load and Edit Parameters. The system ignores the setting of the Claim Production Indicator for batch reprints, spooling them regardless of the setting. If a reprint request is entered for a claim that has an electronic print indicator, the reprint is added to the daily spool file generated for the electronic media, provided the associated claim load and edit parameters specify that reprint claims should be included. If reprint claims are not included, the reprint request spools to the paper spoolfile.

Reload Claim Demographic/Visit Errors

This function reloads any missing information that has been entered in the patient's demographic information or medical record since the time the claim was originally loaded. For example, if a claim fails edits because the patient date of birth was not available and the date of birth has since been entered into the account, you can use this function to load the date of birth into the claim record. Duplication of effort is thereby eliminated since you do not have to enter the information into the claim record once it is entered into the account. In addition, billers can use this function to verify any corrections that may have been made to the account. This process also edits (but does not reload) the charge summary information and displays any errors.

After you select this function, which only displays on the claims options menu if the claim has not been produced, the system displays the following message:

Reloading Claim Demographics

The system accesses the information, loads it, and freezes your terminal for the duration of the process. After the process is complete, the system returns you to the claims options menu.

If you select this option and no errors exist, the system displays the message: *No errors found to reload*. The claims options menu is displayed again.

If a claim is marked for resubmission in the Claim Status Information screen, the Reload Claim Demographic/Visit Errors function is not allowed for the claim. The system displays the following error message.

Reload function not valid for claims marked for resubmission

Information that already exists in the claim record will not be overlaid by selecting this option. Only locators in a Failed status are reloaded.

Errors may still exist if the missing information has not been entered yet for the patient.

ADD CLAIM TO INSURANCE

This function is used to add a claim record to an account for a new insurance without having to rebill an account. An example of when you would use this function is if the hospital received an insurance payment for a self pay account. In this case, there is no need to generate a new bill for the insurance. The business office could use this function to enable the cashier to post the payment to the appropriate claim record.

Another use of this function is to send a claim, requested by a patient for filing after the bill was produced, to a secondary carrier.

The steps for this procedure are:

1. Add the appropriate insurance to the account using account revision. The hospital's procedures regarding financial class change and verification should be followed.

2 Add a claim record for this account using the Add Claim to Insurance function.

When you access this function, the system prompts you to identify the account for which you wish to add a claim.

If the account does not have any insurance, the system displays:

Error: No Insurance exists for Account!

The system returns you to the FPI lookup prompt for you to identify another account. The system does not let you use the Adda Claim function on an account that does not have insurance, but it does not limit the number of claims that you can add to an insurance.

After you identify the account, the system displays the following screen:

```
            General Hospital Add Claim to Insurance Processor
                                                Wed Mar 15, 2006 10:10 am
Account      Name                        FC Typ Admit    Disch        Balance Loc
C01000007    TESTBERRY,EMERGENCY ONE     OH UCC 02/01/24 02/01/24     189.14  AR/FCRV









Add new/additional claim (N), or add combined claim (C) (N/C) [N]--
```

The system displays the account number, financial class, patient name, patient type, admission date, discharge date, current account balance, and account location/sub location. The screen asks if you want to add a new/additional claim, or a combined claim.

NOTE: Canadian users should not request combined claims as combined claims are only allowed on UB92 claimtypes. Since this type is not supported in Canada, the default of N should always be taken.

The system does not prevent the user from selecting C for Combined Claim. However, the error message defined later in this section appears once the requests to add claims are made.

With a new/additional claim, you are required to select a bill sequence to load the claim. Only the charges on this bill sequence will be on the claim. New/additional claims loaded through the Add Claim to Insurance function do not replace existing claims.

With a Combined claim, you are required to select one, more than one, or all bill sequences to load the claim. Only the charges on these bill sequences will be on the claim. This allows you to produce an admit through discharge claim for those accounts that have cycle billed by selecting all of the bills to load the claim. You can only load a combined claim for an insurance set to load a UB-92 claim form. If you choose an insurance that is not loading a UB-92 claim form, the following error message displays:

Can only create combined claims for UB92's

After you answer the prompt at the bottom of the screen (*Add new/additional claim (N), or add combined claim (C) (N/C) [N]--*), the system displays the following screen:

```
         General Hospital Add Claim to Insurance Processor
                                                 Wed Mar 15, 2006 10:10 am
Account      Name                        FC Typ Admit    Disch        Balance Loc
C01000007    TESTBERRY,EMERGENCY ONE     OH UCC 02/01/24 02/01/24     189.14  AR/FCRV

    Bill   Date     Type     From      Thru            Amount            Page:01
( 1) 1   02/01/29  Final  02/01/24  02/01/24         189.14




Enter bill sequence to use to load claim--
```

The system displays the account number, financial class, patient name, patient type, admission date, discharge date, current account balance, and account location/sub location.

Field Explanations

BILL (DISPLAY ONLY)
This column contains the bill sequence number of the displayed bill. Each produced bill is assigned a sequence number. A finalbill or an adjustment bill that has been replaced by a subsequent adjustment bill does not display for selection.

DATE (DISPLAY ONLY)
This column contains the date on which the bill was produced.

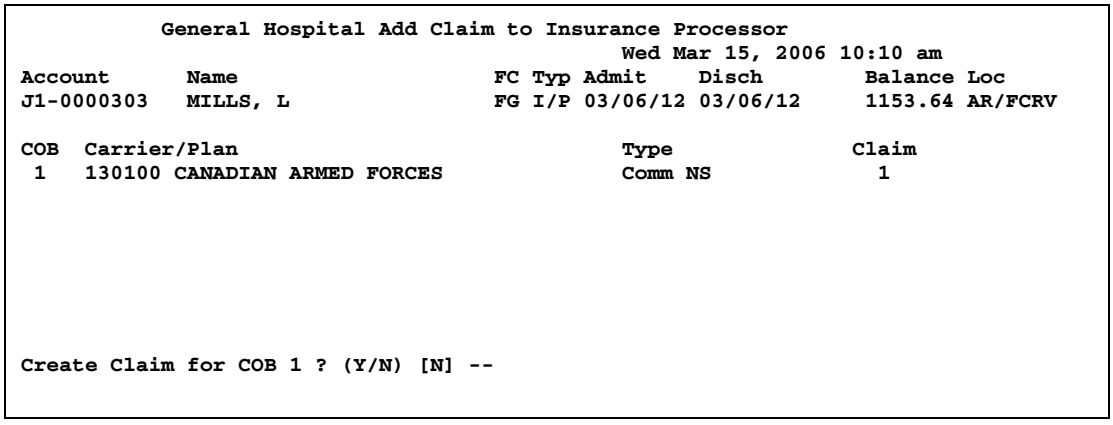
TYPE (DISPLAY ONLY)
This column contains the type of bill (cycle, final, adjustment, or late) that was produced.

FROM (DISPLAY ONLY)
This column contains the beginning date covered by the bill.

THRU (DISPLAY ONLY)
This column contains the ending date covered by this bill.

AMOUNT (DISPLAY ONLY)
This column contains the total amount of charges included on the bill.

If you are adding a new/additional claim, the system prompts you to enter the bill for which you want to add a claim. If adding a combined claim, the system prompts you to enter the bills for which you want to add a claim, or enter an A for all bills. After you enter your choice, the system displays each carrier assigned to the account and any existing claims for the selected bill.



Field Explanations

COB (DISPLAY ONLY)
This column contains the coordination of benefits flag for the displayed carrier/plan. Up to nine insurance plans can be assigned to an account at one time.

CARRIER/PLAN (DISPLAY ONLY)
This column contains the carrier/plan number and description.

TYPE (DISPLAY ONLY)
This column displays the type of claim form that was generated.

CLAIM (DISPLAY ONLY)
This field contains the claim sequence number of the claim relating to this bill. If the claim has not been produced, the status of this claim is displayed.

The system prompts you to add a claim record for each COB by displaying the following prompt:

Create Claim for COB 1? (Y/N) [N]—

If you do not want to add a claim record for this COB, enter **N** or press ENTER. The system continues to the next COB and displays the above prompt for that COB.

If you want to create a claim record for this COB, enter Y. The system displays the following prompt:

Enter add/suppress (A) or add/produce (P) a claim for COB 2—

After you enter either **A** or **P**, the system first checks the STAR Patient Care system to determine if the insurance is assigned to this account.

If you enter **A**, the system sets the Produce Claim flag to No, sets the appropriate claim parameters, loads the claim into the claim file, and then edits the claim according to the Claim Load and Edit parameters. If you enter P, the system uses the Produce Claim flag as set in the insurance plan, sets the appropriate claim parameters, loads the claim into the claim file, and then edits the claim according to the Claim Load and Edit Parameters. Entering a P allows a loaded claim to be produced or spooled.

If you enter **A**, the claim loads but does not print or spool. You are still able to produce a reprint claim for the account, either in batch or immediately. To print the claim in batch, you must use the Add/Produce **(P)** option.

If the insurance that is loading a claim has the Hold Claim for Prior Payment set to Yes in the Claim Parameters for the insurance, the system displays the following prompt:

xxxx claim loaded. Hold claim for prior payment?

The xxxx is the claim type, for example, CPBC.

The system allows the newly added claim to wait on other claims that meet these criteria (these are the only claims that will display to select from):

- the claim is not replaced

- the claim is not completed (is not dispositioned as Final Payment, Adjusted to Zero, or Denied)
- the claim is for the same bill sequence as the added claim
- for combined claims, the system will only display claims for higher priority plan that were loaded from the latest bill sequence that was chosen to load the combined claim
- the claim is for a higher priority insurance plan
- the Pro Fee Coverage Indicator of the Basic Coverage Screen determines which higher priority insurance the added claim can wait on. If the insurance you are adding a claim for “Includes” Pro Fees in the Basic Coverage Screen of the insurance, it allows the plan to wait on all prior plans. If the insurance you are adding a claim for “Excludes” Pro Fees in the Basic Coverage Screen of the insurance, it allows the plan to wait on prior plans set to Include or Exclude Pro Fees in the Basic Coverage Screen. It does not allow the plan to wait on prior plans set to Only Pro Fees in the Basic Coverage Screen. If the insurance you are adding a claim for “Only” Covers Pro Fees in the Basic Coverage Screen of the insurance, it allows the plan to wait on prior plans set to Include or Only Cover Pro Fees in the Basic Coverage Screen. It does not allow the plan to wait on prior plans set to Exclude Pro Fees in the Basic Coverage Screen.

If you enter Y for Yes to hold the claim for prior payment, the following screen displays for you to select the claims to wait on:.

```
             General Hospital Add Claim to Insurance Processor
                                                  Wed Mar 15, 2006 10:10 am
Account      Name                        FC Typ Admit    Disch        Balance Loc
C01000007    TESTBERRY,EMERGENCY ONE     OH UCC 02/01/24 02/01/24     189.14  AR/FCRV

    COB Carrier/Plan                        Type    In/Ex/Only  Claim  Claim Split
Page:01                                                          ##=Current Choices
( 1) 1  111111 BRITISH COLUMBIA MINISTR  BC MSP    Include     1




Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
                                  end select(NL)
```

The system displays the account number, financial class, patient name, patient type, admission date, discharge date, current account balance, and account location/sub location.

Field Explanations

COB (DISPLAY ONLY)
This column contains the coordination of benefits flag for the displayed carrier/plan. Up to nine insurance plans can be assigned to an account at one time.

CARRIER/PLAN (DISPLAY ONLY)
This column contains the carrier/plan number and description.

TYPE (DISPLAY ONLY)
This column displays the type of claim form that was generated. Examples are MOH, BC MSP, and CPBC.

IN/EX/ONLY (DISPLAY ONLY)
This column displays the Pro Fee Coverage Indicator of the Basic Coverage Screen of the insurance. The column will display Include, Exclude, or Only.

CLAIM (DISPLAY ONLY)
This column displays the claim sequence number of the claim that loaded from the same bill sequence for the higher priority insurance. If loading a combined claim, this column displays the claim sequence number of the claim that loaded from the latest bill sequence chosen to load the combined claim for the higher priority insurance.

SPLIT (DISPLAY ONLY)
For British Columbia Out of Province claims, this shows whether the claim had an inpatient or outpatient claim split indicator. The display will be either I or 0.

Users select the claim sequence(s) that the newly added claim should wait for payment on.

If you are loading a non-WCB claim and no charges exist for this claim, either because none were generated, they had offsetting debits and credits, the charges are already assigned to another insurance, or this is a converted account, the system displays:

No Charges to Load, Create Claim Anyway? (Y/N) [N]--

If you do not want to create the claim, enter **N**. The system continues to the next COB that does not have a claim loaded for the selected bill and repeats the above process for that COB. If all other carriers have a claim loaded for the selected bill, the system returns you to the account lookup prompt.

If you do want to create a claim record for this COB, enter **Y**. The system continues to process the claim. The claim loads with demographic data but without charge data.

If you are loading a WCB claim and no charge detail exists for this claim, either because no charges were generated, they had offsetting debits and credits, the charges are already assigned to another insurance, or this is a converted account, the system will display one of the following messages depending on the patient type of the patient.

No Charges to Load for Inpatient, Create Claim Anyway? (Y/N) [N]—

No Charges to Load for Outpatient, Create Claim Anyway? (Y/N) [N]—

NOTE: If there are no charges to load for WCB, the system has no way of knowing which type(s) of WCB claims to load, since the alternate bill summary code 3 from the FIM for the charge determines the WCB claims to load. Therefore, the system defaults to either an inpatient or outpatient WCB claim depending on the patient indicator of the patient. In general, if claims are being added, you would expect charges to exist if the claim forms need to be submitted. The appropriate forms will load based on these charges.

If you do not want to create the claim, enter N. The system continues to the next COB that does not have a claim loaded for the selected bill and repeats the above process for that COB. If all other carriers have a claim loaded for the selected bill, the system returns you to the account lookup prompt.

If you do want to create a claim record for this COB, enter Y. The system continues to process the claim. The claim loads with demographic data but without charge data.

When the process is completed, the claim type and claim number columns are updated. If the claim passes all edits, it is automatically released and the system gives you the option to submit and print the claim as described below. You can print the claim immediately or file a request for it to be printed during midnight processing. This process does not apply to OHIP claims. You must access any OHIP claim added via Claims by Account or Claims by Biller to release the claim.

If the claim fails edits, the system displays the following prompt:

TY Claim failed edits! Manually release claim sequence X? (Y/N) [N]-

X is the claim sequence number. TY is WCB claim form type (Comm Clinic, Inpatient, Laboratory, Outpatient, Radiology, or Therapy).

If you enter Y, the system displays the message:

TY Claim manually released

If the claim has been released, the system displays the following prompt:

Do You Wish to Submit this TY Claim Sequence X Using Today's Date? (Y/N) [N]—

To submit the claim, enter Y. The system then submits the claim using the current date as the submit date. You cannot enter a date different from today's date as the submit date. If you do not want to submit the claim, enter **N** or press ENTER to accept the default. If the carrier has a balance, entering the submit date will start insurance follow up for the claim.

The system then displays the following prompt:

Print this TY claim sequence X (Y/N)? [Y]--

If you do not want to print the claim, enter N. The system files the claim and either prompts you to add a claim for another COB or returns you to the account lookup prompt.

If you do want to print the claim, enter **Y** or press ENTER. The system then displays the following prompt:

Print claim sequence X Immediately or during tonight's Batch (I/B)? [I]—

Enter **I** or press ENTER to start the claim printing immediately. The system displays:

Claim Print Started

Enter **B** to print the claim during the next midnight processing. The system displays:

Claim Print Filed

Once the claim is loaded, it can be accessed like any other claim loaded through the billing process.

ARCHIVE CLAIMS

This function only displays on a menu in data processing. When this option is selected, the system locates all claims eligible to be archived and changes the status of these claims to Archived.

After you select this option, the system prompts you with:

Do you wish to Archive Claims? (Y/N)[N]--

If you enter **Y**, the archive program begins and the system returns you to the Claims Input Options menu. If you enter **N**, the system returns you to the Claims Input Options menu.

Prior to archiving a claim, the claim's disposition date must meet the Carrier Pay Days entry on the Data Retention Parameters of the Maintain Facility Information function. This represents the number of days a claim must meet the archive criteria before the claim is archived. You can establish financial class and financial class/patient type exceptions for this parameter.

There are several claim archive criteria which can qualify a claim for archiving:

- The claim has been paid in full; that is, the final payment flag must be set to Y and the claim disposition is Final Payment (F).
- The claim has been denied and the claim disposition is Denied (D).
- The claim has been adjusted or transferred to zero and the claim disposition is Adjusted to Zero (A) or Transfer (T).
- The claim was marked completed, because the carrier or the account balance equalled zero when the claim was dispositioned.
- The associated carrier balance is equal to zero.

For each of these criteria, the claim disposition date must be set for a number of days equal to or greater than those established in the Data Retention Parameters. If a claim meets all of the archive criteria but the associated carrier has a balance that is greater than zero, the system does not archive the claim.

In addition, claims that have been adjusted (replaced) are archived. Adjusted claims do not need to meet the Carrier Pay Days entry on the Data Retention Parameters. Adjusted (replacement) claims are archived when the archive job is run. Adjusted claims are not included in the archive tape and, consequently, are not recorded on microfiche.

When considering claim records for archive, the system looks at each claim as if it is a shared claim. In order to even be considered, the first claim in the shared claim list

must meet the archive requirements. In other words, even if a claim is stand-alone, it is looked at as if it is a shared claim for the first test of *archive eligibility*.

If the claim is a shared claim, each claim is checked for a disposition code and date. If there is no disposition date, the system checks for a last payment or adjustment date, a first payment date, or a claim submission date. If each shared claim has a valid disposition code or a zero or negative balance and one of the above dates, it is archived. If any of the shared claims does not qualify for archiving, none of the claims is archived.

Before an account is archived, the system checks the refund file to determine if an approved refund is waiting to print. If there is, the account is not archived. If a refund record has a Hold or Exclude status, the account is archived and the refund record is deleted.

When a claim is archived, it is not purged. The archiving process files the claim detail away in anticipation of the next step, which is the purge process. The claim archive and purge dates display on the claim status for the claim record. With the exception of a change in status from archived to purged, you cannot see a difference between an archived claim and a purged claim.

It is possible to post cash, adjustments and balance transfers to an archived or purged claim record. Archive status is a temporary status. Its purpose is to send the report produced by the system to a microfiche vendor, receive the microfiche from the vendor, verify the microfiche, and run purge if the microfiche is verified. If the microfiche cannot be read or any other problems exist, McKesson should be contacted and the archive process can be re-run. Archived claims can be stored on microfiche. The system creates a form of all archived claims that can be stored on microfiche. The format of the form is exactly like the original claim. There are many claim archive reports. Some of these include:

- FMRACK - Universal Claim Archive
- FMRACWR - WCB Community Clinic Claim Archive
- FMRACW1 - WCB Inpatient Claim Archive
- FMRACWL - WCB Laboratory Claim Archive

Refer to the *Reports Volume* in the *STAR Financials Patient Accounting Reference Guide* for a complete list of the claim archive spoolfiles.

There is a sort parameter for these reports so that they can be sorted differently than the production claims that are produced daily.

Transaction history will have a separate entry for archived claims and purged claims. The hospital should try to purge claims as quickly as possible after archiving. In addition, it is recommended that claim archiving occur prior to account archiving.

When an account is archived from AR or Bad Debt, the system deletes the account from the collector insurance workfile.

PURGE ARCHIVED CLAIMS

The Purge Archive Claims function actually deletes a claim from the system. You should run this function after you archive claims. This is a separate function that you select from the menu.

After you select this option, the system displays the following prompt:

Do you wish to Purge all previously archived claims? (Y/N) [N] --

If you enter **Y**, the system will start a job to purge all claims that have been archived since the last purge processing.

If there are no archived claims to be purged, the system displays *Error: There are no archived claims to purge*. If there are archived claims waiting to be purged, the purge process begins and deletes all claim demographic/visit data as well as the charge detail for the claim. Transaction history reflects the claim purge process.

Payments, adjustments, and balance transfers can be posted to a purged claim.

CREATE OUT OF PROVINCE DISKETTE

The Out of Province diskette function is used to download Out of Province claim information from the STAR system to a file for submission to the Department of Health and to produce the following reports:

- Nova Scotia Out of Province Diskette Outpatient Report (FNSOOP)
- Nova Scotia Out of Province Diskette Inpatient Report (FNSOOPI)

When you select the Out of Province Diskette option from the Claims Management menu in Billing and Claims, the system prompts you to enter a code for the hospital (institution) for which you are creating a diskette. You can enter the code (three-character, alphanumeric) or a hyphen (-) to display a list of valid codes. After the code is entered or selected, the system displays the following prompt:

Enter starting date for the diskette (YYYY/MM/DD, "E"arliest)

Valid entry options are **E** for earliest or a **date** in YYYY/MM/DD format. If the user enters a date, that is the starting date the system uses to select claims for placement on the diskette. The date must be a valid date in the past. If the user enters E for earliest, the system spans through the index of claims that are queued up to be placed on the diskette and finds the oldest claim in the index that has not already been submitted on a diskette. That claim will be the starting point for claim selection.

After the starting date is entered, the system displays the following prompt:

Enter Ending date for the diskette (YYYY/MM/DD, "L"atest)

You have two options to stop collecting patient data for the diskette. Valid entry options are **L** for latest or a date in YYYY/MM/DD format.If you enter a date, that is the ending date the system uses to select claims for placement on the diskette. The date must be a date later than the starting date and not a date in the future. If you enter **L** for Latest, the system spans through the index of claims that are queued up to be placed on the diskette and finds the oldest claim in the index that has not already been submitted on a diskette. That claim is the ending point for claim selection.

After the ending date is entered, the following prompt is displayed:

The calculated size for this data to fit on a diskette is" nnnnnn ". Press NL to Continue.

This prompt is displayed to provide the approximate size of the file being created and to allow you to determine if the file can fit on the existing diskette.

Press ENTER to display the next prompt:

The Diskette will be created for Institution (code) from (Start date) through (End date). Is this correct? ("Y"es,"N"o or "E"xit)

Entry options are **Y** for Yes, **N** for No, or **E** for Exit. If you enter **N** for No, the system returns to the *Enter Hospital/institution code* prompt.

If you enter **E** for Exit, the system exits out of the function and the diskette is not created.

If you enter **Y** for Yes, the following prompt is displayed, and the diskette creation process continues.

Enter Drive and file name for diskette creation [:A\OsiteMMMYY]

Enter the drive and the file name for the diskette being created. The default is the A drive with the file name being theletter O followed by the Site/Institution Code followed by a 3 digit month followed by the last 2 digit of the year. The month is determined by the month previously entered for the starting date. If you entered E for earliest, the system defaults the month to the month from the earliest record being placed on the diskette.

The following prompt is then displayed:

Please insert the diskette and type "READY"

Place a diskette in the drive selected in the prior prompt. Once the diskette has been inserted, type **Ready** to create the diskette and the reports.

At this time the system creates the diskette. As part of thecreation process, the system validates that all claims that are in the index to be placed on the diskette are valid. Examples of invalid claims are ones that have been deleted or replaced. Once the data has been written to the diskette and the associated report has been spooled, the following prompt is displayed.

Please remove the diskette, reports FCNSOOP_y% and FCNSOOPI_y% have been spooled. Press NL to continue.

Press ENTER to exit the screen.

RECREATE OUT OF PROVINCE DISKETTE/REPORT

This function is used to recreate both a diskette and/or a FCNSOOP report that have previously been created.

To enable the information to be displayed, when a diskette is originally created, the system marks each record as to what diskette the data was put onto.

When this function is selected from the Claims Management menu, the following screen is displayed:

```
             General Hospital Recreate Out of Province diskette/report Processor
                                                 Mon Oct 13, 2003 01:54 pm
Claims Management Input Options
Downloaded Time Periods
Page:01osp ID  Start Date   End Date   Downloaded       By              Rec
( 1)   0065     2003/01/13  2003/01/14  03/01/16 1013am  Basert, Tom
( 2)   0085     2003/01/09  2003/01/10  03/01/13 0122pm  Basert, Tom       *
( 3)   0085     2003/01/11  2003/01/12  03/01/13 0215pm  Basert, Tom       *
( 4)   0085     2003/01/13  2003/01/14  03/01/16 0955am  Basert, Tom
( 5)   0085     2003/01/15  2003/01/15  03/01/20 1121am  Basert, Tom
( 6)   0085     2003/01/16  2003/01/16  03/01/20 1145am  Basert, Tom
( 7)   0085     2003/01/17  2003/01/17  03/01/20 0156pm  Basert, Tom
( 8)   0085     2003/01/18  2003/01/18  03/01/30 1042am  Basert, Tom
( 9)   0085     2003/01/19  2003/01/19  03/01/30 1150am  Basert, Tom
(10)   0085     2003/01/20  2003/01/20  03/01/22 0159pm  Basert, Tom       *
(11)   0085     2003/01/24  2003/01/24  03/01/29 1122am  Basert, Tom
(12)   0085     2003/01/25  2003/01/25  03/01/29 1126am  Basert, Tom
(13)   0085     2003/01/30  2003/01/30  03/02/03 0148pm  Basert, Tom       *


Enter choice--
```

Field Explanations

HOSPITAL ID (DISPLAY ONLY)
This field contains the hospital code that was used when the original diskette was created.

START DATE (DISPLAY ONLY)
This field contains the starting date that the user entered when the original diskette was created. If the user initially entered "E" for Earliest this is the date of the earliest claim that was copied to the diskette.

END DATE (DISPLAY ONLY)
This field contains the ending date that the user entered when the original diskette was created. If the user initially entered "L" for Latest this is the date of the latest claim that was copied to the diskette.

DOWNLOADED (DISPLAY ONLY)
This field contains the time and date the diskette was downloaded.

BY (DISPLAY ONLY)
This field contains the name of the user who downloaded the diskette.

Select the downloaded diskette you want to recreate and press ENTER. The following screen is displayed:

```
     General Hospital Recreate Out of Province diskette/report Processor
                                                  Mon Oct 13, 2003 01:59 pm
Claims Management Input Options
Downloaded Time Periods

Hospital (Institution) Code: 0065
Start/End Date Downloaded:   2003/01/13 - 2003/01/14









Recreate download data? (Y/N) [N]--
```

The prompt displayed at the bottom of the screen is used to start the recreation process. The prompt is:

Recreate Download Data (Y/N) [N]

If you answer **N** for No, the function is exited. If you answer **Y** for Yes, the following message is displayed:

Collecting Download File

The next prompt displayed tells you the size of the file and asks if you want to continue processing:

There will be 326 bytes of space required to download file

Press (C) to continue or (B) to bypass

If you enter **B** for bypass, the function is exited. If you enter **C** for Continue, the system displays the next three prompts, asking you to enter the drive, subdirectory and PC file name for diskette creation:

Enter drive[A]--

The default is drive A.

Enter subdirectory--

Enter PC File Name [O8500103]

The default is a system-assigned PC file name which contains the hospital code and the month and year the diskette was recreated.

After the above prompts are answered, the system displays the following prompt (including the PC file name that is to be downloaded):

Download Out of Province claims? (Y/N) [Y]--

PC File Name: O8500103

If you enter **N** for No, the function is exited. If you enter **Y** for Yes, the diskette is created. Once the data has been written to the diskette, the following prompts are displayed:

Out of Province Download Successful!

Report FCNSOOPJ have been spooled, press 'enter' to continue

The O/P Reciprocal Billing Report (FCNSOOP) reports are spooled. Press ENTER to exit the function.

PURGE OUT OF PROVINCE DISKETTE

This function is used to remove files from the hard drive of your PC. You can run the purge function at any time, to increase available disk space on your PC system.

When you access the Purge Out of Province Diskette menu option, the system displays a screen listing downloaded files:

```
         General Hospital Purge Out of Province Diskette Processor
                                                 Mon Oct 13, 2003 01:54 pm
Claims Management Input Options
Downloaded Time Periods
Page:01osp ID  Start Date   End Date   Downloaded       By              Rec
( 1)   0065     2003/01/13  2003/01/14  03/01/16 1013am  Basert, Tom
( 2)   0085     2003/01/09  2003/01/10  03/01/13 0122pm  Basert, Tom       *
( 3)   0085     2003/01/11  2003/01/12  03/01/13 0215pm  Basert, Tom       *
( 4)   0085     2003/01/13  2003/01/14  03/01/16 0955am  Basert, Tom
( 5)   0085     2003/01/15  2003/01/15  03/01/20 1121am  Basert, Tom
( 6)   0085     2003/01/16  2003/01/16  03/01/20 1145am  Basert, Tom
( 7)   0085     2003/01/17  2003/01/17  03/01/20 0156pm  Basert, Tom
( 8)   0085     2003/01/18  2003/01/18  03/01/30 1042am  Basert, Tom
( 9)   0085     2003/01/19  2003/01/19  03/01/30 1150am  Basert, Tom
(10)   0085     2003/01/20  2003/01/20  03/01/22 0159pm  Basert, Tom       *
(11)   0085     2003/01/24  2003/01/24  03/01/29 1122am  Basert, Tom
(12)   0085     2003/01/25  2003/01/25  03/01/29 1126am  Basert, Tom
(13)   0085     2003/01/30  2003/01/30  03/02/03 0148pm  Basert, Tom       *


Enter choice--
```

Select the downloaded diskette you want to purge and press ENTER.

PENDING CLAIMS REPORT

After you select this function, the system displays the following prompt:

Print Pending Claims report? (Y/N) --

If you enter **Y**, the report is processed and spooled for printing. This report lists all claims not yet produced in the system. For more detailed information regarding this report, refer to the *Reports Volume* of the *STAR Financials Patient Accounting Reference Guide*.

```
          General Hospital Purge Out of Province diskette Processor
                                                Mon Oct 13, 2003 03:26 pm

Downloaded Time Periods

Hospital (Institution) Code: 0065
Start/End Date Downloaded:   2003/01/13 - 2003/01/14









Purge download data? (Y/N) [N]--
```

The system displays the following prompt:

Purge download data? (Y/N) [N]

To exit the function, enter **N** for No. To purge download data, enter **Y** for Yes. The following prompt is displayed:

Are you sure you want to purge the download data from 2003/01/09 to 2003/01/10? (Y/N)--

If you are sure you want to purge the download data, enter **Y** for Yes. Enter **N** for No to exit the function without purging the file(s). If you enter **Y** for Yes the function is exited.

Chapter 3 - REPORTS

Illustrations

INTRODUCTION

This chapter provides you with information for printing reports. Also provided are sample reports.

OUT OF PROVINCE ACCOUNTS REPORT (FCNSOOA)

This report is created automatically as part of the Out of Province Diskette Creation process. This report can also be created as part of the Recreate Out of Prov diskette/ report process.

This report is generated by the creation of the OOP diskette. For an additional copy of the report, use the Recreate OOP Diskette/Report function.

Patients who are selected for inclusion on the OOP diskette are displayed on the report. The report is sorted by province code and then patient service date. There is a page break between province codes.

The data within each individual province code are to be sorted and printed by Patient Last Name.

Figure 3.1 Out of Province Accounts Report (FCNSOOA)

```
Date: 03/01/16        Nova Scotia Hospital            Page:   1
   Time: 11:14      Out of Province Accounts Report      Report: FCNSOOAx


            Province Of Origin:  150900 NS OUTPATIENT

   ____________________________________________________________________
   Account   Date of   Site  SIM  Description  Amount  Reason
   Number    Service         Code
   ____________________________________________________________________

   Patient Name: AXT, MARK     Unit Number:90  Acct Billed:5000012
   50000102  2003/01/16  01  134  SPLINT       25.90   High Dollar but I/P
```

Field Explanations

ACCOUNT NUMBER
This field displays the patient account number

DATE OF SERVICE
This field displays the service date of the charge being evaluated

SITE
This field displays the last two digits of the Institution code that is on the Patient type for the account.

SIM CODE
This field displays the SIM Code of the charge being evaluated. This is pulled from the charge detail.

DESCRIPTION
This field displays a description of the charge being evaluated. This is pulled from the charge detail.

AMOUNT
This field displays the dollar amount of the charge being evaluated. This is pulled from the charge detail.

REASON CODE
This field displays the Reason code for the account on the report. The following are the valid print options on this report:

Inp - This is the reason code that will indicate that the patient type on this account is Inpatient. These accounts will not qualify as the diskette is only for Outpatients.

Prev - This is the reason code to indicate that this patient had an outpatient patient indicator but this person has already been submitted on a previous diskette for this date of service.

New High $ - This is the reason code that will indicate that this person was previously sent to the DOH for charges for this date of service, but this charge has the new high dollar amount for this date of service. This charge is also being sent to the DoH on this diskette.

Sel - This will be the reason code for the charge that was selected due to being the highest dollar amount for this date of service. This is the charge that will appear on the Diskette.

Not Sel - This reason code will appear for all charges that were not selected for inclusion on the diskette as they did not have the highest dollar amount.

OUTPATIENT RECIPROCAL BILLING REPORT (FCNSOOP)

This report includes the outpatients who have had claims released within the criteria used to produce the Out Of ProvinceOutpatient Diskette. This report provides an audit trail of outpatients who are receiving Out Of Province care. The report uses the exact layout as the Outpatient report.

This report is created automatically as part of the creation of the Out of Province Diskette. This report cannot be recreated.

Outpatients who met all of the criteria for inclusion on the Outpatient diskette appear on this report.

There are two sections per province and there is a page break between the sections. The report contains page breaks by Province code repeating the two sections until all patients have been reported.

The data within each province code is sorted by Patient's Last Name.

Figure 3.2 Outpatient Reciprocal Billing Report (FCNSOOP)

```
FCNSOOPJ                                Outpatient Reciprocal Billing Report                                Page: 1

Site: ST JOSEPH'S DAY SURGERY                        NOVA SCOTIA                                Hospital Code: 01

2004/06/18 11:07 am                     Province of Origin: 150150 ALBERTA
_____________________________________________________________________________________________________________

                                                                                HCN Expiry
PMI Number      Patient Surname      Given Name        Birth Date Sex     Date Service Date  Inv Number     Serv Code Cost of Service

876655884        MERR                 OOP TEST           19441221   M    20050630 20040422      00001544       02              50.00

_____________________________________________________________________________________________________________
                                                                                Total Cost of Service:          50.00


I CERTIFY THAT THE HEALTH INSURANCE I.D. CARDS OF THE PATIENTS LISTED ABOVE
HAVE BEEN EXAMINED AND THE ADDRESS IN EACH CASE APPEARS ON THE HOSPITAL RECORDS.

_____________________________________
Authorized Signature

>
FCNSOOPJ                                Outpatient Reciprocal Billing Report                                Page: 2

Site: ST JOSEPH'S DAY SURGERY                        NOVA SCOTIA                                Hospital Code: 01

2004/06/18 11:07 am                     Province of Origin: 150150 ALBERTA
_____________________________________________________________________________________________________________

Service Code     Service Description        Number of Services       Total Amount
      02         INPATIENT VISIT                    1                    50.00

_____________________________________________________________________________________________________________

                        Total:                      1                    50.00

                                                End of Report
```

Field Explanations

PMI NUMBER
This column displays the medical insurance number.

PATIENT SURNAME
This column displays the patient's last name.

GIVEN NAME
This column displays the patient's first and middle name.

BIRTH DATE
This column displays the patient's date of birth.

SEX
This column displays the patient's gender.

SERVICE DATE
This column displays the date the patient received services.

INVOICE NUMBER
This column displays the invoice number.

SERV. CODE
This column displays the Reciprocal Billing Code (OPC code from the FIM). Each service code is summarized into a separate line.

SERVICE DESCRIPTION
This column displays the description pulled from the Out of Province Service Code table that is associated with the Out of Province Service Code

NUMBER OF SERVICES
This column displays the number of lines in the detail section of the report.

TOTAL AMOUNT
This column displays the total dollar amount for each time that the service code was printed.

INPATIENT RECIPROCAL BILLING REPORT (FCNSOOI)

This report includes the Inpatients who have had claims released within the criteria that the Out Of Province Outpatient Diskette was created using. This report is to provide an audit trail of Inpatients who are receiving Out Of Province care. The report is using the exact layout as the Outpatient report.

This report is created automatically as part of the creation of the Out of Province Diskette Creation process. This report cannot be recreated.

Inpatients who met all of the criteria for inclusion on the Outpatient diskette appear on this report.

There are two sections per province there is a page break between the sections. The report also page breaks by Province code repeating the two sections until all patients have been reported.

The data within each province code is sorted by Patient's Last Name.

Figure 3.3 Inpatient Reciprocal Billing Report (FCNSOOI)

```
FCNSOOIJ                                  Inpatient Reciprocal Billing Report                          Page: 1

Site: ST JOSEPH'S ACUTE CARE                       NOVA SCOTIA                                Hospital Code: 03

2004/04/23 11:49 am                                 Province of Origin: 150150 ALBERTA
_____________________________________________________________________________________________

                                                                                                  HCN Expiry
PMI Number      Patient Surname      Given Name        Birth Date Sex     Date          Service Date  Inv Number    Serv
Code Cost of Service

546788122       MERRITT              INPATIENT OOP     19870321   F   20051231      20040422      10000304      02
100.00

_____________________________________________________________________________________________
                                                                                                  Total
Cost of Service:        100.00
```

Field Explanations

PMI NUMBER
This column displays the medical insurance number.

PATIENT SURNAME
This column displays the patient's last name.

GIVEN NAME
This column displays the patient's first and middle name.

BIRTH DATE
This column displays the patient's date of birth.

SEX
This column displays the patient's gender.

SERVICE DATE
This column displays the date the patient received services.

INVOICE NUMBER
This column displays the invoice number.

SERV. CODE
This column displays the Reciprocal Billing Code (OPC code from the FIM). Each service code is summarized into a separate line.

SERVICE DESCRIPTION
This column displays the description pulled from the Out of Province Service Code table that is associated with the Out of Province Service Code

COST OF SERVICE
This column displays the amount of the service charge.

NUMBER OF SERVICES
This column displays the number of lines in the detail section of the report.

TOTAL AMOUNT
This column displays the total dollar amount for each time that the service code was printed.

Chapter 4 - AUTOMATIC REPRICING BY FINANCIAL CLASS

INTRODUCTION

The STAR Patient Accounting system provides the ability to automatically reassign charges to the patient when the financial class is changed. The automatic repricing function includes the following features:

- Charges are automatically cancelled or credited when the patient's financial class changes.
- Items are automatically recharged to the patient with the current financial class price.
- Online charge reprice inquiry and repricing history provide a snapshot of repricing results and history on an account.
- Daily report provides an audit trail of all patients whose financial class changed and lists any charges that were automatically adjusted.
- Transaction history is updated to reflect that the patient's charges have been adjusted.

The financial class of the patient is assigned based on the patient's primary insurance. It can be changed through any of the following functions:

- The Insurance Process of the Revise Admission function in Patient Care
- The Insurance Process of the Account Revision function in Patient Accounting (which is actually performed by the Insurance Process in Patient Care by way of the network)
- The Insurance Management function in Patient Accounting
- The Account Status option of the Account Revision function in Patient Accounting
- Automatic reassignment based on Insurance Time Out and Balance Designation Parameters at the facility level

If the hospital facility option to implement automatic repricing is set to Yes, charges are automatically credited (or cancelled) and reissued when the financial class changes through the first three functions listed above. Changes made to the financial class through the account status screen, insurance time out, or balance transfer do not affect the charges on the patient's account regardless of the automatic repricing option chosen.

When a patient's financial class is changed through the Insurance Process (Revise Admission in Patient Care or Account Revision - Admission in Patient Accounting) or through Insurance Management, the charges for thepatient are reviewed to determine

if pricing changes are needed for the newly assigned financial class. If there are charges that should be adjusted based on the financial class change, then the system automatically credits the original charge and recharges the item with the current financial class price. The new charge retains all of the original charge data except for the Charge Amount, Charge Date, and the Financial Class.

If one item within a panel of charges requires repricing, then the entire panel is credited and recharged. This is to maintain a true history of charge activities on the account. Manually-priced items are not adjusted since there is no way to determine what the price should be. In addition, if the SIM item is no longer active, the charge is not made. Manually-priced items and inactive SIM items are identified on a report for hospital review. Revenue continues to be reclassified based on current reclassification criteria.

If the repricing parameter is set to Yes at the facility level and the financial class of the account has changed, the charge reassignment is initiated when you accept the Insurance Processor screen through the Revise Admission or Account Revision-Insurance Process. This processing is done in the background and is transparent to you. The credits and charges issued through the reassignment are processed through the current charge functionality of the system.

If the patient's account is active in Patient Care, the charge data is obtained from the Patient Care system, and the resulting credits and charges are handled as regular charges and credits. However, if the patient's account is no longer active in Patient Care, then the charge information must be obtained from the Patient Accounting system. These charges are logged as late charges and credits. In either case, a log entry is made to the patient's transaction history stating that the repricing event occurred.

The Change Financial Class report (FAFCRPT) lists all changes in financial class that occurred during the day and lists any charges that were automatically adjusted showing the credit information and the new charge information. Manually-priced and inactive items are highlighted for hospital review. Refer to the *Reports Volume* of the *STAR Financials Patient Accounting Reference Guide* for more information on this report.

To activate the automatic repricing feature, you must set a parameter in Patient Care. To set this parameter, access Patient Care, Tables, Hospital Facility Options, Order Management and Charging Parameters. In a multi-facility environment, the system asks you to select a facility. When you select the facility, the following screen is displayed:

```
      General Hospital Order Management and Charging Parameters Processor
                                                    Tue Apr 30, 1996 11:36 am

 ORDERS/CHARGES
 1 Cont. Chg. Suspense       2 Room and Bed Charging      3 Display Room/Bed Screen
   60                          Yes                          Yes
 4 Professional Fees         5 Late Charge Days           6 Panels
   Yes                         999                          Yes
 7 Order Hist. Chgs          8 R/B Increase?              9 Cart Report
    No                         No                           Summary
10 Default Service Date     11 AdV SIM Dept              12 Reprice if FC Changes
   Charge Date                                             Yes
13 Edit By                                              14 Edit Date
   Smith,Mary M                                            96/04/11 11.31




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

12. REPRICE IF FC CHANGES (1-A-R)

This field determines if charges are automatically evaluated for repricing when a change in a patient's financial class occurs. Valid options are **Y** for Yes and **N** for No. The default is N.

REPRICED CHARGE INQUIRY

This function provides detailed information regarding the charges and repricing that may have occurred on a particular account. In order to use this inquiry, the patient must be active on STAR Patient Care. The patient may be accessed via account number, bed code, or by name. Once the patient is entered, the system sorts the data in internal order number sequence and prompts you to enter the order number to begin the inquiry. The default for this prompt is A for all. If the account entered has had no repricing done, you receive the message *No Repricing Done for this Account!* and are returned to the account number prompt. Once an account has been selected that has been evaluated for repricing, the following screen is displayed:

```
              General Hospital Repriced Charge Inquiry Processor
                                                    Wed Mar 15, 2006 10:10 am
Account      Name                 FC Typ Admit    Disch        Balance Loc
A9607900003  BERRYMORE,JASON      10 ER  96/03/19 96/03/19     53.90   AR/FCRV
RP  Chg#  Dept Description                Pst Date  Srv Date  Qty      Price
                                  Order#: 3
 *     3  CSR  BABY OIL                    96/03/19  96/03/19    1       3.90
                                  Order#: 2
 *     2  RAD  XR KNEE AP & LAT  735643    96/03/19  96/03/19    1     123.25
 *  Late  RAD  XR KNEE AP & LAT  735643    96/03/24  96/03/19   -1    -123.25
    Late  RAD  XR KNEE AP & LAT  735643    96/03/24  96/03/19    1      35.00
                                  Order#: 1
 *     1  LAB  CBC WITH DIFF               96/03/19  96/03/19    1      21.00
 *  Late  LAB  CBC WITH DIFF               96/03/24  96/03/19   -1     -21.00
    Late  LAB  CBC WITH DIFF               96/03/24  96/03/19    1      15.00




Press NL--
```

Field Explanations

RP (DISPLAY ONLY)
This field displays an asterisk to indicate the beginning of a repricing event.

CHG # (DISPLAY ONLY)
This field contains the charge number. The word *Late* is displayed if the charge was a late charge.

DEPT (DISPLAY ONLY)
This field displays the SIM department of the charge.

DESCRIPTION (DISPLAY ONLY)
This field displays the description of the charge.

PST DATE (DISPLAY ONLY)
This field contains the posting date of the charge.

SRV DATE (DISPLAY ONLY)
This field contains the service date of the charge.

QTY (DISPLAY ONLY)
This field displays the charge quantity.

PRICE (DISPLAY ONLY)
The field displays the total charge amount.

PA REPRICED CHARGE INQUIRY

This function also provides detailed information regarding the charges and repricing that have occurred on a particular account. It displays the same information as the Repriced Charge Inquiry. The only difference is that the PA Repriced Charge Inquiry can be used for both active and inactive patients.

You can access the patient by account number, corporate number, health card number, unit number, or by name. After you select the patient, the system sorts the data in internal order number sequence and prompts you to enter the order number to begin the inquiry. The default for this prompt is A for All. If no repricing has been done for the account, the system displays the message *No Repricing Done for this Account!* and returns to the account number prompt.

If the account has been evaluated for repricing, the following screen is displayed:

```
          General Hospital PA Repriced Charge Inquiry Processor
                                                    Wed Mar 15, 2006 10:10 am
Account      Name                   FC Typ Admit    Disch        Balance Loc
A9607900003  BERRYMORE,JASON        10 ER  96/03/19 96/03/19     53.90   AR/FCRV
RP  Chg#  Dept Description                Pst Date  Srv Date  Qty      Price
                                   Order#: 3
 *     3  CSR  BABY OIL                    96/03/19  96/03/19    1       3.90
                                   Order#: 2
 *     2  RAD  XR KNEE AP & LAT  735643    96/03/19  96/03/19    1     123.25
 *  Late  RAD  XR KNEE AP & LAT  735643    96/03/24  96/03/19   -1    -123.25
    Late  RAD  XR KNEE AP & LAT  735643    96/03/24  96/03/19    1      35.00
                                   Order#: 1
 *     1  LAB  CBC WITH DIFF              96/03/19  96/03/19   1      21.00
 *  Late  LAB  CBC WITH DIFF              96/03/24  96/03/19   -1     -21.00
    Late  LAB  CBC WITH DIFF              96/03/24  96/03/19    1      15.00




Press NL--
```

Field Explanations

RP (DISPLAY ONLY)
This field displays an asterisk to indicate the beginning of a repricing event.

CHG # (DISPLAY ONLY)
This field contains the charge number. The word *Late* is displayed if the charge was a late charge.

DEPT (DISPLAY ONLY)
This field displays the SIM department of the charge.

DESCRIPTION (DISPLAY ONLY)
This field displays the description of the charge.

PST DATE (DISPLAY ONLY)
This field contains the posting date of the charge.

SRV DATE (DISPLAY ONLY)
This field contains the service date of the charge.

QTY (DISPLAY ONLY)
This field displays the charge quantity.

PRICE (DISPLAY ONLY)
The field displays the total charge amount.

REPRICING HISTORY

The repricing history function provides an online history of the repricing events that have occurred in an account. You can access the account by account number, corporate number, health card number, unit number, or name. If the account has had no repricing transactions, the system displays the message *No Repricing Events exist!* and returns to the account entry prompt.

When you select the patient, a prompt is displayed requesting the repricing sequence number. Enter the number or a hyphen (-) to display a list of repricing sequence events. The default for this prompt is the last repricing event that has occurred. The list of resequence events is the FC Repricing Log. It provides the start and start time of the resequence event, the initiating CRT and process, the old financial class, and the new financial class.

When you select the repricing sequence, the following screen is displayed:

```
            General Hospital Repricing History Processor
                                                Wed Mar 15, 2006 10:10 am
Account      Name               FC Typ Admit    Disch        Balance Loc
A9607900003  BERRYMORE,JASON    10 ER  96/03/19 96/03/19     53.90   AR/FCRV
  Reprice Seq#:  1  Started: 96/03/24 10:32   Completed:  96/03/24 10:32
Seq  Srv       Post      SIM Dept/Code/Description           Qty    Amount

2    96/03/19  96/03/19  RAD  7356  XR KNEE AP & LAT  73     1       123.25  O
     96/03/19  96/03/24  RAD  7356  XR KNEE AP & LAT  73    -1       123.25- AL
     96/03/19  96/03/24  RAD  7356  XR KNEE AP & LAT  73     1        35.00  NL

1    96/03/19  96/03/19  LAB  2090  CBC WITH DIFF            1        21.00  O
     96/03/19  96/03/24  LAB  2090  CBC WITH DIFF           -1        21.00- AL
     96/03/19  96/03/24  LAB  2090  CBC WITH DIFF            1        15.00  NL

Original:      $144.25        Adjustments:  $144.25-        New:     $50.00
Manual:          $0.00
Inactive:        $0.00


Press NL--
```

Field Explanations

REPRICE SEQ# (DISPLAY ONLY)
This field contains the sequence number of the repricing event.

STARTED (DISPLAY ONLY)
This field contains the date and time the resequencing event began.

COMPLETED (DISPLAY ONLY)
This field contains the date and time the resequencing event completed.

SEQ (DISPLAY ONLY)
This field contains the sequence number associated with the charge.

SRV (DISPLAY ONLY)
This field contains the service date of the charge.

POST (DISPLAY ONLY)
This field contains the date the charge was posted.

SIM DEPT/CODE/DESCRIPTION (DISPLAY ONLY)
This field contains the SIM Department, SIM Code, and SIM Description.

QTY (DISPLAY ONLY)
This field contains the charge quantity.

AMOUNT (DISPLAY ONLY)
This field contains the charge amount.

Original charges are marked with an O. Adjustment charges are marked with an A. New charges applied are marked with an N. An L beside the indicator means that the charge is considered a late charge in the system. Manually priced items and inactive items display as identified with an M and an I respectively.

Totals are provided for the original charges, the adjusted charges, the new charges, and manually priced and inactive items.

RESTART REPRICING EVENT

Use this function to complete any repricing event that has not completed normally. You should use it only if an error has logged to the Patient Care console indicating that a restart of the repricing event may be necessary. Remember that the charges and credits reissued must be processed through the charge processor. Depending on the network, there may be a delay between the time the financial class is changed and the time the charges are available in Patient Accounting.

The system logs a transaction to the patient's transaction history when repricing begins and logs another transaction when repricing has completed. The Change Financial Class Report also shows the start and completion times of the repricing event.

When you select this option, the system prompts you for the account. You can access the account by account number, corporate number, health card number, unit number, or name. If the repricing events for the account have been completed, the system displays the message *Repricing Completed for Last Event* and returns to the FPI lookup.

If there is an incomplete repricing event, the following screen is displayed:

```
             General Hospital Restart FC Repricing Processor
                                                Wed Mar 15, 2006 10:10 am
Account      Name                    FC Typ Admit    Disch        Balance Loc
A1-00001-96  LONG,BABE                M  NWB 96/04/15 96/04/18     2300.00 AR/FCRV

Using network job starts, Restart FC Repricing continues FC Repricing
for the last Repricing event for the selected account.

If the system has been down or the network is behind,
EXECUTE this later.

Patient Care ABORTS the job if queued network job starts exist.

If Patient Care finds an error or a locked patient, the
process stops and a message appears on the Patient Care console.

If the patient is locked, retry later.
(Repricing may be completing.)

Monitor the Patient Care Console and the Repricing Log
to determine failure or success.
Are you SURE that repricing should restart (YES/N) [N]--
```

Enter **Y** to accept the screen and begin the restart process. The default is N for No. During the restart process, messages appear on the Patient Care console. These messages log under FC Reprice ID XXX, where XX is the ID of the environment being processed. For example, repricing messages for the Live ID, ID 1, would be logged under FC Reprice ID 1.

REPRICE CHARGES

Use this function to reprice individual charge items. It is particularly useful when an item is priced differently based on the patient type of the patient and the patient type has changed. In order to use this function, the patient must be active in Patient Care. It cannot be used once the patient has gone inactive in Patient Care. Therefore, the hospital should carefully review accounts whose patient type has changed.

Select the Reprice Charges function through the Charge/Credit Functions in Billing/ Claims. Select the account through the normal Patient Care lookup (account number, bed code, or name). The system prompts you to enter the date on which to begin the charge review. The default is today.

When you select the date, the following screen is displayed:

```
               General Hospital Reprice Charges Processor
                                                    Tue Apr 30, 1996 01:25 pm
  No        Name              Sex  BD       Room    Physician   SVC     Status
00010195    BERRYMORE,JASON    M  81/01/31 2112-01 ADAIR,FRANK C MED   I/P 36

Charges for  Eligible Departments   During the 24 Hours Ending  96/04/29

No  Chg#  Dept Description                              Srv Date  Qty     Price
 1    38  RMB  DBW SEM/WARD PANEL                       04/29/96    1       .00
 2    37  CSR  CRUTCHES,PR-ADULT                       04/15/96    1     28.60









              All charges have been listed for the date shown!
Enter number, summary(S) or new date [previous date]--
```

Select the Item Number that needs to be repriced. The following screen is displayed:

```
             General Hospital  Reprice Charges Processor
                                                  Tue Apr 30, 1996 02:53 pm
  No      Name               Sex BD       Room    Physician     SVC   Status
00010195  BERRYMORE,JASON    M  81/01/31 2112-01 ADAIR,FRANK C MED   I/P 36

 1 Charge Number       2 From CRT              3 Department          4 Type
   37                    FIN STAR FINANCIAL      CENTRAL SERVICES      Charge
 5 Charge Location              6 Date Charged           7 Charged By
   1E 1 EAST                      96/04/29 12.17           PMB
 8 Code   Bill Code             9 Description
   0472   6251-0472               CRUTCHES,PR-ADULT
10 Quantity 11 Price      12 Date of Service  13 Order Diagnosis
   1          $28.60        04/15/96
14 Charging Physician      15 Performing Physician           16 Fin. Class
   32 ADAIR,FRANK C                                            10 OHIP FINA
17 Revenue Code            18 Accommodation Code    19 SoB    20 Clinic #
   CENTRAL SERVICES                                            0000-000000-00


(E)dit or (R)eprice charge?--
                  next charge(/) or previous charge(/P) [/]
```

Enter **R** at the prompt. The system evaluates the charge and displays the following screen:

```
                 General Hospital Reprice Charges Processor
                                                  Tue Apr 30, 1996 03:09 pm
  No       Name               Sex BD       Room    Physician     SVC   Status
00010195  BERRYMORE,JASON    M  81/01/31 2112-01 ADAIR,FRANK C MED   I/P 36
Chg#      Dept Description                   Qty  Old Price New Price   Status
  37      CSR  CRUTCHES,PR-ADULT              1       28.60     32.00      *









Reprice Charges as Indicated Y/N [N]--
```

If the price for the item remains the same, a message appears at the bottom of the screen saying *Cannot Reprice. No Prices Changed. Press NL to Continue*. Otherwise, to reprice the charges, enter **Y**. The default is N for No. If you enter N, the system displays *No Repricing Done*. Press ENTER and the system returns to the previous screen. If you enter Y, the system cancelsthe charge and reissues the charge with the new price. When the repricing is completed, the system displays *Reprice Complete. Press NL to Continue*. In the above example, the following screen would be displayed:

```
              General Hospital Reprice Charges Processor
                                                  Tue Apr 30, 1996 03:09 pm
  No      Name               Sex BD       Room    Physician     SVC   Status
00010195  BERRYMORE,JASON     M  01/31/81 2112-01 ADAIR,FRANK C MED   I/P 36

Charges for  Eligible Departments   During the 24 Hours Ending  Midnight Tonight

No  Chg#     Dept    Description                        Srv Date  Qty      Price
 1    40     CSR     CRUTCHES,PR-ADULT                  96/04/15    1      32.00
 2    39     CSR     CRUTCHES,PR-ADULT                  96/04/15   -1     -28.60









             All charges have been listed for the date shown!
Enter number, summary(S) or new date [previous date]--
```

Chapter 5 - OUTPATIENT OUT OF PROVINCE DISKETTE

INTRODUCTION

The Out of Province diskette function is used to download Out of Province claim information from the STAR system to a file for submission to the Department of Health and to produce the following reports:

- Nova Scotia Out of Province Diskette Outpatient Report (FNSOOP)
- Nova Scotia Out of Province Diskette Inpatient Report (FNSOOPI)

The Out of Province Diskette option is available from the Claims Management menu in Billing and Claims. For additional information, refer to the following topics in this document:

- "Claim Types" on page 1-3 - The OutPrv NS claim type is used to provide out of province information. No actual claim is produced for Inpatient out of province patients, but the claim data is evaluated to ensure all information required for the download is available. Once the claim passes edits, the account is placed in an index, sorted by date. This index is used to generate the reports and the outpatient out of province diskette. Data is available for downloading after the claim has been released.
- "Outpatient Out of Province Claim Charge Data Screen" on page 2-44
- "CREATE OUT OF PROVINCE DISKETTE" on page 2-66
- "RECREATE OUT OF PROVINCE DISKETTE/REPORT" on page 2-68
- "PURGE OUT OF PROVINCE DISKETTE" on page 2-71
- "OUT OF PROVINCE ACCOUNTS REPORT (FCNSOOA)" on page 3-4

Charges and patients are evaluated as follows and submitted to the Department of Health for billing purposes.

Patients are evaluated by unit number and service dates, not by account number. Therefore, if a person has multiple accounts with the same date of service, all accounts are evaluated. The highest dollar amount charge for each service date is selected for inclusion on the Out of Province Outpatient diskette. Other charges are written off as a contractual adjustment, if you have set up the Nova Scotia reimbursement type (N - Nova Scotia OOP) and attached it to your insurance plan.

NOTE: As of April 1, 2006 for accounts loading Nova Scotia Out of Province claims as the primary insurance, outpatient visit charges that occur on the same day as an inpatient charge, are assessed separately, so that the outpatient charge on those days is also billed. Inpatient charges continue to be identified by report only.

In order to allow the hospital sufficient time to enter charges prior to billing, the NS OOP Billing Requirement is used to hold bills until the 7th of the month. Cycle bills should be set to bill once per month, on the 7th. A final bill is not created during Midnight Processing, unless Midnight Processing is running for the seventh day of the month.

The Nova Scotia Analyze OOP Charges batch job runs during Midnight Processing between Claim Selection and Claim Load. For accounts loading Nova Scotia Out of Province claims for the primary insurance, it selects the high-dollar charges so they can be loaded to the claim during claim load. It tries to select high-dollar charges for accounts with claims being loaded. If the high-dollar charge is on an account that is not being billed, the account needs to be billed to cause the charge to load to a claim. Only the charges that have a service date within the from and through dates of the bill are analyzed.

At the time of billing, the system:

- finds all patients with the same unit number
- sorts charges by date of service and dollar amount
- selects the charge with the highest dollar amount for the date of service for submission to the Department of Health
- flags charges as selected or not selected for submission
- loads claims for accounts with selected charges
- places the account with the high dollar charges in an index used to create the download diskette
- does contractual adjustments on non-selected charges, if the appropriate reimbursement is associated with the out of province insurance
- produces a report for the hospital so they can see all accounts and associated charges that were evaluated. The report indicates which charge was selected for diskette download, and which were not.

NOTE: If a patient is re-admitted after a diskette download has been performed, the dates of service for charges are compared against those previously sent, and if the new account has high dollar charges for the date of service, it is sent on the new diskette.

ERROR MESSAGES

Following are examples of error messages that may display during Out of Province Diskette processing and their explanations.

Error Message	Explanation
Cannot use Add Claim to Insurance for OOP Claim!	Add Claim to Insurance cannot be used if the claim type is 5 (OutPrv NS).
OOP claims cannot be reprinted!	If the claim type is 5 (OutPrv NS), then the claim cannot be reprinted. Do not use Instant Adjustment Bills and Late bills for accounts with claim types of 5 (OutPrv NS), as these types of bills do not process the out of province claims correctly. Use a regular adjustment bill instead.
Charges will be removed from the download index if the claim is deleted. Press NL. Request adjustment bills to re-select high dollar charges. Press NL.	These two warning messages occur when an attempt is made to delete a Nova Scotia OOP claim by changing the Claim Work Status (field 15) to D in Claim Maintenance while charges exist in the Nova Scotia OOP charge index for the claim's bill. If the claim is deleted, then the associated charges for the claim's bill are removed from the Nova Scotia OOP charge index and the charges cannot be downloaded to the diskette. Also, it is necessary to manually reverse the contractual adjustment that was posted to the account as a result of the NS Out of Province Reimbursement calculation.

In addition, if an attempt is made to delete claims in Delete Financial Insurance Activity and one or more Nova Scotia OOP claims exist, the following prompt is displayed after the initial prompt confirming that claims should be deleted:

Nova Scotia OOP claim exists. Do you want to delete? (Y/N)--

If you enter **Y**, all claims are deleted. For Nova Scotia OOP claims, associated charges for the claim's bill are removed from the Nova Scotia OOP charge index and the charges cannot be downloaded to the diskette.

DISKETTE FORMAT

Following is the outpatient out of province diskette format. For the Format column, X=alphanumeric, N=numeric, D=date in YYYYMMDD format.

Field	Field Name	Length	Position	STAR Reference
1	Type	X (1)	1-1	O
2	NS-Hosp	N (2)	2-3	Last 2 digits of Institutuion Code
3	Hosp-Unit	A (9)	4-12	Patient Account Number
4	Prov	N (2)	13-14	Last 2 digits of Reference Number
5	No_of_Svcs	N (1)	15	1
6	Tot-Cost	N (8)	16-23	High dollar charge
7	Reg-No	N (15)	24-38	Health Card Number
8	Surname	X (20)	39-58	Patient last name
9	First	X (19)	59-77	Patient first name
10	Initial	X (1)	78-78	Patient middle initial
11	Birth-Dt	D (8)	79-86	Patient date of birth
12	Sex	X (1)	87-87	Patient Sex
13	Ser-Date	N (8)	88-95	Service date for high dollar chg
14	Ser-Code1	N (2)	96-97	OPC Code from the FIM for high dollar charge
15	Ser-Code2	N (2)	98-99	Zero fill.
16	Ser-Cost	N (8)	100-107	Zero fill.
17	Ser-Time	X (4)	108-111	Blank fill.
18	Comments	X (50)	112-161	Blank fill.
19	Diag-Cd 1	X (6)	162-167	Blank fill.
20	Diag-Cd 2	X (6)	168-173	Blank fill.
21	Diag-Cd 3	X (6)	174-179	Blank fill.
22	Proc-Cd 1	X (10)	180-189	Blank fill.
23	Proc-Cd 2	X (10)	190-199	Blank fill.
24	Proc-Cd 3	X (10)	200-209	Blank fill.
25	Hcnexp-Dt	D (8)	210-217	HC Expiration Date.

NOTE: Diagnosis code fields are being provided by a different system, and are therefore not sent in the download file at this time.

Index

■ Reader Comment Form ■

We value your suggestions for improving our documentation. Please use this form to evaluate the *Nova Scotia Claims Processing Volume* of the *STAR Financials Patient Accounting 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.

_____

_____

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Other Comments:

_____

_____

_____

Thanks for your help in improving the documentation.

Your Name and Position _____

Hospital/Organization Name _____

Telephone Number _____

May we contact you? Yes or No (circle one)

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