STAR 2000™

**STAR FINANCIALS PATIENT ACCOUNTING
REFERENCE GUIDE
Account Transactions Volume**

Preface

The *STAR Patient Accounting Reference Guide* is a multi-volume document written for all users of the system. This volume provides detailed information about the purpose and impact of the account transaction functions in the base Patient Accounting system.

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

Documentation Conventions

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

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

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

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

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

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

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

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

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

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

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

Enter patient name--

Field Characteristics

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

• DISPLAY ONLY for a field you cannot edit.

• For X-YY-Z field types, where:

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

    - P for a field length determined by a Parameter

    - T for a field length determined by a Table

    - U for a field having an Undefined length

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

    - A for Letters only

    - N for Numerals only

    - C for Characters (including punctuation)

    - AC for Letters and Punctuation only (no numbers)

    - NC for Numerals and Punctuation only (no letters)

    - AN for Numerals and Letters only (no punctuation)

  - Z is the requirement indicator of the field:

    - R if an entry is required to complete the function

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

    - O if an entry is Optional to complete the function

    - C if an entry is Conditionally required or optional

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

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

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

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

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

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

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Introduction

This document contains a detailed explanation of the purpose and impact of the account transaction functions in the base Patient Accounting system. The book contains the following chapters:

Chapter 1: Posting Transactions

Posting Transactions discusses the various types of posting transactions handled by the Patient Accounting system.

Chapter 2: Account Reports

Account Reports explains how you define and request various reports such as the ATB Report, Financial Review Report, Transaction History, and Unpaid Claims Report. In addition, this chapter explains the Account Selection reporting procedure.

Chapter 3: Other Account Management Functions

Other Account Management Functions discusses adding and transferring accounts to accounts receivable and bad debt, prelisting accounts for bad debt and archiving, and certain collection agency functions.

Chapter 4: Retired Accounts Module

Retired Accounts Module provides an alternative to archiving/purging accounts with a zero balance and to posting the small balance write off for qualifying BD accounts. The activation of the Retired Accounts Module requires McKesson Implementation Services for implementation.

Chapter 1 - POSTING TRANSACTIONS

STAR Patient Accounting Reference Guide - Account Transactions Volume
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This chapter contains screens, field explanations, and other documentation for Canadian usage of this product. Generally, the documentation reflects the base (U.S.) product. Documentation for the Canadian version appears in the online version with blue highlighting. Canadian documentation is further identified by (CN) or by (CN Only).

MIDNIGHT PROCESSING

For open batches, Midnight Procesing is paused to identify the batch on the console so it can be closed and therefore unlocked.

In the processing for the Patient Accounting R & B Message, if a cash or adjustment batch is found to be locked, it is noted on the console at 5-minute intervals. One of the following messages can appear.

- HH:MM:SS MJ Locked Cash Batch xxx for facility Y (ID N)

  By Job jjj, User Name

  MNP cannot continue until this lock is cleared

- HH:MM:SS MJ Locked Cash Batch xxx for cross facility (ID N)

  By Job jjj, User Name

  MNP cannot continue until this lock is cleared

- HH:MM:SS MJ Locked Guarantor Cash Batch xxx (ID N)

  By Job jjj, User Name

  MNP cannot continue until this lock is cleared

- HH:MM:SS MJ Locked Adjustment Batch xxx for facility Y (ID N)

  By Job jjj, User Name

  MNP cannot continue until this lock is cleared

- HH:MM:SS MJ Locked Adjustment Batch xxx for cross facility (ID N)

  By Job jjj, User Name

  MNP cannot continue until this lock is cleared

If a window cash batch is found to be locked when window cash batches are being posted, the following message appears on the console at 5-minute intervals.

- HH:MM:SS MJ Locked Window Cash Batch xxx for facility Y

  By Job jjj, User Name

  MNP cannot continue until this lock is cleared

IMPACT OF TRANSACTION POSTING

When a payment, adjustment, or balance transfer transaction is accepted, several checks and processes occur in the background. These processes may differ depending on the resulting carrier or account balance and whether the account is in account location PA, AR, or BD.

When an insurance payment, adjustment, or balance transfer is posted to a claim and the disposition assigned is *denied*, *adjusted to zero*, or *final payment,* that claim is flagged as *Complete.* Balance transfers that zero the carrier balance complete claims for accounts in location PA. Completed claims are removed from insurance follow-up and do not appear in the Biller Workfiles or on Claims reports.

If an account is in location AR or BD and an insurance payment or adjustment or balance transfer is posted to a claim and the resulting carrier balance is zero, then, in addition to the individual claim that is flagged as *Complete*, all other claims for that carrier are flagged as *Complete* and dispositioned as *adjusted to zero* if they are not already complete and dispositioned. Replaced claims are not affected, nor are claims that have already been purged. Further, if the insurance plan is set up to suppress claims then any claims for that carrier that are currently *Not Produced* are suppressed. Finally, the number of expected payments and outstanding claims for the carrier is set to zero.

If an account is in location AR or BD and either a patient, insurance payment, or adjustment is posted that results in the overall account balance being zero, the system clears any outstanding carrier, patient, or third-party excess balance if the clear balance flag is set to Yes in the Balance Designation Parameters table. Any uncompleted claims are completed and assigned a disposition of *adjusted to zero* and a disposition date equal to the transaction date if they are not already complete and dispositioned. Replaced claims are not affected, nor are claims that have already been purged. Furthermore, for each insurance plan that is set up to suppress claims, the system suppresses any claims assigned to the patient that are currently *Not Complete* and *Not Produced*. The account zero balance date is set to the payment date. Any refunds with a status of *Hold*, *Delete,* or *Exclude* are deleted. Finally, the number of outstanding claims and expected payments is set to zero for each carrier.

NOTE: If the account has any refunds in an *approved* status, then the system does not clear the balances.

When a claim is suppressed, the work status is set to P (suppressed). This indicates to the biller and collector that the claim was automatically suppressed by the system due to a payment, adjustment, or balance transfer.

For each liability set to zero and for each claim suppressed and/or dispositioned, the system automatically creates an entry in account transaction history. The system uses the transaction code identified in the Key Data Revisions field in PAAR control or the Claim Disposition Parameters.

If a payment or adjustment is posted and the account balance after the transaction is zero, the system performs the following procedures after any automatic balance transfers are processed.

For each liability that the system sets to zero, as well as any claim that is suppressed, the system makes an entry to the account transaction history using the transaction code identified in the Key Data Revisions field in PAAR Control. The system transaction descriptions are as follows:

• The system displays *Set Carrier Liability to Zero* for the carrier balance. The transaction amount is the carrier liability that existed before being set to zero. The From Carrier/Plan field displays the carrier/plan code and description of the carrier being set to zero.

• The system displays *Set Patient Liability to Zero* for the patient balance. The transaction amount is the patient liability that existed before being set to zero.

• The system displays *Set TPX to Zero* for the third-party excess.

• The system references the transaction to the payment or adjustment that caused it to occur.

• The system displays *Claim Suppressed - Account Zero Balance* for any claim that is suppressed due to a transaction resulting in a zero account balance.

• The system displays *Claim Suppressed - Carrier Zero Balance* for any claim that is suppressed due to a transaction resulting in a zero carrier balance.

• The system displays *Claim work status changed from (failed) to suppressed* for any non-completed claim that has a production status of *Not Produced* and is suppressed. The word within the parentheses ( ) indicates the original work status.

  NOTE: If a subsequent payment, adjustment, or balance transfer is posted that gives the carrier a debit balance, the claim is re-added to the appropriate biller index as well as to insurance follow up (if applicable).

If a balance transfer is entered for a previously completed claim, the system informs you that the claim is already complete and prompts you to continue or not to continue. If you choose to continue, the system clears the disposition of the claim. If the claim had been previously suppressed, the work status is set to edit so that it is edited in the next midnight processing run. When the transaction is complete, the system places the claim in insurance follow-up and the appropriate biller workfiles, insurance workfile, and reports.

Canadian users should refer also to the *Canadian Claims Processing* volume and the *Ontario Electronic Claims and Payments Volume* of the *STAR Patient Accounting Reference Guide* for detailed information on cash posting to OHIP claims.

HOW CASH IS POSTED

Cash payments can be posted to an account either from insurance, a guarantor, or the patient. A Miscellaneous Cash function is available to enter cash for other areas of the hospital, such as the cafeteria or vending machines. Unapplied cash processing is available for payments that cannot be immediately applied or identified. Unapplied posting is available through regular and line item cash.

The system provides two posting methods: batch and online. In batch posting, the system updates account balances after the batch is balanced and approved. In online posting (Post Window Cash), the system updates patient account balances as soon as the individual entry is accepted.

All cash batches are identified by a batch code with the system verifying account numbers and carrier codes for each posting. Batch codes can be selected by the user or assigned by the system. Batches can be any three alphanumeric characters. If a batch is not posted, it retains its number until it has been posted. The system does not assign or allow the user to assign that number to another batch until the original batch is posted.

Window cash batches are approved during midnight processing if they were not approved during the day, even if the entered amount and batch total are not equal. This is necessary because account balances are already updated, and the General Ledger (GL) must be updated. The fact that the system approved the batch is noted on the Cash Exception report (FAR140).

Batch components (individual payments) are identified by a system-assigned sequence number beginning with 1 that identifies each entry as it is added to the batch. This number stays with the entry until it is posted. For example, if four entries are made in a batch (numbered 1, 2, 3, 4) and the third entry is deleted, the remaining entries would continue to be numbered 1, 2, 4.

Carrier postings require the system to match the entered carrier plan with the account's carrier plan codes. A claim record must exist in order to post a cash payment associated with the claim.

NOTE: Posting cash to an account that has been prelisted for bad debt places all AR accounts controlled by that guarantor's schedule on *system hold* for bad debt transfer. Posting cash or an adjustment to an account that causes the account balance to become zero changes the prelist status to *Unprelisted* (the account is no longer selected for Bad Debt Prelist).

During cash posting data entry, the system can duplicate fields automatically to speed data entry. These duplicate fields include transaction and remittance dates and carrier plan (which generate the transaction code). You can also request receipts and have them numbered automatically or manually (this has to be set up during the installation phase). If entering patient payments, the transaction code can be entered and duplicated or taken from the financial class code master assigned to the patient. For

additional information regarding the impact of cash posting, refer to the Impact of Transaction Postings topic within this chapter.

You can access Account Inquiry within a batch using the dollar sign ($) when prompted for an account. This feature enhances the accuracy of posting cash on accounts by providing a research mechanism.

NOTE: For a description of the Post Contract Cash and Post Contract Adjustments functions, refer to the *Billing and Claims Volume* of the *STAR Patient Accounting Reference Guide*.

Creating A Batch

For mail cash, use the Post Cash function. The hospital can create batch codes with any three characters or numbers, or you can enter **A** and have the system assign the code automatically. This process includes the Insurance Cash, Patient Cash, Miscellaneous Cash, and Unapplied Cash functions. When the batch is balanced and approved, the system updates account balances.

For patients who pay at the time of service, select the Post Window Cash function. This function allows the same numbering options as the Post Cash function. This process includes Patient Cash and Demand Bill functions. The system immediately updates account balances.

Editing A Batch

During midnight processing, the system deletes approved mail cash batches. Window cash batches are always deleted during midnight processing, even if the entered amount and batch total do not equal. If these amounts do not equal, the window cash batch prints on the Cash Exception Report to let you know the batch was not in balance.

You can make edits or additions to batches that have a status of Balanced or Unbalanced. Once a batch has been approved, it is posted, and you cannot make edits or additions. If you want to edit an existing batch, you can enter the batch code, if known, or you can enter a hyphen (-) to display a list of existing batches.

After you enter or select a batch, the following screen displays a list from which you can select a batch to edit. When a batch is in use by another user, "In Use" displays to the far right of the batch line information. In addition, the following error message is displayed at the bottom of the screen:

Error: Batch 54 is currently in use by Job 293, Smith, Nancy (2011).

The error message identifies the batch number, job number, and name of the person who is using the batch. The user's phone extension may also be displayed if the Lock Comment field on the Create/Edit Personnel Records screen contains the user's phone extension.

```
                     General Hospital Cash Posting Setup Processor
                                             Fri Dec 30, 1988 10:10 am

 Page:01                       Cash Posting Batches
   Batch Status     Type  Creation Date   By   Description/Comment
 ( 1)  48 Ubal       I     11/20, 1140am  JLC  Medicare Voucher
 ( 2)  65 Bal        P     11/20, 1200pm  MCB  Mail Cash 11/19
 ( 3)  72 Ubal       M     11/20, 0110pm  NOB  Mail Cash 11/20
 ( 4) 100 Bal        G     11/20, 0200pm  AOP  Blue Cross Voucher
 ( 5) MCI Hold       I     11/20, 0300pm  DMF  Medicare Remittance









     Enter Choice--
```

Field Explanations

BATCH (DISPLAY ONLY)
This field contains the batch code manually or automatically assigned.

STATUS (DISPLAY ONLY)
This field contains the status of the batch - Unbalanced, Balanced, Approved, Hold, or Posted.

TYPE (DISPLAY ONLY)
This field contains the batch type. Types include (P)atient, (I)nsurance, (M)iscellaneous, (L)ine, (G)uarantor, and (U)napplied. If it is a mixed batch, this field is blank.

NOTE: You cannot edit posted and approved batches. Approved batches display as approved until the system updates all accounts in the batch, then the status becomes Posted.

If an approved batch does not post, refer to Printing Batch Detail in this chapter.

Exiting A Batch

This function is used to place batches on hold, print batch detail, edit batches, accept batches, and approve batches. The exit batch function is a menu selection if a batch is a mixed transaction batch. For a batch that is not a mixed transaction batch, the exit function is available when leaving the Cash Posting function. You can access this function only for unposted batches.

BATCH FUNCTIONS

The system considers a batch balanced if its Batch Total equals the Starting Balance (if any) plus the Total Entered, resulting in a zero variance. You have the following batch options:

- Approving the Batch (posting it)
- Holding the Batch
- Printing Batch Detail
- Editing the Batch
- Returning to the Batch

APPROVING (POSTING) THE BATCH

Approving a balanced batch posts the batch and updates account balances, last payment dates, transaction history, and follow-up information. When a batch is posted, the patient account is updated immediately. The General Ledger is updated during midnight processing. If window cash is involved, the patient account is updated when the entry is made. Approving a window cash batch does not update accounts but shows the batch as balanced and does not allow any additional items to be added to the batch.

Approving the batch causes the following reports to be generated during midnight processing:

- Cash Posting Detail report (FAR130)

- Guarantor Cash Posting Detail report (FAR135)

- Cash Posting Exception report (FAR140)

- Guarantor Cash Posting Exception report (FAR145)

PUTTING A BATCH ON HOLD

If you do not complete a mail cash batch, you may wish to place the batch on hold. Window cash batches are always approved by the system during midnight processing if you do not approve them.

PRINTING BATCH DETAIL

You can print a batch at any time. If the batch has not been posted, enter **P** to print from the Exit Batch screen. If the batch has already been posted, the system displays the following prompt, which allows you to print the batch's contents.

Batch 999 has already been posted, would you like to print? (Y/N) [N]--

Enter **Y** to print the batch. Enter **N** if you do not want to print the batch.

If the batch has already been partially posted or approved and you want to restart the posting process after the batches print on the Batch Audit reports, the system displays the following prompt, which allows you to print the batch's contents.

Batch 999 has already been approved, would you like to print? (Y/N) [N] --

Enter **Y** to print the batch. Enter **N** if you do not want to print the batch.

The following prompt is displayed:

Batch 999 is partially posted, would you like to restart? (Y/N) [N] --

Enter **Y** to restart the partially posted batch. Enter **N** if you do not want to restart the partially posted batch.

The following prompt is displayed:

Batch 999 is partially posted, would you like to restart? (Y/N) [N] --
Batch restarted at seq # 999 for account # A1234567891 amount   99.99

Enter **Y** to restart the partially posted batch at this sequence number. Enter **N** if you do not want to restart the partially posted batch at this sequence number.

NOTE: Check with operations to verify the printer assignment for this report.

The Cash Batch Audit report is FAR120 for all cash batches except for Guarantor Cash Batch report, which is FAR125.

ACCEPTING THE BATCH

You accept the batch by entering **A** for an unbalanced batch. This option does not change the batch status but allows you to exit from the Exit Batch function to obtain information necessary to balance the batch.

EDITING A BATCH

The batch total can be changed only by an employee with a security level of 50 or higher. The batch total is changed on the batch set-up screen.

If a batch total was not originally entered when the batch was created, the total can be entered in the batch total field of the exit batch screen, provided the employee has a security level of 50 or greater.

Enter **E** to change or delete individual items in the batch.

Returning to the Batch

> You can return to the exit batch screen by entering **R**. Enter **R** to return to the set-up batch screen of the batch.

Window Cash

> Window Cash batch totals can only be revised by employees with a security level of 50 or greater. The batch total on the Edit Batch screen can be entered by an employee with a lower security level for Window Cash only.

> You cannot edit individual entries for Window Cash batches. If a batch of Window Cash is unbalanced, use a printed copy of the batch to find errors.

> Reversal postings must be used to correct improper amounts or misapplied payments. If the batch is not balanced prior to running midnight processing, the entries in the batch still update the general ledger. The fact that this occurred prints on the Cash Exception Report.

Mail Cash

> You can edit batch for Mail Cash at the batch total and individual entry level.

> The following screen is displayed when the Exit Batch function is selected:

```
            General Hospital Cash Posting Exit Batch Processor
                                            Fri Dec 30, 1988 10:10 am

  1 Batch code        2 Batch Description                 3 # of Trans
    7                   Blue Cross GA                          3
CASH    4 Starting Balance  5 Total Entered  6 Batch Total    7 Variance
                             145.60            145.60            .00
CONTRACTUAL ADJUSTMENTS      8 Total Entered  9 Batch Total   10 Variance
                             .00
11 Batch Status
   Balanced




 Batch is in balance - Approve(A), Hold (H), Print(P), Edit(E), or Return(R)? --
```

> You cannot edit this batch summary screen. The system repeats this information for your review. If a batch total was not entered in the set-up screen, you are prompted to enter it here. If the batch is in balance and you enter **A** for approved, the system posts the batch. When a batch is posted, it cannot be edited nor can items within it be deleted. If the batch is not balanced, you can accept but not approve the batch.

Field Explanations

1.   BATCH CODE (DISPLAY ONLY)
This field contains the system or user-assigned batch code.

2.   BATCH DESCRIPTION (DISPLAY ONLY)
This field contains the user-defined batch description.

3.   # OF TRANS (DISPLAY ONLY)
This field contains the number of transactions in the batch.

<div align="center">

CASH

</div>

4.   STARTING BALANCE (DISPLAY ONLY)
This field contains the starting balance entered by the user.

5.   TOTAL ENTERED (DISPLAY ONLY)
This field contains the total amount entered during the posting process.

6.   BATCH TOTAL (10-N-C)
This field contains the batch total. This field can be edited only if you have a security level of 50 or greater.

7.   VARIANCE (DISPLAY ONLY)
This field contains the difference between the starting balance plus the total entered and the batch total. The equation is:

Variance = (Starting Balance + Total Entered) - Batch Total

<div align="center">

CONTRACTUAL ADJUSTMENTS

</div>

8.   TOTAL ENTERED (DISPLAY ONLY)
This field displays the total amount entered into the batch.

9.   BATCH TOTAL (10-N-O)
This field contains an amount for Contractual Adjustments.

10. VARIANCE (DISPLAY ONLY)
This field is a calculation of Batch Total less the Total Entered.

11. BATCH STATUS (DISPLAY ONLY)
This field contains the status of the batch - balanced or unbalanced.

You can accept, print, or edit the screen. If you enter **E** to edit the screen, the system displays the following screen.

```
                  General Hospital Cash Posting Exit Batch Processor
                                               Thu Feb 11, 1999 11:40 am

* = Pt Class - a Alert, s Suppressed F/U, c Cleared
Page:01      Batch  71 - PATIENT CLASS                     ##=Current Choices
     Seq#  Type           Amount        C/A Amt *  Account      Name
( 1) 1     Insurance      100.00         600.00-s  9836400001 ANDERSON,DIANE CO
( 2) 2     Patient         10.00            .00 s  9900100039 ANDERSON,CAROLINE
( 3) 3     Insurance       10.00          10.00    9900100042 ANDERSON,ITTY BIT
( 4) 4     Insurance      100.00          20.00 a  9900100040 ANDERSON,CAITLIN
( 5) 5     Insurance       56.55            .00    9800700002 LANIER,PRE-ADMIT
( 6) 6     Patient          1.00            .00    9800700002 LANIER,PRE-ADMIT
( 7) 7     Patient         50.00            .00    9800700002 LANIER,PRE-ADMIT






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

NOTE: In guarantor cash batches, the account number is not formatted. This is because each facility's management format the account number differently.

You can select one, some, or select component transactions to edit. After the transaction is selected, detail information on the transaction is displayed, as on the following screen example. If multiple transactions are selected, the system displays them in batch sequence order.

Name information for Miscellaneous Cash will be blank. Unapplied Cash will reflect the Payment By information within the detail information screen.

You can also select a specific account number. To select a specific account number enter **S**. The system displays the following prompt:

Enter patient account number--

Enter the patient account number that you want to select to edit.

NOTE: If the account number is in a batch multiple times or if the account number is part of a multifacility batch, you are prompted to select the specific entry for the account number that you want to access. The following provides you with an illustration of an account number that is in a batch multiple times.

```
     Seq#  Type           Amount        C/A Amt    Account      Name
( 1) 1     Patient          5.00           .00     9719800012  MARTIN,LOUIS
( 3) 3     Insurance    5,000.00      33,316.50-   9719800012  MARTIN,LOUIS
```

You are then prompted to enter your choice for the account number that you want to access.

After your account number selection is made, detail information on the transaction is displayed, as shown on the following screen example.

```
                General Hospital Patient Cash Posting Revision Processor
                                                Mon Mar 13, 2006 11:59 am
Account        Name                     FC Typ Admit     Disch        Balance Loc
A9800700002  SMITH, LAWRENCE K          O  ADV 01/07/98 01/08/98       509.00  AR/FCRV
  1 Patient Balance    2 Last Payment Date     3 Collection Agency
    90.52
  4 # of Payments      5 Total Payments                  6 Account Balance
                                                           618.05
  7 Seq#   8 Pt Class                                     9 New Account Balance
    1

10 Payment Amount     11 Receipt #        12 Remittance #
->
13 Payment Date       14 Posting Date     15 Trans Code/Description
   07/21/06              07/21/06             P0001-PERSONAL PAYMENT-CHECK

16 Comments
   01
   02
   03


Enter payment amount--
```

You can edit the Payment Amount, Receipt #, Remittance #, Payment Date, Posting Date, Trans Code/Description, and comments and notes fields. The other fields on the screen cannot be edited. Once all editing is completed, you have the option of accepting (Y), not accepting (N), or deleting (D) the entry. Deleting an entry removes it from the batch; sequence numbers are not reassigned. You should delete an entry if the wrong account was selected.

The system then displays the next transaction (if multiple transactions were selected) or asks you to accept the screen (if a single transaction is being edited). If you accept this screen the system returns you to the screen which summarizes the batch. From there you can select to edit another transaction, or, if the batch is now balanced, proceed to post the batch.

POST CASH

Post Cash is used for posting insurance, patient, guarantor, miscellaneous, and unapplied cash. After a batch code is added, entered, or created, the system displays the following screen:

```
                 General Hospital Cash Posting Setup Processor
                                               Fri Jun 13, 2007 10:10 am
  1 Batch code          2 Batch Description                 3 # of Trans
    7                      Blue Cross GA
  4 Posting Date        5 Payment Date       6 Mixed Transactions?
    11/20/97               12/01/97             No
  7 Print Receipts?     8 Beginning Receipt #
    Yes                    100
CASH   9 Starting Balance 10 Total Entered  11 Batch Total    12 Variance
       ->                                      100.00
CONTRACTUAL ADJUSTMENTS    13 Total Entered  14 Batch Total    15 Variance

16 Batch Created By                17 Batch Approved By
   Moon,Pat




UNMATCHED PAYMENTS for filename - Yes






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

Field Explanations

This screen contains basic information about the batch being entered or edited. Fields 1 through 7 are the header information fields that are displayed on each screen.

1. BATCH CODE (DISPLAY ONLY)
This field contains either the batch code you entered or the system-assigned identification code for this batch. Any three alphanumeric numbers can be assigned to identify a batch. If the system assigns a code to this batch, the word "auto" is displayed until you edit this screen, and a system-assigned code is displayed when you enter this screen.

2. BATCH DESCRIPTION (30-C-R)
This field contains the description of this batch (for example, Commercial Insurance Payments). If you are editing a batch, the system displays the batch description entered when the batch was created. This field can be edited until the batch is approved.

3. # OF TRANS (DISPLAY ONLY)

If you are editing a batch, this field contains the number of component transactions within the batch. If you are creating a batch, this field is blank.

4. POSTING DATE (6-N-R)

This field contains the batch posting date. The system automatically assigns the current system date. You have the option of keeping or changing this date which is included in this account's transaction history. This date determines the General Ledger period in which transactions post, and it can be set back only to the number of backdate days indicated in PAAR Control.

5. PAYMENT DATE (6-N-R)

This field contains the date on which the batch payments are made. The system automatically assigns the current system date. You have the option of keeping or changing this date. This date prints on patient statements. If entering a backlog of payments, you may wish to change this date.

6. MIXED TRANSACTIONS? (1-A-R)

This field indicates whether this batch contains more than one type of transaction. Enter **Y** for Yes or **N** for No; the default is Y. If you are only posting one type of cash, you can enter **N** in this field. If the field contains N, you can enter only the type of cash initially selected from the next menu.

7. PRINT RECEIPTS? (1-A-R)

This field indicates whether receipts should print. Enter **Y** for Yes or **N** for No; the default is Y. If receipts have not been designed during the installation process, this field should be set to No, since receipts will not print in either case.

8. BEGINNING RECEIPT # (10-N-R)

This field contains the beginning receipt number if you have decided to print receipts. You can enter a specific receipt number or allow the system to assign one. The range for receipt numbers is 0 to 9999999999. If the system assigns a receipt number, the word auto is displayed.

CASH

9. STARTING BALANCE (10-N-O)

This field contains the opening dollars for reconciliation of a starting bank for cashiers. You can enter up to $99,999,999.99. This field is not required, but it allows the Amount Posted plus Starting Balance to balance to the Batch Total.

10. TOTAL ENTERED (DISPLAY ONLY)

If you are editing a batch, this field contains the total amount of all transactions entered. If you are creating a batch, this field is blank.

11. BATCH TOTAL (10-N-R)

This field contains the total of the batch according to your adding machine/calculator tape. An amount up to $99,999,999.99 can be entered. This field can be completed

only by a user with a security level of 50 or higher. The Total Entered amount plus the Starting Balance must equal the batch total in order to approve a batch.

12. VARIANCE (DISPLAY ONLY)
If you are editing a batch, this field contains the difference between actual postings as Total Entered and the Batch Total. If you are creating a batch, this field is blank.

If a Starting Balance is entered, this variance is the Starting Balance plus the Total Entered, minus the Batch Total.

CONTRACTUAL ADJUSTMENTS

13. TOTAL ENTERED (DISPLAY ONLY)
This field displays the total amount entered into the batch.

14. BATCH TOTAL (10-N-O)
This field contains an amount for Contractual Adjustments.

15. VARIANCE (DISPLAY ONLY)
This field is a calculation of Batch Total minus Total Entered.

16. BATCH CREATED BY
This field contains the name of the person who created the batch.

17. BATCH APPROVED BY
This field contains the name of the person who created the batch.

UNMATCHED PAYMENTS FOR FILENAME (DISPLAY ONLY)
This field notifies you when there are unmatched payments from an ERA file, when an ERA cash batch is selected. A payment is considered unmatched when it cannot be matched to a unique claim. A value of *Yes* is displayed next to the field if unmatched payments exist. If unmatched payments do not exist, a value of *No* is displayed next to the field. The filename is the name of the uploaded ERA file along with the description.

If there are unmatched payments, you can continue with the ERA batch or exit the screen and proceed to the Unmatched Payments Worklist. For information on this function, see the *Electronic Payments Volume* of the *STAR Financials Patient Accounting Reference Guide*.

After you complete this screen, you have the option of accepting or editing the information entered. Accepting the screen displays a list of options for posting cash. You can post the following types of cash:

- Insurance Cash
- Patient Cash
- Miscellaneous Cash

- Unapplied Cash
- Contract Cash

NOTE: For a description of Contract Cash, refer to the *Billing and Claims Volume* of the *STAR Patient Accounting Reference Guide.*

You can post any combination (if you have defined this batch as accepting mixed transactions in the previous screen.) However, only one type of cash can be entered at a time. For example, if you have a mixed batch containing four payments (one each of insurance, patient, miscellaneous, and unapplied cash), you must select the appropriate option, enter the payment, return to the options, select another, etc. This process applies to any types and number of cash payments. When you finish entering the batch, this transaction allows you to exit (post) the batch.

Once a cash type is selected, default information for that type is entered. Each cash type is explained in the order displayed above.

NOTE: After this screen is accepted, if the cash or adjustment batch record contains no entries, the system displays the following prompt:

Delete? (N)

Enter **Y** if you want to delete the batch record. Enter **N** if you do not want to delete the batch record. The default is N.

Insurance Cash

This transaction allows you to enter and edit payments from insurance carriers. To post insurance cash to a patient account, there must be insurance claims for the selected patient already in the system. The system updates account balances after the balanced batch is approved. Posting insurance cash uses two screens. The first is used for entering default information specific to a batch of insurance cash. The second screen records the actual insurance cash payment.

The following functions can be accessed while still within the cash batch:

Account Inquiry - This is accessed by using the dollar sign ($) when prompted for an account. This feature enhances the accuracy of posting cash on accounts by providing a research mechanism.

Account Revision - This is accessed by using the plus sign (+) when prompted for an account. This allows you to revise accounts while still within the cash batch.

Add a Claim - This is accessed by using the number sign (#) when prompted for an account. This allows you to add claims without having to exit the cash batch.

Posting to OHIP claims is done on individual claim charge lines. Refer to the *Canadian Claims Processing Volume* of the *STAR Patient Accounting Reference Guide* for cash posting guidelines for OHIP claims.

```
              General Hospital Insurance Cash Posting Setup Processor
                                          Mon June 14, 2010 11:23 am


Batch#:  1 Desc: DD                                    # of Trans: 0
  CASH    1 Start Balance  2 Total Entered  3 Batch Total    4 Variance
          34.00                             34.00
  CONTRACTUAL ADJUSTMENTS  5 Total Entered  6 Batch Total    7 Variance

  INS CASH    8 Payment Date   9 Req Days Paid 10 Req DRG Pd  11 DRG Edit
              02/11/08                                        Default to M
12 Req Coins 13 Req Deduct   14 Req Co-Pay    15 Req Pt Resp 16 Default Disp

17 Select By 18 Carrier                       19 Plan

20 Trans Code/Desc           21 Claims List   22 Den Trk 23 Claim Disp Rule

24 Remittance #              25 Allow Contr Adj 26 Multiple Denial Codes

27 Adj Trans Code/Desc       28 Adj Bal To Use  29 Svc Dtl 30 Use Pyr Clm Cont#


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

Field Explanations

The batch number and description, number of transactions, and fields 1 through 7 - Batch code, Description, # of Trans, Starting Balance, Cash Total Entered, Cash Batch Total, Cash Variance, Contractual Adjustments Total Entered, Contractual Adjustments Batch Total, and Contractual Adjustments Variance - are displayed from the Batch Header information.

Insurance Cash Defaults

8. PAYMENT DATE (6-N-R)
This field contains the payment date for the batch. The system completes this field from the Batch Header Payment Date field. This date can be edited.

9. REQUIRE DAYS PAID? (1-A-R)
This field indicates whether the number of paid days which this payment covers should be entered with the accompanying payment. The system uses this field to track DRG pay days versus billed days in logs. Enter **Y** for Yes or **N** for No; the default is N. This field is not applicable for Canadian claims (OHIP, WCB, and Universal).

10. REQ DRG PAID? (1-A-R
This field indicates whether the DRG number paid must be entered with the payment. When this field is accessed, the following prompt is displayed:

Is entry of the DRG paid required? (Y/N) [N]--

This field is used in logs to match the billed DRG number with the paid DRG number. Enter Y for Yes or N for No; the default is N. This field is not applicable for Canadian claims (OHIP, WCB, and Universal).

11. DRG EDIT? (1-A-R)
This field indicates the type of edit required when a DRG code is entered for an account in the DRG Paid field. The types of DRG edits are:

• N-No DRG Edit:

The system accepts a DRG Indicator (M,C,T or O) if entered in the DRG Paid field but does validate the DRG code against the table.

• I-DRG Indicator Not Required:

The system accepts a DRG Indicator (M,C,T or O) if entered in the DRG Paid field and attempts to validate the DRG code against the table. However a DRG Indicator is not required.

• R-DRG Indicator Required:

The DRG Paid and DRG Indicator is required in the DRG Paid field. The system attempts to validate the DRG code against the table if an indicator of M or C is entered. If the T or O indicator is used a message displays in the status bar at the bottom of the screen:

> *No DRG table available to edit DRG*

• M-Default to Medicare MSDRG Indicator

The DRG Indicator is defaulted to an M if an indicator is not entered. For example if a DRG code of 111 is entered and the user tabs to the next field, the DRG code is displayed as follows: 111/M

The M indicator may be overridden and re-keyed with another valid DRG Indicator. The system attempts to validate the DRG code against the table if an indicator of M or C is entered. If the T or O indicator is used, a message is displayed as follows:

> *No DRG table available to edit DRG*

• C-Default to Medicare Classic DRG Indicator:

The DRG Indicator is defaulted to a C if an indicator is not entered. The C indicator may be overridden and re-keyed with another valid DRG Indicator. The system attempts to validate the DRG code against the table if an indicator of M or C is entered. If the T or O indicator is used, the following message is displayed:

> *No DRG table available to edit DRG*

- O-Default to Other DRG Indicator:

The DRG Indicator is defaulted to an O if an indicator is not entered. The O indicator may be overridden and re-keyed with another valid DRG Indicator. The system attempts to validate the DRG code against the table if an indicator of M or C is entered.

- T-Default to Tricare/Champus DRG Indicator:

The DRG Indicator is defaulted to a T if an indicator is not entered. The T indicator may be overridden and re-keyed with another valid DRG Indicator. The system attempts to validate the DRG code against the table if an indicator of M or C is entered.

- A-Reimbursed APR DRG Indicator

    The DRG Indicator is defaulted to A if another indicator is not entered.

When this field is accessed, the following prompt is displayed:

Enter DRG Edit Criteria or `-` for table lookup--

You can enter a DRG option or a hyphen (-) to select one from a table:

```
Page:01                    Select Option for DRG Edit
( 1) N-No DRG Edit
( 2) I-DRG Indicator Not Required
( 3) R-DRG Indicator Required
( 4) M-Default to Medicare MS DRG Indicator
( 5) C-Default to Medicare Classic DRG Indicator
( 6) O-Default to Other DRG Indicator
( 7) T-Default to Tricare/Champus DRG Indicator
( 8) A-Default to Reimbursed APR DRG Indicator
```

The following chart shows your entry options and the result displayed in the DRG Edit fields:

If you select this option for the DRG Edit field....	The DRG Edit field is populated with the value of ....
N (None)	None
R (DRG Ind Required)	DRG Ind Required
M (Default to Medicare MS DRG Indicator)	Default to M
C (Default to Medicare Classic DRG)	Default to C
I (DRG Indicator Not Required)	DRG Ind Not Required
O (Default to Other DRG Indicator	Default to O
T (Default to Tricare/Champus DRG Indicator)	Default to T

If you select this option for the DRG Edit field....	The DRG Edit field is populated with the value of ....
A (Default to Reimbursed APR DRG Indicator)	Default to A

NOTE: For Canadian users, this field indicates whether or not the entered DRG should be edited against the DRG Rate Master. The default is N, since this field is not applicable for Canadian claims (OHIP, WCB and Universal).

12. REQUIRE COINS (1-A-R)
This field indicates whether coinsurance is required with the payment. Enter **Y** for Yes or **N** for No; the default is N.

13. REQ DEDUCT (1-A-R)
This field indicates whether a deductible is required with this payment. Enter **Y** for Yes or **N** for No; the default is N.

14. REQUIRE CO-PAY (1-A-R)
This field indicates whether a co-payment can be keyed and whether the entry is required for the insurance cash transaction. When this field is accessed, the following prompt is displayed:

Do you want to (E)nter, (B)ypass, or (R)equire Co-Pay? [E]

You can enter **E** (Enter) to allow entry of a co-payment, but an entry is not required. You can enter **B** (Bypass) to skip the Co-Pay field. If Bypass is entered, the Co-Pay field cannot be used in the insurance cash transaction. You can enter **R** (Require) to allow entry of a co-payment and to require that one is entered for the transaction.

15. REQ PT RESP (1-A-R)
This field indicates whether a patient responsibility can be keyed and whether the entry is required for the insurance cash transaction. When this field is accessed, the following prompt is displayed:

Do you want to (E)nter, (B)ypass, or (R)equire Pt Resp? [E]

You can enter **E** (Enter) to allow entry of a patient responsibility, but an entry is not required. You can enter **B** (Bypass) to skip the Co-Pay field. If Bypass is entered, the Co-Pay field cannot be used in the insurance cash transaction. You can enter **R** (Require) to allow entry of a patient responsibility and to require that one is entered for the transaction.

16. DEFAULT DISP (1-A-R)
This field determines by batch what the default disposition is for payments posted in this batch. Entries are either Final or Partial. The default is Final.

17. SELECT BY (1-A-R)
This field indicates how you want to look up patient accounts for payment application. Enter **C** (by carrier/plan) or **A** (individual accounts); the default is A. If the Carrier field

is blank, the system cannot select by carrier. If the Carrier field is completed but the Plan field is blank, the system lists all claims for the carrier entered. If both the Carrier and Plan fields are completed, the system lists claims for the insurance plan entered.

18. CARRIER (4-N-C)

This field contains the code and description of the insurance carrier making this payment. If you are creating a batch, you can enter the code or a hyphen (-) to display and select from a list of valid codes. In either case, the description accompanies the code entered or selected. If the entry made in the Select By field is C (carrier/plan), this field must be completed. If this field is entered, accounts must be assigned to this carrier to be included in this batch.

19. PLAN (4-N-O)

This field contains the code and description of the insurance plan for which these payments are being entered. If you are creating a batch, you can enter the plan code or a hyphen (-) to display and select from a list of valid codes. The Carrier field must be completed to use this field. If this field is entered, accounts must be assigned to this carrier/plan to be included in this batch.

You should complete the Carrier and Plan fields only if the hospital is posting the same type of insurance cash for all or most of the batch. For example, if you receive a Medicare voucher, you can enter both the carrier and plan in these fields. This saves you a step during the entry process when you specify the carrier/plan responsible for the payment.

You also can enter the carrier and leave the plan blank. An example is a Blue Cross (BC) voucher being posted in which the plan number differs for each patient, but the carrier Blue Cross is the same for every patient. If the patient has only one BC plan, the system does not require the selection of a carrier/plan during the entry process.

If you have various carriers for the batch, leave these fields blank, and enter them for each patient during the entry process.

20. TRANSACTION CODE/DESCRIPTION (5-AN-O)

If the carrier and plan fields are complete, this field contains the transaction type and code for the carrier plan. If the description is included with the transaction code, it is truncated to fit this field. The transaction code is required with each payment entered. The system uses this code in updating the Account Transaction History and the General Ledger. Even if the carrier and plan are not complete, the hospital can set up a generic transaction code such as Insurance Payment, and that code can be entered in this field. This is a default code which can be overridden with each payment posted.

21. CLAIMS LIST (1-A-O)

This field allows you to define which claims display for the selected account in the insurance cash posting process. The following prompt is displayed:

Display only unpaid claims in the claims list by account? (Y/N) --

The field is not required and may be left blank. If you leave the field blank or select **N**, all claims on the account are displayed in the claims list by account. If you select **Y**, only unpaid claims are displayed. This field works with the Carrier and Plan fields on the setup screen to limit the claims displayed for the account. You may override this limit for an account at the time the claims are displayed.

22. DENIAL TRACKING DEF (1-A-O)
This field indicates which types of claim dispositions should be evaluated by the system for denial tracking. When this field is accessed, the following prompt is displayed:

Select Clm Disp(s) to Evaluate for Den Trk- (P)art, (D)enied, (B)oth, or (N)one

You can enter one of the following:

- **P** (Part) - the system evaluates a claim with a Partial disposition for denial tracking.

- **D** (Denied) - the system evaluates a claim with a Denied disposition for denial tracking.

- **B** (Both) - the system evaulates a claim with either a Denied disposition or a Partial disposition for denial tracking.

- **N** (None) - the system does not evaluate the claim for denial tracking.

23. CLAIM DISP RULE (TABLE LOOKUP-CONDITIONAL)
This field contains the claim disposition rule code that is associated with the cash batch. It can be populated automatically for an ERA cash batch if the Claim disposition rule code is associated with the ERA Payment File Definition table. If the cash batch has been analyzed field contains the claim disposition rule code, date and time. If the cash batch has an associated claim disposition rule code but the cash batch hasn't been analyzed against the claim disposition rule code, only the rule code is displayed in the field.

When this field is accessed, the following prompt is displayed:

Enter Claim Disposition Rules Code or key `-` for table lookup--

You can enter a valid Claim Disposition Rules Code or a hyphen (-) to choose a code from the list of codes.

If a cash batch has been analyzed against a claim disposition rule code and you would like to update, you can clear the results of the previous run. The process to clear the results, answer Yes to the following prompt that is displayed when you access this field:

Do you want to clear the previous Claim Disp Analysis Results? (Y/N)

After a response of Y for Yes, the following message is displayed on the screen.

Clearing previous Claim Disp Analysis Results!

24. REMITTANCE # (25-C-O)

This field contains the entered remittance number (if available) for this payment. It is generally a check or remittance advice number. The system updates this number in the transaction history for each account in the batch.

25. ALLOW CONTRACTUAL ADJUSTMENTS? (1-A-R)

This field indicates whether the system should allow contractual adjustments to be entered with the payment. Enter **Y** for Yes or **N** for No; the default is N. If you enter **Y**, the remaining carrier balance after a final payment is adjusted, leaving the carrier a balance of zero. The hospital can also override the adjustment amount. This field can be edited by an employee with a security level of 40 or higher. You can manually enter a contractual adjustment amount for a partial payment.

NOTE: The following conditions must be met in order for the system to calculate the contractual adjustment automatically:

- The Allow Contractual Adjustments? field on this screen must contain Yes.

- The Final Payment field on the Insurance Cash Posting screen must contain Yes.

- The account must be in account location AR or BD. You can place an amount in the adjustment field if the account is in PA, but it is not calculated automatically by the system.

- The expected number of payments on the selected carrier must be less than two.

- The Contractual Adjustment Code must exist on the insurance header, the account's insurance carrier plan table under the billing and collection option, or at the account level at the time entered.

If this field is set to Yes, the value for the Re-calc C/A if Cash Transc is Edited field on the ERA Payment File Definition table is displayed also. The display is one of the following:

- Yes/Re-calc=Yes

- Yes/Re-calc=No

26. MULTIPLE DENIAL CODES (1-A-O)

This field is used to indicate whether multiple denial codes or only a single denial code can be entered for a denied claim on the Insurance Cash Posting screen. Multiple denial codes can be indicated in the Claim Denial Info field (on the Insurance Cash

Posting screen) only if this field is set to allow multiple denial codes. The following conditions must be met in order to add multiple denial codes:

- This field must be set to Yes.

- The Default Disp field must be set to partial or final.

- The Denial Tracking Def field must be set to denied, partial, or both.

When this field is accessed, the following prompt is displayed:

Do you want to enter multiple denial codes for denied claims to be evaluated for denial tracking (Y/N) [Y]--

Entry options are **Y** (Yes), allow multiple denial codes to be entered, or **N** (No), do not allow multiple denial codes. If the field is completed with an N for No, you can't enter multiple denial codes, but you can enter a single denial code if the claim is eligible for denial tracking. If the facility associated with the cash batch is defined not to allow denial tracking under the Denial Tracking Parameters, this field can't be accessed and is blank.

27. ADJ TRANSACTION CODE/DESCRIPTION (5-AN-O)
If the Allow Contractual Adjustments? field is set to Yes, you can select a contractual adjustment code to enter. If a code is entered, this overrides the code at the insurance carrier/plan level on the accounts and enters one for accounts that are blank on the insurance/carrier plan level.

28. ADJ BAL TO USE (1-A-O)
This field allows you to select whether the carrier or the account balance should be used for the contractual adjustment calculation. This field is accessible only if the following fields are set to Yes:

- Req Coins (Require Coinsurance)

- Req Ded (Require Deductible)

- Allow Contractual Adjustment

When this field is accessed, the following prompt is displayed:

Enter (A)ccount or (C)arrier balance (A/C) [C]--

The default is Carrier (C). If C is entered, the system uses the current balance for the carrier in calculating the adjustment. If Account (A) is entered, the system uses the current balance for the account in calculating the adjustment.

29. SVC DTL (1-A-O)

This field allows you to force a manually entered insurance batch to be available for the entry of service line detail information in the Maintain Service Line Information function. This field is only accessible for non-ERA types of insurance cash batches. When this field is accessed, the following prompt is displayed:

Maintain service line detail (Y/N) [N] - -

The default is N (No). If you answer Y (Yes) to this prompt, this batch appears in the Cash Batches list in the Maintain Service Line Information function after the batch is approved. If you answer N (No), this batch does not appear in the list.

NOTE: This field must be set prior to approving the cash batch. This field doesn't control the ERA Service Line Detail for an ERA batch. Service Line Detail from an ERA batch is always uploaded with an ERA file. For an ERA batch this field is always set to blank when the ERA batch is uploaded. and the SVC DTL field can't be updated. The value of blank is the equivalent to a No.

30. USE PYR CLM CONT# (1-A=O)

This field allows you to determine if the Payor Claim Control Number field is used in the cash posting screen. The Internal Control Number is used for UB adjustment claims in Locator 64 a, b and c for Document Control Number. When this field is accessed, the following prompt is displayed:

Use the Payor Claim Control Number Field? (Y/N) [Y]

You can enter **Y** to use the payor claim control number or **N** if you do not want to use it.

SELECTING BY CARRIER/PLAN

If you enter **C** (select by carrier/plan) in the Select By field and accept the screen, the system lists all accounts under the specified carrier/plan in the format below. The system lists all patients who have a claim for this carrier/plan.

```
 Page:01  50-BLUE CROSS OF GEORGIA   0001-BLUE CROSS OUT OF STATE PLAN 1
     Account         Type  Admit    Disch      Balance Name
 ( 1) A88148-00011   ADM 05/27/95 05/30/95      77.33-MARTIN,VIRGINIA J
 ( 2) A88166-00013   CCU 05/27/95 05/28/95     100.97 HOPKINS,HARROLD S
 ( 3) A88168-00010   E/R 05/29/95 06/01/95      85.80 QUIRK,LARRY L
 ( 4) A88145-00018   ADM 06/16/95 06/24/95     109.12 LIDDEN,NANCY S
 ( 5) A88168-00028   ADM 06/16/95 06/19/95    1299.88 PATRICK,HARRIET B
 ( 6) A88169-00005   ECU 06/17/95 06/18/95    7815.65 ALOISIO,CARMEN V
```

Claims that have been replaced are not displayed. If a claim is selected that has been denied, the following message is displayed warning you that if cash is posted or an adjustment is done to the claim, the disposition is cleared.

Disposition denied. . .clear disposition (Y/N) [N]?

If you select **Y**, the disposition is cleared. If you enter **N**, the system returns to the Patient Lookup prompt.

NOTE: If insurance has timed-out while posting a payment or adjustment, the system displays the following message:

> *Carrier has timed-out or Carrier is scheduled for time-out*
> *Do you wish to continue? (Y/N) [N]--*

To exit and select another account, enter **N** or press NEW LINE to accept the default. To continue the posting process for this account, enter **Y**.

The system then prompts you for the account to which you want to post insurance cash. Identify the account using the account identification methods discussed in the *General Information Volume* in the *STAR Patient Accounting Reference Guide*.

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

```
            General Hospital Insurance Cash Posting Processor
                                        Mon Mar 13, 2006 11:59 am
 Account        Name                 FC Typ Admit     Disch     Balance   Loc
 A9733800002  ADMIT,THREE            0  I/P 12/04/97 07/26/98  107528.00 AR/FCRV

       COB 1 500-COMMERCIAL 100-COMMERCIAL BASIC Carrier Balance $47750
      Archived,Purged
                                Unpaid Claims
 Page:01        Bill           Service       Claim      Claim             #  P
        CS      From/Thru      From/Thru     Liability  Amount   Ext Clm # P  d
 ( 1)   2      12/04 01/04/98  12/04 01/04/98  7392.00  7392.00
 ( 2)   3      01/05 02/04/98  01/05 02/04/98  7161.00  7161.00
 ( 3)   4      02/05 03/04/98  02/05 03/04/98  6468.00  6468.00
 ( 4)   5      03/05 04/04/98  03/05 04/04/98  7161.00  7161.00
 ( 5)   6      04/05 05/04/98  04/05 05/04/98  6930.00  6930.00
 ( 6)   7      05/05 06/04/98  05/05 06/04/98  7161.00  7161.00
 ( 7)   8      06/05 07/04/98  06/05 07/04/98  6930.00  6930.00




 Enter choice, (L)ist All, (U)npaid, or (O)ther --
```

NOTE: The system highlights archived and purged claims.

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

BILL FROM/THRU (DISPLAY ONLY)
This field contains the billing from and thru dates of the claim.

SERVICE FROM/THRU (DISPLAY ONLY)
This field contains the service from and thru dates of the claim, from the Statement Covers Period in Locator 6 of the UB04.

CLAIM LIABILITY (DISPLAY ONLY)
This field contains the estimated liability amount for the claim as calculated by proration.

CLAIM AMOUNT (DISPLAY ONLY)
This field contains the amount of charges billed on the claim.

EXT CLM NBR (DISPLAY ONLY)
This field contains the claim number manually assigned through the claim screens, or automatically uploaded from the ANSI 835 electronic payment file.

 # P (DISPLAY ONLY)
This column reflects the number of claim pages for 1500 claims and Non Pro Fee 1500's. The process takes the number of charge lines / 6 and rounds up to the next integer.

PD (DISPLAY ONLY)
This field indicates whether the claim has been paid in full. Displayed values are Y (claim has been paid in full) or N (claim has not been paid in full).

The following prompt is displayed on this screen:

Enter choice, (L)ist All, (U)npaid, or (O)ther --

If you select **L**, all claims are displayed. This may be used when the setup screen for the insurance batch defines only unpaid claims to display. If you select **U**, only unpaid claims are displayed.

If you select O, the following prompt is displayed:

Limit claims by (D)isp, (B)ill Dt, or (S)ubm Dt [D] --

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

```
                   General Hospital Insurance Cash Posting Processor
                                                  Mon Mar 13, 2006 11:59 am
Account       Name                       FC Typ Admit    Disch     Balance   Loc
A9733800002  ADMIT,THREE                  O  I/P 12/04/97 07/26/98  107528.00 AR/FCRV


     COB 1 500-COMMERCIAL 100-COMMERCIAL BASIC Carrier Balance $47750
    Archived,Purged
Page:01                          Claim Disposition Codes         ##=Current Choices
( 1) A-Adjusted to zero
( 2) F-Final Payment
( 3) D-Denied
( 4) P-Partial Payment
( 5) T-Transfer
( 6) C-Clear disposition
( 7) N-No disposition




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

You may select one or more Claim Disposition codes for claims to be displayed for the account. Notice that you may 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**, the system displays the following prompt:

Enter earliest bill thru date [Earliest] --

You may accept the default of Earliest, enter a specific date in the format MMDDYY, 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 to include [Latest] --

You may accept the default of Latest, enter a specific date in the format MMDDYY, or enter T - # to indicate the number of days prior to today to be used as the latest bill through date. Claims are 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**, 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 in the format MMDDYY, 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 in the format MMDDYY, 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.

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 BY INDIVIDUAL ACCOUNT

If you complete field 16 of the initial Posting Insurance Cash screen with **A** (select by individual accounts) and accept the screen, the system prompts you to enter an account. You can do so by using the standard lookup procedure. If the patient has more than one carrier plan and the carrier plan defaults were not entered, you must select the carrier and plan for which the payment is applied for the patient. Then select the proper claim.

After using the carrier/plan or account method to display and select an account, the system displays the following posting transaction screen:

NOTE: If you select a carrier on this screen that has timed out, when you select the claim sequence the system displays the following prompt:

> *Carrier has timed out, do you wish to continue? (Y/N) [N]?--*

To select another account, enter **N** or press ENTER to accept the default. To continue with the selected timed-out account, enter **Y**.

The system then prompts you for the account to which you want to post insurance cash. Identify the account using the account identification methods discussed in the *General Information Volume* in the *STAR Patient Accounting Reference Guide.*

After you select the desired claim sequence, the system displays the following screen:

```
              General Hospital Insurance Cash Posting Processor
                                                 Wed Feb 15, 2008 09:28 am
Account       Name                 FC Typ Admit     Disch        Balance Loc
A06094-00005 BRACH, BOB            PK SER 03/28/06 04/04/06        0.00 AR
Clm Liab:        0.00    Bill Dts: 03/29/06-04/04/06  Ins Bal:        0.00
Ins:  400/100 Den-App Ind: Never Denied     BillDRG/Ind: 121          PCI:

 1 Batch Seq #  2 Pt Class  3 Payor Claim Control Number    4 Clm Dsp/Pmt Ind
   1               GOV
 5 Payment Amount  6 Receipt #              7 Remittance #
                   Auto
 8 Payment Date   9 Posting Date       10 New Account Balance
   05/02/03         05/02/03
11 Trans Code/Description             12 Cont Adj Trans Code/Description
   I0006-BLUE CROSS PAYMENT
13 Expected Reimbursement             14 Outlier  15 Days Paid  16 DRG Paid
   Not Available
17 Coinsurance   18 Deductible        19 Co-Pay         20 Pat Resp

21 Claim Disp 22 Claim Denial Info    23 ERA Other Adj  24 Rev Sys Adj CA
              No
 Contractual Adj    25 Prior Balance  26 Payment Amount 27 Cont Adj Amount

                      |
```

Field Explanations

CLAIM LIABILITY (DISPLAY ONLY)
This field contains the amount billed for this claim. This is the amount of charges billed to the carrier for this claim.

BILL DTS (DISPLAY ONLY)
This field contains the starting and ending bill dates of the selected claim.

INS BALANCE (DISPLAY ONLY)
This field contains the current carrier balance.

DEN-APP IND (DISPLAY ONLY)
This field shows the status of the current denial and appeal. A value of *D* indicates that the claim has been denied at least once and doesn't meet the criteria for *Not Valid*. The values appended to the right of the *D* indicate the status of the appeal that is associated with the denial. Values are:

- D-Inactive - This indicates that the status of the appeal for the most current denial is inactive/turned off which means the Appeal Status field on the Denial/Appeal Tracking parameters was not set to Live at the time of the denial.

- D-Open Appeal - This indicates that the status of the appeal for the most current denial is Active. This applies to all active appeal types such as:

  - Active Appeal

- Active 1st Attempt

- Active 2nd Attempt

- Active 3rd Attempt

- Active 4th Attempt

- Active 5th Attempt

- Active Final Payment

- D-Pre-Appeal - This indicates that the status of the appeal for the most current denial is pre-appeal.

- D-No Appeal - This indicates that the status of the appeal for the most current denial is No Appeal.

- D-Clsd Appeal - This indicates that the status of the appeal for the most current denial is Closed. This applies to all Closed types such as:

  - Closed Withdrawn

  - Closed Manually

  - Closed Final Payment

  - Closed Resequenced

  - Closed Replaced/Submitted

  - Closed Timeout

    NOTE: This also includes closed pre-appeals.

- Not Valid/2nd Ins - A value of Not Valid/2nd Ins indicates denial tracking is not valid because the insurance associated with the claim is not associated with COB 1.

- Not Valid - A value of Not Valid indicates the claim doesn't qualify for denial tracking. This could be if denial tracking is not turned on for the facility. The Denial/ Appeal Parameters, Denial Method field determines if Denial Tracking is turned on for the facility. If a claim has a disposition of *R* for replaced, the denial-appeal indicator would also display as Not Valid.

- Never Denied - A value of Never Denied indicates that a claim hasn't been denied, and it also doesn't meet the criteria for a value of Not Valid.

INS (DISPLAY ONLY)
This field contains the code and description of the carrier and plan associated with this payment for this account.

BILL/DRG IND (DISPLAY ONLY)
This field contains the code and description for the Diagnostic Related Grouping (DRG) that is billed. If no DRG is billed, this field is blank.

PCI (DISPLAY ONLY)
This field contains the claim sequence number used for the Payor Claim ID, If the source of the payment was ERA and the Payor Claim ID was used to match the payment to the claim.

1.   BATCH SEQ # (DISPLAY ONLY)
This field contains the sequence number of this payment within the batch. For example, if there are ten payments to be made in this batch and this is the third payment being entered, the batch sequence number for this payment is 3. The sequence number remains with this payment until the batch is posted or the payment deleted.

2.   PT CLASS (DISPLAY ONLY)
This field displays the financial patient classification combined with the alert and suppression indicators associated with the financial patient classification. The three-character patient classification code is displayed if a patient classification has been assigned to the account. Leading and trailing asterisks (**) display when the assigned patient classification has an alert designation. Finally, the follow-up suppression indicator is displayed as the final character in the field:

• a = alert only; follow-up is not suppressed

• c = suppression of follow-up has been cleared by a user

• s = follow-up is currently being suppressed

3.   PAYOR CLAIM CONTROL NUMBER (5-N-O)
The Internal Control Number can be provided in cash posting for a manually-keyed batch or received via an ERA file. The Internal Control Number is used for UB adjustment claims in Locator 64 a, b, and c for Document Control Number.

If an insurance cash batch is created using Process Electronic RA, this field is set automatically to Y for Yes. The Payor Claim Control Number is loaded from CLP07 in ERA. If the ERA insurance cash batch is edited, the Payor Claim Control Number can be edited.

If the Payor Claim Control Number in CLP07 in ERA contains a colon (:), a hyphen (-) is substituted. If the Payor Claim Control Number in CLP07 in ERA contains a semi-colon (;), a comma (,) is substituted.

4. CLM DSP/PMT IND (DISPLAY ONLY)

This field contains the claim disposition code and the payment indicator for the account. This field contains the results of the claim disposition rule. The first piece contains the disposition that was previously assigned to the claim before the claim disposition rule code was applied. The second piece of data in the field indicates if the claim was identified as an underpayment or overpayment. This field will contain a - if the claim wasn't assigned a payment tracking indicator. This field is a display only field but upon accessing the field, the Clm Disp/Pmt Ind details screen is displayed, as follows:

```
Clm Dsp/Pmt Ind Details

   Claim Disp Rules Code:        1
   Priority/Desc of Rule Used:   1-Underpayments
   Formula:                      ClmAmt-(Pmt-CAdj-
   OAdj+CoPy+PtRsp+Coi+Ded)
 Result of Formula:                     $380.00
   Value for Over/Under Pymt:           $380.00
   Old/New Disp if Changed:      Final/Partial Payment
   Under/Over Payment Indicator: Underpayment
   Suppress Con Adj:             Yes (150.50)
   Error when Calculating:
   ERA Claim Status Code:
   Report Only:
Claim Amount:                           $400.00
   Current Ins Bal:                       $0.00

   Press NL--
```

Field Explanations

CLAIM DISP RULES CODE (DISPLAY ONLY)

This field contains the rule that was used for the claim. For example, if a Claim Disposition Code of COMM for Commercial contained rule 1 for underpayments, rule 2 for final payments/small balances and rule 3 for overpayments and the claim was analyzed according to rule 1, the field would display 1 and the description of the rule.

PRIORITY/DESC OF RULE USED (DISPLAY ONLY)

This field contains the priority associated with the rule and the description associated with the rule.

FORMULA (DISPLAY ONLY)

This field contains the name of the formula associated by the hospital with the rule. The formulas are predefined McKesson-created formulas.

RESULT OF FORMULA (DISPLAY ONLY)

This field contains the calculated result of the formula that was applied to the claim.

VALUE OF OVER/UNDER PYMT (DISPLAY ONLY)
This field contains the value of the underpayment or overpayment. To determine if the value is for an underpayment or overpayment, review the value in the Under/Over Payment Indicator field.

OLD/NEW DISP IF CHANGED (DISPLAY ONLY)
This field contains the Old and New claim disposition associated with the claim.

UNDER/OVER PAYMENT INDICATOR (DISPLAY ONLY)
This field contains the underpayment or overpayment indicator. The field contains the value of *Underpayment* if the Payment Tracking Indicator was set to Underpayment. This field contains the value of *Overpayment* if the Payment Tracking Indicator was set to Overpayment. The field is blank if the Payment Tracking Indicator was not set.

SUPPRESS CON ADJ (DISPLAY ONLY)
This field contains the contractual adjustment amount calculated per the CAS Reason codes.

ERROR WHEN CALCULATING (DISPLAY ONLY)
This field contains the error if the claim encountered an error during the claim disposition rule analyzing process.

ERA CLAIM STATUS CODE (DISPLAY ONLY)
This field contains the associated claim status code for an ERA payment.

REPORT ONLY (DISPLAY ONLY)
This field contains the value of *Yes* if the selected rule was used but nothing changed.

CLAIM AMOUNT (DISPLAY ONLY)
This field contains the claim amount.

CURRENT INS BALANCE (DISPLAY ONLY)
This field contains the current total insurance balance.

Insurance Cash Posting Screen Field Definitions - Continued

5. PAYMENT AMOUNT (11-A/N-R)
This field contains the payment amount being posted. When the field is accessed, the following prompt is displayed:

Enter payment amount, `O` for OPPS Info, or `R` for COB1 Rmb Info--

Entry options are:

- Payment Amount—If the payment amount is entered, the range is from 0 to $999,999,999.99. If the payment is a payment reversal, enter a minus sign (-) before the amount. If you change the amount, the system displays the amount in the Contractual Adjustment Amount field whether or not a contractual adjustment is calculated automatically. Entering a payment amount of $0.00 allows you to

enter a note or a comment on the account without updating the claim disposition on the account and without changing the claim completion status. If you want to post a note or comment to the account without changing the current claim disposition or claim completion status, you must also enter *No Disposition* in the Claim Disposition field.

After a payment amount is entered, the system may display one of the following warning messages:

- If the payment exceeds the account balance and/or the carrier balance, the following message is displayed:

  Payment Amount Exceeds Account Balance

- If the payment exceeds the carrier balance but not the account balance, the following message is displayed:

  Payment Amount Exceeds Carrier Balance

- Should the payment exceed the claim amount (the amount billed), the following message is displayed:

  Payment Amount Exceeds Bill Balance

Warnings let you know that you may be posting the payment to the wrong account carrier or claim. These warnings should alert you to investigate the account. The payment can still be entered. The warnings print on the Cash Exception report according to the cash exception parameters. Payments by carriers that are for less than the Bill Balance also are printed on the Cash Exception Report. These do not include a warning on the screen, but do indicate on the report that the carrier paid less than expected.

In addition to the warning messages described above, you may also receive an informational message for Electronic Remittance Advice Part A and Part B insurance cash batches when a claim payment matches an ERA rejected payment with service lines detail. The message is as follows:

ERA service line detail retained and applied

- **O** (OPPS)—O can be entered in this field to display OPPS information. If no OPPS information exists for the selected claim, the following message is displayed:

  No OPPS data is available!

If OPPS information is available, the following prompt is displayed:

  Press NL to return or press `S` for summary OPPS information, `C` for OPPS

information by claim, or `W` for OPPS information by claim with charges

If the ENTER key is pressed, the Insurance Cash Posting screen is displayed. If you enter S, C, or W, OPPS information screens are displayed. For details on these screens, see .

- **R** (COB1 Rmb Info)—If R is keyed, Billing Reimbursement information is displayed for the latest final, adjustment, or late bill. If R is keyed but the account has not final billed, then no reimbursement information is available and the following error message is displayed:

Account has not final billed!

If R is keyed when the payment is being made for a secondary insurance, the screen is provided for the primary insurance with the following prompt:

This is the Reimb Summary for COB1. You are posting a payment to COBx.

The following screen with reimbursement information is displayed if the account has final billed:

```
              General Hospital Insurance Cash Posting Processor
                                              Mon Mar 13, 2006 11:59 am
Account       Name                   FC Typ Admit    Disch      Balance   Loc
A01155-00002 MOORE,LAURA             B  OPS 06/04/01 06/04/01   30869.83- AR/FCRV
 1 Carrier-Plan                          2 Payor
   500005 TEST PLAN H&W FUND                CM Pathways Contract Management
 3 Covered Days 4 Post Date               5 Error Description
                                             Pathways Contr Mgmt-no more resends
 6 Table No.    7 Reimb. Type            8 Calc. Method     9 Stop Loss
   001             PCON/Cycle

   Covered Charges              0.00
   Payments/Adjustments         0.00
   Balance                    538.10
```

For details on this screen, refer to the *Billing and Claims Volume* of the *Patient Accounting Reference Guide.*

6. RECEIPT # (10-AN-R)
If you have requested that receipts be printed, this field contains the receipt number for this payment. This number can be entered or automatically assigned by the system. The entry range is 0 to 9999999999 or A. If the system assigns a receipt number, this field contains auto. You can change the receipt number on an individual basis.

7. REMITTANCE # (25-C-O)
This field contains the remittance number (if any) for this payment. It is usually a check or remittance advice number. This is supplied from the default screen or can be entered for each account.

8. PAYMENT DATE (6-N-R)
This field contains the date on which the payment was made. The default is the date
from the batch header. You can change the date in this field to a prior date but not to
a future one. This date is used on bills and statements as the date payment was
received.

9. POSTING DATE (6-N-R)
This field contains the date on which this payment is posted. The default is from the
batch header. You can change the date in this field to a prior date but not to a future
one. This date updates the appropriate General Ledger fiscal period.

10. NEW ACCOUNT BALANCE (11-N-R)
This field displays the new account balance when the payment field has been
completed. Changing or adding a value to this field causes the New Account Balance
to calculate and display.

11. TRANS CODE/DESCRIPTION (5-AN-R)
This field contains the transaction type and code that is used to update this payment
in this account's transaction history. If the description is included with the transaction
code, it is truncated to fit this field. The transaction type and code are automatically
assigned by the system if they are included on the default screen or from the insurance
plan function options. If not, display and select from a list of codes under the
transaction type I (insurance payment).

12. CONT ADJ TRANS CODE/DESCRIPTION
This field contains the adjustment transaction type used to map the adjustment code
to the general ledger. If a code is entered on the header screen, it is displayed in this
field. If a code is not entered on the header screen, the code is pulled from the
Insurance Carrier Plan screen under the biller and collector option. If the code does not
exist there, you can choose to enter one or override the one displayed. The code is
entered only if the Allow Contractual Adjustments? field on the header screen is set to
Yes.

13. EXPECTED REIMBURSEMENT (DISPLAY ONLY)
This field contains the expected reimbursement amount which can be used to
determine if the payment should be marked Final or Partial.

- If the payment is not being made to the primary insurance or the expected
  reimbursement is unknown, the field displays the description of Not Available.

- If the reimbursement type for the bill associated with the claim is H (OPPS), then
  the field displays the expected reimbursement for the claim calculated by the 3M
  OPPS Interface.

- If the reimbursement type for the bill associated with the claim is not H (OPPS), the
  expected reimbursement for the bill is displayed. This can be the expected
  reimbursement per one of the STAR Financials Patient Accounting calculations for
  estimated reimbursement or per Pathways Contract Management. Since this is the

estimated reimbursement for the bill (and not the claim), it can be overstated when split claims were submitted or if the account had cycle bills.

If an expected reimbursement is displayed, it is followed by COBn, where n signifies the COB for the insurance payment (n will equal 1). The COB is followed by RMB x where x signifies the reimbursement type. For example H is for OPPS and I or J is for PCON. If the account has cycle bills and the reimbursement type is not H for OPPS, "Cycles" appears at the end of the field. If "Cycles" appears, the estimated reimbursement may be overstated if it includes charges for previous bills (and therefore previous claims).

14. OUTLIER CODE (1-A-O)
This field contains the outlier code associated with this account. Entry options are C (cost) or D (day). Setting this code indicates additional money was paid to the hospital because of a cost or stay outlier. This field is not applicable for Canadian claims (OHIP, WCB, and Universal).

15. DAYS PAID (3-N-R)
This field contains the number of paid days for this payment. This field is not applicable for Canadian claims (OHIP, WCB, and Universal).

16. DRG PAID (3-N-C)
This field contains the paid DRG code for this payment and a DRG edit indicator, if one is required by the setting of the DRG Edit field on the Cash Posting Setup screen. DRG indicators are:

- N-No DRG Edit:

The system accepts a DRG Indicator (M,C,T or O) if entered in the DRG Paid field but does validate the DRG code against the table.

- I-DRG Indicator Not Required:

The system accepts a DRG Indicator (M,C,T or O) if entered in the DRG Paid field and attempts to validate the DRG code against the table. However a DRG Indicator is not required.

- R-DRG Indicator Required:

The DRG Paid and DRG Indicator is required in the DRG Paid field. The system attempts to validate the DRG code against the table if an indicator of M or C is entered. If the T or O indicator is used a message displays in the status bar at the bottom of the screen:

   No DRG table available to edit DRG

- M-Default to Medicare MSDRG Indicator

The DRG Indicator is defaulted to an M if an indicator is not entered. For example if a DRG code of 111 is entered and the user tabs to the next field, the DRG code is displayed as follows: 111/M

The M indicator may be overridden and re-keyed with another valid DRG Indicator. The system attempts to validate the DRG code against the table if an indicator of M or C is entered. If the T or O indicator is used, a message is displayed as follows:

> *No DRG table available to edit DRG*

- C-Default to Medicare Classic DRG Indicator:

The DRG Indicator is defaulted to a C if an indicator is not entered. The C indicator may be overridden and re-keyed with another valid DRG Indicator. The system attempts to validate the DRG code against the table if an indicator of M or C is entered. If the T or O indicator is used, the following message is displayed:

> *No DRG table available to edit DRG*

- O-Default to Other DRG Indicator:

The DRG Indicator is defaulted to an O if an indicator is not entered. The O indicator may be overridden and re-keyed with another valid DRG Indicator. The system attempts to validate the DRG code against the table if an indicator of M or C is entered.

- T-Default to Tricare/Champus DRG Indicator:

The DRG Indicator is defaulted to a T if an indicator is not entered. The T indicator may be overridden and re-keyed with another valid DRG Indicator. The system attempts to validate the DRG code against the table if an indicator of M or C is entered.

- A-Reimbursed APR DRG Indicator

    The DRG Indicator is defaulted to A if another indicator is not entered.

This field is not applicable for Canadian claims (OHIP, WCB, and Universal).

17. COINSURANCE (12-N-C)
This field contains the coinsurance amount associated with the payment. Enter the coinsurance amount associated with this payment.

18. DEDUCTIBLE (12-N-C)
This field contains the deductible amount associated with the payment. Enter the deductible amount associated with this payment.

19. CO-PAY (4-N-O)

This field contains the amount of the co-payment. Access to this field is not allowed if the Req Co-Pay field on the Insurance Cash Posting Setup screen is blank or contains B (Bypass). When this field is accessed, the following prompt is displayed:

Enter co-pay amount--

You can enter a positive or negative amount containing up to two decimal places. You do not have to enter decimal places. If the amount is negative, enter a hyphen before the amount.

20. PAT RESP (7-N-C)

This field contains the amount of the patient's responsibility. Access to this field is not allowed if the Req Pat Resp field on the Insurance Cash Posting Setup screen is blank or contains B (Bypass). When this field is accessed, the following prompt is displayed:

Enter patient responsibility amount --

You can enter a positive or negative amount containing up to two decimal places. You do not have to enter decimal places. If the amount is negative, enter a hyphen before the amount.

21. CLAIM DISPOSITION (1-A-R)

This field indicates the disposition of the claim and the payment tracking indicator. The Pymt Ind field contains the Payment Tracking Indicator that is associated with the Underpayment or Overpayment. The payment tracking indicator contains a value on the detail transaction history associated with the payment that resulted in the assignment of a payment tracking indicator. For example if the claim was an underpayment and the new disposition was partial disposition, the field would contain: Clm Dsp/Pymt Ind: Partial/U

When this field is accessed, the following prompt is displayed:

Enter claim disposition or '-' for list [F]--

Entry options are F, A, C, P, T, or D; the default is F. You may also enter a hyphen (-) to do a table lookup. If the payment amount is $0.00, the default of F is no longer available, forcing you to enter a claim disposition. Also, if the payment amount is $0.00, you may enter **N** for No disposition.

If this is a final payment, enter **F** (final payment). If the claim is to be denied, enter **D** (denied). If the claim is to be written off, enter **A** (adjusted to zero). A disposition of F, A, or D flags the claim as paid in full and completes the claim.

If this is a partial payment and you do not wish to complete the claim, enter a disposition of **P** (partial), **T** (transfer), or **C** (clear disposition).

If you want to enter a note or a comment on the account without changing the current claim disposition or claim completion status, enter **N** for No Disposition.

This field also controls the transfers of remaining balances. Balances are transferred to another insurance, the patient, or third party excess. This happens only on accounts in AR and BD. This also occurs only when all claims for the carrier have either been paid or denied (dispositioned as Final Payment, Adjusted to Zero, or Denied).

Patients with only one insurance always have any remaining balance transferred to the patient. Patients that have more than one insurance can have the remaining balance transferred to the next carrier or the patient. The remaining balance goes to the next carrier only if the Balance Designation parameters have been set with this option and the Patient Prorate Flag is set to Y on the primary carrier of the account.

If the patient has more than one insurance and the Primary Plan's Prorate Flag is set to N, the system assumes that all carriers pay 100% of all charges. The amount of the liability that exceeds that account balance is kept in a field called Third Party Excess. Payments made on accounts with this situation reduce the Third Party Excess field until all insurance has been paid, and then the remaining balance becomes the patient liability.

Payments that exceed the carrier balance are left as the carrier liability only if the account balance has a credit balance.

You cannot transfer money to a carrier that has either no claim records or only archived or purged claim records. If a payment is received or if the insurance times out, any additional money is transferred to the patient if the additional carrier does not have a claim, even if the insurance time-out parameters or the balance designation parameters specify to transfer to the next carrier. Additionally, to prevent carrier balances from remaining without any follow-up, any balance on a carrier without a claim record is also transferred to the patient.

Final payments (i.e. disposition of adjusted to zero, final, or denied) made for the last claim to be final dispositioned for the carrier also remove the carrier from insurance follow-up. If a claim is adjusted to zero, it is removed from insurance follow-up. If money is transferred to a carrier and the carrier has a debit balance and released claims, the carrier is put into insurance follow-up.

22. CLAIM DENIAL INFO (1-A-O)
This field is used to access and change claim denial information. The field displays the following information for denials:

• For ERA denials (for example, 1/CAS/CO18/100.22++)

  Claim Status Code - This comes from the ERA file in the CLP segment.

CAS - The abbreviation of CAS is displayed if the denial was a result of a denial CAS code associated with a claim and the Track Denials by Reason code field on the claim status code associated with the claim is set to *Yes*.

STS - The abbreviation of STS is displayed if the denial was a result of a claim status code set to track denials.

Denial Reason Code concatenated with the Claim Adjustment Group Code - These values are from the CAS segment in the ERA file.

Denial amount - This amount is the denial amount associated with the denial reason code that is displayed in this field. For an ERA denial, this information comes from the CAS segment in the ERA file. If there are multiple denial reason codes, all of the denial amounts associated with each denial reason code are shown on the Claim Denial Info Edit screen that is displayed when you access the Claim Denial Info field.

The Claim Denial Info field is populated with a blank if the facility is not set to track denials according to the Denial/Appeal Parameters which means the Denial Method field isn't set to track denials either with or without Pathways Contract Management.

The Claim Denial Info field is populated with *No* and the associated claim status if available when any of the following conditions exist for the claim in the ERA file:

- Denial Tracking Payor Code doesn't exist or is filed as deleted.

- Insurance Plan doesn't have associated denial parameters or the insurance plan is filed as deleted.

- Denial Tracking Reason Group doesn't exist or is set to filed as deleted.

- Denial Tracking Reason Code Exception set to Not Track Denial

- Denial Tracking Patient Type Exception set to Not Track Denial

- For manually entered denials (for example, Yes/CO18/200.00++)

  In the example above, the system displays *Yes* if there is associated denial tracking information, CO18- CO is the claim adjustment group code, 18 is the denial reason code, 200 is the associated denial amount for CO18, and a ++ indicates there are additional denial codes that can be viewed on the Claim Denial Info screen.

When this field is accessed, the following prompt is displayed:

Enter CAS code, CAS code/CAS Clm Adj Group, `-` for table lookup, or Press ENTER if no Denial Tracking--

If you entered only a CAS code in response to the prompt, the system displays the following prompt asking for a claim adjustment group code:

Enter CAS Clm Adj Group (CO,CR,OA,PI,PR)--

Next, the system displays the following prompt for the denial amount:

Enter the denial amount or press Enter for the denial amount to equal the claim amount [400.00]--

After you enter the first denial code, the system prompts for additional codes as follows, if the Track Multiple Denial field on the Insurance Default screen is set to Yes. You can also enter a plus (+) sign to access the Claim Denial Information Edit screen.

Enter CAS code, CAS code/CAS Clm Adj Group, `-` for table lookup, or Key `+` for edit screen--

If you enter a plus sign (+) or a CAS code, the following screen is displayed:

```
                                                     Mon Jul 23, 2007 11:40 am
Account        Name               FC Typ Admit    Disch        Balance Loc
A0720000001   KANE, CAROL          O  O/P 07/19/07 07/19/07      320.00 AR /ACCF
                         Claim Denial Information Edit
Seq Code Grp  Description                    Priority  Code  Cause  Denial Amount
                                  HCPCS      Charge Amt       Pymt Amount
1    18   CO  PK18                               1     300     1          33.00
                                  51600                      620.25       193.18
2    18   CO  PK18                               1     300     1          50.22
                                  51600                      620.25       193.18




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

```

Field Explanations

SEQ (DISPLAY ONLY)
This is the sequence number associated with the line.

CODE (TABLE LOOKUP-O)
This column contains the payor's denial reason code(s). This field is either manually entered by the user or for an ERA cash batch, it comes from the CAS segment in an ERA file.

GRP (DISPLAY ONLY)
This field contains the claim adjustment group code which is the general grouping of reasons for denials. The standard ANSI X12 835 codes are CO for Contractual Obligations, CR- Correction and Reversals, OA- Other Adjustments, PI- Payor Initiated Reductions, Pr-Patient Responsibility. This field is either manually entered by the user or for an ERA cash batch, it comes from the CAS segment in an ERA file.

DENIAL AMOUNT (8-N-O)
This field contains the denial amount for this denial reason code. This field is either manually entered by the user or for an ERA cash batch, it comes from the CAS segment in an ERA file.

HCPCS CODE (DISPLAY ONLY)
This field contains the HCPCS procedure code with any attached HCPCS modifiers for the charge. This field is used only for ERA, and it comes from SVC01-2.

LINE ITEM CHARGE AMT (DISPLAY ONLY)
This field contains the charge amount that is related to the service line on the claim. his field is used only for ERA, and it comes from SVC01-2.

LINE ITEM PTMT AMT (DISPLAY ONLY)
This field contains the payment that is related to the service line on the claim. This field is used only for ERA, and it comes from SVC03.

Field Explanations Continued (Insurance Cash Posting Screen)

23. ERA OTHER ADJUSTMENT (DISPLAY ONLY)
If the cash transaction was created from ERA processing, and an Other Adjustment was determined from reason codes, this field contains the adjustment amount, transaction code, and the beginning of the transaction code description. This field is not applicable for Canadian claims (OHIP, WCB, and Universal).

24. REV SYS ADJ CA (DISPLAY ONLY)
This field displays the contractual adjustment amount that is reversed via a separate transaction when the ERA cash batch is approved. This field is used for COB1 claims where a contractual adjustment was previously posted and is being reversed with a new adjustment from an ERA file.

Contractual Adjustment

The system displays the following fields only if **Y** is entered in the Allow Contractual Adjustments? field on the Insurance Cash Posting Setup screen. For more information about this option refer to the Allow Contractual Adjustments? field.

25. PRIOR BALANCE (DISPLAY ONLY)
The system displays the carrier balance in this field if the Allow Contractual Adjustment field on the Default screen contains a Y and the Contractual Adjustment Transaction code is present on the patient insurance plan. Both of these conditions must be met for the current carrier balance to display in this field.

26. PAYMENT AMOUNT (DISPLAY ONLY)
The system displays the payment amount in this field if the Allow Contractual Adjustment field on the Default screen contains a Y and the Contractual Adjustment Transaction code is present. Both of these conditions must be met for the payment amount to display in this field.

27. CONT ADJ AMOUNT (11-N-C)
This field contains the system-calculated amount of the adjustment if the following are true:

- The Allow Contractual Adjustment field contains **Y** on the Default screen.

- The Contractual Adjustment Transaction code is present on the patient insurance plan.

- The adjustment was added to the header screen or added by the user at the account level.

- This is the final payment for the claim.

- The account is in AR or BD.

Depending on whether you selected Carrier or Account Balance on the Insurance Cash Posting Setup Processor default screen, this balance is used to subtract the insurance payment minus the co-insurance amount (this can be the amount due, if not collected) minus the deductible amount (this can be the amount due, if not collected) to calculate the contractual adjustment. If the account is in location PA or you wish to override the amount, you can set it manually. You can also manually enter an adjustment amount if this is a partial payment. An adjustment with a hyphen (-) reduces the balance. An amount entered without a hyphen adds dollars to the account.

A lowercase letter may be displayed to the right of the field, indicating the following:

- A lowercase *d* indicates that this ERA transaction contains a denial and the parameter is set not to take a contractual adjustment if it is a denial.

- A lowercase *t* indicates that a takeback transaction, which previously didn't have a contractual adjustment, posted due to a denial.

- A lowercase *s* indicates that this ERA transaction contains a subsequent denial and the parameter is set not to take a contractual adjustment if it is a denial.

NOTE: If the Final Payment field is changed from Yes to No, the system blanks out
the Adjustment fields.

When all fields are completed, the system asks if you want to accept the posting. Enter
Y for Yes or **N** for No; the default is **Y**. If you enter **N**, you can edit any of the fields on
the screen. If you enter **Y**, the system asks if you want to make a comment. The system
prompts you with:

Enter comments (C) or notes (N) --

If you enter **C** for comments, you are prompted to enter a comment about this payment.
You can enter up to three lines of comments for this payment. Press F4 when you finish
entering your comments. If you enter **N** for notes, the notes program is displayed on
your screen. Refer to the Notes section in the *Billing and Claims Volume* of the *STAR
Patient Accounting Reference Guide* for a description of entering notes for this
payment.

 If a comment or note is not necessary, press ENTER.

The prompts that are displayed at the bottom of the screen differ according to the file
type:

- For Part A and Part B ERA files with insurance payments, the following prompts
  are displayed:

  If the batch is in balance: *Batch is balanced - Approve(A), Hold(H), Print Batch
  (P), Print F(X)RERABB, D (Display ERA Batch Information), or Return(R)? --*

  If the batch is out of balance: *Batch is out of balance - (A)ccept, (P)rint Batch,
  (E)dit, Print F(X)RERABB, (D)isplay ERA batch information, or (R)eturn? --*

- For non-ERA batches, the following prompts are displayed:

   If the batch is out of balance: *Batch is out of balance - Accept(A), Print(P),
  Edit(E), or Analyze* (B)atch, *Return(R)? --*

  If the batch is balanced: *Batch is balanced - (A)pprove, (H)old, (P)rint Batch,
  (E)dit, Analyze* (B)atch, *or (R)eturn?-*

The following options are available:

- Approve (A) - The system posts the batch. When a batch is posted, it
  cannot be edited nor can items within it be deleted.

If A for Approve is entered, and the Post Date in the batch header does not match the current date, indicating transactions may exist where the post date does not match the current date, the following prompt is displayed:

Do you want to update the post date to match the current date? (Y/N) [N]--

You can enter Yes to have the system update the post date for each transaction in the cash batch to the current date. If you enter Yes, the batch is posted to the current fiscal period. If No is entered, the batch is posted to the fiscal period of the post date.

- Edit (E) - You can change or delete individual items in the batch.

- Hold (H) - The system places the batch on hold.

- Print Batch (P) - The system prints the batch detail.

- Analyze Batch (B) - You can analyze the insurance cash batch against the claim disposition rules code. This prompt is displayed only if the insurance cash batch has an associated claim disposition rules code.

- Return (R) - The system displays the Cash Posting Processor screen.

- Print F(X)RERABB - The system prints the ERA Batch Balancing Report (FXRERABB). This option is available for Electronic Remittance Advice files only. For details on this report, refer to the *Electronic Payments Volume* of the *STAR Patient Accounting Reference Guide.*

- Display ERA Batch Information (D) - This option is available for Electronic Remittance Advice files only. For details on this function, refer to the *Electronic Payments Volume* of the *STAR Patient Accounting Reference Guide.*

OPPS INFORMATION

For an Outpatient Prospective Payment System (OPPS) claim, the following screen is displayed when you enter an **O** in the Payment Amount field on the Insurance Cash Posting Processor screen.

```
              General Hospital Insurance Cash Posting Processor
                                              Mon Mar 13, 2006 11:59 am
Account       Name                  FC Typ Admit    Disch      Balance Loc
A0204400003   ANDERSON,BRYAN         M  O/P 02/13/02 02/13/02    12.34- AR/FCRV


Total Claim Payment:            4,268.01
Total Ins Payment:              3,282.70

Total Coinsurance:                885.31

Patient Deductible:               100.00

Liability:                        804.31-
Contractual Adjustment:         4,087.01
Posted:
User Reduced Coins:



(E)rrors, (O)PPS, OPPS Chgs(OC), (L)ine, (LI)nes, C(P)rc, (C)lm Chgs, Reim(B),
Pai(D), or E(X)it OPPS Information--
```

Field Explanations

TOTAL CLAIM PAYMENT (DISPLAY ONLY)
This field contains the total amount of payments applied to this claim.

TOTAL INS PAYMENT (DISPLAY ONLY)
This field contains the total amount of payments received for this claim from the carrier.

TOTAL COINSURANCE (DISPLAY ONLY)
This field contains the total amount of coinsurance received for this claim.

PATIENT DEDUCTIBLE (DISPLAY ONLY)
This field contains the patient deductible amount for the claim.

LIABILITY (DISPLAY ONLY)
This field contains the liability of the carrier for the claim.

CONTRACTUAL ADJUSTMENT (DISPLAY ONLY)
This field contains the contractual adjustment for the claim.

POSTED (DISPLAY ONLY)
This field contains the amount posted to the selected account.

USER REDUCED COINS (DISPLAY ONLY)
This field contains the amount of covered charges for the carrier/plan which are the responsibility of the patient.

The following options are displayed at the bottom of the screen:

(E) rrors, (O) PPS, OPPS Chgs (OC), (L) ine, (LI) nes, C (P) rc, (C) lm Chgs, Reim (B), Paid (D), or E(X) it OPPS Information.

For information on the screens that are displayed when the options at the bottom of the screen are chosen, please refer to the *Outpatient Prospective Payment System Volume* of the *STAR Patient Accounting Reference Guide.*

Patient Cash

This function enables you to enter and edit batches of patient payments. Patient cash can be entered using the Post Cash or Post Window Cash functions.

The Post Cash function updates accounts once the batch is balanced and approved. Entries made using the Post Window Cash function update the accounts immediately.

You can access Account Inquiry by entering the dollar sign ($) when prompted for an account. This feature enhances the accuracy of posting cash on accounts by providing a research mechanism.

There are two screens used in this transaction. The first displays basic information you entered about this batch and provides an opportunity for you to complete the patient cash defaults for this batch. The second is the actual entry screen.

```
              General Hospital Patient Cash Posting Setup Processor
                                             Fri Dec 30, 1988 10:10 am

   1 Batch Code        2 Batch Description                 3 # of Trans
     8                    Patient Cash
   4 Starting Balance  5 Total Entered    6 Batch Total    7 Variance
     100.00                                 2,400.00
                             Patient Cash Defaults
   8 Print Receipts                  9 Beginning Receipt #
     Yes                               Auto
  10 Trans Code/Description
     P0005-Personal Check




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

Field Explanations

Fields 1 through 7 - Batch code, Description, # of Trans, Starting Balance, Total Entered, Batch Total, and Variance - are completed by the system. These fields cannot be edited and are displayed to help you confirm that the payments are entered in the correct batch. These fields display from the batch header.

Patient Cash Defaults

8. PRINT RECEIPTS (1-A-R)

This field indicates whether receipts should be printed. Enter **Y** for Yes or **N** for No; the default is Y. If receipts have not been implemented, you can make an entry in this field.

9. BEGINNING RECEIPT # (10-AN-O)

This field contains the beginning receipt number (if any). You can enter the number or **A** for automatic assignment. If you enter **A**, the system displays the word auto in this field. This field is completed only if **Y** is entered in the Print Receipts field.

10. TRANS CODE/DESCRIPTION (5-AN-O)

This field contains the transaction type and code that can be used for all patient payments if the hospital wishes to use the same transaction code for all or the majority of the payments being posted. If the description is included, it is truncated to fit this field. This transaction code is repeated for each patient in the batch. You can enter the code or a hyphen (**-**) to display and select from a list of valid codes under transaction type P (patient payment).

After you complete this screen, the system asks you to select a patient account to which this cash payment is applied. You do so by using the standard lookup procedure. After a patient is selected, the system displays each account associated with that patient (if more than one). After you select the account, the system displays the following screen:

```
                General Hospital Patient Cash Posting Processor
                                          Mon Mar 13, 2006 11:59 am
Account        Name                  FC Typ Admit     Disch       Balance Loc
A9800700002  SMITH, LAWRENCE K         O  ADV 01/07/98 01/08/98      509.00 AR/FCRV
1 Patient Balance    2 Last Payment Date      3 Collection Agency
   27,590.00-
 4 # of Payments       5 Total Payments                6 Account Balance
                                                         509.00
 7 Seq#    8 Pt Class                           9 New Account Balance
   11

10 Payment Amount    11 Receipt #        12 Remittance #
->
13 Payment Date      14 Posting Date     15 Trans Code/Description
   05/22/06             05/22/06            P0001-PERSONAL PAYMENT-CHECK

16 Comments
   01
   02
   03


Enter payment amount--
```

Field Explanations

1. PATIENT BALANCE (DISPLAY ONLY)

This field contains the patient balance for this account.

2.   PAYMENT DATE (DISPLAY ONLY)
This field contains the last date on which a patient payment was received on this account.

3.   COLLECTION AGENCY (DISPLAY ONLY)
This field contains the code of the collection agency assigned to this account if the account is in account location BD.

4.   # OF PAYMENTS (DISPLAY ONLY)
This field contains the number of payments, either insurance or patient, made on this account.

5.   TOTAL PAYMENTS (DISPLAY ONLY)
This field contains the total dollar amount of all patient and insurance payments made on this account.

6.   ACCOUNT BALANCE (DISPLAY ONLY)
This field contains the current account balance.

7.   SEQ # (2-N-R)
This field indicates the order in which this payment is entered in this batch. For example, if there are ten payments made in this batch and this is the third payment entered, the batch sequence number for this payment is 3. The sequence number remains with this payment until the batch is posted or the payment deleted.

8.   PT CLASS (DISPLAY ONLY)
This field displays the financial patient classification combined with the alert and suppression indicators associated with the financial patient classification. The three-character patient classification code is displayed if a patient classification has been assigned to the account. Leading and trailing asterisks (**) display when the assigned patient classification has an alert designation. Finally, the follow-up suppression indicator is displayed as the final character in the field:

• a = alert only; follow-up is not suppressed

• c = suppression of follow-up has been cleared by a user

• s = follow-up is currently being suppressed

9.   NEW ACCOUNT BALANCE (11-N-R)
This field displays the new account balance when the payment field has been completed. Changing or adding a value to this field causes the New Account Balance to calculate and display.

10.   PAYMENT AMOUNT (9-N-R)
This field contains the amount of this payment. The entry range is 0 to $9,999,999.00. If the payment amount exceeds the account balance, a message is displayed to that effect. The system accepts payments that exceed the balance. If you wish to enter a payment reversal for an NSF check, enter a minus sign (-) before the dollar amount.

11. RECEIPT # (10-AN-O)
If you requested that receipt numbers be printed, this field contains the receipt number for this payment. This number can be entered or automatically assigned by the system. The entry range is 0 to 9999999999 or A. If you enter **A**, this field contains auto. You can change the receipt number on an individual basis.

12. REMITTANCE # (25-C-O)
This field contains the check, credit card, or remittance advice number associated with this payment. This identification number is displayed in the patient's transaction history.

13. PAYMENT DATE (6-N-O)
This field contains the date on which this payment is made. The system displays the date from the batch header. You can enter a prior date in the format MMDDYY or MM/DD/YY. This date is used as the transaction date in this account's transaction history and the remittance date in account transaction history detail.

14. POSTING DATE (6-N-O)
This field contains the date on which this payment is posted. The system defaults to the date from the batch header. You can enter a prior date in the format MMDDYY or MM/DD/YY. This date is used as the posting date in this account's transaction history.

15. TRANS CODE/DESCRIPTION (5-AN-R)
This field contains the transaction type and code used to record this payment in this account's transaction history. If the description is included with the transaction code, it is truncated to fit this field. You can enter the code or a hyphen (**-**) to display and select from a list of valid codes under transaction type P (patient cash payment).

If the Transaction Code field on the default screen is blank, this field is completed by the system using information from the Financial Class table. The patient's financial class is used in the lookup. If the field is completed on screen 1, the system displays it in this field. This code can then be changed if necessary.

16. COMMENTS (210-C-O)
This field provides space (three lines of 70 characters) for entering a comment about the payment. Three lines of comment text are available. When you access this field, the system prompts you with:

Enter comments (C) or notes (N) --

If you enter **C** for comments, you are prompted to enter a comment about this payment. You can enter up to three lines of comments for this payment. Press F4 when you finish entering your comments. If you enter **N** for notes, the notes program is displayed on your screen. Refer to the Notes section in the *Billing and Claims Volume* of the *STAR Patient Accounting Reference Guide* for a description of entering notes for this payment.

If a comment or note is not necessary, press ENTER.

When these fields are completed and accepted, you have the option of entering another patient cash payment, another type of payment (if this batch accepts mixed transactions), or accessing the exit batch transaction.

UPDATE OF PATIENT PAYMENTS

Payments received from the guarantor for the patient portion of an account posted via patient cash or guarantor cash do various types of updating.

The system checks to see if the account has been prelisted for bad debt. If it has been prelisted, the system puts the account on a system hold. It also puts any other accounts for the guarantor on hold unless this account or other accounts are on a custom follow-up schedule.

The follow-up schedule is checked to determine if the guarantor has paid the amount expected based on the restart amount and/or percent. If the guarantor has paid the expected amount, the next follow-up sequence number to which the guarantor is currently assigned is checked to determine what the restart sequence number is, and the next follow-up sequence is set according to this number.

If the guarantor paid less than what was expected based on the follow-up schedule, the guarantor and the account appear on the Cash Exception report based on the cash exception parameters.

If the guarantor has paid more than the account balance, the account prints on the Cash Exception report based on the cash exception parameters.

If an account is in BD, a record is created for the Agency Cash report. This is a report that lists payments that were received directly by the hospital.

NOTE: If the batch is in balance and the user exits from the menu, the system offers the options to Approve, Hold, Print, or Edit the batch. Refer to the Exit Batch function in this chapter for an explanation of these options.

Miscellaneous Cash

This function posts miscellaneous cash to GL accounts. Miscellaneous cash can be such items as parking lot, gift shop, and cafeteria receipts. The miscellaneous cash table must be completed before this function can be used.

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

```
                    General Hospital Miscellaneous Cash Posting Processor
                                              Fri Dec 23, 1988 10:10 am

     1 Posting Date        2 Receipt #        3 Batch Seq #
       04/15/88              Auto               3
     4 Amount to Post      5 Misc Code        6 Miscellaneous Cash Description
       100.00               321                   Medicare Check #12345676
     7 Entity              8 Department
       A                    200
     9 Account                               10 Trans Code/Desc
       200
    11 Comments
       01
       02
       03




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

Field Explanations

1. POSTING DATE (DISPLAY ONLY)
This field contains the posting date from the batch header. This date can be changed.
The date entered is used in selecting the proper GL period in which the payment is
posted. The backdate days in PA/AR control the number of days back that this date
can be set.

2. RECEIPT # (10-AN-O)
If you requested that receipt numbers be printed, this field contains the receipt number
for this payment. This number can be entered or automatically assigned by the system.
If you enter **A**, this field contains auto. You can change the receipt number on an
individual basis.

3. BATCH SEQ # (DISPLAY ONLY)
This field contains the sequence number of this payment within the batch. For
example, if there are ten payments to be made in this batch and this is the third
payment being entered, the batch sequence number for this payment is 3. The
sequence number remains with this payment until the batch is posted or the payment
deleted.

4. AMOUNT TO POST (9-N-R)
This field contains the amount of this miscellaneous cash posting. The range is 0 to
$9,999,999.00. If the payment is a payment reversal, enter a minus sign (-) before the
amount.

5. MISC CODE (3-N-R)
This field contains the miscellaneous cash code associated with this posting. After you enter the code, the system completes fields 6, 8, 9, and 10. Once this field is entered, the posting can be accepted.

NOTE: When you enter the predefined code in this field, the system uses the values associated with that code to complete the Miscellaneous Cash Description, Department, Account, and Transaction Code Description fields.

6. MISCELLANEOUS CASH DESCRIPTION (DISPLAY ONLY)
This field contains the description associated with the miscellaneous cash code. You can enter the code or a hyphen (-) to display and select from a list of valid codes. These codes represent sources of miscellaneous cash such as parking lot, cafeteria and gift shop receipts.

7. ENTITY (DISPLAY ONLY)
This field contains the GL entity to which this miscellaneous cash posting is directed.

8. DEPARTMENT (4-N-R)
This field displays the GL department receiving the revenue for this posting. The system enters the default value assigned for this miscellaneous cash code in the Miscellaneous Cash Code table. You can override this default with a valid department code. The length of this field is determined by the Dept # Size and Subaccount Size fields on the Fiscal Year Definitions screen in the STAR Financials General Ledger System.

9. ACCOUNT (4-N-R)
This field contains the number and description of the GL subaccount receiving the revenue for this posting. The system enters the default value assigned for this miscellaneous cash code in the Miscellaneous Cash Code table. You can override this default with a valid subaccount for the department identified in the Department field. The length of this field is determined by the Dept # Size and Subaccount Size fields on the Fiscal Year Definitions screen in the STAR Financials General Ledger System.

10. TRANS CODE/DESC (DISPLAY ONLY)
This field contains the transaction type and code used to generate the GL cash entry.

11. COMMENTS (210-C-O)
This field provides space (three lines of 70 characters) for entering a comment about the payment. Three lines of comment text are available. When you access this field, the system prompts you with:

Enter comments (Y/N) [N]?--

Comments display on the Cash Posting Audit report (FAR120) and Cash Posting Detail report (FAR130).

When these fields are completed, the system returns to the cash posting options.

NOTE: If the batch is in balance and the user exits from the menu, the system offers the options to approve, hold, print, or edit the batch. Refer to the Exit Batch function in this chapter for an explanation of these options.

Unapplied Cash

This function is used to record unidentified payments received. Unapplied cash is any payment that cannot be immediately matched to a patient account. In completing the associated screen fields, the purpose is to record as much information as possible about the payment to aid in its eventual identification and transfer to the correct account.

After this option is selected, the following screen is displayed.

```
                  General Hospital Unapplied Cash Posting Processor
                                                Fri Jan 30, 2008 10:10 am

                                  GL Account:
  1 Payment By                            2 Payment For
 -> Ross,Rowena                             Ross,Marvin
  3 Address Line 1                         4 Address Line 2
  768 Trailing Vine Rd.
  5 City                                   6 State              7 Zip code
  Butte              MN         76841-3041
  8 Remittance/Check/Card #                9 Payment Amount     10 DRG Paid
  324                100.00
11 Trans Code/Description                 12 Days Paid          13 Outlier Code
  U0001-Unapplied Cash
14 Payment Date      15 Posting Date      16 Batch Seq #
   03/31/98              03/31/98             2
17 Comments
        01
        02
        03




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

Field Explanations

1. PAYMENT BY (30-C-R)
This field contains any information about how the payment was received. Information entered here could include the carrier name, or the name on the check.

2. PAYMENT FOR (30-C-R)
This field contains information regarding the purpose of the payment (that is, for or to whom the payment was made).

3. ADDRESS LINE 1 (25-C-R)
This field contains the first line of the payor's address.

4. ADDRESS LINE 2 (25-C-O)
This field contains the second line of the payor's address (for example, an apartment number).

5. CITY (17-C-O)
This field contains the name of the city where the payor is located.

6. STATE (2-C-O)
This field contains the two-character abbreviation of the state in which the payor is located.

7. ZIP CODE (9-AN-O)
This field contains the ZIP code portion of the payor's address. The five- or nine-digit ZIP code is accepted.

8. REMITTANCE/CHECK/CARD # (25-C-O)
This field contains the check, credit card, or remittance number.

9. PAYMENT AMOUNT (9-N-R)
This field contains the amount of this payment. The range is 0 to $9,999,999.00. If the payment is a payment reversal, enter a minus sign (-) before the amount.

10. DRG PAID (3-N-O)
If the payment is a Medicare voucher, you may want to include the DRG for which the payment is being made.

11. TRANS CODE/DESCRIPTION (5-AN-O)
This field contains the transaction type and code and the description that can be used to record the transaction. If the description is included with the transaction code, it is truncated to fit this field. You can enter the code or a **U** to display a list of valid unapplied cash codes.

12. DAYS PAID (1-N-O)
This field contains the number of days paid.

13. OUTLIER CODE (1-A-O)
This field contains the outlier code that applies to this payment if one is known. Entry options are **C** (cost) or **D** (day).

14. PAYMENT DATE (6-N-O)
This field contains the date on which this payment is made. The system displays the date from the batch header. You can enter a prior date. This date is used as the transaction date in this account's transaction history and the remittance date in account transaction history detail.

15. POSTING DATE (6-N-O)
This field contains the date on which this payment is posted. The default is from the batch header. You can change the date in this field to a prior date but not to a future one. This date updates the appropriate General Ledger fiscal period.

16. BATCH SEQ # (DISPLAY ONLY)

This field contains the sequence number of this payment within the batch. For example, if there are ten payments to be made in this batch and this is the third payment being entered, the batch sequence number for this payment is 3. The sequence number remains with this payment until the batch is posted or the payment deleted.

17. COMMENTS (180-C-O)

This field provides space for comments regarding this payment. Three lines of 60 characters are provided. You should enter as much descriptive information about this payment as possible. This is helpful when trying to locate the proper accounts. It is also included when the payment is transferred to the proper account.

When these field are completed, the system prompts you to accept the screen. Accepting it completes the transaction. You have the option of entering another unapplied cash payment or returning to the cash posting options.

NOTE: If the batch is in balance and the user exits from the menu, the system offers the options to approve, hold, print, or edit the batch. Refer to the Exit Batch function in this chapter for an explanation of these options.

Contract Cash

This function is used to record cash received on contract accounts. For more information on this function, refer to Contract Cash Posting in the Contract Billing section of the *Billing and Claims Volume* of the *STAR Patient Accounting Reference Guide.*

POST LINE ITEM CASH

Post Line Item Cash is used to post patient and insurance cash. Line Item Cash batches can be for patient payments only, insurance payments only, or a line item batch which includes both patient and insurance payments. Line Item Cash cannot be used for posting to Canadian OHIP claims.

You can access Account Inquiry within a batch using the dollar sign ($) when prompted for an account. This feature enhances the accuracy of posting cash on accounts by providing a research mechanism.

From the Account Transactions Process screen, select Post Line Item Cash. Next select your facility. After the facility is selected the following prompt is displayed on your screen:

Enter a batch code, 'A' for a system assigned number or '-' for list --

When you display a list of existing line item cash batches, the type displayed is **P** for patient, **I** for insurance, or **B** for both.

After your batch code is selected or entered, the following screen is displayed. This example screen provides an illustration using the both patient and insurance option.

```
            General Hospital Line Item Cash Posting Setup Processor
                                              Tue Apr 18, 2000 01:30 pm


  1 Batch Code        2 Batch Description              3 # of Transactions
      3                 WARNICK1
  4 Posting Date      5 Payment Date
     01/15/99            01/15/99
  6 Type              7 Allow Contractual Adj?         8 C/A Batch Total
     Both                No
  9 Trans Code                             10 Remittance #
     P0002, I0002                             23432
 11 Carrier                                12 Plan
     100-MEDICARE                             100-MEDICARE PART A BASIC PLAN
 13 Outlier          14 Days              15 DRG              16 DRG Edit?
     No                 No                   No                   Yes
 17 Coinsurance      18 Deductible        19 Default Disposition
     No                 No                   Partial payment
 20 Batch Total      21 Total Entered     22 Variance         23 Claims List
 ->                                                              Unpaid Only

 Enter batch total--            |
                    next(/) or previous screen(/P) [/]
```

Field Explanations

This screen contains basic information about the batch being entered or edited.

1.   BATCH CODE (DISPLAY ONLY)
This field contains either the batch code you entered or the system-assigned identification code for this batch. Any three characters or numbers can be assigned to

identify a batch. If the system assigns a code to this batch, the word auto is displayed until you edit this screen, and the system-assigned code is displayed when you enter this screen.

2. BATCH DESCRIPTION (30-C-R)
This field contains the description of this batch (for example, Commercial Insurance Payments). If you are editing a batch, the system displays the batch description entered when the batch was created. This field can be edited until the batch is posted.

3. # OF TRANSACTIONS (DISPLAY ONLY)
If you are editing a batch, this field contains the number of component transactions within the batch. If you are creating a batch, this field is blank.

4. POSTING DATE (6-N-R)
This field contains the batch posting date. The system automatically assigns the current system date. You have the option of keeping or changing this date, which is included in this account's transaction history. This date determines the General Ledger period in which transactions post, and it can be set back only to the number of backdate days indicated in PAAR Control.

5. PAYMENT DATE (6-N-R)
This field contains the date on which the batch payments are made. The system automatically assigns the current system date. You have the option of keeping or changing this date. This date prints on patient statements. If entering a backlog of payments, you may wish to change this date.

6. TYPE (1-A-R)
This field contains the type of the line item cash batch. Enter **P** for patient, **I** for Insurance, or **B** for both.

7. ALLOW CONTRACTUAL ADJ? (1-A-C)
This field indicates whether the system should allow contractual adjustments to be entered with the payment. Enter **Y** for Yes or **N** for No; the default is N. If you enter **Y**, the remaining carrier balance after a final payment is adjusted, leaving the carrier a balance of 0. This field is only used with the line item cash batch type of insurance (I) or both (B) and only applies to final insurance payments in the batch. You can override the adjustment amount on the cash entry screen. You can also manually enter a contractual adjustment amount for a partial payment. This field can be edited by an employee with a security level of 40 or higher.

NOTE: The following conditions must be met in order for the system to calculate the contractual adjustment automatically:

- The Allow Contractual Adjustments? field on this screen must contain Yes.
- The Final Payment field on the Insurance Cash Posting screen must contain Yes.
- The account must be in account location AR or BD. You can place an amount in the adjustment field if the account is in PA, but it is not calculated automatically by the system.

- The expected number of payments on the selected carrier must be less than two.
- A contractual adjustment code must be entered on the batch header, exist on the account's insurance carrier plan, or be entered manually by the cash posting personnel.

8. C/A BATCH TOTAL (10-N-O)

This field allows you to enter an amount for the Contractual Adjustments. You can access this field only if the Allow Contractual Adj? field is set to Yes.

9. TRANS CODE (25-AN-O)

This field contains the default transaction type and code used to record this payment in this account's transaction history. If the description is included with the transaction code, it is truncated to fit this field. Depending on the type of line item cash batch, you can enter the code or a hyphen (-) to display and select from a list of valid codes under the transaction type of P (patient), I (insurance), or one of each for B (both). If only one code is selected, the transaction code and description are displayed. If the patient and insurance transaction code is selected, only the transaction code is displayed. If this field is left blank, the system defaults the payment transaction code according to the patient indicator (inpatient or outpatient).

10. REMITTANCE # (25-C-O)

This field contains the remittance number (if available) for this payment. It is generally a check or remittance advice number. The system updates this number in the transaction history for each account in the batch.

11. CARRIER (4-N-O)

This field contains the code and description of the insurance carrier making this payment. If you are creating a batch, you can enter the code or a hyphen (-) to display and select from a list of valid codes. In either case, the description accompanies the code entered or selected. This field is used only with the line item cash batch type of insurance (I) or both (B). If there is an entry in this field, the selected account must have this insurance carrier assigned.

12. PLAN (4-N-O)

This field contains the code and description of the insurance plan for which these payments are being entered. If you are creating a batch, you can enter the plan code or a hyphen (-) to display and select from a list of valid codes. The Carrier field must be completed to use this field. This field is used only with the line item cash batch type of insurance (I) or both (B). If there is an entry in this field, the selected account must have this insurance plan assigned.

You should complete the Carrier and Plan fields only if the hospital is posting the same type of insurance cash for all or most of the batch. For example, if you receive a Medicare voucher, you can enter both the carrier and plan in these fields. This saves you a step during the entry process when you specify the carrier/plan responsible for the payment. The system automatically defaults to this carrier/plan code.

You can enter the carrier and leave the plan blank. An example is a Blue Cross voucher posted in which the plan number differs for each patient, but the carrier Blue Cross is the same for every patient. If the patient has only one Blue Cross plan, the system does not require the selection of a carrier/plan during the entry process but automatically defaults to this carrier/plan code.

If you have various carriers for the batch, leave these fields blank, and enter them for each patient during the entry process.

13. OUTLIER (1-A-R)
This field determines if outlier codes are required on each insurance payment in the batch. Enter **Y** for Yes or **N** for No; the default is N. This field is used only with the line item cash batch type of insurance (I) or both (B). This field is not applicable for Canadian claims (OHIP, WCB, and Universal).

14. DAYS (1-A-R)
This field indicates whether the number of paid days which this payment covers should be entered with the accompanying payment. The system uses this field to track DRG pay days versus billed days in third party logs. Enter **Y** for Yes or **N** for No; the default is N. This field is used only with the line item cash batch type of insurance (I) or both (B). This field is not applicable for Canadian claims (OHIP, WCB, and Universal).

15. DRG (1-A-R)
This field indicates whether the DRG paid should be entered with the payment. This field is used in third party logs to match the billed DRG number with the paid DRG number. Enter **Y** for Yes or **N** for No; the default is N. This field is used only with the line item cash batch type of insurance (I) or both (B). This field is not applicable for Canadian claims (OHIP, WCB, and Universal).

16. DRG EDIT (1-A-R)
This field indicates whether or not the entered DRG should be edited against the DRG Rate Master. Enter **Y** for Yes and **N** for No; the default is Y. For Canadian users, the default is N, since this field is not applicable for Canadian claims (OHIP, WCB and Universal).

17. COINSURANCE (1-A-R)
This field determines if coinsurance amounts are required on each insurance payment in the batch. Enter **Y** for Yes or **N** for No to indicate if it is required. The default is N. This field is used only with the line item cash batch type of insurance (I) or both (B).

18. DEDUCTIBLE (1-A-R)
This field determines if deductible amounts are required on each insurance payment in the batch. Enter **Y** for Yes or **N** for No to indicate if it is required. The default is N. This field is used only with the line item cash batch type of insurance (I) or both (B).

19. DEFAULT DISPOSITION (1-A-R)
This field determines by batch what the default disposition is for payments posted in this batch. Entries are either Final or Partial. The default is Final.

20. BATCH TOTAL (10-N-R)
This field contains the total of the batch according to your adding machine/calculator tape. An amount up to $99,999,999.99 can be entered. This field can be completed only by a user with a security level of 50 or higher.

21. TOTAL ENTERED (DISPLAY ONLY)
This field contains the total amount of all transactions entered.

22. VARIANCE (DISPLAY ONLY)
This field contains the difference between actual postings as Total Entered and Batch Total.

23. CLAIMS LIST (1-A-O)
This field allows you to define which claims display for the selected account in the line item insurance cash posting process. The following prompt is displayed:

Display only unpaid claims in the claims list by account? (Y/N) --

The field is not required and may be left blank. If you leave the field blank or select **N**, all claims on the account are displayed in the claims list by account. If you select **Y**, only unpaid claims are displayed. This field works with the Carrier and Plan fields on the setup screen to limit the claims displayed for the account. You may override this limit for an account at the time the claims are displayed.

Depending on the type of line item cash that you selected (**P**, **I**, or **B**), the system displays one of the following screens when you accept the Line Item Cash Posting Setup Processor screen.

NOTE: Post Line Item Cash uses several function keys. Refer to the explanation of function keys in the *General Information Volume* of the *STAR Patient Accounting Reference Guide*.

Patient

If you enter **P** for patient in the type field on the Line Item Cash Posting Setup Processor screen, the system displays the following screen.

```
             General Hospital Patient Line Item Cash Posting Processor
                                             Mon Feb 15, 1999 09:49 am

  Batch #     Description                    # of Transactions  # of Unapplied
   72         PATIENT BATCH 2/15/99          3
CASH                         Total Entered        Batch Total        Variance
                                   30.00             100.00             70.00
CONTRACTUAL ADJUSTMENTS   Total Entered        Batch Total        Variance
                                  680.00-            100.00            780.00


Name: DIANE WINTERS              PT:ER  Loc:AR  PC:BRD*s Acct Bal: $1,100.00
  Seq Account      T   Cr/Pln  CS   Amount       Disp Tran  Adj Tran/Amount
      Outlier Days DRG Coinsurance     Deductible        Remittance Number
   1   A9836400001  I   500/100 1              10.00   F  0008 0001 690.00-

   2   A9900100041  P                          10.00      0001
                                                            3
   3   A9900100038  I   500/200 1              10.00   F  0008 0001 10.00


Enter account number, '@'unapplied, '$'inq, '+'rev, '*'add clm  or '-'MPI lookup
 F1Prev Page F2Next Page F3 Insert  F4 Delete  F5Cmt/Not F6 Reset  F7  Exit   ?
```

Field Explanations

Fields 1-3 and 5-10 are the header information fields that are displayed on each screen. Field 4 is displayed everywhere except on the header screen and is needed to make you aware that unapplied cash entries exist on the batch. The Total Entered fields for Cash and Contractual Adjustments are continually updated as entries are added to the screen. The Cash Variance and Contractual Adjustments Variance fields are updated as entries are added to the screen. For a description of the function keys used on this screen, refer to the *General Information Volume* in the *STAR Patient Accounting Reference Guide.*

SEQ (DISPLAY ONLY)
This is the sequence number within this batch. For example, if there are ten payments to be made in this batch and this is the third payment being entered, the batch sequence number for this payment is 3.

ACCOUNT (10-N-R)
This field contains the account number. Enter the patient account number or use the Financial Patient Index (FPI) to select the patient. The account number must be in location PA, AR, or BD and in the selected facility. The account number is displayed with the facility code. Once selected, the account name and number are displayed above the batch detail. As you move among the batch entries, the name and balance of the individual entries display.

AMOUNT (9-N-R)

This field contains the amount of this payment. The range is 0 to $9,999,999.00. If the payment is a payment reversal, enter a minus sign (-) before the amount.

TRANSACTION CODE (4-N-R)

This field contains the patient transaction code. If you entered a default patient payment transaction code then this field is automatically filled in with that code when you press ENTER. If no default patient transaction code is entered on the Line Item Cash Posting Setup Processor screen but there is a payment transaction code on the patient's financial class then that code is automatically filled in when you press ENTER. If no default codes exist or you want to override the default code, you can select a valid code by entering a valid code or by using Table Lookup.

COMMENTS (210-C-O)

This field provides space for comments about the payment. Three lines of text, each with 70 characters, is provided. The comments lines display between the screen header fields and screen detail lines. The comment line is displayed for each entry that has a comment when the cursor is placed on the entry. Press the F5 function key to enter in your comments. Refer to the explanation of function keys in the *General Information Volume* in the *STAR Patient Accounting Reference Guide.*

NOTE: Until the batch is approved, entries to this screen may be modified, deleted, or added to the batch. The batch must be in balance to be approved. You may use your up and down arrow keys to move among the entries. You can insert a line by pressing the up arrow or down arrow at the top or bottom of the batch.

Insurance

If you enter **I** for insurance in the type field on the Line Item Cash Posting Setup Processor screen, the system displays the following screen.

```
           General Hospital Patient Line Item Cash Posting Processor
                                            Fri May 2, 2003  06:42 pm

  Batch #    Description                  # of Transactions  # of Unapplied
   11        INSURANCE ONLY
 CASH                       Total Entered        Batch Total        Variance
                                   .00            321,321.00       321,321.00
 CONTRACTUAL ADJUSTMENTS   Total Entered          Batch Total        Variance
                                   .00              1,090.00         1,090.00



 Name: BOB MOORE               PT:SER Loc:AR  PC:      Acct Bal: $347.76
   Seq Account        Cr/Pln   CS    Amount       Disp Tran  Adj Tran/Amount
     Out    Days DRG Coinsurance     Deductible     DS Remittance Number
   1   A02222-00001 500/700   1           300.00   F  0001  0001 1,234.00

   2   A01155-00002 500/005   5           100.00   F  0001  0001 100.00
       Days  123  120         123.00    12,345.00  Y  remittance number here...
   3   A01155-00002 500/005   5     1,234,567.00   D  0001  0001 10.00
       Cost  123  120   123,456.00         123.00  N  remittance number




  F1Prev Page F2Next Page F3 Insert  F4 Delete  F5Cmt/Not F6 Reset  F7  Exit   ?
 Screen Header Information
```

Field Explanations

Fields 1-3 and 5-10 are the header information fields that are displayed on each screen. Field 4 is displayed everywhere except on the header screen and is needed to make you aware that unapplied cash entries exist on the batch. The Total Entered fields for Cash and Contractual Adjustments are continually updated as entries are added to the screen. The Cash Variance and Contractual Adjustments Variance fields are updated as entries are added to the screen. For a description of the function keys used on this screen, refer to the *General Information Volume* in the *STAR Patient Accounting Reference Guide*.

SEQ (DISPLAY ONLY)
This is the sequence number within this batch. For example, if there are ten payments to be made in this batch and this is the third payment being entered, the batch sequence number for this payment is 3.

ACCOUNT (10-N-R)
This field contains the account number. Enter the patient account number or use the Financial Patient Index (FPI) to select the patient. The account number must be in location PA, AR, or BD and in the selected facility. The account number is displayed with the facility code. Once selected the account name and number are displayed above the batch detail. As you move among the batch entries, the names and balances of the individual entries are displayed.

CR/PLN (6-N-R)
This field contains the code of the carrier and plan associated with the payment for this account. If a default carrier is entered and the selected account has only that carrier assigned, the screen displays the plans for that carrier associated with the patient and you are prompted to select a plan to post the payment. If a default carrier/plan is entered and the selected account has only that carrier/plan assigned, this field is then automatically loaded for you and automatically goes to the CS field. If no default value has been entered, the system then displays a list of all carriers and plans assigned to the account and prompts you to select a carrier/plan to post the payment. If no default has been entered and the selected account has only one carrier assigned, the system will automatically load it for you.

If you entered a default carrier and the selected account does not have that carrier assigned, the following message is displayed on your screen:

> *Selected insurance not assigned to this account!*

The cursor returns to the account look up field.

If the account does not have any insurance and this batch is type I insurance, the following message is displayed:

> *Patient does not have any assigned insurance*

The cursor returns to the account number field.

CS (3-N-R)
This field contains, for the selected carrier/plan, the claim sequence number to post this payment. If there is only one sequence number for the selected carrier/plan, the system defaults to this number and automatically goes to the Amount field. If there are multiple claim sequences for the selected carrier/plan, a list is displayed at the bottom of your screen. You can then select the claim for which the payment is applied for the patient. The following provides you with a sample table that contains multiple claim sequences.

```
       CS     Bill             Service          Ext Claim #     Dsp
              From/Thru        From/Thru
( 1)   1      01/29 01/29/95   01/29 01/29/95   1246A           T
( 2)   5      02/29 02/29/95   02/29 02/29/95   22448           T
```

When this portion of your scrolling screen displays the multiple claim sequences, enter the claim sequence number that you want for the patient.

The claim sequence list is defined as follows:

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

BILL FROM/THRU (DISPLAY ONLY)
This field contains the billing from and through dates.

SERVICE FROM/THRU (DISPLAY ONLY)
This field contains the service from and through dates, from the Statement Covers Period in Locator 6 of the UB04..

EXT CLM # (DISPLAY ONLY)
This field contains the claim number manually assigned through the claim screens.

DSP (DISPLAY ONLY)
This field contains the current disposition of the claim.

NOTE: Even though the system allows you to enter an Ontario Ministry of Health carrier/plan, no OHIP claims are eligible for posting through Line Item Cash. Therefore, the system returns a *No Entries Defined* error even though OHIP claims exist.

AMOUNT (10-N-R)
This field contains the amount posted to the selected account. Enter the amount posted to the selected account. Negative numbers can be entered in this field.

Entering a payment amount of $0.00 allows you to enter a note or a comment on the account without updating the claim disposition on the account and without changing the claim completion status. If you want to post a note or comment to the account without changing the current claim disposition or claim completion status, you must also enter *No Disposition* as the Claim Disposition.

DISP (1-A-R)
This field contains the disposition of the claim. Entry options are F, A, C, P, T, or D; the default is F. You may also enter a hyphen (**-**) to do a table lookup. If the payment amount is $0.00, the default of F is no longer available, forcing you to enter a claim disposition. Also, if the payment amount is $0.00, you may enter **N** for No disposition.

If this is a final payment, enter **F** (final payment). If the claim is to be denied, enter **D** (denied). If the claim is to be written off, enter **A** (adjusted to zero). A disposition of F, A, or D flags the claim as paid in full and completes the claim.

If this is a partial payment and you do not wish to complete the claim, enter a disposition of **P** (partial), **T** (transfer), or **C** (clear disposition).

If you want to enter a note or a comment on the account without changing the current claim disposition or claim completion status, enter **N** for No Disposition.

This field also controls the transfers of remaining balances. Balances are transferred to another insurance, the patient, or third party excess. This happens only on accounts in AR and BD and only when all claims for the carrier are dispositioned as Final Payment, Adjusted to Zero, or Denied.

TRAN (4-N-R)
This field contains the insurance transaction code. If you entered a default insurance payment transaction code, this field is automatically filled in with that code when you press ENTER. If no default insurance transaction code is entered on the Line Item Cash Posting Setup Processor screen but there is a payment transaction code on the patient's insurance plan, that code is automatically filled in when you press ENTER. The system uses the payment transaction code associated with the master level insurance, not the account level insurance. If no codes exist, the system defaults the payment transaction code according to the patient indicator (inpatient or outpatient). If you want to override the default code, you can select a code by entering a valid code or by using Table Lookup.

ADJ TRAN/AMOUNT (10-N-O)
If the batch is set up to allow automatic contractual adjustments and this account qualifies for a contractual adjustment, the calculated adjustment amount and code is displayed. You can override the amount if necessary. Remember that contractual adjustments are automatically calculated only for final payments, but you may enter them for partial payments.

This code is displayed from the header if one exists. If not, the code is displayed from the Insurance/Carrier Plan table. The code may also be manually entered or overridden.

OUTLIER (1-A-C)
This field contains the outlier code associated with this payment. Enter **C** (cost) or **D** (day). Setting this code indicates additional money was paid to the hospital because of a cost of stay outlier. This field updates third party logs. This field is not applicable for Canadian claims (OHIP, WCB, and Universal).

DAYS (3-N-C)
This field contains the number of days paid that are associated with this payment. Enter the number of paid days. This field updates third party logs. This field is not applicable for Canadian claims (OHIP, WCB, and Universal).

DRG (3-N-C)
This field contains the paid DRG code associated with this payment. This must be a valid, three-digit DRG code. This field updates third party logs. This field is not applicable for Canadian claims (OHIP, WCB, and Universal).

COINSURANCE (12-N-C)
This field contains the coinsurance amount associated with the payment. Enter the coinsurance amount associated with this payment. This field updates third party logs.

DEDUCTIBLE (12-N-C)
This field contains the deductible amount associated with this payment. Enter the deductible amount associated with this payment. This field updates third party logs.

DS (1-A-0)
This field contains the Claim Denial Status, which indicates whether or not the claim is denied.

A question mark entered for this field displays the following help text:

Denied claim (Y/N)

A response of **N** for No indicates that the claim was not denied. If the field is left blank, it is interpreted as No.

If you respond with Yes to indicate that the claim was denied, the Denial Tracking Reason Code table is displayed and you are required to enter a Denial Tracking Reason Code from the Denial Tracking Reason Group associated with the insurance carrier plan. After selecting a Denial Tracking Reason Code from the table, the Insurance Cash Posting Processor screen is redisplayed. The system displays only Y or N, but the reason code is retained.

REMIT # (25-C-O)
This field contains the remittance number for this payment entered in the Post Line Item Cash Setup screen. You can override this number or enter a new remittance number if it was not entered on the set-up screen. When you press ENTER, the default value is automatically loaded into this field.

COMMENTS (210-C-O)
This field provides space for comments about the payment. Three lines of text, each with 70 characters, are allowed. The comments lines are between the screen header fields and screen detail lines. The comment line is displayed for each entry that has a comment when the cursor is placed on the entry. Press the F5 function key to enter your comments. Refer to the explanation of function keys in the *General Information Volume* in the *STAR Patient Accounting Reference Guide.*

NOTE: Until the batch is approved, entries to this screen may be modified, deleted, or added to the batch. The batch must be in balance to be approved.

No error messages are displayed for each account. For example, if the amount posted exceeds the carrier balance, a warning is not displayed. Line Item Cash assumes that you want to post the cash to the selected account regardless of any variance or discrepancy. However, accounts that qualify for the Cash Posting Exception report (FAR140) are included on that report.

The following prompt is displayed on this screen:

Enter choice, (L)ist All, (U)npaid, or (O)ther --

If you select **L**, all claims are displayed. This may be used when the setup screen for the insurance batch defines only unpaid claims to display. If you select **U**, only unpaid claims are displayed.

If you select O, the following prompt is displayed:

Limit claims by (D)isp, (B)ill Dt, or (S)ubm Dt [D] --

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

```
          General Hospital Patient Line Item Cash Posting Processor
                                             Thu Apr 20, 2000 01:19 pm

   Batch #    Description                    # of Transactions  # of Unapplied
   147        LAURA SMITH
 CASH                        Total Entered         Batch Total        Variance
                                     .00               100.00          100.00
 CONTRACTUAL ADJUSTMENTS    Total Entered         Batch Total        Variance
                                     .00                  .00             .00



 Name: THREE ADMIT                PT:I/P Loc:AR  PC:     Acct Bal: $107,528.00
   Seq Account          Cr/Pln   CS   Amount        Disp Tran  Adj Tran/Amount
     Outlier Days DRG Coinsurance      Deductible      Remittance Number
 Page:01                       Claim Disposition Codes        ##=Current Choices
 ( 1) A-Adjusted to zero                ( 6) C-Clear disposition
 ( 2) F-Final Payment                   ( 7) N-No disposition
 ( 3) D-Denied
 ( 4) P-Partial Payment
 ( 5) T-Transfer

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

You may select one or more Claim Disposition codes for claims to be displayed for the account. Notice that you may 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**, the system displays the following prompt:

Enter earliest bill thru date [Earliest] --

You may accept the default of Earliest, enter a specific date in the format MMDDYY, 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 to include [Latest] --

You may accept the default of Latest, enter a specific date in the format MMDDYY, or enter T - # to indicate the number of days prior to today to be used as the latest bill through date. Claims are 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**, 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 in the format MMDDYY, 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 in the format MMDDYY, 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**, then you may 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.

Both Patient and Insurance

If you enter **B** for both patient and insurance in the type field on the Line Item Cash Posting Setup Processor screen, the system displays the following screen.

```
          General Hospital Patient Line Item Cash Posting Processor
                                            Fri May 2, 2003  06:42 pm

   Batch #    Description                    # of Transactions  # of Unapplied
    11        INSURANCE ONLY
 CASH                       Total Entered         Batch Total          Variance
                                    .00          321,321.00        321,321.00
 CONTRACTUAL ADJUSTMENTS    Total Entered         Batch Total          Variance
                                    .00            1,090.00          1,090.00



 Name: DAN MOORE                   PT:SER Loc:AR  PC:     Acct Bal: $347.76
   Seq Account       T   Cr/Pln  CS   Amount        Disp Tran  Adj Tran/Amount
     Out    Days DRG Coinsurance      Deductible     DS  Remittance Number
   1   A02222-00001 I  500/700  1          300.00    F  0001 0001 1,234.00

   2   A01155-00002 I  500/005  5          100.00    F  0001 0001 100.00
       Days 123  120         123.00    12,345.00     Y  remittance number here...
   3   A01155-00002 I  500/005  5    1,234,567.00    D  0001 0001 10.00
       Cost 123  120   123,456.00          123.00    Y  Remittance number



  F1Prev Page F2Next Page F3 Insert  F4 Delete  F5Cmt/Not F6 Reset  F7  Exit   ?

```

Field Explanations

Fields 1-3 and 5-10 are the header information fields that are displayed on each screen. Field 4 is displayed everywhere except on the header screen and is needed to make you aware that unapplied cash entries exist on the batch. The Total Entered fields for Cash and Contractual Adjustments are continually updated as entries are added to the screen. The Cash Variance and Contractual Adjustments Variance fields are updated as entries are added to the screen. For a description of the function keys used on this screen, refer to the *General Information Volume* in the *STAR Patient Accounting Reference Guide.*

SEQ (DISPLAY ONLY)
This is the sequence number within this batch. For example, if there are ten payments to be made in this batch and this is the third payment being entered, the batch sequence number for this payment is 3.

ACCOUNT (10-N-R)
This field contains the account number. Enter the patient account number, or use the Financial Patient Index (FPI) to select the patient. The account number must be in location PA, AR, or BD and in the selected facility. The account number is displayed with the facility code. Once selected, the account name and number are displayed above the batch detail. As you move among the batch entries, the names and balances of the individual entries are displayed.

T (1-A-R)
This field contains the type of the line item cash batch. Enter **P** for patient or **I** for insurance. If you enter **P**, the cursor moves automatically to the Amount field. If you enter **I**, you are prompted to enter information in the Carrier Plan, Claim Sequence, Disposition, and Adjustment fields, as well as other insurance-related fields for the line.

CR/PLN (6-N-C)
This field contains the code of the carrier/plan associated with the payment for this account. If a default carrier is entered and the selected account has only that carrier assigned, the screen displays the plans for that carrier associated with the patient, and you are prompted to select a plan to post the payment. If a default carrier/plan is entered and the selected account has only that carrier/plan assigned, this field is then automatically loaded for you. If no default value has been entered, the system then displays a list of all carriers and plans assigned to the account and prompts you to select a carrier/plan to post the payment. If no default has been entered and the selected account has only one carrier assigned, the system automatically loads it for you.

If you entered a default carrier and the selected account does not have that carrier assigned, the following message is displayed on your screen:

Selected insurance not assigned to this account!

The cursor returns to the account look up field.

If the account does not have any insurance and this batch is type I for insurance, the following message is displayed on your screen:

Warning, patient does not have any assigned insurance

The cursor returns to the account number field.

CS (3-N-R)
This field contains the claim sequence number to post this payment for the selected carrier/plan. If there is only one sequence number for the selected carrier/plan, the system defaults to this number. If there are multiple claim sequences for the selected carrier/plan, a list is displayed at the bottom of your screen. You can then select the claim for which the payment is applied for the patient. The following provides you with a sample table that contains multiple claim sequences.

```
 CS    Bill    Service          Ext Claim #     Dsp
               From/Thru        From/Thru
 ( 1)  1       01/29 01/29/95   01/29 01/29/95  12403          T
 ( 2)  5       02/29 02/29/95   02/29 02/29/95  12244          T
```

When this portion of your scrolling screen displays the multiple claim sequences, enter the claim sequence number that you want for the patient.

The claim sequence list is defined as follows:

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

BILL FROM/THRU (DISPLAY ONLY)
This field contains the billing from and through dates.

SERVICE FROM/THRU (DISPLAY ONLY)
This field contains the service from and through dates, from the Statement Covers Period in Locator 6 of the UB04..

EXT CLM # (DISPLAY ONLY)
This field contains the claim number manually assigned through the claim screens.

DSP (DISPLAY ONLY)
This field contains the current disposition of the claim.

NOTE: Even though the system allows you to enter an Ontario Ministry of Health carrier/plan, no OHIP claims are eligible for posting through Line Item Cash. Therefore, the system returns a *No Entries Defined* error even though OHIP claims exist.

AMOUNT (10-N-R)

This field contains the amount posted to the selected account. Enter the amount posted to the selected account. Negative numbers can be entered in this field.

Entering a payment amount of $0.00 allows you to enter a note or a comment on the account without updating the claim disposition on the account and without changing the claim completion status. If you want to post a note or comment to the account without changing the current claim disposition or claim completion status, you must also enter *No Disposition* as the Claim Disposition.

DISP (1-A-R)

This field contains the disposition of the claim. Entry options are F, A, C, P, T, or D; the default is F. You may also enter a hyphen (**-**) to do a table lookup. If the payment amount is $0.00, the default of F is no longer available, forcing you to enter a claim disposition. Also, if the payment amount is $0.00, you may enter **N** for No disposition.

If this is a final payment, enter **F** (final payment). If the claim is to be denied, enter **D** (denied). If the claim is to be written off, enter A (adjusted to zero). A disposition of F, A, or D flags the claim as paid in full and completes the claim.

If this is a partial payment and you do not wish to complete the claim, enter a disposition of **P** (partial), **T** (transfer), or **C** (clear disposition).

If you want to enter a note or a comment on the account without changing the current claim disposition or claim completion status, enter **N** for No Disposition.

This field also controls the transfers of remaining balances. Balances are transferred to another insurance, the patient, or third party excess. This happens only on accounts in AR and BD, and only when all claims for the carrier are dispositioned as Final Payment, Adjusted to Zero, or Denied.

TRAN (4-N-R)

This field contains the patient or insurance transaction code. If you entered a default payment transaction code then this field is automatically filled in with that code when you press ENTER. If no default transaction code is entered on the Line Item Cash Posting Setup Processor screen but there is a payment transaction code on the patient's insurance plan, that code is automatically filled in when you press ENTER. If no default codes exist, the system defaults the payment transaction code according to the patient indicator (inpatient or outpatient). If you want to override the default code, you can select a valid code by entering a valid code or by using Table Lookup.

ADJ TRAN/AMOUNT (10-N-O)

If the batch is set up to allow automatic contractual adjustments and this account qualifies for a contractual adjustment, the calculated adjustment amount and code are displayed. You can override the amount if necessary. Remember that contractual adjustments are automatically calculated only for final payments, but you may enter them for partial payments.

This code is displayed from the header if one exists. If not, the code is displayed from the Insurance/Carrier Plan table. The code may also be manually entered or overridden.

OUTLIER (1-A-C)
This field contains the outlier code associated with this payment. Enter **C** (cost) or **D** (day). Setting this code indicates that additional money was paid to the hospital because of a cost of stay outlier. This field updates third party logs. This field is not applicable for Canadian claims (OHIP, WCB, and Universal).

DAYS (3-N-C)
This field contains the number of days paid that are associated with this payment. Enter the number of paid days. This field updates third party logs. This field is not applicable for Canadian claims (OHIP, WCB, and Universal).

DRG (3-N-C)
This field contains the paid DRG code associated with this payment. This must be a valid, three-digit DRG code. This field updates third party logs. This field is not applicable for Canadian claims (OHIP, WCB, and Universal).

COINSURANCE (12-N-C)
This field contains the coinsurance amount associated with the payment. Enter the coinsurance amount associated with this payment. This field updates third party logs.

DEDUCTIBLE (12-N-C)
This field contains the deductible amount associated with this payment. Enter the deductible amount associated with this payment. This field updates third party logs.

DS (1-A-0)
This field contains the Claim Denial Status, which indicates whether or not the claim is denied.

A question mark entered for this field displays the following help text:

Denied claim (Y/N)

A response of **N** for No indicates that the claim was not denied. If the field is left blank, it is interpreted as No.

If you respond with Yes to indicate that the claim was denied, the Denial Tracking Reason Code table is displayed and you are required to enter a Denial Tracking Reason Code from the Denial Tracking Reason Group associated with the insurance carrier plan. After selecting a Denial Tracking Reason Code from the table, the Insurance Cash Posting Processor screen is redisplayed. The system displays only Y or N, but the reason code is retained.

REMIT # (25-C-O)
This field contains the remittance number for this payment that was entered in the Post Line Item Cash Setup screen. You can override this number or enter a new remittance

number if it was not entered on the set-up screen. When you press ENTER, the default value is automatically loaded into this field.

COMMENTS (210-C-O)

This field provides space for comments about the payment. Three lines of text, each with 70 characters, are allowed. The comments lines are displayed between the screen header fields and screen detail lines. The comment line is displayed for each entry that has a comment when the cursor is placed on the entry. Press the F5 function key to enter in your comments. Refer to the explanation of function keys in the *General Information Volume* in the *STAR Patient Accounting Reference Guide.*

NOTE: Until the batch is approved, entries to this screen may be modified, deleted, or added to the batch. The batch must be in balance to be approved.

No error messages are displayed for each account. For example, if the amount posted exceeds the carrier balance, a warning is not displayed. Line Item Cash assumes that you want to post the cash to the selected account regardless of any variance or discrepancy. However, accounts that qualify for the Cash Posting Exception report (FAR140) are included on that report.

Unapplied

This function is used to record unidentified payments received. Unapplied cash is any payment that cannot be immediately matched to a patient account. In completing the associated screen fields, the purpose is to record as much information as possible about the payment to aid in its eventual identification and transfer to the correct account.

After this option is selected, the following screen is displayed.

```
           General Hospital Patient Line Item Cash Posting Processor
                                      Thu Apr 03, 2010 11:41 am

  Batch #    Description                # of Transactions  # of Unapplied
  255        LINE ITEM CASH BATCH 4/3/97  3                         1
  CASH                    Total Entered           Batch Total         Variance
                             3,000.00               3,000.00              .00
 CONTRACTUAL ADJUSTMENTS   Total Entered          Batch Total         Variance
                             13,700.38-              250.00          13,950.38


                              Unapplied Cash
  Seq  Payment By           Payment For              Amount
       Trans Code    Outlier  Days     DRG    Remit/Check/Card #
  1    CHECK                UNKNOWN PATIENT                  55.65
       0001                                    12311




  F1Prev Page F2Next Page F3 Insert  F4 Delete  F5Note F6 Reset  F7  Exit   ?
```

Field Explanations

SEQ (DISPLAY ONLY)
This is the sequence number within the unapplied function within the batch. For example, if there are ten payments within the batch and this is the third payment within Unapplied, the sequence number for this payment is 3.

PAYMENT BY (21-C-R)
This field contains any information about how the payment was received. Information entered here could include the carrier name, or the name on the check.

PAYMENT FOR (24-C-R)
This field contains information regarding the purpose of the payment (that is, for or to whom the payment was made).

AMOUNT (9-N-R)
This field contains the amount of this payment. The range is 0 to $9,999,999.00. If the payment is a payment reversal, enter a minus sign (-) before the amount.

TRANS CODE (5-AN-O)
This field contains the transaction type and code and the description that can be used to record the transaction. If the description is included with the transaction code, it is truncated to fit this field. You can enter the code or a hyphen (-) to display and select from a list of valid unapplied cash codes.

OUTLIER (1-A-O)
This field contains the outlier code that applies to this payment if one is known. Entry options are C (cost) or D (day).

DAYS (1-N-O)
This field contains the number of patient stay days covered by this payment. If this is a Medicare voucher, you may want to enter data in this field.

DRG EDIT? (12-C-O)
If the payment is a Medicare voucher, you can enter the DRG criteria for the payment. When this field is accessed, the following prompt is displayed:

Enter DRG Edit Criteria or `-` for table lookup--

You can enter the edit criteria or a hyphen (-) to display the list of DRG edit codes:

```
age:01                    Select Option for DRG Edit
( 1) N-No DRG Edit
( 2) I-DRG Indicator Not Required
( 3) R-DRG Indicator Required
( 4) M-Default to Medicare MS DRG Indicator
( 5) C-Default to Medicare Classic DRG Indicator
( 6) O-Default to Other DRG Indicator
( 7) T-Default to Tricare/Champus DRG Indicator
( 8) A-Default to Reimbursed APR DRG Indicator
```

REMIT/CHECK/CARD # (25-C-O)

This field contains the check, credit card, or remittance number.

POST WINDOW CASH

Post Window Cash provides immediate online posting of cash payment and adjustments. After a window batch is added, entered, or created, the following screen is displayed:

```
                   General Hospital Window Cash Posting Setup Processor
                                                    Thurs. Mar 21, 2002 10:10 am
   1 Batch code           2 Batch Description                    3 # of Trans
     CL1                    Cashier Lobby
   4 Posting Date         5 Print Receipts      6 Beginning Receipt Number
     11/20/89               Yes                   Auto
   CASH   7 Starting Balance  8 Total Entered   9 Batch Total    10 Variance

  ADJUSTMENTS                 11 Total Entered








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

Field Explanations

Fields 1 through 7 are the header fields that are displayed on various screens (as noted). This screen contains basic information about the batch being entered or edited.

1.   BATCH CODE (DISPLAY ONLY)
This field contains either the batch code you entered or the system-assigned identification code for this batch. Any three characters or numbers can be assigned to identify a batch. If the system assigns a code to this batch, the word auto is displayed until you edit this screen and a system-assigned code then is displayed when you enter this screen.

2.   BATCH DESCRIPTION (30-C-R)
This field contains the description associated with this batch. If you are editing a batch, the system displays the batch description entered when the batch was created. This field can be edited until the batch is posted.

3.   # OF TRANS (DISPLAY ONLY)
This field contains the number of component transactions within the batch if you are editing a batch. If you are creating a batch, this field is blank.

4. POSTING DATE (6-N-R)

This field contains the batch posting date. The system automatically assigns the current system date as the batch posting date. You have the option of keeping or changing this date, which is included in this account's transaction history. This date determines the GL period in which transactions post.

5. PRINT RECEIPTS? (1-A-R)

This field indicates whether receipts should print. Enter **Y** for Yes or **N** for No; the default is Y. If receipts have not been implemented, this field can be set to Yes or No, since receipts do not print in either case.

6. BEGINNING RECEIPT # (10-N-R)

This field specifies, if you have decided to print receipts, the beginning receipt number. You can enter a specific receipt number or allow the system to assign one. If the system assigns a receipt number, the word Auto is displayed.

7. STARTING BALANCE (10-N-O)

This field contains the opening dollars for reconciliation of a starting bank for cashiers. You can enter up to $99,999,999.99. This field is not required, but it allows the Amount Posted plus Starting Balance to balance to the Batch Total.

8. TOTAL ENTERED (DISPLAY ONLY)

If you are editing a batch, this field displays the total amount of all transactions entered. If you are creating a batch, this field is blank.

9. BATCH TOTAL (10-N-C)

This field contains the total of the batch according to your adding machine/calculator tape. An amount up to $99,999,999.99 can be entered. This field can only be completed by a user with a security level of 50 or higher. The Total Entered amount plus the Starting Balance must equal the batch total to approve a batch.

10. VARIANCE (DISPLAY ONLY)

If you are editing a batch, this field indicates the difference between actual postings as Total Entered and the Batch Total. If you are creating a batch, this field is blank. If a Starting Balance is entered, this variance is the Starting Balance plus the Total Entered, minus the Batch Total.

11. TOTAL ENTERED (DISPLAY ONLY)

If you are editing a batch, this field displays the total amount of all patient adjustments entered. If you are creating a batch, this field is blank.

After you accept this screen, the next screen displayed is the Window Cash Posting Selection Processor screen:

```
              General Hospital Window Cash Posting Selection Processor
                                                    Fri May 31, 2002 01:32 pm
Window Cash Posting Selection Input Options

              Option No.  Option
              ---------------------------------------
Post            1         Patient Cash


Print           2         Demand Bill


                3         Exit Batch







      Enter option number--
```

NOTE: For a description of the demand bill process, refer to the Patient Billing section
in the *Billing and Claims Volume* of the *STAR Patient Accounting Reference
Guide*.

To enter patient cash, select the Patient Cash option. The following screen is
displayed:

```
          General Hospital Patient Window Cash Posting Setup Processor
                                                    Fri May 31, 2002 01:43 pm


 1 Batch Code         2 Batch Description                    3 # of Trans
   156                  Friday batch
 4 Starting Balance   5 Total Entered      6 Batch Total     7 Variance
   444.00                                    444.00

                       Patient Cash Defaults
 8 Print Receipts                      9 Beginning Receipt #
   Yes                                   Auto
10 Trans Code/Description
->

                       Patient Adjustment Defaults
11 Trans Code/Description




   Enter transaction code, or '-' for list --

```

Field Explanations

1.   BATCH CODE (DISPLAY ONLY)
This field contains either the batch code you entered or the system-assigned identification code for this batch.

2.   BATCH DESCRIPTION (DISPLAY ONLY)
This field contains the description associated with this batch. If you are editing a batch, the system displays the batch description entered when the batch was created. This field can be edited until the batch is posted.

3.   # OF TRANS (DISPLAY ONLY)
This field contains the number of component transactions within the batch.

4.   STARTING BALANCE (DISPLAY ONLY)
This field contains the opening dollars for reconciliation of a starting bank for cashiers. The Amount Posted plus Starting Balance should equal the Batch Total.

5.   TOTAL ENTERED (DISPLAY ONLY)
This field displays the total amount of all transactions entered. If you are creating a batch, this field is blank.

6.   BATCH TOTAL (DISPLAY ONLY)
This field contains the total of the batch according to your adding machine/calculator tape. The Total Entered amount plus the Starting Balance must equal the batch total to approve a batch.

7.   VARIANCE (DISPLAY ONLY)
If you are editing a batch, this field indicates the difference between actual postings as Total Entered and the Batch Total. If you are creating a batch, this field is blank. If a Starting Balance is entered, this variance is the Starting Balance plus the Total Entered, minus the Batch Total.

The next fields are patient cash defaults.

8.   PRINT RECEIPTS? (1-A-R)
This field indicates whether receipts should print. Enter **Y** for Yes or **N** for No; the default is Y. If receipts have not been implemented, this field can be set to Yes or No, since receipts do not print in either case.

9.   BEGINNING RECEIPT # (10-N-R)
This field specifies, if you have decided to print receipts, the beginning receipt number. You can enter a specific receipt number or allow the system to assign one. If the system assigns a receipt number, the word Auto is displayed. This field is not accessible unless you entered Yes in the Print Receipts? field.

10. TRANS CODE/DESCRIPTION (5-AN-O)
This field contains the transaction type and code used to record this payment in the appropriate account's transaction history and in the general ledger. If the description is

included with the transaction code, it is truncated to fit this field. You can enter the code or a hyphen (-) to display and select from a list of valid codes under transaction type P (payment).

The next field is a patient adjustment default.

11. TRANS CODE/DESCRIPTION (5-AN-O)
This field contains the transaction type and code used to record this adjustment in the appropriate account's transaction history and in the general ledger. If the description is included with the transaction code, it is truncated to fit this field. You can enter the code or a hyphen (-) to display and select from a list of valid codes under transaction type A (adjustment).

After you accept this screen and enter an account number, the following screen is displayed:

```
                General Hospital Patient Window Cash Posting Processor
                                         Mon Mar 13, 2006 11:59 am
Account       Name                  FC Typ Admit    Disch       Balance Loc
A9902500002  ANDERSON,DIANE COOK     O  I/P 01/25/99            8550.25 PA/FCRV
 1 Patient Balance    2 Last Payment Date     3 Collection Agency
   5,000.00
 4 # of Payments      5 Total Payments                 6 Account Balance
                                                         8550.25
 7 Seq#   8 Pt Class                            9 New Account Balance
   1

10 Payment Amount    11 Receipt #        12 Remittance #
->
13 Payment Date      14 Posting Date     15 Trans Code/Description
   07/20/06              07/20/06            P0001-PERSONAL PAYMENT-CHECK
16 DB/CR             17 Adjust Amount    18 Adj Trans Code/Description
   CR

19 Comments
   01
   02
   03


Enter payment amount--
```

Field Explanations

1. PATIENT BALANCE (DISPLAY ONLY)
This field contains the patient balance for this account.

2. LAST PAYMENT DATE (DISPLAY ONLY)
This field contains the last date on which a patient payment was received on this account.

3. COLLECTION AGENCY (DISPLAY ONLY)
This field contains the code of the collection agency assigned to this account if the account is in account location BD.

4.   # OF PAYMENTS (DISPLAY ONLY)

This field contains the number of payments, either insurance or patient, made on this account.

5.   TOTAL PAYMENTS (DISPLAY ONLY)

This field contains the total dollar amount of all patient and insurance payments made on this account.

6.   ACCOUNT BALANCE (DISPLAY ONLY)

This field contains the current account balance.

7.   SEQ # (2-N-R)

This field indicates the order in which this payment is entered in this batch. For example, if there are ten payments made in this batch and this is the third payment entered, the batch sequence number for this payment is 3. The sequence number remains with this payment until the batch is posted or the payment deleted.

8.   PT CLASS (DISPLAY ONLY)

This field displays the financial patient classification combined with the alert and suppression indicators associated with the financial patient classification. The three-character patient classification code is displayed if a patient classification has been assigned to the account. Leading and trailing asterisks (**) display when the assigned patient classification has an alert designation. Finally, the follow-up suppression indicator is displayed as the final character in the field:

- a = alert only; follow-up is not suppressed

- c = suppression of follow-up has been cleared by a user

- s = follow-up is currently being suppressed

9.   NEW ACCOUNT BALANCE (11-N-R)

This field displays the new account balance when the payment field has been completed. Changing or adding a value to this field causes the New Account Balance to calculate and display.

10. PAYMENT AMOUNT (9-N-R)

This field contains the amount of this payment. The entry range is 0 to $9,999,999.00. If the payment amount exceeds the account balance, a message is displayed to that effect. The system accepts payments that exceed the balance. If you wish to enter a payment reversal for an NSF check, enter a minus sign (-) before the dollar amount.

11. RECEIPT # (10-AN-O)

If you requested that receipt numbers be printed, this field contains the receipt number for this payment. This number can be entered or automatically assigned by the system. The entry range is 0 to 9999999999 or A. If you enter **A**, this field contains auto. You can change the receipt number on an individual basis.

12. REMITTANCE # (25-C-O)
This field contains the check, credit card, or remittance advice number associated with this payment. This identification number is displayed in the patient's transaction history.

13. PAYMENT DATE (6-N-O)
This field contains the date on which this payment is made. The system displays the date from the batch header. You can enter a prior date in the format MMDDYY or MM/DD/YY. This date is used as the transaction date in this account's transaction history and the remittance date in account transaction history detail.

14. POSTING DATE (6-N-O)
This field contains the date on which this payment is posted. The system defaults to the date from the batch header. You can enter a prior date in the format MMDDYY or MM/DD/YY. This date is used as the posting date in this account's transaction history.

15. TRANS CODE/DESCRIPTION (5-AN-R)
This field contains the transaction type and code used to record this payment in this account's transaction history. If the description is included with the transaction code, it is truncated to fit this field. You can enter the code or a hyphen (-) to display and select from a list of valid codes under transaction type P (patient cash payment).

If the Transaction Code field on the default screen is blank, this field is completed by the system using information from the Financial Class table. The patient's financial class is used in the lookup. If the field is completed on screen 1, the system displays it in this field. This code can then be changed if necessary.

16. DB/CR (1-A-R)
This field indicates whether this is a debit or credit entry. Entry options are D (debit) or C (credit); the default is C. The system assumes a credit adjustment unless you override it. A credit adjustment decreases the balance of the account, while a debit increases the balance of the account.

17. ADJUSTMENT AMOUNT (9-N-C)
This field contains the user-entered adjustment amount. The entry range is 0 to $9,999,999.99.

18. ADJ TRANS CODE/DESCRIPTION (5-AN-0)
This field contains the transaction type and code used to record this adjustment in the appropriate account's transaction history and in the general ledger. If the description is included with the transaction code, it is truncated to fit this field. You can enter the code or a hyphen (-) to display and select from a list of valid codes under transaction type A (adjustment). This code is loaded from the batch header if a code was entered there. If you are doing a batch of the same adjustment, this field should be completed; otherwise, it must be entered for every account. If a Patient Adjustment Default was entered on the Patient Window Cash Posting Setup Processor Screen, this field is populated with the adjustment transaction code/description. Users can override the default adjustment transaction code.

19. COMMENTS (210-C-O)
This field provides space (three lines of 60 characters) for entering a comment about the payment or adjustment. Three lines of comment text are available. When you access this field, the system prompts you with:

Enter comments (C) or notes (N) --

If you enter **C** for comments, you are prompted to enter a comment about this payment. You can enter up to three lines of comments for this payment. Press F4 when you finish entering your comments. If you enter **N** for notes, the notes program is displayed on your screen. Refer to the Notes section in the *Billing and Claims Volume* of the *STAR Patient Accounting Reference Guide* for a description of entering notes for this payment.

If a comment or note is not necessary, press ENTER.

POST GUARANTOR CASH

Post Guarantor Cash is used to post patient cash by guarantor. It allows you to post patient cash across multiple facilities.

Accounts can be accessed by name, soundex, corporate number, social security number, unit number, account number, and EPN. The account number is accessed by entering **F** and the facility and account number. An example of an account number is *FA9711112345* with A as the facility indicator.

You can access Account Inquiry within a batch using the dollar sign ($) when prompted for an account. This feature enhances the accuracy of posting cash on accounts by providing a research mechanism.

From the Account Transactions Process screen, select Post Guarantor Cash. The following prompt is displayed on your screen:

Enter a batch code, 'A' for a system assigned number or '-' for list --

After your batch code is entered, the following screen is displayed.

```
              General Hospital Guarantor Cash Posting Setup Processor
                                                Wed Aug 18, 1993 03:26 pm

 1 Batch code          2 Batch Description                   3 # of Trans
   003                    Guarantor Batch 1                         2
 4 Posting Date        5 Payment Date     6 Trans Code/Description
   05/28/93               05/28/93           P0001-CASH PAYMENT
 7 Print Receipts?     8 Beginning Receipt #
   Yes                    Auto
 9 Starting Balance  10 Total Entered   11 Batch Total      12 Variance
->                            50.00             50.00               00.00
13 Comments
   01 Batch entries were entered on 8/18/92.




 Enter starting balance--            |
                    next screen(/) or previous screen(/P) [/]
```

Field Explanations

1. BATCH CODE (DISPLAY ONLY)
This field contains either the batch code you entered or the system-assigned identification number for this batch. Any three characters or numbers can be assigned to identify a batch. If the system assigns a code to this batch, the word "Auto" is displayed until you edit this screen, and a system-assigned code is then displayed when you enter this screen.

2.   BATCH DESCRIPTION (30-C-R)

This field contains the description of this batch. If you are editing a batch, the system displays the batch description entered when the batch was created. This field can be edited until the batch is posted.

3.   # OF TRANSACTIONS (DISPLAY ONLY)

If you are editing a batch, this field contains the number of component transactions within the batch. If you are creating a batch, this field is blank.

4.   POSTING DATE (6-N-R)

This field contains the batch posting date. The system automatically assigns the current system date. You have the option of keeping or changing this date, which is included in this account's transaction history. This date determines the GL period in which transactions post. Since guarantor cash batches may contain entries for multiple facilities, the posting date can only be set back to the lowest number of backdate days indicated in PAAR Control for all facilities.

5.   PAYMENT DATE (6-N-R)

This field contains the date on which the batch payments are made. The system automatically assigns the current system date. You have the option of keeping or changing this date. This date prints on patient statements. If entering a backlog of payments, you may wish to change this date.

6.   TRANS CODE/DESCRIPTION (25-AN-O)

This field contains the default transaction type and code and the description that is used to record the payment in each account's transaction history.

7.   PRINT RECEIPTS (1-A-R)

This field indicates whether receipts should print. Entry options are Y for Yes or N for No; the default is Y. If receipts have not been designed during the installation process or implemented since then, this field can be set to Yes or No, since receipts will not print in either case. If Yes is entered, receipts print for the facility of each individual entry in the batch.

8.   BEGINNING RECEIPT # (10-N-R)

This field specifies, if you have decided to print receipts, the beginning receipt number. You can enter a specific receipt number or allow the system to assign one. If the system assigns a receipt number, the word Auto is displayed.

9.   STARTING BALANCE (10-N-O)

This field contains the opening dollars for reconciliation of a starting bank for cashiers. You can enter up to $99,999,999.99. This field is not required, but it is included with the amount posted balance to the Batch Total.

10. TOTAL ENTERED (DISPLAY ONLY)

If you are editing a batch, this field displays the total amount of all transactions entered. If you are creating a batch, this field is blank.

11. BATCH TOTAL (10-N-C)
This field contains the total of the batch according to your adding machine/calculator tape. An amount up to $99,999,999.99 can be entered. This field can only be completed by a user with a security level of 50 or higher. The Total Entered amount plus the Starting Balance must equal the batch total to approve a batch.

12. VARIANCE (DISPLAY ONLY)
This field indicates the difference between actual postings as Total Entered and the Batch Total. When you are creating a batch, this field is blank. If a Starting Balance is entered, this variance is the Starting Balance plus the Total Entered, minus the Batch Total.

13. COMMENTS (210-C-O)
This field provides space (three lines of 70 characters) for entering a comment about the payment. Three lines of comment text are available. When you access this field, the system prompts you with:

Enter comments (Y/N) [N] --

Enter **Y** for Yes to enter up to three lines of comments. Enter **N** for No or press ENTER if you do not want to enter comment text.

NOTE: The comment that you enter here updates the entries within the batch. You can override this comment by entering in a new comment for a particular entry within the batch. Comments entered here will not update entries which already exist in the batch. Further modification to an existing comment will not update existing entries in the batch.

After you complete this screen, the system asks you to select a guarantor to which the patient payment is applied. You do so by using the standard lookup procedure. After a guarantor is selected, the system displays each account associated with that guarantor in all facilities, as shown in the following screen:

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```
                 General Hospital Guarantor Cash Posting Processor
                                               Wed Jun 6, 1999 01:58 pm
Corporate    Guarantor Name              Birthdate   Phone              PC
00001290     ANDERSON,DIANE COOK         03/03/59    (770)288-8288      *BRD*
Guarantor/Account - * Custom Sched, # Pymt Plan, @ Separate Schedule
Pt Class - a Alert, s Suppressed F/U, c Cleared
Page:01              PA, AR, BD Guarantor Accounts
     Account      Patient Name   PT  Disch   FC  Account    Patient Loc  P

( 1) c A9902500002 ANDERSON,DIANE I/P          O   8550.25    457.50 PA
( 2) s A9900100039 ANDERSON,CAROL ER  01/01/99 O    100.00    100.00 AR    F
( 3) a A9900100040 ANDERSON,CAITL ER  01/01/99 O    100.00      5.00 PA
( 4)  @A9900100041 ANDERSON,BAILE ER  01/01/99 S     90.00     90.00 AR    F
( 5)   A9900100042 ANDERSON,ITTY  ER  01/01/99 O    100.00    100.00 AR    F
( 6) s A9836400001 ANDERSON,DIANE ER  12/30/98 O   1100.00    375.00 AR    F




Select account--
```

After you select an account, the system displays the following screen:

```
                 General Hospital Guarantor Cash Posting Processor
                                               Mon Mar 13, 2006 11:59 am
Account      Name               FC Typ Admit    Disch       Balance Loc
A0613900004  KANE, BOB          O  I/P 05/19/06             43243.15 PA /INSR
 1 Patient Balance    2 Last Payment Date    3 Collection Agency
   27,590.00-
 4 # of Payments      5 Total Payments                6 Account Balance
                                                        43,243.15
 7 Seq#   8 Pt Class                                  9 New Account Balance
   1

10 Payment Amount     11 Receipt #        12 Remittance #
->
13 Payment Date       14 Posting Date     15 Trans Code/Description
                                             P0001-PERSONAL PAYMENT-CHECK

16 Comments
   01
   02
   03


Enter payment amount--
```

Field Explanations

1. PATIENT BALANCE (DISPLAY ONLY)
This field contains the patient balance for this account.

2. LAST PAYMENT DATE (DISPLAY ONLY)
This field contains the last date on which a patient payment was received on this account.

3. COLLECTION AGENCY (DISPLAY ONLY)
This field contains the code of the collection agency assigned to this account if the account is in account location BD.

4. # OF PAYMENTS (DISPLAY ONLY)
This field contains the number of payments, either insurance or patient, made on this account.

5. TOTAL PAYMENTS (DISPLAY ONLY)
This field contains the total dollar amount of all patient and insurance payments made on this account.

6. ACCOUNT BALANCE (DISPLAY ONLY)
This field contains the current account balance.

7. SEQ # (DISPLAY ONLY)
This field indicates the order in which this payment is entered in this batch. For example, if there are ten payments made in this batch and this is the third payment entered, the batch sequence number for this payment is 3. The sequence number remains with this payment until the batch is posted or the payment deleted.

8. PT CLASS (DISPLAY ONLY)
This field displays the financial patient classification combined with the alert and suppression indicators associated with the financial patient classification. The three character patient classification code is displayed if a patient classification has been assigned to the account. Leading and trailing asterisks (**) display when the assigned patient classification has an alert designation. Finally, the follow-up suppression indicator is displayed as the final character in the field:

- a = alert only; follow-up is not suppressed

- c = suppression of follow-up has been cleared by a user

- s = follow-up is currently being suppressed

9. NEW ACCOUNT BALANCE (11-N-R)
This field displays the new account balance when the payment field has been completed. Changing or adding a value to this field causes the New Account Balance to calculate and display.

10. PAYMENT AMOUNT (9-N-R)
This field contains the amount of this payment. The entry range is 0 to $9,999,999.00. If the payment amount exceeds the account balance, a message is displayed to that effect. The system accepts payments that exceed the balance. If you wish to enter a payment reversal, enter a minus sign (-) before the dollar amount.

11. RECEIPT # (10-AN-C)
If you requested that receipt numbers be printed, this field contains the receipt number for this payment. This number can be entered or automatically assigned by the system.

The entry range is 0 to 9999999999 or A. If you enter **A**, this field contains auto. You can change the receipt number on an individual basis.

12. REMITTANCE # (25-C-O)
This field contains the check, credit card, or remittance advice number associated with this payment. This identification number displays in the patient's transaction history.

13. PAYMENT DATE (6-N-R)
This field contains the date on which this payment is made. The system displays the date from the batch header. You can enter a prior date in the format MMDDYY or MM/DD/YY. This date is used as the transaction date in this account's transaction history and the remittance date in account transaction history detail.

14. POSTING DATE (6-N-R)
This field contains the date on which this payment is posted. The system defaults to the date from the batch header. You can enter a prior date in the format MMDDYY or MM/DD/YY. This date is used as the posting date in this account's transaction history.

15. TRANS CODE/DESCRIPTION (25-AN-R)
This field contains the transaction type and code used to record this payment in this account's transaction history. If the description is included with the transaction code, it is truncated to fit this field. You can enter the code or a hyphen (-) to display and select from a list of valid codes under transaction type P (cash payment).

If the Transaction Code field on screen 1 is blank, this field is completed by the system using information from the Financial Class table. The patient's financial class is used in the lookup. If the field is completed on screen 1, the system displays it in this field. This code can then be changed if necessary.

16. COMMENTS (210-C-O)
This field provides space (three lines of 70 characters) for entering a comment about the payment. Three lines of comment text are available. When you access this field, the system prompts you with the following:

> *Enter comments (C) or notes (N) --*

If you enter **C** for comments, you are prompted to enter a comment about this payment. You can enter up to three lines of comments for this payment. Any comment entered in this field overrides the default comment entered on the setup screen. Press F4 when you finish entering your comments. If you enter **N** for notes, the notes program is displayed on your screen. Refer to the Notes section in the *Billing and Claims Volume* of the *STAR Patient Accounting Reference Guide* for a description of entering notes for this payment.

If you enter **N** for notes, you can choose to enter standard or free-form notes that post to the account for the guarantor for which you are posting cash.

If you enter **S** for selected accounts, you select either the account(s) that you want to enter a standard or free-form note on or **A** for all of the accounts for the guarantor.

If a comment is not necessary, press ENTER.

When these fields are completed, you have the option of selecting another guarantor, exiting from the function, or returning to the set-up screen.

POST AGENCY CASH

This function is used to post agency cash for both BD and AR accounts. When this function is accessed, the following options are displayed:

- Manually Post BD Agency Cash

- Upload BD Agency Cash Process

- Upload AR Agency Cash Process

- Manually Post AR Agency Cash

Each of these options is discussed below.

Manually Post BD Agency Cash

This function is used to update accounts with payments on BD accounts collected by collection agencies. After you select this function, the system prompts you to select a facility (if this is a multifacility installation) and then to enter a batch code. You can create a new batch to post this agency cash or add it to an existing, unposted batch of agency cash. After the records are uploaded, the system creates the Collection Agency Tape Errors Report, FXPCPTE, which lists payments with various types of errors. The Collection Agency Tape Payments Report (FXPCPTP) is created. The report identifies payments posted to patient accounts.

You can access Account Inquiry within a batch using the dollar sign ($) when prompted for an account. This feature enhances the accuracy of posting cash on accounts by providing a research mechanism.

NOTE: This transaction accesses agency cash batches only.

After a batch code is entered, the system displays the following screen, which records basic information about this agency cash batch.

```
                  General Hospital Agency Cash Posting Setup Processor
                                                     Fri Dec 30, 1988 10:10 am
   1 Batch code         2 Batch Description                    3 # of Trans
     5                    ACME Fees for October                  1
   4 Agency Code/Description              5 Total Entered
     ACME-ACME COLLECTION AGENCY            1100.00
   6 Check Amount       7 Agency Fees     8 Batch Total     9 Variance
     1000.00              100.00            1100.00
  10 Posting Date       11 Payment Date   12 Remittance #
     05/02/88             05/02/88           400192
  13 Trans Code/Description
     E0001-Collect from agency






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

Field Explanations

1. BATCH CODE (DISPLAY ONLY)
This field contains the batch code entered or auto if the system assigned the code for this batch. Any three characters or numbers can be used to identify a batch.

2. BATCH DESCRIPTION (30-C-R)
This field contains the description of this batch.

3. # OF TRANS (DISPLAY ONLY)
This field contains the number of transaction in this batch.

4. AGENCY CODE/DESCRIPTION (6-N-R)
This field identifies the agency from where the payments have come. You can enter the code or a hyphen (-) to display and select from a list of valid codes.

5. TOTAL ENTERED (DISPLAY ONLY)
This field contains the total amount entered.

6. CHECK AMOUNT (9-N-R)
This field contains the amount of the agency payment. The entry range is: -999,999.99 to $9,999,999.99.

7. AGENCY FEES (9-N-R)
This field contains the amount withheld from the check amount for the agency's collection fee. The entry range is -9,999,999.99 to $9,999,999.99. The amount of this fee plus the agency payment is used to balance with the batch total. The Check

Amount plus the Agency Fee is compared to the batch total. If the agency did not withhold its fee from the check, enter 0.00 in this field.

8. BATCH TOTAL (9-N-R)
This field contains the total for this batch according to the information supplied by the collection agency. The range is 0 to $9,999,999.99.

9. VARIANCE (DISPLAY ONLY)
This field contains the difference, if any, between the Batch Total and the Total Entered fields. If this field contains any amount other than 0, the batch is unbalanced.

10. POSTING DATE (6-N-O)
This field contains the date on which this payment is posted. The default is from the batch header. You can change the date in this field to a prior date but not to a future one. This date updates the appropriate General Ledger fiscal period.

11. PAYMENT DATE (6-N-O)
This field contains the date on which this payment is made. The system displays the date from the batch header. You can enter a prior date. This date is used as the transaction date in this account's transaction history and the remittance date in account transaction history detail.

12. REMITTANCE # (25-C-O)
This field contains the check, credit card or remittance advice number associated with this payment. This appears in the patient's transaction history.

13. TRANS CODE/DESCRIPTION (5-AN-R)
This field contains the transaction type and code that is used to record the payment in the account's transaction history. If the description is included with the transaction code, it is truncated to fit this field. You can enter the code or a hyphen (-) to display and select from a list of valid codes under transaction type E (agency cash collected). If not entered, it is supplied by the code indicated in the Collection Agency table.

When these fields are completed, the system prompts you to select the patient account to which this agency payment is to be applied. Use the standard lookup procedure to select an account. The system then displays this screen used to define the patient-specific posting details.

NOTE: To post agency cash to a patient account, that account must be assigned to the collection agency specified or must have been previously assigned to the collection agency and then transferred back to Accounts Receivable. The system verifies the account/agency combination is valid. If the combination is

not valid, the system displays an error message and does not allow the payment to be posted.

```
                General Hospital Agency Cash Posting Processor
                                        Mon Mar 13, 2006 11:59 am
Account      Name                   FC Typ Admit    Disch       Balance Loc
A9720500002  TAYLOR,SILVA            S  O/P 07/24/97 07/24/97      35.00  BD/FCRV
 1 Bad Debt Balance     2 BD Transfer Date   3 Batch Seq #  4 New Acct Balance
   35.00                  01/13/98               3
 5 Pt Class
   **BNK**a
 6 Payment Amount       7 Remittance #                   8 Payment Date
->                                                          02/10/99
 9 Posting Date        10 Trans Code/Desc
   02/10/99               E0001-COLLECTION AGENCY CASH

11 Comments
   01
   02
   03




 Enter payment amount--
```

Field Explanations

Fields 1, 2, 3, 4, and 5 - Bad Debt Balance, BD Transfer Date, Batch Sequence #, New Account Balance, and Pt Class - cannot be edited.

1. BAD DEBT BALANCE (DISPLAY ONLY)
This field contains the current balance of the account.

2. BD TRANSFER DATE (DISPLAY ONLY)
This field contains the date on which the account was sent to the agency.

3. BATCH SEQ # (DISPLAY ONLY)
This field contains the system-assigned sequence number of the payment within the batch.

4. NEW ACCOUNT BALANCE (11-N-R)
This field displays the new account balance when the payment field has been completed. Changing or adding a value to this field causes the New Account Balance to calculate and display.

5. PT CLASS (DISPLAY ONLY)
This field displays the financial patient classification combined with the alert and suppression indicators associated with the financial patient classification. The three-character patient classification code is displayed if a patient classification has been assigned to the account. Leading and trailing asterisks (**) display when the assigned patient classification has an alert designation. Finally, the follow-up suppression indicator is displayed as the final character in the field:

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- a = alert only; follow-up is not suppressed

- c = suppression of follow-up has been cleared by a user

- s = follow-up is currently being suppressed

6. PAYMENT AMOUNT (9-N-R)
This field contains the amount being posted. The range is -9,999,999.99 to
$9,999,999.99. If the payment exceeds the account balance for this account, the
system displays a message to that effect but allows the payment to be entered. This
payment prints on the Cash Exception report if it exceeds the balance. If the payment
is a payment reversal, enter a minus sign (**-**) before the amount.

7. REMITTANCE # (25-C-O)
This field contains the remittance number (if any) for this payment. It is usually a check
or remittance advice number.

8. PAYMENT DATE (6-N-O)
This field contains the date on which this payment is made. The system displays the
date from the batch header. You can enter a prior date. This date is used as the
transaction date in this account's transaction history and the remittance date in account
transaction history detail.

9. POSTING DATE (6-N-O)
This field contains the date this payment is posted. The system defaults to the date
from the batch header. You can enter a prior date. This date is used as the posting date
in this account's transaction history.

10. TRANS CODE/DESCRIPTION (5-AN-R)
This field contains the transaction type and code used to record this payment in this
account's transaction history. If the description is included with the transaction code, it
is truncated to fit this field. This code can be changed for each cash posting. It is
supplied from the batch header.

11. COMMENTS (240-C-O)
This field provides space (three lines of 80 characters) for entering a comment about
the payment. When you access this field, the system prompts you with:

   Enter comments (Y/N) [N]?--

Enter **Y** for Yes, to enter up to three lines of comments. Enter **N** for No or press ENTER
if you do not want to enter comment text.

When these fields are completed, you can enter another agency payment or exit the batch. If you exit the batch, the following screen is displayed:

```
              General Hospital Agency Cash Posting Exit Batch Processor
                                            Fri Jul 12, 2008 02:08 pm

* = Pt Class - a Alert, s Suppressed F/U, c Cleared
Page:01      Batch  74 - agency payment                    ##=Current Choices
   Seq#  Type              Amount       C/A Amt   *   Account     Name
( 1) 1    Agency            10.00          .00    a   9720500002 TAYLOR,SILVA
( 2) 2    Agency            19.95          .00    a   9720500002 TAYLOR,SILVA
( 3) 3    Agency            20.00          .00    a   9720500002 TAYLOR,SILVA














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

Field Explanations

1. SEQ (DISPLAY ONLY)
This field contains the system-assigned number identifying the claim in a batch.

2. TYPE (DISPLAY ONLY)
This field contains the batch type. Types include (P)atient, (I)nsurance, (M)iscellaneous, (L)ine, (G)uarantor, and (U)napplied. If it is a mixed batch, this field is blank. If the batch type is Insurance, asterisk folows (for example Insurance*) if the claim disposition rule selected the claim. If the claim disposition rule selected the claim but encountered an error, the Type field dispays with an E, for example, InsuranceE.

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

4. C/A AMT (DISPLAY ONLY)
This field contains the contractual adjustment amount. A lowercase letter may be displayed to the right of the field, indicating the following:

• A lowercase *d* indicates that this ERA transaction contains a denial and the parameter is set not to take a contractual adjustment if it is a denial.

• A lowercase *t* indicates that a takeback transaction, which previously didn't have a contractual adjustment, posted due to a denial.

- A lowercase *s* indicates that this ERA transaction contains a subsequent denial and the parameter is set not to take a contractual adjustment if it is a denial.

5. ACCOUNT (DISPLAY ONLY)
This field contains the account number for the patient.

6. NAME (DISPLAY ONLY)
This field contains the patient's name.

Upload BD Agency Cash Process

This function is used to upload an interface file from either the PC or from a UNIX directory. When this function is accessed, the BD Agency Cash Posting Setup Processor is displayed, as shown under . After you select a batch, the following prompt is displayed:

Upload from (P)C or (U)NIX (P/U) [U]--

- If you choose **U** (UNIX), the following prompt is displayed:

Enter the file name to upload --

After you enter the file name to upload, the following prompt is displayed. The UNIX directory used is taken from information defined in the Collection Agency Code table:

Upload interface file? (Y/N) [Y]--

UNIX File Name: /hbo/tmp/yyyy

If you enter **Y** (Yes) to upload the interface file, the upload process begins, and the system notifies you when the upload is complete.

- If you choose **P** (PC), the following prompt is displayed:

Enter the drive [A]--

After you enter the drive name, the following prompt is displayed:

Enter the directory [\]--

After you enter the directory, the following prompt is displayed:

Enter the file name to upload --

After you enter the file name to upload, the following prompt is displayed:

Upload interface file? (Y/N) [Y]--

PC File Name: A:\yyyy

If you enter **Y** (Yes) to upload the interface file, the upload process begins, and the system notifies you when the upload is complete.

Manually Post AR Agency Cash

This option is used to edit an uploaded batch file. There are two screens used in this process. The first screen displays basic information about this batch and provides an opportunity to update starting balance and agency fee information. The second screen allows you to print receipts and to define a payment transaction code. After this point, you can select an account for posting payments.

Upload AR Agency Cash Process

This function is used to upload an interface file from a UNIX directory. Payments may be posted to accounts in location PA, AR, BD. When this function is accessed, the system displays files available to be uploaded. Files reviewed have a file extension of .pmt and are located in UNIX directories defined in the Collection Agency Code table and in the Patient Compass parameter screen. When this field is accessed, the following screen is displayed:

```
               General Hospital AR Agency Cash Posting Setup Processor
                                                Tue Aug 14, 2007 09:51 am


Page:01                         Payment Upload Files

( 1) /hbo/tmp/PCpay.pmt


Enter choice--

```

After a file is selected, the following prompt is displayed:

Are you sure you want to process this file? (Y/N) [Y]--

File Name: /hbo/tmp/PCpay.pmt

After the file is uploaded, the file can be updated by using the menu option of Manually Post AR Agency Cash.

MAINTAIN UNAPPLIED CASH

This function transfers payments made through the Post Unapplied Cash transaction to their proper destination (for example, patient, insurance, guarantor, or a miscellaneous account). The system provides a detailed, online listing of all postings in the unapplied account for your review and selection. After you select a detail line, you can indicate its proper account destination. For audit purposes, both sides of the unapplied transfer posting appear on the daily cash report. After the payment is posted, the amount transferred is deleted from the unapplied cash log and the appropriate account transaction history is updated. The entire payment must be transferred to an account. Partial transfer of the dollars is not allowed.

After you select the Maintain Unapplied Cash option, the system prompts you to decide if you want to print receipts for these transfers and, if so, what the beginning receipt number should be. If you want to print receipts, you can enter an up to 10-digit beginning receipt number or **A** to let the system assign receipt numbers automatically. Once you respond to these prompts, the system asks you to enter an unapplied cash sequence number or a hyphen (-) to display and select from a list of existing unapplied cash entries.

```
                 General Hospital Maintain Unapplied Cash Processor
                                         Fri Dec 30, 1988 10:10 am

 Page:01                         Unapplied Cash Transactions        ##=Current Choices
        Seq     Post Date        Amount Out Day DRG   TCode  Remittance/Check/Card #   ID
  ( 1) 1       04/20/98           20.00                U2000
  ( 2) 2       04/20/98           30.00                U3000
  ( 3) 3   R   04/20/98           20.00                U0001  324                      JLP
  ( 4) 4       04/20/98           30.00                U3000
  ( 5) 10      04/27/98            1.00                U1000  remittance number 123456
  ( 6) 11      04/27/98            1.00                U1000
  ( 7) 13      04/27/98            5.00                U1000
  ( 8) 14      04/25/98           25.00                U3000  3454




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

Unapplied cash transfers backed out and accounts transferred print on the Daily Cash Detail report in Batch O.

NOTE: Printed receipts must be available for your facility to receive them.

Information listed includes the sequence number of the unapplied payment, its posting date, the payment amount, the outlier code, the number of patient stay days paid, the DRG code associated with this payment (if any), the transaction type and code, and the remittance number.

After you make your selection, the system displays the following screen:

```
               General Hospital Maintain Unapplied Cash Processor
                                        Thu Apr 23, 1998 11:25 am

 1 Payment By                          2 Payment For
   ROBERTS,MARTIN                         ROBERTS,MARTIN
 3 Address Line 1                      4 Address Line 2
   786 WINDING LANE                       APT. 42-N
 5 City                                6 State              7 Zip Code
   TALLAHASSEE                            FL                   33346
 8 Remittance/Check/Card #             9 Payment Amount     10 DRG Paid
   1                                      100.00
11 Trans Code/Description             12 Days Paid          13 Outlier Code
   U9999-UNAPPLIED CASH CODE
14 Payment Date     15 Posting Date   16 Trans Seq #
   03/26/98            03/26/98           1
17 Comments
        01 COMMENT LINE 1
        02 COMMENT LINE 2
        03 COMMENT LINE 3
18 Type of Cash                       19 Edit By
->                                        Harrison,Geneva S
Select `A`gency,`G`uar,`I`ns,`C`ontract,`M`isc,`P`atient,or `R`efund [A]--  |
```

All of the fields on this screen, with the exception of the Type of Cash field, are completed by the system using information entered in the unapplied cash batch. You have the option of applying this payment to an Agency, Guarantor, Insurance, Contract, Miscellaneous, Patient account, or Refund. If you choose **R** (refund) for Type of Cash, the Address information is required to complete the screen.

NOTE: Unapplied cash to Canadian OHIP claims is posted to individual claim charge detail lines.

Unapplied Cash to an Agency Payment

To transfer unapplied cash to an agency payment, enter **A**. The system displays the following screen:

```
               General Hospital Maintain Unapplied Cash Processor
                                            Fri Dec 30, 1988 10:10 am

  1 Agency Code/Description                     2 Trans Amount
    AAA - AAA COLLECTIONS                          350.00
  3 Check Amount              4 Agency Fees
    325.00                      25.00












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

Field Explanations

1. AGENCY CODE/DESCRIPTION (6-N-R)
This field contains the code of the collection agency that made this payment. You can enter the code or a hyphen (-) to display and select from a list of valid collection agency codes.

2. TRANSACTION AMOUNT (DISPLAY ONLY)
This field contains the total amount of this transaction as entered in the Post Unapplied Cash function.

3. CHECK AMOUNT (9-N-O)
This field contains the same amount here as it does in the Transaction Amount field. You can change this amount with an entry of an amount up to $9,999,999.99. If the changed amount exceeds the transaction amount, the system displays an error message but posts the transaction amount. This field is used only for balancing of the transaction amount and agency fee with the check amount.

4. AGENCY FEES (DISPLAY ONLY)
This field contains the amount retained by the agency as its fee for collecting this account. This amount plus the check amount must equal the transaction amount. The system automatically completes this field. For example, if the transaction amount is $1000.00 and the check amount is $650.00, the system automatically completes the Agency Fees field with $350.00.

When these fields are completed, the system prompts you to use the standard lookup procedure to select the patient account associated with this payment. When the account is selected, the system displays the following screen:

```
            General Hospital Maintain Unapplied Cash Processor
                                            Mon Mar 13, 2006 11:59 am
Account      Name                 FC Typ Admit    Disch      Balance Loc
A05002-92073 SOUTHERLAND,CARY        SP E/R 10/10/88 10/10/88    104.00  BD
 1 Bad Debt Balance    2 BD Transfer Date   3 Trans Seq #
   433.59                02/15/89              5

 4 Payment Amount      5 Remittance #                6 Payment Date
   104.00                0001                           10/17/88
 7 Posting Date        8 Trans Code/Desc
   10/17/88






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

Field Explanations

Fields 1 through 3 - Bad Debt Balance, BD Transfer Date, and Batch Sequence # - are completed by the system and cannot be edited.

1. BAD DEBT BALANCE (DISPLAY ONLY)
This field contains the current balance of the account.

2. BD TRANSFER DATE (DISPLAY ONLY)
This field contains the date on which the account was sent to the agency.

3. TRANS SEQ # (DISPLAY ONLY)
This field contains the unapplied cash sequence number of this transaction within the unapplied cash batch.

Fields 4 through 7 are supplied by the system based on the original payment applied to the unapplied account. They cannot be edited.

4. PAYMENT AMOUNT (DISPLAY ONLY)
This field contains the amount being posted.

5. REMITTANCE # (DISPLAY ONLY)
This field contains the remittance number (if any) entered previously for this payment. It is usually a check or remittance advice number.

6. PAYMENT DATE (DISPLAY ONLY)
This field contains the date on which this payment is made.

7. POSTING DATE (DISPLAY ONLY)

This field contains the date on which this payment is posted.

8. TRANS CODE/DESCRIPTION (5-AN-R)

This field contains the transaction type and code used to record this payment in this account's transaction history. If the description is included with the transaction code, it is truncated to fit this field. The system loads the transaction code used on screen 1. This code can be changed for each cash posting.

After the entry is transferred, it is deleted from Unapplied Cash and entered in the patient account transaction history. The comment in the transaction history for this transfer is Unapplied Cash Transfer and the batch code becomes 0.

After you complete this screen, you can enter another unapplied cash payment or exit the batch.

Unapplied Cash to a Guarantor Payment

If you want to transfer unapplied cash to a guarantor payment, enter **G**. The system prompts you to select a guarantor using the standard lookup procedure. After a guarantor is selected, the patient accounts for which the guarantor is responsible are displayed in the following format:

```
Corporate   Guarantor Name                 Birthdate       Phone        PC
00001415    HALL,FRED                      01/01/01
Page:01              PA, AR, BD Guarantor Accounts
    Patient Name         Pt  Disch   FC   Account    Patient   Insurance Loc
( 1) HALL,FRED           I/P 01/02/95 DD   3210.17     298.07    2912.10 AR
( 2) HALL,JEFF           Ser          J   57610.00   57495.03    114.97 PA
```

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

```
        General Hospital Maintain Unapplied Cash Processor
                                       Mon Mar 13, 2006 11:59 am
Account      Name                 FC Typ Admit    Disch        Balance Loc
A00000-04079 HALL,FRED            SB AAA 01/01/88 01/02/88     2912.10 AR/FCRV
 1 Patient Balance      2 Last Payment Date    3 Collection Agency
   52,470.00
 4 # of Payments        5 Total Payments       6 Account Balance
                                                  841,020.48
 7 Trans Seq #
   20

 8 Payment Amount      9 Receipt #       10 Remittance #
   100.00                                   12345
11 Payment Date       12 Posting Date    13 Trans Code/Description
   06/20/06               07/24/06           ->




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

Field Explanations

Fields 1 through 8 are completed when the system selects the account, and these fields cannot be changed.

1. PATIENT BALANCE (DISPLAY ONLY)
This field contains the current patient balance for this account.

2. LAST PAYMENT DATE (DISPLAY ONLY)
This field contains the last date on which the patient payment was received for this account.

3. COLLECTION AGENCY (DISPLAY ONLY)
This field contains the code of the collection agency assigned to this account if the account is in account location Bal.

4. # OF PAYMENTS (DISPLAY ONLY)
This field contains the number of payments (either insurance or patient) made on this account.

5. TOTAL PAYMENTS (DISPLAY ONLY)
This field contains the total dollar amount of all patient and insurance payments made on this account.

6. ACCOUNT BALANCE (DISPLAY ONLY)
This field contains the current account balance.

7. TRANS SEQ # (DISPLAY ONLY)
This field contains the unapplied cash sequence number of this transaction within the unapplied cash batch.

Fields 8 through 13 are supplied through the original posting to the Unapplied Cash function.

8. PAYMENT AMOUNT (DISPLAY ONLY)
This field contains the amount of this payment. This amount cannot be changed, and the entire payment must be the transferred amount.

9. RECEIPT # (DISPLAY ONLY)
This field contains the original receipt number.

10. REMITTANCE # (DISPLAY ONLY)
This field contains the check, credit card, or remittance advice number originally entered for this payment.

11. PAYMENT DATE (DISPLAY ONLY)
This field contains the date on which this payment was made.

12. POSTING DATE (DISPLAY ONLY)
This field contains the date on which this payment was posted.

13. TRANS CODE/DESCRIPTION (5-N-R)
This field contains the transaction type and code used to record this payment in this account's transaction history. If the description is included with the transaction code, it is truncated to fit this field. You can enter the code or a hyphen (-) to display and select from a list of valid codes under transaction type P (cash payment). This field is required.

When all the fields are completed, the system prompts you to accept the screen. Accepting the screen completes the transaction. You then have the option of entering another unapplied to guarantor cash transfer or returning to the menu.

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Unapplied Cash to an Insurance Payment

If you want to transfer unapplied cash to an insurance payment, enter **I**. The system displays the following screen:

```
          General Hospital Maintain Unapplied Cash Processor
                                      Mon Mar 13, 2006 11:59 am
Account      Name                 FC Typ Admit    Disch     Balance   Loc
A9733800002  ADMIT,THREE          O  I/P 12/04/97 07/26/98  107528.00 AR/FCRV
 1 Carrier                            2 Plan
   400-BLUE CROSS                       100-BLUE CROSS BASIC PLAN
 3 Allow Contractual Adjustments?     4 Select By      5 Claims List
   No                                   Account          Unpaid Only




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

Field Explanations

1. CARRIER (4-N-O)
This field contains the code and description of the insurance carrier making this payment. If you are creating a batch, you can enter the code or a hyphen (**-**) to display and select from a list of valid codes. If you enter **C** (carrier/plan) in the Select By field, this field must be completed.

2. PLAN (4-N-O)
This field contains the code of the insurance plan for which these payments are being entered. If you are creating a batch, you can enter the code or a hyphen (-) to display and select from a list of valid codes. The Carrier field must be completed to use this field.

You should complete the Carrier and Plan fields only if your hospital is posting the same type of insurance cash for all or most of the batch. For example, if you receive a Medicare voucher, you can enter both the carrier and plan in these fields. This saves you a step during the entry process when you specify the carrier/plan responsible for the patient's payment. You can also enter the carrier and leave the plan blank when posting a Blue Cross voucher, for example. The plan number differs for each patient, but the carrier Blue Cross is the same for every patient. If the patient has only one Blue Cross plan, the system does not require the selection of a carrier/plan during the entry process.

If you have various carriers for the batch, leave these fields blank and enter them for each patient during the entry process.

NOTE: Unapplied cash posting to Canadian OHIP claims is done on a claim charge detail line level. Refer to the *Canadian Claims Processing Volume* of the *STAR Patient Accounting Reference Guide* for cash posting guidelines for OHIP claims.

3. ALLOW CONTRACTUAL ADJUSTMENTS? (1-A-R)

This field indicates whether the system should allow contractual adjustments to be entered with the payment. Entry options are Y for Yes or N for No; the default is N. If you enter **Y**, the remaining balance after payment is written off. A carrier balance of 0 is left. It also allows the hospital to override the adjustment amount. This field can be edited by an employee with a security level of 40 or higher.

4. SELECT BY (1-A-R)

This field indicates how you want to look up patient accounts for payment application. Entry options are C (by carrier/plan) or A (individual accounts); the default is A. If the Carrier field is blank, the system cannot select by carrier. If the Carrier field is completed but the Plan field is blank, the system lists all claims for the carrier entered. If both the Carrier and Plan fields are completed, the system lists claims for the insurance plan entered.

5. CLAIMS LIST (1-A-O)

This field allows you to define which claims are displayed for the selected account in the maintain unapplied insurance cash posting process. The following prompt is displayed:

Display only unpaid claims in the claims list by account? (Y/N) --

The field is not required and may be left blank. If you leave the field blank or select **N**, all claims on the account are displayed in the claims list by account. If you select **Y**, only unpaid claims are displayed. This field works with the Carrier and Plan fields on the setup screen to limit the claims displayed for the account. You may override this limit for an account at the time the claims are displayed.

After you select an account, the system displays the following screen:

```
            General Hospital Maintain Unapplied Cash Processor
                                            Mon Jul 24, 2006 02:11 pm
Account        Name              FC Typ Admit    Disch      Balance      Loc
A0613900005  OSBORN,GZ ONE        O  O/P 05/19/06 05/19/06   525.46    AR /PCA1
 1 Bill Balance      2 Bill From      3 Bill Through    4 Carrier Balance
    .00                 05/19/06          05/19/06                 .00
 5 Carrier/Plan                                     6 Account Balance
   100/557-TERRYS NONPROFEE PLAN FOR RBC              525.46
 7 Trans Seq #
     8

 8 Payment Amount     9 Receipt #       10 Remittance #
        150.00                                 EOB 07/20/06
11 Payment Date                        12 Posting Date
   05/22/06                               07/24/06
13 Trans Code/Description              14 Cont Adj Trans Code/Description
     I0008-COMMERCIAL INSURANCE PAYMENT
15 Outlier Code  16 Days Paid   17 DRG Paid           18 Claim Disposition
->
 Contractual Adj   19 Prior Balance    20 Payment Amount   21 Cont Adj Amount

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

Field Explanations

The only fields that can be edited on this screen are the Trans Code/Description, Outlier Code, Days Paid, DRG Paid, and Final Payment fields. If contractual adjustments are allowed on this payment, the Adjustment Amount field can also be edited. If contractual adjustments are not allowed on this payment, these fields do not display.

14. TRANS CODE/DESCRIPTION (5-AN-R)
This field contains the transaction type and code that is used to record this transfer in the account's transfer history. If the description is included with the transaction code, it is truncated to fit this field. You can enter the code or a hyphen (-) to display and select from a list of valid codes under transaction type I (Insurance).

15. OUTLIER CODE (1-A-O)
This field contains the code describing the outlier (if any) associated with the payment. Entry options are C (cost) or D (day).

16. DAYS PAID (3-N-R)
This field contains the number of paid days for this payment. Enter the number of paid days.

17. DRG PAID (3-N-O)
This field contains the paid DRG code for this payment.

18. CLAIM DISPOSITION (1-A-R)
This field contains the disposition of the claim. Entry options are F, A, C, P, T, or D; the default is F. You may also enter a hyphen (-) to do a table lookup. If this is a final payment, enter **F** (final payment). If the claim is to be denied, enter **D** (denied). If the

claim is to be written off, enter **A** (adjusted to zero). A disposition of F, A, or D flags the claim as paid in full and completes the claim.

If this is a partial payment and you do not wish to complete the claim, enter a disposition of **P** (partial), **T** (transfer), or **C** (clear disposition)

This field also controls the transfers of remaining balances. Balances are transferred to another insurance, the patient, or third party excess. This happens only on accounts in AR and BD, and only when all claims for the carrier are dispositioned as Final Payment, Adjusted to Zero, or Denied.

Contractual Adjustments
These fields are displayed only if the Allow Contractual Adjustments field on the previous screen contains Y for Yes and the insurance plan allows contractual adjustments.

19. PRIOR BALANCE (DISPLAY ONLY)
This field contains the account's balance prior to this payment.

20. PAYMENT AMOUNT (DISPLAY ONLY)
This field contains the amount of this payment.

21. ADJUSTMENT AMOUNT (DISPLAY ONLY)
This field contains the amount of the contractual adjustment (calculated by the system). The payment amount plus the adjustment amount reduces the carrier balance to zero.

When you complete these fields, the system prompts you to accept the screen. Accepting the screen completes this transaction. The entry is deleted from the unapplied cash log and updates the patient account transaction history.

Unapplied Cash to a Contract Account Payment

If you want to transfer unapplied cash to a contract account payment, enter **C**. The system displays the following screen:

```
        General Hospital Maintain Unapplied Cash Processor
                                Thu Apr 04, 1996 09:31 am
Account ID       Code    Description                     Balance      Loc
A14214556        SMI     SMITH LABORATORY ENTERPRI        $10.00-     AR
 1 Contract Last Paid        2 Total # of Payments     3 Total Payments
   06/29/95                     1                        10.00
 4 Bill Seq #      5 Bill Date      6 Bill Last Paid    7 Bill Payments
   1                 03/02/92
 8 Batch Seq #
   1
 9 Payment Date             10 Posting Date       11 Current Bill Balance
   01/17/96                    01/17/96              10.00-
12 Payment Amount           13 Trans Code/Description
                               N0001-CONTRACT CASH




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

Field Explanations

1. CONTRACT LAST PAID (DISPLAY ONLY)
This field contains the last date on which a payment was posted on this contract.

2. TOTAL # OF PAYMENTS (DISPLAY ONLY)
This field contains the number of payments made on this contract.

3. TOTAL PAYMENTS (DISPLAY ONLY)
This field contains the total dollar amount of all payments made on this contract.

4. BILL SEQ # (DISPLAY ONLY)
This field contains the bill sequence number the payment is posted against. This should agree with the option selected on the previous screen.

5. BILL DATE (DISPLAY ONLY)
This field displays the bill date coinciding with the bill sequence number in the Bill Seq # field.

6. BILL LAST PAID (DISPLAY ONLY)
This field contains the last payment date to this specific bill. If no previous payments have been made, this field is blank.

7. BILL PAYMENTS (DISPLAY ONLY)
This field contains the total payments made to this specific bill. If no previous payments have been made, the field is blank.

8. BATCH SEQ # (DISPLAY ONLY)

This field contains the sequence number of this payment within batch zero. This sequence number is for reporting purposes only.

9. PAYMENT DATE (DISPLAY ONLY)

This field contains the date the payment was made.

10. POSTING DATE (DISPLAY ONLY)

This field contains the date the payment is applied to the contract. This date is used as the transaction and posting date in the transaction history.

11. CURRENT BILL BALANCE (DISPLAY ONLY)

This field contains the balance on the specific bill. It is automatically adjusted to reflect the amount of payments posted through field 12.

12. PAYMENT AMOUNT (DISPLAY ONLY)

This field contains the amount of the payment.

13. TRANS CODE/DESCRIPTION (4-N-R)

This field contains the transaction type and code used to record this payment in the contract's transaction history and on contract bills. You can enter the code or a hyphen (-) to display a list of valid codes under transaction type N (non-patient cash).

When you complete the Trans Code/Description field, the system prompts you to accept the screen. Accepting this screen completes the transaction.

Unapplied Cash to Miscellaneous

If you want to transfer unapplied cash to miscellaneous cash, enter **M**. The system displays the following screen:

```
                 General Hospital Maintain Unapplied Cash Processor
                                           Thur May 1, 2003 10:10 am

 1 Posting Date       2 Receipt #       3 Trans Seq #
   04/27/03                               11
 4 Amount to Post     5 Misc Code       6 Miscellaneous Cash Description
   1.00                 33                Cafeteria Receipts
 7 Entity             8 Department
   BA                   50-00
 9 Account                             10 Trans Code/Desc
   520-1 Cafeteria Revenue                F002-Cafeteria Receipts

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

Field Explanations

1. POSTING DATE (6-N-O)

This field contains the posting date from the batch header. This date can be changed. The date entered is used in selecting the proper GL period to post the payment. The backdate days in PAAR control the number of days back the date can be set.

2. RECEIPT # (10-AN-O)

If you requested that receipts be printed, this field contains the receipt number. You can enter the receipt number or **A** to have the system automatically assign one to this payment. If you enter **A**, this field contains Auto.

3. TRANS SEQ # (DISPLAY ONLY)

This field contains the unapplied cash sequence number of this transaction within the unapplied cash batch.

4. AMOUNT TO POST (9-N-R)

This field contains the amount of this miscellaneous cash posting. The entry range is 0 to $9,999,999.00

5. MISC CODE (2-N-R)

This field contains the miscellaneous cash code associated with this posting. After you enter the code, the system completes fields 6, 8, 9, and 10. Once this field is entered, the posting can be accepted. You can enter the code or a hyphen (**-**) to display and select from a list of valid codes or enter a description lookup. The miscellaneous cash code lookup requires the use of capital letters.

NOTE: If you enter a predefined code in this field, the system uses the values associated with that code to complete the Miscellaneous Cash Description, Department, Account, and Transaction Code Description fields.

6. MISCELLANEOUS CASH DESCRIPTION (DISPLAY ONLY)

This field contains the description associated with the miscellaneous cash code. These codes represent sources of miscellaneous cash such as parking lot, cafeteria and gift shop receipts.

Fields 7 through 9 reside in the Miscellaneous Cash code table and display when you make an entry in field 5.

7. ENTITY (DISPLAY ONLY)

This field contains the GL entity for miscellaneous cash posting.

8. DEPARTMENT (DISPLAY ONLY)

This field contains the GL department receiving the revenue for the posting.

9. ACCOUNT (DISPLAY ONLY)

This field contains the number and description of the GL subaccount receiving the revenue for the posting.

10. TRANS CODE/DESC (DISPLAY ONLY)

This field contains the transaction type and code used to generate the GL entry for the cash account.

When you complete these fields, the system prompts you to accept the screen. Accepting the screen completes the transaction. You have the option of entering another unapplied to miscellaneous transfer or returning to the menu.

Unapplied Cash to a Patient Account

If you want to transfer unapplied cash to a patient account, enter **P**. The system prompts you to use the standard lookup procedure.

```
                  General Hospital Maintain Unapplied Cash Processor
                                                Mon Jul 24, 2006 09:22 am
Account       Name                   FC Typ Admit    Disch       Balance Loc
A03138-00011 Norton, Bob              S  I/P 05/18/03 05/18/03    1772.32 AR /ACCF
 1 Patient Balance      2 Last Payment Date    3 Collection Agency
   1,772.32               11/19/03
 4 # of Payments        5 Total Payments       6 Account Balance
   1                       1.00                   1,772.32
 7 Trans Seq #
   19

 8 Payment Amount      9 Receipt #        10 Remittance #
   5.00                                      1234567890
11 Payment Date       12 Posting Date     13 Trans Code/Description
   05/30/06              07/24/06          ->




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

Field Explanations

1. PATIENT BALANCE (DISPLAY ONLY)
This field contains the patient balance for this account.

2. LAST PAYMENT DATE (DISPLAY ONLY)
This field contains the last date on which a patient payment was received on this account.

3. COLLECTION AGENCY (DISPLAY ONLY)
This field contains the code of the collection agency assigned to this account if the account is in account location BD.

4. # OF PAYMENTS (DISPLAY ONLY)
This field contains the number of payments, either insurance or patient, made on this account.

5. TOTAL PAYMENTS (DISPLAY ONLY)
This field contains the total dollar amount of all patient and insurance payments made on this account.

6. ACCOUNT BALANCE (DISPLAY ONLY)
This field contains the current account balance.

7. TRANS SEQ # (DISPLAY ONLY)
This field indicates the unapplied cash sequence number of this transaction within the unapplied cash batch.

8. PAYMENT AMOUNT (DISPLAY ONLY)

This field contains the amount of this payment. If the payment amount exceeds the account balance, a message is displayed to that effect. The system accepts payments that exceed the balance.

9. RECEIPT # (DISPLAY ONLY)

If you requested that receipt numbers be printed, this field contains the receipt number for this payment. If the receipt number is automatically assigned by the system, this field contains Auto.

10. REMITTANCE # (DISPLAY ONLY)

This field contains the check, credit card, or remittance advice number associated with this payment. This identification number is displayed in the patient's transaction history.

11. PAYMENT DATE (DISPLAY ONLY)

This field contains the date on which this payment is made. The system displays the date from the batch header. This date is used as the transaction date in this account's transaction history and the remittance date in account transaction history detail.

12. POSTING DATE (DISPLAY ONLY)

This field contains the date on which this payment is posted. The system defaults to the date from the batch header. This date is used as the posting date in this account's transaction history.

13. TRANS CODE/DESCRIPTION (5-AN-R)

This field contains the transaction type and code used to record this payment in this account's transaction history. If the description is included with the transaction code, it is truncated to fit this field. You can enter the code or a hyphen (-) to display and select from a list of valid codes under transaction type P (cash payment). This is the only field on this screen you can edit.

The Trans Code/Description field is the only field to be completed on this screen. All other fields are completed by the system using information already entered and cannot be edited. Entering the Trans Code/Description field completes this transaction. You have the option of entering another unapplied to patient cash transfer or returning to the menu.

Unapplied Cash to a Refund

If you want to transfer unapplied cash to a refund, enter **R**. The address information is required for entry. This causes the unapplied entry to transfer to the refund workfile.

NOTE: Until the refund check is printed the entry remains in the unapplied cash workfile with a refund status.

Following are the steps that you must follow to create a refund once the transaction is flagged as a refund:

1. Once the entry has been flagged as a refund, the entry is displayed with an R next to the SEQ number.

    NOTE: The GL Journal Entry to remove the money from the unapplied cash account does not occur until the refund is approved.

2. Once the refund is approved, the R in Maintain Unapplied Cash changes to an A to reflect that the entry has been approved. After the refund check has been printed, or the AP optional batch job has been run, the entry is removed from Maintain Unapplied Cash.

3. The refund clerk has only the following options for U type of refunds:

    •   **Hold** - keeps the refund on Hold, the entry remains in the Maintain Unapplied Cash processor with an R next to the sequence number.

    •   **Approve** - performs General Ledger Journal Entries to move the money around. Once the refund is approved the R in Maintain Unapplied Cash changes to an A to reflect that the entry has been approved for a refund

    •   **Delete** - removes the entry from refunds and puts the entry back into Maintain Unapplied Cash. If the refund was on Hold then no Journal Entries are made, and the R is removed from the Maintain Unapplied Cash processor. If the refund has been approved, the Journal Entries are reversed to put the money back into UACASH, and the A is removed from Maintain Unapplied Cash.

The Journal Entries that are performed are:

Key Unapplied Cash
DEBIT - TRANU
CREDIT - UACASH

Approve refund type Unapplied
DEBIT - UACASH
CREDIT - TRANJ

Delete an approved refund type Unapplied
DEBIT - TRANJ
CREDIT - UACASH

Print a refund check type unapplied (both PA and AP make the same Journal Entries)
DEBIT - TRANJ
CREDIT - RFCASH

POST ADJUSTMENTS

This transaction enables you to post adjustments to either patient or carrier balances on accounts. During posting, the system verifies account numbers and transaction codes. Carrier postings require the system to match the carrier plan entered against the account's verified account plan codes.

Adjustments can be entered as flat rate amounts or as a percentage of the balance. Data entry for adjustments is simplified by a client-defined and system-controlled field duplication. Duplicate fields can include posting date, transaction code, and carrier plan.

Examples of adjustments are employee discounts, small balances, and contractual allowances. You can access account information by patient name, account number, guarantor name, carrier, or carrier/plan combinations. To ensure accuracy when posting adjustments to patient accounts, the system displays the account's patient name, carrier plan codes, and respective liabilities on all screens.

You can access Account Inquiry within a batch using the dollar sign ($). This feature further enhances the accuracy of posting adjustments on accounts.

When you post an adjustment to an account that has been prelisted for transfer to bad debt, the system places all AR accounts controlled by that guarantor's schedule on System Hold for bad debt transfer. If the adjustment causes the account to zero balance, the system flags the account as not selected for BD prelisting.

If an account is prelisted for Bad Debt and you post an adjustment leaving a debit or credit balance on the account, the system places the account on BD Prelist hold. The system reflects this new status in the Transaction History report and the online Transaction History function by displaying the comment *System Hold - Adjustment Made*. The BD Pre-Listed flag and BD Pre-List Date remain on the Account Follow-Up Screen. The BD Pre-List Flag on the Bad Debt Pre-List Screen is changed to System Hold.

Similarly, if an account is prelisted for Bad Debt and you post an adjustment leaving a zero balance on the account, the system removes the BD Pre-List Flag from the Bad Debt Pre-List Screen. The Transaction History report and the online Transaction History function display Account un-prelisted - Adjustment Made. The BD Pre-List flag is changed to No, and the BD Pre-List Date is removed from the BD Prelist and follow-up screens.

If you post an adjustment that reduces the carrier balance to zero or a credit, the system removes the claim from insurance follow-up. If you post an adjustment that creates a debit balance, the system restarts insurance follow-up if the claim has been submitted.

For additional information regarding the impact of cash posting, refer to the Impact of Transaction topic within this chapter.

For audits, the system defines postings to a batch code and compares the posted total amount against the batch total you enter. These totals must match before you can indicate that the batch is complete. You can request a printed version of the individual transactions within the batch or review the batch online. If errors are present in the batch, you must provide correcting entries to rectify actual batch totals or correct errors in existing entries by, for example, changing the adjustment amount or deleting an entry from the batch. The system supports contractual discounts and other adjustments for insurance carriers and patients.

After these selections are made, the system prompts you to select a facility (if this is a multifacility installation) and enter or select a batch code. Adjustments, like cash payments, are entered and posted in batches. In this transaction, the first screen displayed is used to enter basic information about this batch while subsequent screens record specific types of adjustments. You can enter different types of adjustments in one batch.

After a batch number is entered or assigned by the system, the system displays the following screen:

```
              General Hospital Adjustment Posting Setup Processor
                                               Tue May 09, 2000 02:15 pm


   1 Batch #              2 Batch Description              3 # of Trans
     1                      WARNICK1
   4 Posting Date         5 Mixed Transactions?
     01/15/99               Yes
   6 Total Entered        7 Batch Total                   8 Variance

   9 Adjustment Type     10 Adjustment Percent
     Flat amount
  11 Ins Balance to Use  12 Patient Balance to Use
     Account                 Account




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

Field Explanations

1.   BATCH # (DISPLAY ONLY)
This field contains the entered batch number or auto if automatic assignment was chosen.

2.   BATCH DESCRIPTION (30-C-R)
This field contains the description of the purpose or contents of this batch.

3.   # OF TRANS (DISPLAY ONLY)
This field contains the number of component transactions in the batch. If you are creating a new batch, this field is blank.

4. POSTING DATE (6-N-R)

This field contains the date on which the batch is posted. You can enter a prior date or use the current system date as a default. The date is used to select proper G/L period to direct the postings. Backdate days in PAAR Control ensure dates too far in the past cannot be used.

5. MIXED TRANSACTIONS? (1-A-R)

This field indicates whether this batch contains more than one type of transaction. A batch of adjustments can contain contractual, other insurance, patient discount, and other patient in any combination. Entry options are Y for Yes or N for No; the default is Y.

6. TOTAL ENTERED (DISPLAY ONLY)

This field contains the total amount of adjustments entered for this batch. If you are creating a new batch, this field is blank.

7. BATCH TOTAL (10-N-R)

This field contains the batch total from your adding machine or calculator tape that you intend to post in this batch. To enter a credit batch, enter a hyphen (-) prior to the amount.

8. VARIANCE (DISPLAY ONLY)

This field contains the difference between the total entered and the batch total. If this is a new batch, this field is blank.

9. ADJUSTMENT TYPE (1-A-R)

This field indicates the adjustment procedure that is used in this batch. Entry options are F (flat rate) or P (percent); the default is F.

A percent type is entered if you want the system to calculate the amount based on a percentage.

10. ADJUSTMENT PERCENT (3-N-O)

This field contains the adjustment percent if the Adjustment Type field contains P. Enter the adjustment percent without the percent sign (%). If the percentage changes for each adjustment being added, this field can be left blank and completed for each posting.

11. INS BALANCE TO USE (TABLE LOOKUP)

This field contains the balance type used in calculating the write-off percentage for Insurance Contractual Adjustments. Your choices are:

* Account Balance - the current balance of the account

* Current Carrier Balance - the current carrier balance

* Original Bill Balance - the estimated liability for the carrier (prorated)

* Manually Entered Balance - a user-defined balance

12. PATIENT BALANCE TO USE (TABLE LOOKUP)
This field contains the balance type used in calculating the write-off percentage for Patient Discount Adjustments. Your choices are:

- Account Balance - the current balance of the account

- Patient Balance - the current balance of the patient

- Manually Entered Balance - a user-defined balance

After you complete and accept this screen, the system displays a list of adjustment posting options. The list includes these options:

- Contractual Adjustments

- Other Insurance Contractual Adjustments

- Patient Discount Adjustments

- Other Patient Adjustments

- Balance Transfer & Claim Disposition

- Exit Batch

CN: Refer to the *Canadian Claims Processing volume* and the *Ontario Electronic Claims and Payment Volume* of the STAR Patient Accounting Reference Guide for information on posting adjustments to OHIP claims.

Post Contractual Adjustments

The Post Contractual Adjustments option enables you to post contractual adjustments for insurance carriers. Automatic contractual adjustments, which occur at final billing, can be established within the Reimbursement Master File and Insurance Coverage table for each specific carrier/plan. Contractual adjustments can also be made when an insurance payment is posted.

This option provides another method you can use to apply the adjustments.

This transaction uses two screens: the first is used to enter default insurance/ contractual information about this entry, and the second displays the results of the adjustment calculation. After you select this option, the system displays the screen containing information already entered about this batch and specific insurance/ contractual adjustment fields.

The only difference between this option and other insurance adjustments is the ability to have the system calculate percentage adjustment as indicated in the Ins Balance To Use field.

This option allows you to post contractual adjustments regardless of the account location or the expected number of payments. The only requirement is that the insurance plan itself must be defined to allow contractual adjustments at payment.

CN: Refer to the *Canadian Claims Processing volume* and the *Ontario Electronic Claims and Payment Volume* of the STAR Patient Accounting Reference Guide for information on posting adjustments to OHIP claims.

NOTE: Claims that have been replaced are not displayed. If a claim is selected that has been denied, the following message is displayed warning you that if cash is posted or an adjustment is done to the claim, the disposition is cleared.

> *Disposition denied. . .clear disposition (Y/N) [N]?*

Enter **Y** to clear the disposition and update transaction history. Enter **N** to return to the Patient Lookup prompt.

```
            General Hospital Contractual Adjustment Posting Processor
                                             Tue May 09, 2000 02:19 pm


 1 Batch #          2 Description
   1                  WARNICK1
 3 # of Trans       4 Total Entered      5 Batch Total       6 Variance


                    Insurance/Contractual Adjustment Defaults
 7 Posting Date
   01/15/99
 8 Carrier                              9 Plan

10 Transaction Code/Description        11 Select By      12 Claims List
   A0001-I/P MEDICARE PART A ALLOWANCE     Account              Unpaid Only




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

Field Explanations

Fields 1 through 6 - Batch number, Description, number of Trans, Total Entered, Batch Total, and Variance - are completed by the system using information already entered and cannot be edited.

Insurance/Contractual Adjustment Defaults

7. POSTING DATE (6-N-O)
This field contains the posting date from the batch header. This date can be changed. The date entered is used in selecting the proper GL period to post the payment. The backdate days in PAAR control the number of days back the date can be set.

8. CARRIER (4-N-C)

This field contains the code and description of the insurance carrier making this payment as defined in the Insurance Carrier table. If you are creating a batch, you can enter the code or a hyphen (-) to display and select from a list of valid codes. If you enter **C** (carrier/plan) in the Select By field, this field must be completed.

9. PLAN (4-N-C)

This field contains the code and description of the insurance plan for which these adjustments are being entered. If you are creating a batch, you can enter the code or a hyphen (-) to display and select from a list of valid codes. The Carrier field must be completed to access this field.

You should complete the Carrier and Plan fields only if the hospital is posting the same type of insurance cash for all or most of the batch. For example, if you receive a Medicare voucher, you can enter both the carrier and plan in these fields. This saves you a step during the entry process when you specify the carrier/plan.

10. TRANSACTION CODE/DESCRIPTION (5-AN-O)

This field contains the transaction type and code used to record this adjustment in the appropriate account's transaction history and in the general ledger. If the description is included with the transaction code, it is truncated to fit this field. You can enter the code or a hyphen (-) to display and select from a list of valid codes under transaction type A (adjustment). This code is loaded from the batch header if a code was entered there. If you are doing a batch of the same adjustment, this field should be completed; otherwise, it must be entered for every account.

11. SELECT BY (1-A-R)

This field indicates how you want to look up patient accounts for adjustment application. Entry options are C (by carrier/plan) or A (individual accounts); the default is A. If the Carrier field is blank, the system cannot select by carrier. If the Carrier field is completed but the Plan field is blank, the system lists all claims for the carrier entered. If both the Carrier and Plan fields are completed, the system lists claims for the insurance plan entered.

12. CLAIMS LIST (1-A-O)

This field allows you to define which claims are displayed for the selected account in the contractual adjustment posting process. The following prompt is displayed:

> *Display only unpaid claims in the claims list by account? (Y/N) -- |*

The field is not required and may be left blank. If you leave the field blank or select **N**, all claims on the account display in the claims list by account. If you select **Y**, only unpaid claims are displayed. This field works with the Carrier and Plan fields on the setup screen to limit the claims displayed for the account. You may override this limit for an account at the time the claims are displayed.

When these fields are completed, you have the option of editing or accepting the information entered on the screen. If you accept the screen, the system prompts you for the account to which you want to post the contractual insurance adjustment. Identify

the account using the account identification methods discussed in the *General Information Volume* of the STAR Patient Accounting Reference Guide.

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

```
      General Hospital Contractual Adjustment Posting Processor
                                         Mon Mar 13, 2006 11:59 am
Account      Name                  FC Typ Admit    Disch      Balance Loc
A97357-00002 ABEL,CASH             H  O/P 12/23/97 12/23/97     29.79- AR/FCRV

      COB 1    400-BLUE CROSS    100-BLUE CROSS BASIC PLAN 11111111111
    Archived,Purged
                              Unpaid Claims
Page:01        Bill           Service        Claim      Claim              #  P
     CS        From/Thru      From/Thru      Liability  Amount   Ext Clm # P  d
( 1)   8       12/23 12/23/97 12/23 12/23/97   200.00  3945.00
( 2)   7       12/23 12/23/97 12/23 12/23/97  3745.00  3745.00
( 3)   5       12/23 12/23/97 12/23 12/23/97   200.00   200.00




Enter choice, (L)ist All, (U)npaid, or (O)ther --
```

If you select L, all claims are displayed. This may be used when the setup screen for the insurance batch defines only unpaid claims to display. If you select U, only unpaid claims are displayed.

If you select O, the following prompt is displayed:

Limit claims by (D)isp, (B)ill Dt, or (S)ubm Dt [D] --

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

```
      General Hospital Contractual Adjustment Posting Processor
                                         Mon Mar 13, 2006 11:59 am
Account      Name                  FC Typ Admit    Disch      Balance Loc
A97357-00002 ABEL,CASH             H  O/P 12/23/97 12/23/97     29.79- AR/FCRV

      COB 1    400-BLUE CROSS    100-BLUE CROSS BASIC PLAN 11111111111
    Archived,Purged
Page:01                    Claim Disposition Codes        ##=Current Choices
( 1) A-Adjusted to zero
( 2) F-Final Payment
( 3) D-Denied
( 4) P-Partial Payment
( 5) T-Transfer
( 6) C-Clear disposition
( 7) N-No disposition




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

You may select one or more Claim Disposition codes for claims to be displayed for the account. Notice that you may 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**, the system displays the following prompt:

> *Enter earliest bill thru date [Earliest] --*

You may accept the default of Earliest, enter a specific date in the format MMDDYY, 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 to include [Latest] --*

You may accept the default of Latest, enter a specific date in the format MMDDYY, or enter T - # to indicate the number of days prior to today to be used as the latest bill through date. Claims are 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**, 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 in the format MMDDYY, 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 in the format MMDDYY, 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.

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.

NOTE: Archived and purged claims are highlighted.

This screen contains a list of claim sequences for this carrier. Select the desired claim sequence and press ENTER.

NOTE: If the carrier has timed out, when you select the claim sequence the system displays the following prompt:

> *Carrier has timed out, do you wish to continue? (Y/N) [N]?--*

To select another account, enter **N** or press ENTER to accept the default. To continue with the selected timed-out account, enter **Y**.

When you select the claim sequence, the system displays the following screen:

```
          General Hospital Contractual Adjustment Posting Processor
                                             Mon Jul 24, 2009 09:57 am
Account       Name                FC Typ Admit    Disch          Balance   Loc
A0613900005  OSBORN,GZ ONE         O  O/P 05/19/06 05/19/06       525.46    AR /PCA1
 1 Carrier Balance    2 Adjustments        3 Payments
   3,551.37                                   1,800.00
 4 Carrier Liability  5 Last Adjustment Date  6 Last Payment Date
   5,351.37                                   07/03/08
 7 Seq#                8 Pt Class          9 Principal/Admitting Diagnosis
   1                                        10/INJ EXTERNAL CAROTID ART
10 Posting Date       11 Trans Code/Description
   07/03/08              A0030-I/P OTHER ALLOWANCES
12 Adjustment Type    13 Adjustment %  14 Balance to Use   15 Beginning Balance
   Flat amount                            Account            4,989.21
16 DB/CR?  17 Adjustment Amount 18 New Balance    19 Final?
   CR        5.00                4,984.21          No
20 Comments
   01
   02
   03

Enter transaction code, or '-' for list --
```

Field Explanations

Fields 1 through 9 - Carrier Balance, Adjustments, Payments, Carrier Liability, Last Adjustment Date, Last Payment Date, Batch Seq #, Pt Class, and Billed DRG are completed by the system based on the patient selected and cannot be edited.

1. CARRIER BALANCE (DISPLAY ONLY)
This field contains the current balance of the carrier.

2. ADJUSTMENTS (DISPLAY ONLY)
This field contains the total dollar amount of all adjustments for the carrier.

3. PAYMENTS (DISPLAY ONLY)
This field contains the total dollar amount of payments for the carrier.

4. CARRIER LIABILITY (DISPLAY ONLY)
This field contains the prorated liability of the carrier for the selected claim.

5. LAST ADJUSTMENT DATE (DISPLAY ONLY)

This field contains the date on which the last adjustment was made for this carrier and this account.

6. LAST PAYMENT DATE (DISPLAY ONLY)

This field contains the date on which the last payment was made for this carrier and this account.

7. BATCH SEQ # (DISPLAY ONLY)

This field contains the sequence number of this adjustment within the batch.

8. PT CLASS (DISPLAY ONLY)

This field displays the financial patient classification combined with the alert and suppression indicators associated with the financial patient classification. The three-character patient classification code is displayed if a patient classification has been assigned to the account. Leading and trailing asterisks (**) display when the assigned patient classification has an alert designation. Finally, the follow-up suppression indicator is displayed as the final character in the field:

- a = alert only; follow-up is not suppressed

- c = suppression of follow-up has been cleared by a user

- s = follow-up is currently being suppressed

9. PRINCIPAL/ADMITTING DIAGNOSIS (DISPLAY ONLY)

This field displays a leading 9 for ICD-9 or 10 for ICD-10, a slash (/), then the Principal, or if blank, the Admitting Diagnosis Description. If the account has both ICD-10 and ICD-9 diagnoses, the ICD-10 diagnosis description is displayed.

10. BILLED DRG (DISPLAY ONLY)

This field displays the code and description of the final Diagnostic Related Grouping (DRG) for the account. This information is taken from the bill audit record for the corresponding bill sequence number. If no billed DRG for this account exists, the field is blank.

11. POSTING DATE (6-N-R)

This field contains the date on which this adjustment is posted. The default is from the batch header. This field is used in the transaction history and to select the appropriate General Ledger fiscal period for posting.

12. TRANSACTION CODE/DESCRIPTION (5-AN-O)

This field contains the transaction type and code that can be used to record this adjustment in the appropriate account's transaction history and in the GL. If the description is included with the transaction code, it is truncated to fit this field. You can enter the code or a hyphen (-) to display and select from a list of valid codes under transaction type A (adjustment). This field is from the batch header and can be changed.

13. ADJUSTMENT TYPE (1-A-R)
This field indicates the type of adjustment. This field is displayed from the batch header screen. F indicates a flat amount adjustment. P indicates that you want the system you wish the system to calculate the adjustment.

14. ADJUSTMENT PERCENT (3-N-C)
This field contains the percentage of the adjustment write-off if the Adjustment Type field contains P. The range is 0.1 to 100 percent.

15. BALANCE TO USE (1-A-C)
This field indicates the balance that is used to calculate the adjustment. Entry options are the account balance, the current bill balance, the original bill balance, or a manually entered balance. This field is required if a percentage adjustment is being entered.

16. BEGINNING BALANCE (9-N-O)
This field contains the balance on which the adjustment percent is based. If this is a flat adjustment, this is the current account balance. If manually entered, this is where the manually entered balance is entered.

17. DB/CR? (1-A-R)
This field indicates whether this is a debit or credit entry. Entry options are D (debit) or C (credit); the default is C. The system assumes a credit adjustment unless you override it. A credit adjustment decreases the balance of the account, while a debit increases the balance of the account.

18. ADJUSTMENT AMOUNT (9-N-C)
This field contains the adjustment amount if this account's balance is being adjusted by a flat amount (depending on entry in the Adjustment Type field). The entry range is 0 to $9,999,999.99.

If this account's balance is being adjusted by a percentage, the system calculates and displays the adjustment amount based on the beginning balance and the adjustment percent. If a percentage adjustment is displayed, this field cannot be edited. The adjustment amount reduces or increases the current carrier balance and account balance by the amount of the adjustment.

19. NEW BALANCE (DISPLAY ONLY)
This field contains the account's new balance based on the beginning balance. It displays what the balance is after the adjustment is applied.

20. FINAL? (1-A-O)
This field allows you to final disposition a claim when you are posting an adjustment to the claim. When the field is accessed, the following prompt is displayed:

Is this a final disposition? (Y/N) [N]--

Entry options are Y for "Yes, this is a final disposition" or N for "No, this is not a final disposition." The default is No. If you enter **Y** for Yes, the system allows you to select one of the current disposition types. The following prompt is displayed:

Final disposition is A(Adjusted to zero), D(Denied) or F(Final payment)[F]--

Options are Adjusted to zero (A), Denied (D), or Final Payment (F). If the response is Denied, and this is an adjustment for the primary carrier, then the system allows the user to select a Denial Tracking Reason code from the payor-specific denial tracking reasons associated with the primary insurance carrier/plan.

21. COMMENTS (180-C-O)
This field contains any comments pertaining to this adjustment transaction that you want to enter. You can enter up to 180 characters. When you access this field, the system displays the following prompt:

Enter comments (C) or notes (N) --

If you enter **C** for comments, you are prompted to enter a comment about this payment. You can enter up to three lines of comments for this payment. Press F4 when you finish entering your comments. If you enter **N** for notes, the notes program is displayed on your screen. Refer to the Notes section in the *Billing and Claims Volume* of the STAR Patient Accounting Reference Guide for a description of entering notes for this payment.

 If a comment or note is not necessary, press ENTER.

When all fields are completed, you have the option of accepting or editing the information entered on this screen. Accepting the screen completes this adjustment entry. You have the option of entering another adjustment for this account, selecting another account or another carrier, or returning to the list of adjustment posting options.

If this field is the current account balance, that number is displayed, and a percentage is calculated on that balance.

Post Other Insurance Adjustments

This option enables you to post adjustments for insurance carriers. The system does not perform calculations based on percentage adjustment using this option.

You can access Account Inquiry within a batch using the dollar sign ($) when prompted for an account. This feature enhances the accuracy of posting cash on accounts by providing a research mechanism.

This option uses two screens. The first screen is used to enter default information, and the second screen is used to enter the adjustment. After you select this option, the system displays the following screen:

CN: Refer to the *Canadian Claims Processing volume* and the *Ontario Electronic Claims and Payment Volume* of the STAR Patient Accounting Reference Guide for information on posting adjustments to OHIP claims.

NOTE: Claims that have been replaced are not displayed. If a claim is selected that has been denied, the following message is displayed warning you that if cash is posted or an adjustment is done to the claim, the disposition is cleared.

Disposition denied. . .clear disposition (Y/N) [N]?

Enter **Y** to clear the disposition and update transaction history. Enter **N** to return to the Patient Lookup prompt.

```
              General Hospital Insurance Adjustment Posting Processor
                                                  Wed Apr 19, 2000 10:57 am


  1 Batch #          2 Description
    1                  WARNICK1
  3 # of Trans       4 Total Entered      5 Batch Total        6 Variance

                    Insurance/Contractual Adjustment Defaults
  7 Posting Date
    01/15/99
  8 Carrier                              9 Plan
    100-MEDICARE                           100-MEDICARE PART A BASIC PLAN
 10 Transaction Code/Description        11 Select By      12 Claims List
    A0001-I/P MEDICARE PART A ALLOWANCE    Account           Unpaid Only




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

Field Explanations

Fields 1 through 6 - Batch #, Description, # of Trans, Total Entered, Batch Total, and Variance - are completed by the system with information already entered and cannot be edited.

Insurance/Contractual Adjustment Defaults

7. POSTING DATE (6-N-R)
This field contains the posting date from the batch header. This date can be changed. The date entered is used in selecting the proper GL period to post the payment. The backdate days in PAAR control the number of days back the date can be set.

8. CARRIER (4-N-C)
This field contains the code and description of the insurance carrier making this payment. If you are creating a batch, you can enter the code or a hyphen (**-**) to display and select from a list of valid codes. If you enter C (carrier/plan) in the Select By field, you must make an entry in this field.

9. PLAN (4-N-O)
This field contains the code and description of the insurance plan for which these payments are being entered. If you are creating a batch, you can enter the code or a

hyphen (**-**) to display and select from a list of valid codes. The Carrier field must be completed to use this field.

You should complete the Carrier and Plan fields only if the hospital is posting the same type of insurance cash for all or most of the batch. For example, if you receive a Medicare voucher, you can enter both the carrier and plan in these fields. This saves you a step during the entry process when you specify the carrier/plan.

10. TRANSACTION CODE/DESCRIPTION (5-AN-O)
This field contains the transaction type and code used to record this adjustment in the appropriate account's transaction history and in the general ledger. If the description is included with the transaction code, it is truncated to fit this field. You can enter the code or a hyphen (**-**) to display and select from a list of valid codes under transaction A (adjustment). If you are doing a batch of the same adjustment, this field should be completed; otherwise, it must be entered for every account.

11. SELECT BY (1-A-R)
This field indicates how you want to look up patient accounts for adjustment application. Entry options are C (by carrier/plan) or A (individual accounts); the default is A. If the Carrier field is blank, the system cannot select by carrier. If the Carrier field is completed but the Plan field is blank, the system lists all claims for the carrier entered. If both the Carrier and Plan fields are completed, the system lists claims for the insurance plan entered.

12. CLAIMS LIST (1-A-O)
This field allows you to define which claims are displayed for the selected account in the contractual adjustment posting process. The following prompt is displayed:

Display only unpaid claims in the claims list by account? (Y/N) -- |

The field is not required and may be left blank. If you leave the field blank or select **N**, all claims on the account display in the claims list by account. If you select **Y**, only unpaid claims are displayed. This field works with the Carrier and Plan fields on the setup screen to limit the claims displayed for the account. You may override this limit for an account at the time the claims are displayed.

When you complete these fields, the system prompts you to edit or accept the information on the screen. When you accept the screen, the system prompts you for the account to which you want to post the insurance adjustment. Identify the account using the account identification methods discussed in the *General Information Volume* of the STAR Patient Accounting Reference Guide. After you identify the account, the system displays the following screen:

```
          General Hospital Insurance Adjustment Posting Processor
                                             Mon Mar 13, 2006 11:59 am
Account        Name                    FC Typ Admit    Disch       Balance Loc
A97357-00002 ABEL,CASH                 H  O/P 12/23/97 12/23/97      29.79- AR/FCRV

        COB 1   400-BLUE CROSS    100-BLUE CROSS BASIC PLAN 11111111111
     Archived,Purged
                                 Unpaid Claims
Page:01        Bill            Service        Claim     Claim               #  P
       CS      From/Thru       From/Thru      Liability Amount   Ext Clm #  P  d
( 1)   8       12/23 12/23/97  12/23 12/23/97  200.00  3945.00
( 2)   7       12/23 12/23/97  12/23 12/23/97 3745.00  3745.00
( 3)   5       12/23 12/23/97  12/23 12/23/97  200.00   200.00


Enter choice, (L)ist All, (U)npaid, or (O)ther --
```

If you select **L** (List All), all claims are displayed. This can be used when the setup screen for the insurance batch defines only unpaid claims to display. If you select **U** (Unpaid), only unpaid claims are displayed. If you select **O** (Other), the following prompt is displayed:

Limit claims by (D)isp, (B)ill Dt, or (S)ubm Dt [D] --

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

```
          General Hospital Insurance Adjustment Posting Processor
                                             Mon Mar 13, 2006 11:59 am
Account        Name                    FC Typ Admit    Disch       Balance Loc
A97357-00002 ABEL,CASH                 H  O/P 12/23/97 12/23/97      29.79- AR/FCRV

        COB 1   400-BLUE CROSS    100-BLUE CROSS BASIC PLAN 11111111111
     Archived,Purged
Page:01                        Claim Disposition Codes        ##=Current Choices
( 1) A-Adjusted to zero
( 2) F-Final Payment
( 3) D-Denied
( 4) P-Partial Payment
( 5) T-Transfer
( 6) C-Clear disposition
( 7) N-No disposition




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

You may select one or more Claim Disposition codes for claims to be displayed for the account. Notice that you may 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**, the system displays the following prompt:

Enter earliest bill thru date [Earliest] --

You may accept the default of Earliest, enter a specific date in the format MMDDYY, 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 to include [Latest] --

You may accept the default of Latest, enter a specific date in the format MMDDYY, or enter T - # to indicate the number of days prior to today to be used as the latest bill through date. Claims are 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**, 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 in the format MMDDYY, 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 in the format MMDDYY, 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.

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.

NOTE: Archived and purged claims are highlighted.

This screen contains a list of claim sequences for this carrier. Select the desired claim sequence and press ENTER.

NOTE: If the carrier has timed out, when you select the claim sequence the system displays:

Carrier has timed out, do you wish to continue? (Y/N) [N]?--

To select another account, enter **N** or press ENTER to accept the default. To continue with the selected timed-out account, enter **Y**.

When you select the claim sequence, the system displays the following screen:

```
                 General Hospital Insurance Adjustment Posting Processor
                                          Mon Mar 27, 2009 09:58 am
C0722900001  OLAF,HANS              O   I/P 08/10/07 08/17/07    $4989.21 AR
Den-App Ind: Never Denied             BillDRG/Ind: 987/C/25.0
 1 Carrier Balance      2 Adjustments         3 Payments
   3,551.37                                     1,800.00
 4 Carrier Liability    5 Last Adj Date        6 Last Pay Date
   5,351.37                                       07/03/08
 7 Seq#                 8 Pt Class             9 Principal/Admitting Diagnosis
   1                                             9/INJ EXTERNAL CAROTID ART

10 Posting Date        11 DB/CR?    12 Adjustment Amount    13 New Balance
   07/03/08               DB           25.00                   5,014.21
14 Trans Code/Description                15 Final?
   A0030-I/P OTHER ALLOWANCES                No
16 Comments
   01
   02
   03

```

Field Explanations

Fields 1 through 9 - Carrier Balance, Adjustments, Payments, Carrier Liability, Last Adjustment Date, Last Payment Date, Batch Seq #, Pt Class, and BillDRG IND, are completed by the system and cannot be edited.

1. CARRIER BALANCE (DISPLAY ONLY)
This field contains the current balance of the carrier.

2. ADJUSTMENTS (DISPLAY ONLY)
This field contains the total dollar amount of all adjustments for the carrier.

3. PAYMENTS (DISPLAY ONLY)
This field contains the total dollar amount of payments for the carrier.

4. CARRIER LIABILITY (DISPLAY ONLY)
This field contains the prorated liability of the carrier for the selected claim.

5. LAST ADJUSTMENT DATE (DISPLAY ONLY)
This field contains the date on which the last adjustment was made for this carrier and this account.

6. LAST PAYMENT DATE (DISPLAY ONLY)
This field contains the date on which the last payment was made for this carrier and this account.

7. BATCH SEQ # (DISPLAY ONLY)
This field contains the sequence number of this adjustment within the batch.

8. PT CLASS (DISPLAY ONLY)
This field displays the financial patient classification combined with the alert and suppression indicators associated with the financial patient classification. The three-character patient classification code is displayed if a patient classification has been assigned to the account. Leading and trailing asterisks (**) display when the assigned patient classification has an alert designation. Finally, the follow-up suppression indicator is displayed as the final character in the field:

•   a = alert only; follow-up is not suppressed

•   c = suppression of follow-up has been cleared by a user

•   s = follow-up is currently being suppressed

9. PRINCIPAL/ADMITTING DIAGNOSIS (DISPLAY ONLY)
This field displays a leading 9 for ICD-9 or 10 for ICD-10, a slash (/), then the Principal, or if blank, the Admitting Diagnosis Description. If the account has both ICD-10 and ICD-9 diagnoses, the ICD-10 diagnosis description is displayed.

10. POSTING DATE (6-N-R)
This field contains the date on which this payment is posted. The default is from the batch header. This field is used in the transaction history and to select the appropriate General Ledger fiscal period for posting.

11. DB/CR? (1-A-R)
This field indicates whether this is a debit or credit entry. Entry options are **D** (debit) or **C** (credit); the default is C. The system assumes a credit adjustment unless you override it. A credit adjustment decreases the balance of the account, while a debit increases the balance of the account.

12. ADJUSTMENT AMOUNT (DISPLAY ONLY)
This field contains the adjustment amount for this account.

13. NEW BALANCE (DISPLAY ONLY)
This field contains the account's new balance based on the beginning balance. It displays what the balance is after the adjustment is applied.

14. TRANSACTION CODE/DESCRIPTION (5-AN-R)
This field contains the transaction type and code that is used to record this adjustment in the appropriate account's transaction history and in the GL. If the description is included with the transaction code, it is truncated to fit this field. You can enter the code or a hyphen (**-**) to display and select from a list of valid codes under transaction type A (adjustment). This field is supplied from the batch header and can be changed if necessary.

15. FINAL? (1-A-O)
This field allows you to final disposition a claim when you are posting an adjustment to the claim. When the field is accessed, the following prompt is displayed:

Is this a final disposition? (Y/N) [N]--

Entry options are Y for "Yes, this is a final disposition" or N for "No, this is not a final disposition." The default is No. If you enter **Y** for Yes, the system allows you to select one of the current disposition types. The following prompt is displayed:

Final disposition is A(Adjusted to zero), D(Denied) or F(Final payment)[F]--

Options are Adjusted to zero (A), Denied (D), or Final Payment (F). If the response is Denied, and this is an adjustment for the primary carrier, then the system allows the user to select a Denial Tracking Reason code from the payor-specific denial tracking reasons associated with the primary insurance carrier/plan.

16. COMMENTS (180-C-O)
This field contains any comments pertaining to this adjustment transaction that you want to enter. You can enter up to 180 characters. When you access this field, the system displays the following prompt:

Enter comments (C) or notes (N) --

If you enter **C** for comments, you are prompted to enter a comment about this payment. You can enter up to three lines of comments for this payment. Press F4 when you finish entering your comments. If you enter **N** for notes, the notes program is displayed on your screen. Refer to the Notes section in the *Billing and Claims Volume* of the *STAR Patient Accounting Reference Guide* for a description of entering notes for this payment.

 If a comment or note is not necessary, press ENTER.

When all fields are completed, you have the option of accepting or editing the information entered on this screen. Accepting the screen completes this adjustment entry. You have the option of entering another adjustment for this account, selecting another account, another carrier or returning to the list of adjustment posting options.

Post Patient Discount Adjustments

This option enables you to post adjustments representing patient discounts. The transaction uses two screens: the first is used to enter default information about this entry and the second to enter the adjustment on the account. After you select this option, the system displays this screen containing information already entered about this batch and the patient adjustment default information.

You can access Account Inquiry within a batch using the dollar sign ($) when prompted for an account. This feature enhances the accuracy of posting cash on accounts by providing a research mechanism.

Use this option if you want the system to calculate an adjustment based on percentage.

```
           General Hospital Patient Discount Adjustment Posting Setup Processor
                                                 Thu Jul 14, 1988 09:47 am

   1 Batch #         2 Batch Description
     4                 Patient Discount Adjustments
   3 # of Trans       4 Total Entered      5 Batch Total       6 Variance
     11                 190.68               100.00              90.68-

                           Patient Adjustment Default
   7 Trans Code/Description
     A0001-ADJUSTMENT







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

Field Explanations

Fields 1 through 6 - Batch #, Description, # of Trans, Total Entered, Batch Total, and Variance - are completed by the system with information already entered and cannot be edited.

Patient Adjustment Default

7.   TRANSACTION CODE/DESCRIPTION (5-AN-R)
This field contains the transaction type and code that can be used to record this adjustment in the appropriate account's transaction history and in the general ledger. If the description is included with the transaction code, it is truncated to fit this field. You can enter the code or a hyphen (-) to display and select from a list of valid codes under transaction type A (adjustment). If you are doing a batch of the same adjustment, this field should be completed; otherwise, it must be entered for every account.

After this screen is completed and accepted, the system prompts you to select the patient account to which this adjustment is being made. Use the standard lookup to do so. After you select an account, the system displays the following screen:

```
            General Hospital Patient Discount Adjustment Posting Processor
                                                  Mon Mar 13, 2009  11:59 am
                                      C0722900001  OLAF,HANS              O   I/P
08/10/07 08/17/07    $4989.21 AR
 1 Patient Balance    2 Adjustments          3 Payments
   1,437.84
 4 Account Balance    5 Last Adjustment Date  6 Last Payment Date
   4,989.21
 7 Batch Seq #        8 Pt Class              9 Principal/Admitting Diagnosis
   1                                          9/INJ EXTERNAL CAROTID ART

10 Posting Date     11 Trans Code/Description
   07/03/08            A0035-I/P CHARITY ALLOWANCES
12 Adjustment Type  13 Adjustment %    14 Balance to Use   15 Beginning Balance
   Flat amount                         Account                  4,989.21
16 DB/CR?   17 Adjustment Amount       18 New Balance
   CR         20.00                       4,969.21
19 Comments
   01
   02
   03

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

Enter comments (C) or notes (N)--
```

Field Explanations

Fields 1 through 9 - Patient Balance, Adjustments, Payments, Account Liability, Last Adjustment Date, Last Payment Date, Batch Seq #, and Pt Class, are completed by the system based on the patient selected and cannot be edited.

1. PATIENT BALANCE (DISPLAY ONLY)
This field contains the current balance of the patient portion of the account.

2. ADJUSTMENTS (DISPLAY ONLY)
This field contains the total adjustment amount made to the patient's portion of this account.

3. PAYMENTS (DISPLAY ONLY)
This field contains the total payment amount made to the patient's portion of this account.

4. ACCOUNT BALANCE (DISPLAY ONLY)
This field contains the current account balance.

5. LAST ADJUSTMENT DATE (DISPLAY ONLY)
This field contains the date on which the last adjustment was made on the patient's portion of this account.

6. LAST PAYMENT DATE (DISPLAY ONLY)
This field contains the date on which the last payment was made on the patient's portion of this account.

7. BATCH SEQ # (DISPLAY ONLY)
This field contains the sequence number of this adjustment within the batch.

8. PT CLASS (DISPLAY ONLY)
This field displays the financial patient classification combined with the alert and suppression indicators associated with the financial patient classification. The three-character patient classification code is displayed if a patient classification has been assigned to the account. Leading and trailing asterisks (**) display when the assigned patient classification has an alert designation. Finally, the follow-up suppression indicator is displayed as the final character in the field:

- a = alert only; follow-up is not suppressed

- c = suppression of follow-up has been cleared by a user

- s = follow-up is currently being suppressed

9. PRINCIPAL/ADMITTING DIAGNOSIS (DISPLAY ONLY)
This field displays a leading 9 for ICD-9 or 10 for ICD-10, a slash (/), then the Principal, or if blank, the Admitting Diagnosis Description. If the account has both ICD-10 and ICD-9 diagnoses, the ICD-10 diagnosis description is displayed.

10. POSTING DATE (6-N-R)
This field contains the date on which this payment is posted. The default is from the batch header. This field is used in the transaction history. It is also used to select the appropriate General Ledger fiscal period for posting.

11. TRANSACTION CODE/DESCRIPTION (5-AN-R)
This field contains the transaction type and code used to record this adjustment in the appropriate account's transaction history and in the GL. If the description is included with the transaction code, it is truncated to fit this field. You can enter the code or a hyphen (-) to display and select from a list of valid codes under transaction type A (adjustment). This field is from the batch header and cannot be changed.

12. ADJUSTMENT TYPE (1-A-R)
This field indicates the type of adjustment that is being made. This entry is displayed from the batch header screen. F indicates a flat amount adjustment. P indicates that you want the system to calculate the adjustment.

13. ADJUSTMENT PERCENT (3-N-C)
This field contains the percentage of the adjustment write-off if the Adjustment Type field contains P. The range is 0.1 to 100 percent.

14. BALANCE TO USE (1-A-C)

This field indicates the balance that is used to calculate the adjustment. Entry options are the account balance, the patient balance, or a manually entered balance. This field is required if a percent adjustment is being entered.

15. BEGINNING BALANCE (9-N-O)

This field contains the balance on which the percent adjustment bases its calculation. If this is a flat adjustment, this is the current account balance. If manually entered, this is where the balance is manually entered.

16. DB/CR? (1-A-R)

This field indicates whether this is a debit or credit entry. Entry options are **D** (debit) or **C** (credit); the default is C. The system assumes a credit adjustment unless you override it. A credit adjustment decreases the balance of the account, while a debit increases the balance of the account.

17. ADJUSTMENT AMOUNT (9-N-C)

This field contains the adjustment amount if this account's balance is being adjusted by a flat amount (depending on entry in the Adjustment Type field). The entry range is 0 to $9,999,999.99.

If this account's balance is being adjusted by a percentage, the system calculates and displays the adjustment amount based on the beginning balance and the adjustment percent. If a percentage adjustment is displayed, this field cannot be edited. The adjustment amount reduces or increases the current patient balance and account balance by the amount of the adjustment.

18. NEW BALANCE (DISPLAY ONLY)

This field contains the account's new balance based on the beginning balance. It displays what the balance is when the adjustment is applied.

19. COMMENTS (180-C-O)

This field contains any comments pertaining to this adjustment transaction that you want to enter. You can enter up to 180 characters. When you access this field, the system displays the following prompt:

Enter comments (C) or notes (N) --

If you enter **C** for comments, you are prompted to enter a comment about this payment. You can enter up to three lines of comments for this payment. Press F4 when you finish entering your comments. If you enter **N** for notes, the notes program is displayed on your screen. Refer to the Notes section in the *Billing and Claims Volume* of the STAR Patient Accounting Reference Guide for a description of entering notes for this payment.

 If a comment or note is not necessary, press ENTER.

When all fields are completed, you have the option of accepting or editing the information entered on this screen. Accepting the screen completes this adjustment

entry. You have the option of entering another adjustment for this account, selecting another account, selecting another carrier, or returning to the list of adjustment posting options.

Post Other Patient Adjustments

This option has fewer fields that need to be completed. There are no calculations performed on percentage adjustments. This function enables you to post adjustments other than discounts to patient accounts. These adjustments may include billing error corrections, etc. This transaction uses two screens: the first is used to enter default patient adjustment information about this entry and the second to enter the adjustment. After you select this option, the system displays this screen containing information already entered about this batch and the patient adjustment default information.

You can access Account Inquiry within a batch using the dollar sign ($) when prompted for an account. This feature enhances the accuracy of posting cash on accounts by providing a research mechanism.

```
        General Hospital Patient Adjustment Posting Setup Processor
                                            Thu Jul 14, 1988 09:47 am

 1 Batch #          2 Batch Description
   4                  Other Patient Adjustments
 3 # of Trans       4 Total Entered       5 Batch Total         6 Variance
   11                 1,432.89              1,401.80              31.09-

                        Patient Adjustment Default
 7 Trans Code/Description
   A0001-ADJUSTMENT








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

Field Explanations

The Batch #, Description, # of Trans, Total Entered, Batch Total, and Variance fields are completed by the system using information already entered and cannot be edited.

Patient Adjustment Default

7.   TRANSACTION CODE/DESCRIPTION (5-AN-R)
This field contains the transaction type and code used to record this adjustment in the appropriate account's transaction history and in the general ledger. If the description is included with the transaction code, it is truncated to fit this field. You can enter the code or a hyphen (-) to display and select from a list of valid codes under transaction type A

(adjustment). If you are doing a batch of the same adjustment, this field should be completed; otherwise, it must be entered for every account.

When this screen is completed and accepted, the system prompts you to select the patient account to which this adjustment is being made. Use the standard lookup to do so. After you select an account, the system displays the following screen:

```
            General Hospital Patient Adjustment Posting Processor
                                     Mon Mar 13, 2009 11:59 am
Account      Name                FC Typ Admit    Disch      Balance Loc
A9900100038  ANDERSON,JOHN COOK    N  ER  01/01/99 01/01/99   90.00   AR/FCRV
 1 Patient Balance    2 Adjustments           3 Payments
   10.00-                                        10.00
 4 Account Balance    5 Last Adjustment Date  6 Last Payment Date
   735.12                                        02/20/08
 7 Batch Seq #        8 Patient Class         9 Principal/Admitting Diagnosis
   2                                            10/HEART FAILURE


10 Posting Date    11 DB/CR? 12 Adjustment Amount    13 New Balance
   07/03/08           CR         10.00                  725.12
14 Trans Code/Description
   A0099-I/P PATIENT ALLOWANCES
15 Comments
   01
   02
   03




Enter comments (C) or notes (N)--
```

Field Explanations

Fields 1 through 9 - Patient Balance, Adjustments, Payments, Account Balance, Last Adjustment Date, Last Payment Date, Batch Seq #, and Pt Class - are completed by the system and cannot be edited.

10. POSTING DATE (6-N-R)
This field contains the date on which this payment is posted. The default is from the batch header. This field is used in the transaction history and to select the appropriate General Ledger fiscal period for posting.

11. DB/CR? (1-A-R)
This field indicates whether this is a debit or credit entry. Entry options are D (debit) or C (credit); the default is C. The system assumes a credit adjustment unless you override it. A credit adjustment decreases the balance of the account, while a debit increases the balance of the account.

12. ADJUSTMENT AMOUNT (9-N-C)
This field contains the adjustment amount.

13. NEW BALANCE (DISPLAY ONLY)
This field contains the account's new balance based on the beginning balance. It displays what the balance is after the adjustment is applied.

14. TRANS CODE/DESCRIPTION (5-AN-R)
This field contains the transaction type and code used to record this adjustment in this account's transaction history and the general ledger. If the description is included with the transaction code, it is truncated to fit this field. You can enter the code or a hyphen (-) to display and select from a list of valid codes under transaction type A (adjustment).

15. COMMENTS (180-C-O)
This field contains any comments pertaining to this adjustment transaction that you want to enter. You can enter up to 180 characters. When you access this field, the system displays the following prompt.

> *Enter comments (C) or notes (N) --*

If you enter **C** for comments, you are prompted to enter a comment about this payment. You can enter up to three lines of comments for this payment. Press F4 when you finish entering your comments. If you enter **N** for notes, the notes program is displayed on your screen. Refer to the Notes section in the *Billing and Claims Volume* of the STAR Patient Accounting Reference Guide for a description of entering notes for this payment.

If a comment or note is not necessary, press ENTER.

When all fields are completed, you have the option of accepting or editing the information entered on this screen. Accepting the screen completes this adjustment entry. You have the option of entering another adjustment for this account, selecting another account, or returning to the list of adjustment posting options.

Balance Transfer & Claim Disposition

This function allows you to transfer account balance liability amounts between one or more carriers and the patient balance for an account, disposition claims, and change the financial class of an account in accounts receivable and bad debt. For detailed information regarding this function, refer to Post Balance Transfer & Claim Disposition within this chapter.

Exit Batch

This function is used to post batches, place batches on hold, print batch detail, edit batches, accept batches, and approve batches. The exit batch is a menu selection if a batch is a mixed-transaction batch. For a batch that is not a mixed transaction batch, the exit function is available when leaving the Adjustment Posting function. Only unposted batches can be accessed using this function.

Batch Functions

The system considers a batch balanced if its Batch Total equals the Starting Balance (if any) plus the Total Entered, resulting in a zero variance. You have these batch options:

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- Approving the Batch (posting it)

- Holding the Batch

- Printing Batch Detail

- Editing the Batch

APPROVING (POSTING) THE BATCH

Approving a balanced batch posts the batch and updates account balances, last adjustment dates, and transaction history follow-up information. When a batch is posted, the patient account is updated immediately. The General Ledger is updated during the midnight processing run.

During midnight processing the following reports are generated:

- Adjusted Posted Detail report (FAR210)

- Adjustment Posting Detail Exception report (FAR220)

PUTTING A BATCH ON HOLD

If you do not complete an adjustment batch, you may want to place the batch on hold.

PRINTING BATCH DETAIL

You can print the batch contents as long as the batch has not been posted. Enter **P** to print the items within the batch on the selected printer. Check with operations for the printer assignment for this report. The name of this report is Adjustment Posting Audit report (FAR200).

ACCEPTING THE BATCH

You accept the batch by entering **A** for an unbalanced batch. This option does not change the batch status but allows you to exit from the Exit Batch function to obtain information necessary to balance the batch.

EDITING A BATCH

The system enables you to edit a batch at the batch total and component level. Changing the batch total must be done on the batch header screen by an employee with a security level of 50 or higher. The fact that the batch total was changed is included on the Adjustment Exception report.

The following screen is displayed when the Exit Batch function is selected:

```
                General Hospital Cash Posting Exit Batch Processor
                                             Thurs May 15, 2002 10:10 am

  1 Batch code        2 Batch Description                    3 # of Trans
     7                  Blue Cross GA                              3
CASH   4 Starting Balance  5 Total Entered  6 Batch Total    7 Variance
                             145.60           145.60            .00
CONTRACTUAL ADJUSTMENTS      8 Total Entered  9 Batch Total   10 Variance
                             .00
11 Batch Status            12 Agency Fees
   Balanced                   9.00




Batch is balanced - Approve(A), Hold(H), Print Batch (P), Edit(E), or Return(R)? --
```

You cannot edit this batch summary screen. The system repeats this information for your review.

Field Explanations

1. BATCH # (DISPLAY ONLY)
This field contains the system- or user-assigned batch code.

2. BATCH DESCRIPTION (DISPLAY ONLY)
This field contains user-defined batch description.

3. # OF TRANS (DISPLAY ONLY)
This field contains the number of transactions in the batch.

Cash

4. STARTING BALANCE (DISPLAY ONLY)
This field contains the starting balance entered by the user.

5. TOTAL ENTERED (DISPLAY ONLY)
This field contains the total amount entered during the posting process.

6. BATCH TOTAL (DISPLAY ONLY)
This field contains the batch total.

7. VARIANCE (DISPLAY ONLY)
This field contains the difference between the starting balance plus the total entered and the batch total. The equation is:

 Variance = (Starting Balance + Total Entered) - Batch Total

Contractual Adjustments

8. TOTAL ENTERED (DISPLAY ONLY)
This field displays the total amount entered into the batch.

9. BATCH TOTAL (DISPLAY ONLY)
This field contains an amount for Contractual Adjustments.

10. VARIANCE (DISPLAY ONLY)
This field is a calculation of Batch Total less the Total Entered.

11. BATCH STATUS (DISPLAY ONLY)
This field contains the status of the batch - balanced or unbalanced.

12. AGENCY FEES (DISPLAY ONLY)
This field displays the user-entered amount of the agency's fees.

If you enter E (Edit) after the prompt, the following screen is displayed:

```
            General Hospital Adjustment Posting Exit Batch Processor
                                          Fri Feb 12, 1999 01:53 pm

* = Pt Class - a Alert Only, s Suppressed F/U, c Cleared
Page:01        Batch 6    - ADJ                          ##=Current Choices
     Seq#  Type            Amount   *    Account     Name
( 1) 1     Contractual     500.00- a    9900100038 ANDERSON,JOHN COOK
( 2) 2     Insurance       100.00-      9900100042 ANDERSON,ITTY BITTY COOK
( 3) 3     Insurance       100.00- s    9900100039 ANDERSON,CAROLINE COOK
( 4) 4     Insurance        10.00- s    9900100039 ANDERSON,CAROLINE COOK
( 5) 5     Pat Disc         10.00-      9900100041 ANDERSON,BAILEY COO
( 6) 6     Pat Disc         19.00-      9900100042 ANDERSON,ITTY BITTY COOK
( 7) 7     Patient          33.00-      9900100041 ANDERSON,BAILEY COO
( 8) 8     Patient         200.00- a    9900100038 ANDERSON,JOHN COOK




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

You can select one, some, or all component transactions to edit. After the transaction is selected, detail information on the transaction is displayed. See the detail screen example on the next page. If multiple transactions are selected, the system displays them in batch sequence order.

The screen below is an example of the detail information you can access on a transaction:

```
         General Hospital Patient Adjustment Posting Processor
                                        Mon Mar 13, 2006 11:59 am
Account      Name                 FC Typ Admit    Disch       Balance Loc
A9823600001  HENDERSEN,JOHN        N  ER 01/01/99 01/01/99     10.00- AR/FCRV
 1 Patient Balance    2 Adjustments           3 Payments
   90.52                20.00-
 4 Account Balance    5 Last Adjustment Date  6 Last Payment Date
   618.05                05/22/06
 7 Batch Seq #        8 Patient Class
   1

 9 Posting Date     10 DB/CR? 11 Adjustment Amount      12 New Balance
   07/21/06             ->
13 Trans Code/Description
   A0002-O/P M'CARE B HOSPITAL ALLOW
14 Comments
   01
   02
   03



Enter comments (C) or notes (N) --
```

You can edit the Payment Amount, Receipt #, Remittance #, Payment Date, Posting Date, Trans Code/Description, and Comment fields. The other fields on the screen cannot be edited. Once all editing is completed, you have the option of accepting (Y), not accepting (N), or deleting (D) the entry. Deleting an entry removes it from the batch; sequence numbers are not reassigned. You should delete an entry if the wrong account has been selected.

The system then displays the next transaction (if multiple transactions were selected) or asks you to accept the screen (if a single transaction is being edited). If you accept this screen the system returns you to the screen summarizing the batch. From there you can choose to edit another transaction, or, if the batch is now balanced, to post the batch.

POST BALANCE TRANSFER & CLAIM DISPOSITION

This function enables you to transfer account balance liability amounts between one or more carriers and the patient balance for an account, disposition claims, and change the financial class of an account in accounts receivable (AR) and bad debt (BD).

After you select the Balance Transfer & Claim Disposition function, the system prompts you to select a facility (if this is a multifacility installation). The system displays the standard lookup prompt. After you select an account, the system displays the following screen:

```
         General Hospital Balance Transfer & Claim Disposition Processor
                                          Mon Mar 13, 2006 11:59 am
Account        Name                  FC Typ Admit    Disch      Balance  Loc
A9733800002  ADAMS, BOB             O  I/P 12/04/01 07/26/02   107528.00 AR/FCRV

 1 C  2 Carrier/Plan       3 EP     4 Pd    5 Orig Balance   6 New Balance
   1    500100 COMMERCIAL B   7        5        47,750.00        47,750.00
   2    500200 1500 BASIC P                          0.00             0.00
   P                                          59,778.00        59,778.00
                                          =============    =============
        PC-         Total                    107,528.00       107,528.00



                              All Claims
  Archived,Purged
     CS     Bill          Service        Ext Claim #     Dsp       Page:01
            From/Thru      From/Thru
( 1)   2    12/04 01/04/98 12/04 01/04/98                 P
( 2)   3    01/05 02/04/98 01/05 02/04/98                 P
M
Enter choice, (A)ll, (I)ncomplete, (C)omplete, or (O)ther --
                  next pg(/ or PG DN)  Search(TAB)
```

You may select a claim by entering the number of the claim you want to view, select all claims by entering **A**, or you may choose to limit the claims that are displayed by entering **I**, **C**, or **O**. If you select I, only incomplete claims are displayed. If you enter C, only completed claims are displayed. If you select L, all claims are displayed, and it is included in this prompt to allow you to see all claims after limiting the claims that are displayed.

If you select O, the following prompt is displayed:

Limit claims by (D)isp, (B)ill Dt, or (S)ubm Dt [D] --

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

```
          General Hospital Balance Transfer & Claim Disposition Processor
                                            Mon Mar 13, 2006 11:59 am
Account       Name                      FC Typ Admit    Disch     Balance   Loc
A02008-00004 MOORE, BOB                 M  I/P 01/08/02           766049.25 PA/FCRV

 1 C  2 Carrier/Plan      3 EP    4 Pd   5 Orig Balance   6 New Balance
   1    100300 MEDICARE PAR    6      1       21,967.66        21,967.66
   2    500100 BASIC  COMER    5               279,477.01       279,477.01
   3    500200 COMMERCIAL 1                          0.00             0.00
   P                                           464,604.58       464,604.58
                                            ============     ============
        PC-         Total                      766,049.25       766,049.25


     From                        To
COB CS Dsp           Amount  Cmp COB  CS   Tran Code/Description     Cmt
2       D/C045      $100.00  Yes  P         001-Bal Transfer After In   Yes




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

You may select one or more Claim Disposition codes for claims to be displayed for the account. Notice that you may 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**, the system displays the following prompt:

Enter earliest bill thru date [Earliest] --

You may accept the default of Earliest, enter a specific date in the format MMDDYY, 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 to include [Latest] --

You may accept the default of Latest, enter a specific date in the format MMDDYY, or enter T - # to indicate the number of days prior to today to be used as the latest bill through date. Claims are 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**, 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 in the format MMDDYY, 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 in the format MMDDYY, 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.

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.

Each account balance represents the sum of the account's carrier balances and the patient balance and Third Party excess, if applicable. The liability assigned to each of these components is determined initially by the proration of charges as defined by the account's respective carrier plans. As payments, adjustments, and refunds are posted to the account, the appropriate balance is reduced. This distribution may be adjusted among the carriers and the patients without affecting the account's total balance.

Transfers of liability among the components of the account balance can be accomplished by posting a balance transfer. Balance transfers can be posted between carriers, from a carrier to the patient or from the patient to a carrier. Each posting is recorded in the account detail as an audit of account activity, but no general ledger postings are generated since the account balance has remained unchanged. This function is allowed on accounts (that have a claim record) in account location PA, AR, or BD.

If all of the carrier's claims have been archived and/or purged, the message *All claims archived, insurance follow-up will not be initiated* is displayed on the Balance Transfer screen when money is transferred to that carrier. This comment is maintained in Transaction History for the balance transfer transaction in the comment field. If desired, you can enter a comment which overrides the system comment.

Field Explanations

1. C (DISPLAY ONLY)
This field contains the coordination of benefits sequence for this account if there is insurance coverage involved. It displays the numbers 1 through 9 from the COB field, P for patient balance, or T for Third Party excess.

2. CARRIER/PLAN (DISPLAY ONLY)
This field contains the carrier code, plan code, and name for each carrier associated with this account. Up to nine carriers can be displayed.

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3. EP (DISPLAY ONLY)

This field contains the expected number of payments. The expected number of payments is incremented for each cycle, final, and late claim loaded for the carrier. Expected number of payments is decremented for each cycle, final, late, or adjustment claim dispositioned as final payment, adjusted to zero, or denied.

4. PD (DISPLAY ONLY)

This field contains the number of payments received from the carrier.

5. ORIG BALANCE (DISPLAY ONLY)

This field contains the current balance of the carrier or patient of the account.

6. NEW BALANCE (DISPLAY ONLY)

This field contains the proposed balance for each carrier and patient if the transfer is accepted. The system calculates the balances based on the transfer amount entered below.

FROM (1-AN-R)

This field indicates the portion of the account's liability dollars from which the transfer is being made. Entry options are numbers 1 through 9 from the COB field, P for Patient, or T for Third Party Excess. The COB field (field 1) displays the eligible indicators that can have balances transferred from and to them.

TO (1-AN-R)

This field indicates the portion of the account's liability dollars to which the transfer is being made. Entry options are numbers 1 through 9 from the COB field, P for Patient, or T for Third Party Excess. The COB field (field 1) displays the eligible indicators that can have balances transferred from and to them.

NOTE: The *From* and *To* selections may not be the same. If you enter the same code, the following message appears:

> *Error: transfer to and transfer from selection cannot be the same.*

You are prompted to enter a new selection.

CS (3-AN-O)

If the *From* or *To* field is a carrier, a table is displayed that shows each claim associated with the carrier. If the selected carrier has only one claim, this field automatically defaults to that claim sequence number and proceeds to the next field.

The following provides you with a sample table that contains multiple claim sequences.

```
        CS    Bill              Service           Ext Claim #      Dsp
              From/Thru         From/Thru
( 1)    1     01/29 01/29/95    01/29 01/29/95    1246A            T
( 2)    5     02/29 02/29/95    02/29 02/29/95    22448
```

When this portion of your scrolling screen displays the multiple claim sequences, enter the claim sequence number that you want. You can select a specific claim sequence number or all claim sequence numbers.

When you access this table and there is more than one sequence number, the system displays the following prompt:

Enter choice or (A) for all--

Enter the specific claim sequence number or **A** for all claim sequence numbers.

NOTE: The *All* option applies only to the *From* carrier's information.

The claim sequence list is defined as follows:

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

BILL FROM/THRU (DISPLAY ONLY)
This field contains the billing from and through dates.

SERVICE FROM/THRU (DISPLAY ONLY)
This field contains the service from and through dates, from the Statement Covers Period in Locator 6 of the UB04..

EXT CLM # (DISPLAY ONLY)
This field contains the claim number manually assigned through the claim screens.

DSP (DISPLAY ONLY FOR CLAIM SEQUENCE LIST)
This field contains the current disposition of the claim.

DSP (1-AN-R ONCE SELECT CLAIM OR A FOR ALL)
This field contains the selected claim disposition and denial tracking reason code, if the claim disposition is Denied. The valid entries are: D (denied), P (partial payment), F (final payment), A (adjusted to zero), C (clear disposition), and T (transferred). You can enter a claim disposition code or a hyphen (**-**) to display and select from a table lookup of the claim disposition codes. If you enter a disposition code that completes the claim (a disposition of Final Payment, Adjusted to Zero, or Denied), and this is the last claim not previously completed for the selected carrier, you must transfer the entire carrier balance. If the amount entered is not the carrier balance, the following message is displayed:

Error: Final disposition entered, must transfer full balance.

Enter the correct carrier balance.

If the selected claims have been dispositioned the following message is displayed:

All claims previously dispositioned. Continue? Y/N [N]

If you enter **Y** for Yes, the disposition is cleared. If you enter **N** for No, the system returns to the lookup screen so that you can select another carrier and/or claim.

If you enter Clear (**C**) as the disposition, the carrier must have a balance. If the carrier does not have a balance, the system displays the following error message:

Carrier Zero Balance, Must Enter Activity.

You must either enter a debit insurance adjustment to the carrier in the Post Adjustment function or transfer money to the carrier in the Balance Transfer & Claim Disposition function before you can enter Clear (**C**) as the disposition.

NOTE: You can use this function to modify a claim's disposition without transferring any money. If the selected disposition completes the claim and there are no other open claims remaining for the carrier, you must transfer the entire carrier balance. If a claim is dispositioned as Final Payment, Adjusted to Zero, or Denied, any claims that were waiting payment on this claim are updated not to wait on it.

If you enter **D** for Denied as the disposition, you can select a Denial Tracking Reason Code from the payor-specific denial tracking reasons associated with the primary insurance carrier/plan.

AMOUNT (12-N-O)
This field contains the amount being transferred. Transfers can be from one insurance to another insurance, from an insurance to the patient, from the patient to an insurance, from Third Party Excess to the patient or an insurance, or from the patient or insurance to Third Party Excess. 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 is displayed in this field. For dispositions of T (transferred), C (clear disposition), or P (partial), No is displayed 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 or follow-up.

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 is displayed. You can enter the code or a hyphen (**-**) to display and select from a list of valid codes under transaction type B (balance transfer).

COMMENT (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 comments. Comments entered are displayed in the account's transaction history under Comment.

When you complete these fields, this procedure can be repeated for another balance transfer for this account until all transfer possibilities are exhausted. Press F7 to accept your entries. After you press F7 and your selected account is in location AR or BD, the following 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 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* is displayed. After you make your selection, the transaction is complete, and you are returned to the account lookup.

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

For additional information regarding the impact of cash posting, refer to the Impact of Transaction topic within this chapter.

CN: Generally, this transaction will not be used for OHIP claims. Refer to the *Canadian Claims Processing volume* and the *Ontario Electronic Claims and Payments Volume* of the STAR Patient Accounting Reference Guide for additional information about OHIP claims.

MAINTAIN SERVICE LINE INFORMATION

This function allows you to edit service line detail information for non-ERA cash batches only. You can add and modify service line detail information and manually enter the service line payment information received from printed Explanation of Benefits (EOB) statements.

After you select the Maintain Service Line Information function, the system prompts you to select a facility (if this is a multifacility installation). After you select a facility, the system displays the following screen:

```
        General Hospital Maintain Service Line Item Information Processor
                                              Thu Apr 25, 2002 09:36 am
      Ins Seq Trns Dt Created  Batch   Src    Batch Description      Posted
( 1) M   1   Nov 03  Jun 10    179     835 A  Mcare A 06/00 Type 13  Jun 10




Do you want to (A)dd, (Q)uick Add, (D)elete, (E)dit, or (S)peed Edit service
line detail [E] --
```

This screen displays a list of existing approved insurance cash batches. Cash batches can be accessed up to five (5) days after approval, depending on the setting of the Service Line Info Days in the Data Retention parameters. Posted ERA batches are not displayed in the Maintain Service Line Detail lookup. This is to keep the integrity of the Remittance Data received via ERA. The system displays non-ERA cash batches that have been posted.

Do you want to (A)dd, (Q)uick Add, (D)elete, (E)dit, or (S)peed Edit service line detail [E] --

- If you select A (Add), the system only displays the entries in the cash batch that exist without any service line detail present. On the service line detail entry screen, the cursor stops at every field.

- If you select Q (Quick Add), the system displays the same accounts as with the A (Add) option. On the service line detail entry screen, the cursor stops only at the payment amount, adjustment amount, coinsurance amount, and deductible amount.

- If you select E (Edit), the system displays all entries in the insurance cash batch. On the service line detail entry screen, the cursor stops at every field. The default is Edit.

- If you select S (Speed Edit), the system displays all entries in the insurance cash batch. On the service line detail entry screen, the cursor stops only at the payment amount, adjustment amount, coinsurance amount, and deductible amount fields.

The following screen is displayed after you select an option from the prompt:

```
            General Hospital Maintain Service Line Information Processor
                                              Thurs May 16, 2002 04:53 pm
* = Pt Class - a Alert, s Suppressed F/U, c Cleared
Page:01       Batch 999 - TEST                              ##=Current Choices
   Seq#  Type              Amount       C/A Amt   *  Account     Name
( 1) 1    Insurance     50,000.00-         .00       0115200003 CASH, MARK
( 2) 2    Insurance        150.00-         .00       0115200003 CASH, MARK












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

```

The entries display in cash batch order. You can select one or more insurance cash batches or enter **S** to select an account by patient account number. After selecting an account either from the list or by entering the account number, the following screen is displayed:

```
         General Hospital Maintain Service Line Information Processor
                                               Mon Mar 13, 2006 11:59 am
Account       Name                   FC Typ Admit    Disch       Balance Loc
A0204400002  ATKINSON,ALICE          M  O/P 02/13/02 02/13/02      0.00   AR/FCRV
 1 Claim Liability    2 Bill From      3 Bill Through  4 Carrier Balance
   $0.00                  01/01/41        02/13/02               $0.00
5 Carrier/Plan                6 Batch Seq #  7 ICN
   100/100-MEDICARE A           A2              20129010563504
                              Claim Totals
 8 Payment Amount  9 Cont Adj Amount  10 Coinsurance    11 Deductible
   $1,500.17          $1,500.17
12 Claim SubChg                       13 RA SubChg
   $6,792.60                             $20,129,010
14 RA Claim Status                    15 RA Claim Filing Ind
   1 Processed as Primary                MA Medicare Part A
16 Claim Level Remarks                17 Claim Level Adjustment Codes
   MA01,MA07,MA11
Seq   Adjustment   Group   Reason
1       1234.56     CO      A2
2        250.00     PR      35


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

```

Field Explanations

1. CLAIM LIABILITY (DISPLAY ONLY)
This field displays the claim liability amount for the claim.

2. BILL FROM (DISPLAY ONLY)
This field displays the bill from date for the claim.

3. BILL THROUGH (DISPLAY ONLY)
This field displays the bill through date for the claim.

4. CARRIER BALANCE (DISPLAY ONLY)
This field displays the carrier balance for the carrier associated with the claim.

5. CARRIER/PLAN (DISPLAY ONLY)
This field displays the carrier/plan for the claim.

6. BATCH SEQ # (DISPLAY ONLY)
This field displays the batch sequence number associated with the insurance payment for the claim.

7. ICN (DISPLAY ONLY)
This field displays the Internal Control Number associated with the insurance payment for the claim.

8. PAYMENT AMOUNT (DISPLAY ONLY)
This field displays the insurance payment amount for the claim.

9. CONT ADJ AMOUNT (DISPLAY ONLY)
This field displays the total contractual adjustment amount associated with the insurance payment for the claim.

10. COINSURANCE (DISPLAY ONLY)
This field displays the coinsurance amount associated with the insurance payment for the claim.

11. DEDUCTIBLE (DISPLAY ONLY)
This field displays the deductible amount associated with the insurance payment for the claim.

12. CLAIM SUBCHG (DISPLAY ONLY)
The total submitted charges from the STAR claim.

13. RA SUBCHG (DISPLAY ONLY)
The total submitted charges reported on the electronic Remittance Advice.

14. RA CLAIM STATUS (TABLE LOOKUP-O)
The claim status code associated with this claim. The claim status code may be added or edited.

15. RA CLAIM FILING IND (TABLE LOOKUP-O)
This field contains the claim filing indicator associated with this claim. The claim filing indicator may be added or edited.

16. CLAIM LEVEL REMARKS (TABLE LOOKUP-O)
This field contains the claim level remarks codes to be associated with the insurance payment for the claim. Up to five remarks codes can be entered. The codes may be added or edited, but must exist in the ERA Remarks Codes table. Users are encouraged to add payor-specific remarks codes to the ERA Remarks Codes table.

17. CLAIM LEVEL ADJUSTMENT CODES (TABLE LOOKUP-O)
When this field is accessed, the system displays the adjustment group, the adjustment reason code, and the amount associated with the claim level adjustments for the insurance payment. Up to 5 adjustment group/reason code combinations can be entered.

After accepting this screen, the following screen is displayed:

NOTE: Most of the values on the following screen are from the claim charges.

```
          General Hospital Maintain Service Line Information Processor
                                        Mon Mar 13, 2006 11:59 am
Account      Name                  FC Typ Admit    Disch      Balance Loc
A0204400002  ATKINSON,ALICE        M  O/P 02/13/02 02/13/02     0.00   AR/FCRV

Remit: Mcare A 06/00 Type 13         ICN: 20129010563504
Unmatched claim lines: 6             HIC: 299226259B
Seq Rev   PT  Proc  Mod   APC    Serv Date   Units  SubCharges  Sts RelHCPCS
   Payment Adjustment   Dtl        Coins Deductible  Remrk  SubHCMods  ClmHCMods
5    710  NU                     02/13/02      1        333.00  M
     73.26      193.14   Yes               66.60
6    760  NU                     02/13/02      1         19.00  M
      4.18       11.02   Yes                3.80
7    360  HC  36535 M1M2   789   02/13/02      1       1755.00  M
    386.10                             351.00                    36535
8    320  HC  71010        678   02/13/02      1        168.00  M
     36.96       97.44   Yes               33.60                 71010
9    320  HC  75961        567   02/13/02      1       1381.00  M
    303.82      800.98   Yes              276.20                 75961
10   300  HC  80048              02/13/02      1         46.00  M
     10.14                                                       80048



 F1Prev Page F2Next Page F3 Insert  F4 Delete  F5Adj/Rem F6 Reset  F7  Exit   ?
```

Field Explanations

REMIT (DISPLAY ONLY)
This field displays the Remittance description from the insurance cash batch.

ICN (DISPLAY ONLY)
This field displays the Internal Control Number extracted from the Electronic Remittance Advice.

UNMATCHED CLAIM LINES (DISPLAY ONLY)
This field displays the number of unmatched claim lines.

HIC (DISPLAY ONLY)
This field displays the HIC number extracted from the Electronic Remittance Advice.

SEQ (DISPLAY ONLY)
This field displays the internal sequence number assigned to the service line.

REV (4-N-O)
This field contains the revenue code for the service line.

PT (2-A-O)
This field contains the code for the procedure type. The default is HC for HCPCS.

PROC (5-AN-O)
This field contains the procedure code for the service line. A table look-up is provided for the HCPCS codes. The default is the HCPCS code for the service line if it is available.

MOD (4-AN-O)
This field contains the modifiers for the service line. The table look-up is provided for the HCPCS modifiers, which are two-digit codes. Two codes can be selected from the table.

APC (5-N-O)
This field contains the APC code for the service line, if it is available. A table look-up is provided for the APC codes.

SERV DATE (6-DATE-O)
This field contains the service date for the service line.

UNITS (5-N-O)
This field contains the units of service, which is a quantitative measure of services rendered by revenue category to or for the patient.

SUB CHARGES (11-M-O)
This field contains the submitted charges for the service line.

NON COVERED (11-M-O)
This field contains the non-covered charge amount for the service line.

PAYMENT (11-M-O)
This field contains the insurance payment amount for the service line.

NOTE: A **T** can be entered in this field to toggle back and forth from the short (speed/quick) entry method to the expanded (add/edit) entry method.

ADJUSTMENT (11-M-O)
This field contains the insurance adjustment amount for the insurance. If you enter **C** (Calculate) in this field, the system calculates the amount for this field by subtracting the payment amount from the submitted charge amount.

DTL (DISPLAY ONLY)
This field displays **Yes** if additional adjustment detail, such as the adjustment group and reason code, has been entered. Press **F5** to view, enter, or edit adjustment information for this service line.

COINS (11-M-O)
This field contains the coinsurance amount for the service line.

DEDUCTIBLE (11-M-O)
This field contains the deductible amount for the service line.

REMRK (TABLE - O)
This field contains the remarks codes associated with this service line. A plus sign (+) following a remarks code indicates that additional remarks codes are present for the service line. Press F5 to view, add, or edit remarks codes for this service line.

SUBHCMODS (9-AN-O)
The HCPCS code and modifiers that the payor used for the service line if different from the submitted HCPCS code.

CLMHCMODS (4-AN-O)
The HCPCS code and modifiers from the claim.

Service Line Remarks and Adjustments

If you select **F5** from any field on the service line, the system displays the detail entry screen for the service line remarks and adjustments. The following screen is displayed:

```
        General Hospital Maintain Service Line Information Processor
                                          Mon Mar 13, 2006 11:59 am
Account       Name                 FC Typ Admit     Disch       Balance Loc
A0100400076   BARNES, BILL          O  I/P 01/14/01 01/18/01     449.49- AR/FCRV

Remit: Mcare A 06/00 Type 13          ICN: 20130211283304
Unmatched claim lines: 6              HIC: 159033738D
Seq Rev   PT  Proc  Mod  APC   Serv Date  Units  SubCharges  Sts RelHCPCS
    Payment Adjustment  Dtl        Coins Deductible  Remrk  SubHCMods ClmHCMods
 1 Service Line Remarks
   M10,M100,M123,MA17,M1
 2 Service Line Adjustments

Seq    Adjustment   Group   Reason

1         109.00     OA      18
2          36.00     OA      18


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

Field Explanations

SERVICE LINE REMARKS (MULTIPLE FIELDS - O)
This field contains the remarks associated with this service line. Up to five remarks codes can be selected from the table, or may be keyed directly into the field. The table look-up provided is the ERA Remarks Codes. You can enter additional codes in this table to facilitate entry of remarks for each service line. A dash allows a free-form comment to be entered for the service line.

SERVICE LINE ADJUSTMENTS (TABLE LOOKUP - O)
When this field is accessed, the system displays the adjustment amount, group code and reason fields. You can enter the adjustment amount, group code, and reason code associated with the service line. Multiple adjustments can be entered. The sum of the adjustment amounts displays on the previous screen.

GP (TABLE LOOKUP - O)
The adjustment group code associated with the adjustment amount. The table look-up provided is the ERA Claim Adjustment Groups table. The default value for this field is CO. The value entered must match an entry in the table, or it can be left blank.

RSN (TABLE LOOKUP-O)
The reason code associated with the adjustment amount. The table look-up provided is the ERA CAS Reason Codes. The value entered must match an entry in the table, or it can be left blank.

Press ENTER to return to the Maintain Service Line Information Processor screen.

LINK/UNLINK SERVICE LINE INFORMATION

This function provides the ability to link paid Electronic Remittance Advice service lines and STAR claim service lines for reconciliation and payment analysis. In addition, it enables you to unlink paid service lines from claim lines in order to correct errors made in matching. Transaction History, Claim Charge Reconciliation, and the Payment Analysis Reports are updated with the newly linked or unlinked information.

Remittance Advice and STAR Claim service lines are listed on the Link/Unlink Service Line Information Processor screen. Remittance Advice information (RA Data) displays on the left; claim information (Claim Data) displays on the right.

- A line displaying RA Data without Claim Data represents a paid service line that has not been matched to a claim service line.

- A line displaying Claim Data without RA Data represents a claim service line that has not been matched to a paid service line.

- A line displaying both RA Data and Claim Data represents a paid line matched to a claim line.

To link service lines, select one service line containing only RA Data and another service line containing only Claim Data, and press ENTER. The separate lines are combined into one line.

To unlink service lines, select one service line containing both RA Data and Claim Data, and press ENTER. The single line is split into two separate lines on the screen.

```
          General Hospital Link/Unlink Service Line Information Processor
                                           Mon Mar 13, 2006 11:59 am
Account       Name                  FC Typ Admit    Disch       Balance Loc
A0204400004   ATKINSON,COLIN        S2 O/P 02/03/02 02/27/02      64.74   AR/FCRV

     RA Data                                    Claim Data
     Date  Rev  PdProc    SubProc    SubChg  Date  Rev   Proc      SubChg Mtc
Page:03                         Service Line Detail         ##=Current Choices
( 1) 02/20 942  99241                $45.00  02/20 942   99241      $45.00 Y M
( 2) 02/21 300  ATP07     80051      $35.00  02/21 300   80051      $35.00 Y M
( 3) 02/21 300  80202               $148.00  02/21 300   80202     $148.00 Y M
( 4) 02/21 300  ATP07     82550      $33.00  02/21 300   82550      $33.00 Y M
( 5) 02/21 300  82553               $70.00   02/21 300   82553      $70.00 Y M
( 6) 02/21 300  ATP07     82565      $32.00  02/21 300   82565      $32.00 Y M
( 7) 02/21 300  ATP07     84520      $32.00  02/21 300   84520      $32.00 Y M
( 8) 02/21 949  99195                $90.00                                N M
( 9) 02/22 320  71101               $155.00  02/22 320   71101     $155.00 Y M
(10)                                          02/22 300   85651      $23.00 C X
(11) 02/27 250                      $930.85   02/27 250             $930.85 Y M
(12) 02/27 258                     $1729.00                                N M
(13)                                          02/27 258            $1729.00 C X

Select two service lines to link or one service line to unlink--
   end select(NL)  next pg(/ or PG DN)  previous pg(/P or PG UP)  Search(TAB)
```

Field Explanations

The following RA Data fields display:

DATE (DISPLAY ONLY)
This field displays the service date of the paid service line.

REV (DISPLAY ONLY)
This field displays the revenue code of the paid service line.

PDPROC (DISPLAY ONLY)
This field displays the procedure code actually paid.

SUBPROC (DISPLAY ONLY)
This field displays the procedure code reported on the RA as the submitted procedure code. This may be different that the paid procedure code.

SUBCHG (DISPLAY ONLY)
This field displays the charge amount reported on the RA as the submitted charge amount.

The following Claim Data fields display:

DATE (DISPLAY ONLY)
This field displays the service date of the service on the claim.

REV (DISPLAY ONLY)
This field displays the revenue code of the service on the claim.

PROC (DISPLAY ONLY)
This field displays the procedure code of the service on the claim.

SUBCHG (DISPLAY ONLY)
This field displays the charge amount of the service on the claim.

MTC (DISPLAY ONLY)
This field displays the matching status field containing two columns of indicators. The first column displays the following:

Y	Yes
	The RA Data matches the Claim Data. Both Claim and RA Data display for the service line.
N	No
	RA Data is present - No claim service line found to match.Only RA Data displays for this service line.

C	No
	No Claim Data is present - No RA service line found to match. Only Claim Data displays for this service line.

The second column displays the following:

M	Simple service line.
H	First bundled charge.
B	Subsequent bundled charge.
T	First unbundled charge.
U	Subsequent unbundled charge.
P	Partial unbundled charge.
X	Not returned.

DELETE CASH/ADJUSTMENT BATCHES

This function is used to delete batches for which transactions have been indicated. After the function is selected, the available options are as follows:

- Delete Cash Batch

- Delete Line Item Cash Batch

- Delete Guarantor Cash Batch

- Delete BD Agency Cash Batch

- Delete AR Agency Cash Batch

- Delete Patient Pymt/Adj Interface Pymt Batch

- Delete Adjustment Batch

- Delete Patient Pymt/Adj Interface Adj Batch

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

NOTE: An adjustment batch can be deleted with this feature only if the adjustment batch was started under Post Adjustments after this feature was installed.

The following batches cannot be deleted:

- ERA - those batches must be deleted with the Delete Electronic RA function.

  If you attempt to delete an ERA batch, the following message is displayed:

  ERA Batch. Use Delete Electronic RA files from STAR!

- Approved batches - If you attempt to delete an approved batch, the following message is displayed:

  Batch has been approved already. Press ENTER.

- Posted batches

  If you attempt to delete a posted batch, the following message is displayed:

  Batch has been posted already. Press ENTER.

When one of the options is selected, the facility (for multifacility) is selected, The user can key in the batch number or a hyphen (-) to select the batch from a table lookup. The table lookup shows the open batches for the selected cash or adjustment type. Once the batch is selected, the cash or adjustment batch header screen is displayed.

The potential error messages for a cash batch are as follows. If any of these messages appears, the batch cannot be removed.

- Batch xx does not exist!

- ERA Batch. Use Delete Electronic RA files from STAR!

- Batch xx is not an agency batch

- Batch xx is not a line item batch

- Batch xx is not an AR agency batch

- Batch xx is not a Patient Payment Posting batch

If the batch could not be locked meaning it is being used by another user, the following message appears. The batch cannot be deleted until the lock is removed.

Batch xx in use by Job jj, Name

Other messages which can appear indicating the batch could not be deleted are as follows:

- Batch has been posted already. Press ENTER.

- Batch has been approved already. Press ENTER.

If the batch qualifies to be deleted, two prompts must be answered with a response of Y (Yes). They are as follows:

Delete? (Y/N) [N]--

Are you sure that you want to delete batch xx? (Y/N)--

If an adjustment batch exists for the cash batch due to the Patient Payment/Adjustment Interface, a third prompt must be answered with a response of Y (Yes) in order to delete the cash batch:

Adjustment batch yy also exists for interface file. Are you sure you want to delete this cash batch? (Y/N)--

If the batch could not be locked, meaning it is being used by another user, the following message appears:

Batch xx in use by Job jj, Name

If the associated adjustment batch could not be locked, the cash batch is not deleted and the following message appears:

Cash batch not deleted because adjustment batch yy could not be locked!

Batch xx in use by Job jj, Name

For adjustment batches one of the following messages can appear indicating that the adjustment batch cannot be deleted:

- Batch xx in use by Job jj, Name

- Adjustment Batch for Patient Pymt/Adj Interface!

- Adjustment Batch is not for Patient Pymt/Adj Interface!

If a cash batch is associated with the adjustment batch due to the Patient Payment/ Adjustment Interface, the following prompt appears:

Cash batch xx also exists for interface file. Are you sure you want to delete this adjustment batch? (Y/N)--

If the adjustment batch could not be locked because it was being used by another user, the following message appears:

Adjustment batch yy was not deleted!

If the associated cash batch could not be locked, the adjustment batch is not deleted and the following message appears:

Adjustment batch not deleted because cash batch xx could not be locked!

Batch xx in use by Job jj, Name

The deletion of the cash or adjustment batch is affirmed with the following prompt:

Batch xx Deleted!

The batch header and all batch entries are deleted.

Deleted cash batches are reported in FAR801x. Separate sections of the report are used for cash and guarantor cash batches. Deleted cross facility cash batches will be reported in FAR801.

Deleted adjustment batches are reported in FAR802x in a separate section. Deleted cross facility adjustment batches will be reported in FAR802.

PRINT UNAPPLIED CASH LOG

The Unapplied Cash report (FAR110) is a demand report listing all transactions designated as unapplied cash. To generate the report, you respond to a prompt, and the report prints at its assigned location.

After these selections are made, the system prompts you to confirm your intentions to print the log. Entry options are Y for Yes or N for No; the default is N. If you enter **Y**, the system generates and prints the report and then returns you to the menu. If you enter **N**, the system returns you to the menu.

For detailed information about this report, refer to the *Reports Volume* of the *STAR Patient Accounting Reference Guide*.

PRINT UNAPPLIED CHARGE LOG

The Unapplied Charge Log (FAR010) is a demand report that lists the charges that have not been applied to a patient account by account.

To generate the report, respond to the prompt, and the system prints the report at its assigned location.

After these selections are made, the system prompts you to confirm your intentions to print the log. Entry options are Y for Yes or N for No; the default is N. If you enter **Y**, the system generates and prints the report and then returns you to the menu. If you enter **N**, the system returns you to the menu.

For detailed information about this report, refer to the *Reports Volume* of the STAR Patient Accounting Reference Guide.

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PRINT AGENCY CASH/ADJUSTMENT REPORT

The Agency Cash and Adjustment report (FAR150) is a demand report that prints all payments and adjustments entered on accounts in account location BD by agency since the last time the report was run.

Cash includes cash collected only by the hospital -- not collected by an agency and reported to the hospital.

The system displays the following prompt:

Run Collection Agency Cash/Adj Report (N)ow, or (T)onight? [T]--

Enter **N** to run the report now. Enter **T** to schedule the job to run during midnight processing. If the report is already scheduled to run tonight, you are given the option to run the report now (N) or cancel (C) tonight's scheduled run.

For detailed information about this report, refer to the *Reports Volume* of the *STAR Patient Accounting Reference Guide*.

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PRINT ELECTRONIC RA AUDIT REPORT (PRINT OHIP RA AUDIT REPORT) (CN ONLY)

The Electronic RA Audit report (FXRERAR) provides an audit of payment data uploaded onto the STAR Financials Patient Accounting CPU. The report displays all uploaded data formatted for easy review. For detailed information about this report, refer to the *Electronic Payments* volume or the *Ontario Electronic Claims and Payments Volume* of the STAR Patient Accounting Reference Guide.

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Chapter 2 - ACCOUNT REPORTS

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DEFINE ATB REPORT

The Define ATB Report function enables you to review and edit existing ATB (Aged Trial Balance) report definitions or create new ATB report definitions. The ATB report can be produced using a detail, collector, and/or summary format.

Four reports can be produced through this function.

The four reports are as follows:

- FARATB - Detail ATB

  The Detail ATB report prints one line of information for every account in account location AR.

- FARCATB - Collector ATB (Standard Version)

  The Collector ATB report prints one line of information for each account, using the collector as the primary sort.

- FARCATB - Collector ATB (Insurance Version)

  The Collector ATB report prints one line of information for each account, using the collector as the primary sort. The report includes carrier/plan as a secondary sort if the insurance version of the report is generated.

- FARSATB - Summary ATB

  The Summary ATB report provides an aged breakdown by patient indicator and financial class of the number and balance of the selected accounts. The Summary ATB report also provides the Bad Debt Reserve Recap which reports the reserve percentages and dollars by patient indicator within financial class for each aging category.

After you select this function, the system prompts you to select a facility (if this is a multifacility installation). You are then asked to enter the number of the ATB report to define. You can enter the code (up to three digits) or a hyphen (-) to display and select from a list of valid codes. If you are defining a new report, enter the desired code number. The system then asks you to confirm the addition of this report.

After a report has been selected, the system displays the following screen:

```
                    General Hospital ATB Report Request Processor

                                               Mon Jun 02, 2003 02:25 pm

  1 Code      2 Description                    3 Type of Report
    999          COLLECTOR ATB REPORT             Collector
  4 Collector Type        5 Collectors
    Guarantor               55,1
  6 Insurance Version      7 Sort By                    8 Aging Base
    No                       Statistical Group            Final Bill Date
  9 Aging Categories
    LORI'S 30/60/90
 10 Suppress Zero Balance Accounts            11 Combine ER and Outpatients
    No                                           Yes
 12 Run Monthly            13 Run Now/Tonight
    No                       ->




 Run (N)ow, or (T)onight--


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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the ATB report code that was entered or selected.

2. DESCRIPTION (30-AN-R)
This field contains the description of the ATB report. If you are entering a new report definition, the description should include the purpose of the report to avoid confusion with other ATB report definitions. The description displays in the spooler comments.

3. TYPE OF REPORT (1-A-R)
This field determines the type of report that is produced for this definition. Entry options are **D** (detail), **S** (summary), **C** (collector), and **A** (all). There is no default.

- Detail (D) prints a line for each AR account and a recap of dollars by patient indicator within aging category.

- Summary (S) prints subtotals by aging category for each financial class and patient indicator and a reserve recap, which places accounts in an aging category based on the aging date, financial class, and patient indicator and calculates a percent reserve for bad debt. If the ATB report definition is set to produce a Summary ATB (FARSATB) report and the Combine ER and Outpatient field is set to Yes, the sub-totals of the report will combine the ER and outpatient information. In order for ER and Outpatient to be combined the Sort By parameter must be set to: Financial Class and Dollars, Financial Class and Name or Statistical Group. The combined

ER and Outpatient will be grouped under the heading "Outpatient/ER". The recap totals will also reflect the Outpatient/ER combination with the heading O-E-$.

- Collector (C) prints one line of information for each account, sorted by collector, and provides aging totals for each collector. All (A) prints the Detail, Collector, and Summary reports.

4. COLLECTOR TYPE (1-A-R)
This field displays the following prompt:

Enter Collector Types, (I)nsurance, (G)uarantor, or (B)oth --

This field can only be selected if the Type of Report field contains Collector. If **I** (Insurance) is chosen and the account has multiple claims for one collector, the account appears only once. If multiple collectors are chosen and the account has claims in follow-up for more then one collector, then the account appears once under all appropriate collectors. This causes the dollars to be overstated as a whole.

5. COLLECTORS (1-A-O)
This field displays the following prompt:

Enter Selected Collectors "S" or "All "--[A]

If **S** is selected, the collector table is displayed, and you can select one or all collector codes defined in the table. This field can be selected only if the Type of Report field contains Collector.

6. INSURANCE VERSION (1-A-O)
This field is accessible only if the Report Type is collector and the Collector Type is defined as insurance. The field allows you to request the standard report format or the insurance version. If either of the fields of type or insurance is updated to other than Collector and Insurance respectively, the insurance version is changed to No.

When this field is accessed, the following prompt is displayed:

Do you want the Insurance Version of the report (Y/N) [N] ? –

The default is No. If you respond with **Y** for Yes, the insurance version of the report is generated. If you respond with **N** for No, the standard version of the report is generated.

7. SORT BY (TABLE LOOKUP-C)
This field indicates how the report should be sorted. Entry options are Account Name, Account Number, Financial Class and Dollars, Financial Class and Name, Statistical Group, and Carrier/Plan. This field is required if Detail or Collector is selected in the Type of Report field. Carrier Plan can be selected only if the Insurance Version field is set to Yes.

8. AGING BASE (1-A-R)
This field indicates the aging parameter that should be used in aging the information in this report. Entry options are final bill date (F), last payment date (L), or discharge date (D).

9. AGING CATEGORIES (TABLE LOOKUP)
This field indicates the aging categories that should be used for this report. You must make your selection from the displayed table, which lists the aging parameters previously defined in the Report Aging Code table. These parameters define the aging range as well as the reserve percentages. For more detailed information regarding the Report Aging Code, refer to the *Tables Volume* of the *STAR Patient Accounting Reference Guide.*

10. SUPPRESS ZERO BALANCE ACCOUNTS (1-A-R)
This field indicates whether or not zero balance accounts should be suppressed from the ATB reports. Enter **Y** for yes to suppress zero balance accounts. Zero balance accounts are not included in the ATB report. Enter **N** for No to not suppress zero balance accounts. Zero balance accounts are included in the ATB report.

11. COMBINE ER AND OUTPATIENTS (1-A-R)
This field displays the following prompt:

Combine E/R and Outpatients? (Y/N) -- [N]

The default value is N. If set to N, the Emergency Room patients are separated from the Outpatients on the ATB report. If set to Y, the totals are combined. The combining of the E/R and Outpatient totals only will be reflected if the report sub-totals by Patient type.

NOTE: When you select a secondary sort of either Account Name or Account Number, the report sub-totals by the aging category, not by patient type, so combining ER and Outpatients has no impact. If you select for a secondary sort one of the Financial Class or the Statistical Group options, the report will sub-total by patient type.

12. STATUS (DISPLAY ONLY)
This field indicates whether the report definition code is active or inactive. A code that is filed as *deleted* by the user becomes inactive and may be reactivated at any time. The system defaults this field to active when you create the entry.

13. EDIT BY (DISPLAY ONLY)
The system displays the name of the user who last edited this report definition.

14. EDIT DATE (DISPLAY ONLY)
The system displays the date and time this report definition was last edited.

When these fields are completed. you have the option of accepting, editing, or deleting the information on the screen. Accepting the screen completes the transaction and stores this report definition in the system.

FINANCIAL REVIEW REPORT

This function enables you to request a financial review report. This report enables the hospital to review balance information on patients not yet discharged or final billed. This report includes the unbilled balance, the estimated insurance liability, expected reimbursement, and contractual adjustment per account.

This report is a demand report that runs after an online request.

After you select this function, the system prompts you to select a facility (if this is a multifacility installation) and then displays the following screen:

```
          General Hospital Financial Review Report Processor
                                        Fri Dec 22, 1989 09:44 am

 1 Inpatients?    2 Outpatients?      3 E/R Patients?
   Yes              Yes                 Yes
 4 Smallest Balance                  5 Highest Balance
         1000.00                            100,000.00










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

You can select the patients that you want included on this report as well as the minimum and maximum account balances.

The system also prompts you to decide if you want to print the report. Enter **Y** for Yes or **N** for No; the default is Y.

Field Explanations

1. INPATIENTS? (1-A-R)
This field indicates whether or not inpatients should be included on the report. Entry options are Y for Yes or N for No; the default is Y.

2. OUTPATIENTS? (1-A-R)
This field indicates whether or not outpatients should be included on the report. Entry options are Y for Yes or N for No; the default is Y.

3. E/R PATIENTS? (1-A-R)
This field indicates whether or not emergency room patients should be included on the report. Entry options are Y for Yes or N for No; the default is Y.

4. SMALLEST BALANCE (12-AN-R)
This field contains the new smallest balance that should be included on the report. You can enter a dollar amount or **A** for all balances.

5. HIGHEST BALANCE (12-AN-R)
This field contains the highest balance that should be included on the report. You can enter a dollar amount or A for all balances.

After you accept the screen, the following prompt is displayed:

Do you want to run the Financial Review report (N)ow, or T(onight)? [T]--

Enter **N** to run the Financial Review report now. Enter **T** to run the Financial Review report tonight. If the report is scheduled for tonight and you try to access the report, the following prompt is displayed:

(C)ancel tonight's Financial Review report, or run (N)ow?--

REQUEST ATB REPORT

This function enables you to request an ATB (aged trial balance) report for printing. The report definition must already exist in order to request the report. You can enter the code or a hyphen (-) to display and select from a list of valid codes. After you enter or select a report code, the system displays the following screen:

```
            General Hospital ATB Report Request Processor
                                          Tue Apr 13, 1999 10:55 am

 1 Code      2 Description                    3 Type of Report
   12           TEST                            Detail
 4 Collector Type           5 Collectors

 6 Sort By                  7 Aging Base
   Statistical Group          Discharge Date
 8 Aging Categories
   TESTING TABLE
 9 Suppress Zero Balance Accounts          10 Combine ER and Outpatients
   Yes                                        Yes
11 Run Monthly              12 Run Now/Tonight
   No




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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the report code that is assigned when the ATB report was defined.

2. DESCRIPTION (DISPLAY ONLY)
This field contains the description of the ATB report.

3. TYPE OF REPORT (DISPLAY ONLY)
This field indicates the type of ATB to be generated. This includes Detail, Collector, and/or Summary.

4. COLLECTOR TYPE (DISPLAY ONLY)
This field displays the collector types indicated when the ATB Report was defined.

5. COLLECTORS (DISPLAY ONLY)
This field displays the collectors indicated when the ATB Report was defined.

6. SORT BY (DISPLAY ONLY)
This field indicates whether this report should be sorted by account name, account number, financial class and dollars, financial class and name, or statistical group.

7. AGING BASE (DISPLAY ONLY)
This field indicates the aging date that should be used in aging the information for the summary report either the final bill date, last payment date, or discharge date.

8. AGING CATEGORIES (DISPLAY ONLY)
This field indicates the aging categories that should be used for this report.

9. SUPPRESS ZERO BALANCE ACCOUNTS (DISPLAY ONLY)
This field indicates whether or not zero balance accounts should be suppressed from the ATB reports.

10. COMBINE ER AND OUTPATIENTS (DISPLAY ONLY)
This field displays the selection indicated when the ATB Report was defined.

11. RUN MONTHLY (1-A-R)
This field indicates whether the ATB report should run at month-end. Entry options are Y for Yes or N for No.

12. RUN NOW/TONIGHT (1-A-R)
This field indicates whether the ATB report should be run now, tonight, or not at this time. Entry options are N (now), T (tonight), or ENTER for not at this time. If you want reports to be run at month-end, press ENTER. If the ATB is set to run Tonight, you have the option to run N (now) or to C (cancel).

If you choose to run a report N (now), you may receive the following error message:

> *Another "NOW" report is running. Try again later.*

Your request is not saved. After the NOW ATB completes, you may enter your request.

When these fields are completed, you have the option of accepting or changing the information you entered on the screen. Accepting the screen completes the transaction. If you entered **Y** in the Run Now field, exiting the transaction prompts the system to begin compiling and printing the report.

ACCOUNT SELECTION

This function enables the hospital to select various options for the production of reports. These reports can be used as follow-up tools for the collectors or billers. They can also be used as management tools to study problem areas or to report on performance of insurance carriers.

Five different reports can be produced through this function. You are asked to fill out various screens on the patients that should be included on the report, how the report sorts, the level of detail that should be included on the report, and the reports that should be included.

The five reports are as follows:

- FARASC - Account Selection Criteria

    Prints the selection from the online screen, and prints every time a selection is made.

- FARASA - Account Selection Report (One Line ATB)

    Prints a one-line recap of each account selected for the report. This information includes:

    Patient Account Name
    Patient Name
    Financial Class
    Patient Type
    Final Bill Date
    Discharge Date
    Last Payment Date
    Account Balance
    Aging Category

    This report contains the report code and description as indicated on the online screen. The one-line recap report is generated by entering **Only** or **Include** in the ATB Rpt field on the selection screen. Accounts appear only one time and grand totals are provided if the Insurance Selection field is set to **Primary only**. Accounts may appear multiple times on the report, and grand totals are not provided if the Insurance Selection field is set to **All insurance plans**. Subtotals are available on the report when the Page Break on Primary Sort field is set to **Yes**, regardless of the setting of the Insurance Selection field.

    The insurance version of this report is generated by entering **Ins Version** at the prompt on the selection screen when the ATB Rprt field is accessed. The accounts selected for the insurance version of the report are identical to the standard ATB report, but the report format is different.

• FARASF - Account Selection Report (Financial Class Summary)

Prints the number of accounts and dollars for the appropriate aging category and financial class in a summary format. A separate report is produced for inpatients, outpatients, and emergency room patients. A total of all patient indicators is also included.

Only financial classes with account information print on the report. Accounts with blank financial classes are not included. This report is generated by entering **Only** or **Include** in the Summary Rpts field on the selection screen.

• FARASP - Account Selection Report (Summary Recap)

Prints the number of accounts and dollars for the appropriate aging category and financial class in a summary format. This report is generated by entering **Only** or **Include** in the Summary Rpts field on the selection screen.

• FARASR - Account Selection Report

Enables the user to request the level of detail that is printed on the report for each patient who meets the selection criteria. The patient information includes balance, follow-up, and payment information. The guarantor information includes demographic information and a recap of the account balances. Transaction history detail may be included or excluded, and includes all of the account's transaction history. This report is generated by entering **Yes** in the Detail Report field.

NOTE: A detail report cannot be created if you choose to use fiscal period balances because the account balances are saved, but insurance and patient balances are not. Guarantor information is not included if the report is run using the "tonight" option.

Generating the Report

There are six screens involved in generating an account selection report. They deal with general information, primary and secondary sort keys, ranges of dates, and selection criteria (three screens).

After accessing this function, you are asked to select a facility (if this is a multifacility installation). You receive the following prompt when you select a facility:

Enter report code to limit table selection or Press NL for entire table

NOTE: For the first seven days of the fiscal period, the system provides the option of generating a report using fiscal period balances. For that seven-day period, the system displays the following prompt for fiscal period balances after the facility is selected and before displaying a list of the previously defined selection criteria:

Use 02/28/98 fiscal period balances? (Y?N) [N] --

Enter the three-character code or the partial code and a hyphen (-) to display and select from a list of the pre-defined reports that begin with this code. Press ENTER to display all reports previously defined.

```
              General Hospital Account Selection Processor
                                         Sat Aug 05, 2006 01:21 pm

Page:01                          Account Selection
     Code Description              Status     Freq Type           Next Run Date
( 1) MLK   BAD DEBT ACCOUNTS       DEFINED    One Time Only
( 2) MLK   MONTH END BALANCE TS    SCHEDULED  Day of Month        08/04/06
( 3) MLK   PA ACCOUNTS-INS VER     DEFINED    One Time Only
( 4) MLK   SER ACCOUNTS            DEFINED    One Time Only
( 5) MLK   TEST OF F9210           DEFINED    One Time Only
( 6) PK    PMK AR ACCT             DEFINED
( 7) SMM   INS 500900              DEFINED    One Time Only
( 8) SMM   SUSAN'S ER VS. AMB S    DEFINED    One Time Only



Enter choice or (A) to add [A]--
```

NOTE: MPI deletion of an account is not allowed if an Account Selection report is being produced. If the report does not complete, the deletion is allowed.

This screen displays selection criteria that have already been defined for Account Selection reports. You can create a report using one of these criteria or define a new set of criteria for a report. To use an existing criteria set, enter the option number of the desired set. To add a new set of criteria, enter **A** or press ENTER to accept the A default.

Field Explanations

CODE (DISPLAY ONLY)
This field contains the code identifying this report.

DESCRIPTION (DISPLAY ONLY)
This field contains the description of the report.

STATUS (DISPLAY ONLY)
This field contains the current status of the report. The following list defines the possible status for this screen:

• DEFINED - This status is displayed when the report has been defined. The report is processed at the time that you specify to run the report. When the report is processed, the status line again reads "DEFINED."

• IN USE - This status is displayed if you try to access a report definition that is currently being edited by someone at a different CRT. If you try to access a report that is being edited, the following message is displayed on your screen:

Definition in use - try again later

- PROCESSING - This status is displayed if a report is processing. If a report is selected and the report is being processed, one of two messages is displayed:

  - *(Report code, report description status) status is processing. Clear flag (Y/N) [N]--*

    This message is displayed if the report has not completed normally. For example, this message is displayed if you stopped the report before the report completed successfully. Enter **Y** to clear the flag. This allows you to reschedule the report for processing again. Enter **N** to not clear the flag. If **N** is entered the report can not be accessed or rescheduled for reporting.

  - *Report processing*

    This message is displayed if you select a report with the status of PROCESSING when this report is running. When the report has completed, the status returns to DEFINED displaying in the status field.

FREQ TYPE (DISPLAY ONLY)
This field contains the frequency type with which the report should be run. Options are: Interval, specified day of the month, a specified day within a certain week of the month, and One Time Only. If the report is set to run on a scheduled day, the date the report is scheduled to run is displayed in the Next Run Date field.

NEXT RUN DATE (DISPLAY ONLY)
This field contains the next run date for a report that is scheduled to run.

After you select a defined selection criteria or enter **A** to begin adding a new set of selection criteria, the system displays the General Information screen, where basic information about the report you want to generate is recorded. Since the detail report cannot be created and the guarantor information cannot be printed if you choose to use fiscal period balances, the system updates the Detail Rpt field to No and the Print Guarantor Information field to Exclude when fiscal period balances are used. If you select an existing report definition that has the Detail Rpt field set to Yes and/or the Guarantor Information field set to Include, and you choose to use fiscal period balances, the system displays the following prompts to warn you that the fields are being changed:

Defaulting Guarantor Information to Exclude. Press NL.

This prompt is displayed only if the Guarantor Information field is set to Yes and the Account Selection Report is using fiscal period balances.

Defaulting Print Detail to No. Press NL.

This prompt is displayed only if the Print Detail field is set to Include and the Account Selection Report is using fiscal period balances.

Keep in mind, while using the Account Selection Report function, that many of the fields are used to determine what information the system should check to determine an account's inclusion on the report. If you do not want the system to consider certain criteria in determining whether to include accounts on the report, make sure that you either make no entry to the appropriate field or select all available options from the appropriate table.

Remember when selecting insurance-related criteria, such as collector, claim, and follow-up related items, all insurances are compared to the selection criteria. Replaced claims are not included on account selection reports. Prior claims, such as cycle claims, are considered and may be the reason the account is included on the report, although the most recent claim information is printed on the report.

```
                  General Hospital Account Selection Processor
                                           Mon Apr 14, 2008 07:01 pm
 1 Report Code                    2 Report Description
   FUH                              F/UP HOLD ACCTS
 3 Aging by                        4 Age Category
   1-ADMISSION DATE                  LORI 30/60/90
 5 Summary Rpts (FARASF & FARASP)  6 ATB Rpt (FARASA)   7 Detail Rpt (FARASR)
   Include                           Include              Yes
 8 Print Detail Transactions (FARASR)   9 Print Guarantor Information (FARASR)
   No                                     Exclude
10 Suppress Zero Balance Accounts     11 Insurance Selection
   Yes                                   Primary Only
12 Sort Sequence
   4
13 Page Break on Primary Sort
   No
14 Edit By                         15 Edit Date/Time
   Rush,Bill                          04/10/08 02:51pm




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

Field Explanations

1. REPORT CODE (3-AN-R)
This field contains the code identifying this report. The report code prints on the FARASR and FARASA versions of the report.

2. REPORT DESCRIPTION (20-AN-R)
This field contains the description of the report. This description prints on the FARSAR and FARASA versions of the report.

3. AGING BY (TABLE LOOKUP)
This field, which is required, contains the date associated with the accounts selected that is used to determine aging criteria for the summary report categories. You must

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select from the displayed table. Some of the Aging By options also restrict selection of accounts as noted below.

- ADMISSION DATE

- BILL DATE - Uses the last bill sequence.

- CLAIM DATE - Account must have a claim. The most recent claim is used for aging.

- DISCHARGE DATE

- LAST ACCOUNT PAYMENT

- LAST INSURANCE F/U DATE * - Account must have a claim. The most recent claim is used for aging.

- LAST INSURANCE PAYMENT * - Account must have insurance.

- LAST PATIENT F/U DATE

- LAST PATIENT PAYMENT

* Indicates that Insurance Selection field is referenced for account selection.

Aging is needed for the summary reports, and the one-line ATB report, FARASA, FARASF and FARASP.

4. AGE CATEGORY (TABLE LOOKUP)
This field contains the aging table that is used for the report. You must select from the displayed table. Up to thirteen aging groups can be specified in the Report Aging Code table.

5. SUMMARY RPTS - FARASF & FARASP (1-A-O)
This field indicates whether summary reports, FARASF and FARASP, should be produced for this selection. The value in this field is defaulted to Exclude if the Insurance Selection field is set to All. If defaulted, the field cannot be changed. Entry options are:

O (only) - produce only summary reports. If you select this option, the system bypasses and will not allow you to make any entries in fields 6 through 9 of this screen.

I (include) - include summary reports as well as the one-line ATB report and the Detail Account Selection report.

E (exclude) - exclude summary reports from printing.

6.   ATB RPT - FARASA (1-A-O)

This field indicates whether the one-line per patient ATB, FARASA, should be printed for this selection and whether the standard or insurance version should be printed. Even if this field is set to Only, the user can specify a page break for the primary sort. Entry options are:

O (only) - only produce this report. If you select this option, the system does not allow you to access fields 5, 7, 8, and 9 of this screen.

I (include) - include this report and/or the summary report and the Detail Account Selection report.

E (exclude) - exclude this report from printing.

V (Insurance Version) - print the insurance version of this report.

7.   DETAIL RPT - FARASR (1-A-R)

This field indicates whether a detail report, FARASR, (one page per account) is printed. Enter **Y** for Yes or **N** for No. If the Summary Rpts and ATB Rpt fields contain Exclude, the system completes this field with Yes, and you cannot access it. The Detail report is not available if you are using fiscal period balances. If you are using fiscal period balances to generate the report, the system automatically updates this field to No.

8.   PRINT DETAIL TRANSACTIONS - FARASR (1-A-R)

This field indicates whether the transaction history of each account should be included on the detail report, FARASR. Enter **Y** for Yes or **N** for No. If you press ENTER, the system completes the field with No. This option is available only if the Detail Account Selection Report is being generated.

9.   PRINT GUARANTOR INFORMATION - FARASR (1-A-R)

This field indicates whether the guarantor information should be included in the detail report, FARASR. This option is available only if the Detail Account Selection Report is being generated. Entry options are:

O (only) - one line of guarantor demographics and the guarantor summary prints.

I (include) - patient information, guarantor demographics, and guarantor summary print.

E (exclude) - guarantor information does not print.

If fiscal period balances are used to generate the Account Selection Report, the system automatically updates this field to Exclude.

10. SUPPRESS ZERO BALANCE ACCTS (1-A-R)

In this field, you may define whether to suppress accounts with a $0.00 account balance. The system displays the following prompt:

Suppress zero balance account (Y/N)? [N] - -

N indicates accounts with $0.00 account balances print on the report(s). Y indicates accounts with $0.00 account balances do not print on the selected report(s). The default is N.

If Y, accounts are excluded from the One Line ATB, FARASA, and the Account Selection Detail Report, FARASR. Zero balance accounts are excluded from the "counts" on the Financial Class Summary Report, FARASF, and the Summary Recap Report, FARASP.

11. INSURANCE SELECTION (1-A-R)
This field is used to define whether to select insurance related information for all insurance plans on the account, only for the primary (COB 1) insurance plan, or only for non-primary plans. The system displays the following prompt:

Limit selection to (P)rimary, (N)on primary, (A)ll, or (C)ob's [P]--

The default is **P**. If **P**, Primary only is displayed as the response in the field. The insurance information included on the generated reports is for COB 1 only. When the accounts are included on the report based only on the primary carrier/plan, then the resulting Account Selection Reports, FARASA and FARASR, include the account if the primary COB qualifies; summary level reports, FARASP and FARASF, are provided based on information related to the primary COB.

If **A**, "All Insurance Plans" is displayed as the response in the field. The insurance information for all insurance plans is included on the generated reports and accounts may appear multiple times due to multiple insurance plans on the account. When all insurance plans on the account are searched, then the resulting Account Selection Reports, FARASA and FARASR, include the account one time for each qualifying insurance, and the summary level reports, FARASP and FARASF, are not be provided. The field, Summary Rpts, are defaulted to Exclude. The Account Selection Criteria Report, FARASC, displays that the Summary Reports were not produced.

If **N**, Non Primary is displayed as the response in the field. The insurance information included on the generated reports is for non-primary insurance plans only.

If **C**, the list of COBs is displayed. After you select the COBs, the ones selected are displayed in the field.

12. SORT SEQUENCE
This field determines the sort criteria of the one-line ATB report, FARASA, and/or the Detail Account Selection report, FARASA (no sort options on summary are available). You select the primary sort key followed by the secondary keys. You can choose one or more codes you want to use and the order from these system-supplied keys:

- 1 - BILLER CODE

- 2 - INSURANCE COLLECTOR CODE - Account must have a claim. The most recent claim is used for sorting.

- 3 - PATIENT NAME

- 4 - PATIENT NUMBER

- 5 - DESCENDING BALANCE ACCT

- 6 - DESCENDING BALANCE PAT

- 7 - DESCENDING BALANCE INS. - The Account Balance minus the Patient Balance. Accounts with no insurance will have a calculated insurance balance of $0.00.

- 8 - AGING CATEGORY

- 9 - INSURANCE CARRIER/PLAN - Accounts with no insurance will sort to the beginning.

- 10 - FINANCIAL CLASS

- 11 - GUARANTOR NAME

- 12 - PATIENT COLLECTOR CODE

- 13 - DESCENDING BAL ACCT (Guar)

- 14 - DESCENDING BAL PAT. (Guar)

- 15 - DESCENDING BAL INS. (Guar) - The Guarantor's Insurance Balance is calculated as the sum of the Guarantor's Account Balances minus the sum of the Guarantor's Patient Balances.

- 16 - FINANCIAL PATIENT CLASS - Accounts sort in date order for the date selected under the Aging By field. If the date for the aging category is blank, the discharge or admission date for the account is used.

- 17 - AGE CATEGORY VALUE - Accounts sort in date order for the date selected under the Aging By field. If the date for the aging category is blank, the discharge or admission date for the account is used.

- 18 - PATIENT COLLECTOR GROUP

- 19 - INSURANCE COLLECTOR GROUP

- 20 - EMPLOYER CODE

- 21 - COB

You can enter one, some, or all of these keys in any order, with the first key selected considered the primary sort key, the second key the secondary sort key, etc. For example, if you wanted to sort the report by financial class and then by age category and patient name, enter 10, 8, 3.

After the sort keys are selected, the system displays the following screen:

```
            General Hospital Account Selection Processor
                                        Tue Aug 27, 1991 03:09 pm
                          PRIMARY SORT KEY
              1
                            PATIENT NAME
                        SECONDARY SORT KEYS
      2                              3
        FINANCIAL CLASS                    AGE CATEGORY
      4                              5

      6                              7

      8                              9

     10                             11

     12                             13

     14                             15


Page Break by Primary Sort? (Y/N) [N]--
```

This screen displays the order in which the Account Selection report sorts. At the bottom of the screen the system displays the following prompt:

Page Break by Primary Sort? (Y/N) [N]--

13. PAGE BREAK ON PRIMARY SORT (1-A-C)
To start a new page of the one-line ATB report, FARASA at the beginning of each primary sort, enter **Y**. To create the report without this page break at the beginning of each primary sort, enter **N** or press ENTER to accept the default. If the ATB Rpt field is set to Only, after you define the sort criteria, you may request a page break to occur for the primary sort. The one-line ATB report, FARASA, provides subtotals for the primary sort key when the Page Break on Primary Sort field is set to **Y**.

14. EDIT BY (DISPLAY ONLY)
This field contains the name of the person who performed the last edit.

15. EDIT DATE/TIME (DISPLAY ONLY)
This field contains the date and time this job was last edited.

After you make your entry, the system displays the General Information screen and prompts you to accept it. After you accept the screen, the system displays the Date Range screen:

```
                 General Hospital Account Selection Processor
                                              Fri Jul 17, 1992 10:45 am
  1 Admission Dates                    2 Discharge Dates
    Earliest thru Latest                 Earliest thru Latest
  3 Last Bill Dates                    4 Last Patient Payment Dates
    Earliest thru Latest                 Earliest thru Latest
  5 Last Account Payment Dates         6 Last Insurance Payment Dates
    Earliest thru Latest                 Earliest thru Latest
  7 Last Insurance F/U Dates           8 Last Patient F/U Dates
    Earliest thru Latest                 Earliest thru Latest
  9 Next Insurance F/U Dates          10 Next Patient F/U Dates
    Earliest thru Latest                 Earliest thru Latest
 11 Insurance Claim Released Dates    12 Insurance Claim Submit Dates
    Earliest thru Latest                 Earliest thru Latest
 13 Last Account Adjustment Dates     14 Last Patient Adjustment Dates
    Earliest thru Latest                 Earliest thru Latest
 15 Last Insurance Adjustment Dates   16 Bad Debt Transfer Dates
    Earliest thru Latest                 Earliest thru Latest
 17 Payment Plan Delinquent Dates
    Earliest thru Latest


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

This screen enables you to define the date ranges for items on the report, which allows you to limit the information on the report to certain date ranges or to concentrate on old accounts.

Each field defaults to Earliest thru Latest. Accepting this default results in the inclusion of all accounts, regardless of dates for this criteria. Thus, you can include on your report all accounts, regardless of admission date, by selecting the Earliest to Latest default for the Admission Date field but limit the report to accounts discharged within a range of dates by entering the starting and ending date to the Discharge Dates field. For example, if you accept the Earliest through Latest default for the Admission Dates field and enter 01/01/99 to 06/30/99 to the Discharge Dates field, the system does not check the admission dates of patients for the report. If a patient has a discharge date of 05/01/99, the account is included on the report, regardless of the admission date.

For information on entering dates, refer to the *General Information Volume* of the *STAR Patient Accounting Reference Guide.*

When you access any of the fields on this screen, the system prompts you to enter the first date for this criteria to include on the report. Enter this date, or press ENTER to accept the default of Earliest. The system then prompts you to enter the last date in include on the report. Enter this date, or press ENTER to accept the default of Latest.

Field Explanations

1.   ADMISSION DATES (6-N-O)
This field contains the range of admission dates used to select accounts for this report.

2. DISCHARGE DATES (6-N-O)
This field contains the range of discharge dates used to select accounts for this report. "None" may be entered to select accounts without a discharge date.

3. LAST BILL DATES (6-N-O)
This field contains the range of last bill dates used to select accounts for this report. Last bill refers to the most recent final, cycle, late, or adjustment bill issued to an account.

4. LAST PATIENT PAYMENT DATE (6-N-O)
This field contains the range of the most recent dates on which payments were received for the patient portion of the account. "None" may be entered to select accounts without a last patient payment date.

5. LAST ACCOUNT PAYMENT DATES (6-N-O)
This field contains the range of the most recent dates on which payments were received from the guarantor or insurance for the account. "None" may be entered to select accounts without a last account payment date.

6. LAST INSURANCE PAYMENT DATE (6-N-O)
This field contains the range of the most recent dates on which payments were received from insurance carriers or third party payors. "None" may be entered to select accounts without a last insurance payment date. If dates or "None" is entered in this field, then the account must have insurance to be included on the report.

7. LAST INSURANCE F/U DATES (6-N-O)
This field contains the range of the most recent dates of insurance follow-up according to the assigned insurance follow-up schedules. If dates are entered in this field, then the account must have a claim to be included on the report.

8. LAST PATIENT F/U DATES (6-N-O)
This field contains the range of the most recent dates of guarantor follow-up according to the assigned follow-up schedules.

9. NEXT INSURANCE F/U DATES (6-N-O)
This field contains the range of the next insurance follow-up dates according to the assigned insurance follow-up schedules. If dates are entered in this field, then the account must have a claim to be included on the report.

10. NEXT PATIENT F/U DATES (6-N-O)
This field contains the range of the next guarantor follow-up dates according to the assigned follow-up schedules.

11. INSURANCE CLAIM RELEASE DATES (6-N-O)
This field contains the range of insurance claim release (printed) dates. The claim release date is the date the system actually prints the claim. If dates are entered in this field, then the account must have a claim to be included on the report.

12. INSURANCE CLAIM SUBMIT DATES (6-N-O)
This field contains the range of insurance claim submission dates. A claim is marked as submitted by the biller assigned to the associated carrier plan. If dates are entered in this field, then the account must have a claim to be included on the report.

13. LAST ACCOUNT ADJUSTMENT DATES (6-N-O)
This field contains the range of dates of the most recent adjustments made to either the patient or an insurance balance for the account.

14. LAST PATIENT ADJUSTMENT DATES (6-N-O)
This field contains the range of dates of the most recent adjustments made to the patient's portion of the account balance.

15. LAST INSURANCE ADJUSTMENT DATES (6-N-O)
This field contains the range of dates of the most recent adjustments made to the carrier's portion of the account balance. If dates are entered in this field, then the account must have a claim to be included on the report.

16. BAD DEBT TRANSFER DATES (6-N-O)
This field contains the range of dates for accounts transferred to bad debt.

17. PAYMENT PLAN DELINQUENT DATES (6-N-O)
This field contains the range of dates for accounts that are delinquent based on the payment plan criteria.

NOTE: If you use this criteria for your report, you must also enter a Schedule Type of Guarantor Payment Plan (GPP) and/or Account Payment Plan (APP) in the Account Selection screen. If you fail to do this, the system does not collect accounts based on the payment plan delinquent date.

When this screen is completed and accepted, the system displays the first of two General Selection Criteria screens.

```
              General Hospital Account Selection Report Processor
                                            Thu Mar 30, 2006 10:08 am
                     Account Report Selection-General Selection
( 1)Account Locations       :PA, AR, BD
( 2)Sub locations           :DNFB, FCRV
( 3)Patient Indicators      :
( 4)Patient Types           :
( 5)Hospital Services       :
( 6)Financial Classes       :
( 7)Biller Codes            :
( 8)Employer Codes          :Insurance - 123456,COCACO,ASDF98,1,998765,O,OBC
( 9)Patient Last Name Range  : -
(10)Guarantor Last Name Range: -
(11)Include Converted Accts? :
(12)Converted Indicator      :
(13)Collector Codes/Groups   :Collector Group 8 (Both)
(14)Invalid Address/Phone    :Both - J,Y




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

This screen and the next three screens enable you to refine the focus of this report.

Field Explanations

1. ACCOUNT LOCATIONS (TABLE LOOKUP)
This field contains the locations of the accounts that you want to select. You must make your selection from the displayed table. Entry options, which must be selected from the displayed table, are **PA** (patient accounting), **AR** (accounts receivable), **BD** (bad debt), and **ARR** (Retired From AR). You can select accounts in one to three account locations. If a location is deleted, the system checks the PA Follow-up Schedule field, AR Follow-up Schedule field, and Agency Follow-up Schedule field, and deletes any schedules corresponding to the deleted location. For example, if location PA was defined and there were values in the PA Follow-up schedule field, then the system deletes the values in the PA Follow-up schedule field. If you do not want to limit the report selection key account location, leave this field blank.

2. SUB LOCATIONS (TABLE LOOKUP)
This field contains the sub locations of the accounts you want to select. Entry options, which must be selected from the displayed table, are blank, **INSR** (insurance verification not completed), **FCRV** (financial counseling), **ND** (not discharged), **DNFB** (discharged, not final billed), **ACCF** (active internal guarantor collections), **PCA#** (# of collect agency), **RFBD** (reinstated from bad debt), **BDP** (bad debt prelisted), **BDI** (bad debt internal collections), and **BDE** (bad debt external agency). You can select any or all of the sub locations available.

NOTE: The Account Location of the patient account determines which sub locations can be selected for the account. For more information about sub locations and their corresponding locations, see the McKesson-Maintained Information chapter of the *Tables, Masters and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide.*

3. PATIENT INDICATORS (TABLE LOOKUP)
This field allows you to limit the report to certain patient indicators. Entry options, which must be selected from the displayed table, are **emergency**, **inpatient**, and **outpatient**. You can select up to three patient indicators. If you do not want to limit the report selection by patient indicator, leave this field blank.

4. PATIENT TYPES (TABLE LOOKUP)
This field allows you to limit the report to certain patient types. You can select up to 50 patient types from the displayed table. You can select inactive table entries for patient types. An asterisk (*) precedes the description of inactive entries during selection.

If you do not want to limit the report selection by patient type, leave this field blank.

5. HOSPITAL SERVICES (TABLE LOOKUP)
This field is used to identify the hospital services for the accounts that you want to select. You can select up to five hospital services to be included on the report. If you do not want to limit the report selection by hospital service, leave this field blank.

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6. FINANCIAL CLASSES (TABLE LOOKUP)

This field contains the financial classes of the accounts that you want to select. Financial classes are codes identifying the primary form of payment for an account. Select from the table the financial classes to include. You can select inactive table entries for financial classes. An asterisk (*) precedes the description of inactive entries during selection.

If you do not want to limit the report selection by financial class, leave this field blank. Due to screen limitations, all selected financial classes may not display on the screen. All of the selected financial classes do print on the Selection Criteria report, FARASCx.

7. BILLER CODES (TABLE LOOKUP)

This field is used to identify the billers assigned to the accounts that you want to select. Select from the table the billers whose accounts you want to include on the report. You can select up to five billers. You can select inactive table entries for biller codes. An asterisk (*) precedes the description of inactive entries during selection.

If you do not want to limit the report selection by billers, leave this field blank.

8. EMPLOYER CODES (12-N-O)

This field is used to identify the employers for the accounts that you want to select. Select from the table the employers whose accounts you want to include on the report. You can select up to five employers. If you do not want to limit the report selection by employers, leave this field blank. After the employer codes are selected, the following prompt is displayed:

Employer to compare against is (P)atient, (G)uarantor, or primary (I)nsurance (P/G/I) [I]--

Options are **P** (Patient), **G (**Guarantor) or **I** (Primary). Indicate whether you want to compare against the Patient, Guarantor, or primary Insurance. The default is **I**, primary insurance.

9. PATIENT LAST NAME RANGE

This field contains the range of patient last names associated with the accounts that you want to select. When you first access this field, the system prompts you to enter the first patient name of the range. Enter as many letters as necessary to appropriately define the beginning of the name range. The system then prompts you to enter the ending patient name of the range. Enter as many letters as necessary to appropriately define the end of the name range. Press ENTER if you do not want to limit the report by patient last name.

10. GUARANTOR LAST NAME RANGE

This field contains the range of guarantor last names associated with the accounts that you want to select. When you first access this field, the system prompts you to enter the first guarantor name of the range. Enter as many letters as necessary to appropriately define the beginning of the name range. The system then prompts you to enter the ending guarantor name of the range. Enter as many letters as necessary to appropriately define the end of the name range. Press ENTER if you do not want to limit the report by guarantor last name.

NOTE: The criteria are valid only if you entered Include or Only to the Print Guarantor Information field on the first screen of this function.

11. INCLUDE CONVERTED ACCTS? (1-A-R)
This field indicates whether accounts converted from another financial system to STAR Financials should be included on this report. Entry options are **O** (use converted accounts only), **E** (exclude converted accounts from the selection), or **I** (include converted accounts in the selection); the default is I.

12. CONVERTED INDICATOR (1-A-C)
This field enables you to select only those accounts converted by the system (S), only those accounts manually converted (M), or all converted accounts if you are including converted accounts in this report. The default is All. This field is completed only if the Include Converted Accts? field contains O or I. Manually converted accounts are AR or BD adds.

13. COLLECTOR CODES/GROUPS (TABLE LOOKUP)
This field is used to identify the collectors or collector groups assigned to the accounts that you want to select. When this field is accessed, the following prompt is displayed:

Use Collector (G)roup or Collector (C)ode? (G/C) [C]--

This prompt is used to identify whether collector codes or collector groups are to be used. Select from the table the collectors or collector groups whose accounts you want to include on the report. You can select up to five collectors or collector groups. If you do not want to limit the report selection by collectors, leave this field blank.

After you identify the collector(s) or collector groups, the system displays the following prompt:

Guarantor or Insurance or Both (G/I/B) [B]--

To include only guarantor accounts for the selected collectors, enter **G**. To include only insurance accounts for the selected collectors, enter **I.** To include both, enter **B**. The default response is **B**. If this field is set to **I**, then an account must have a claim in order to be selected, and the Insurance Selection field on the first Account Selection screen is referenced to determine whether to select on the primary insurance only or on all insurance plans. If this field is set to **B**, accounts that have collectors assigned as either the Guarantor or the Insurance Collector are selected for the report.

14. INVALID ADDRESS/PHONE (1-A-R)
This field enables you to select accounts that have an invalid address flag for patient, guarantor, or both patient and guarantor. You can also specify a code to include on the report from the STAR Patient Processing Invalid Address/Phone table. When this field is accessed, the following prompt is displayed:

Use (P)atient, (G)uarantor, or (B)oth type flag (P/G/B) [B]--

You can enter **P** for Patient, **G** for Guarantor or **B** for Both. After you enter the flag type, the Invalid Address Codes table is displayed. Select one or more codes and press ENTER. The Invalid Address/Phone field displays your choices.

When this screen is completed and accepted, the system displays the second of two General Selection Criteria screens:

```
                General Hospital Account Selection Report Processor
                                                  Wed Mar 26, 2003 01:59 pm
                  Account Selection Report - Add'l General Selections
( 1)Account Balance        : /
( 2)Guarantor Balance      : /
( 3)Patient Balance        : /
( 4)Total Charges          :
( 5)Insurance Balance      : /
( 6)Patient Classification :
( 7)Pt Class Alert/Suppress :


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

Field Explanations

1. ACCOUNT BALANCE (12-N-O)

This field contains the range of account balances used in selecting accounts for this report. The first entry is the starting account balance and the second is the ending account balance. The starting balance can be .01 if only debit balances are wanted or -99999999.00 if credit balances are wanted. Leave this field blank if you do not want to limit the report by account balance. You can enter a range that includes debit and credit balance accounts and set the Suppress Zero Balance Accounts field on the first screen to **Yes** to exclude zero balance accounts from the report.

2. GUARANTOR BALANCE (12-N-O)

This field contains the range of guarantor balances used in selecting accounts for this report. The first entry is the starting guarantor balance and the second is the ending guarantor balance. The starting balance can be .01 if only debit balances are wanted or -99999999.00 if credit balances are wanted. Leave this field blank if you do not want to limit the report by guarantor balance.

NOTE: If a guarantor balance is specified and one or more Account Locations (PA, AR, BD) has been identified, the guarantor balance is *only* for the specified location(s).

3. PATIENT BALANCE (12-N-O)

This field contains the range of patient balances used in selecting accounts for this report. The first entry is the starting patient balance and the second is the ending patient balance. The starting balance can be .01 if only debit balances are wanted or -99999999.00 if credit balances are wanted. Leave this field blank if you do not want to limit the report by patient balance. If the Suppress Zero Balance Accounts field on

screen 1 is set to **Yes**, then accounts are excluded based on the account (not patient) balance being zero.

4. TOTAL CHARGES (12-N-O)
This field contains the minimum dollar value and maximum dollar value for patient charges to review. When this field is accessed, the following prompt is displayed:

Enter starting total charge balance--

After the amount is entered, and you press ENTER, the next prompt is displayed:

Enter ending total charge balance--

The value of valid ranges for both amounts is -99,999,999,999.99 to 99,999,999,999.99. The dollar value from the patient record is the accumulation of the total billed and unbilled charges.

5. INSURANCE BALANCE (12-N-O)
This field contains the range of insurance balances used in selecting accounts for this report. The first entry is the starting insurance balance and the second is the ending insurance balance. The starting balance can be .01 if only debit balances are wanted or -99999999.00 if credit balances are wanted. Leave this field blank if you do not want to limit the report by patient balance.

Example of Balances:

If the hospital wants to report patient balance credit, insurance balance debit, and the account balance debit, the fields should be defined in the following manner:

Field	Starting Balance	Ending Balance
10	.01	999999999.00
11	-999999999.00	-.01
12	.01	99999999.00

6. PATIENT CLASSIFICATION (TABLE LOOKUP)
This field allows you to limit accounts selected for the reports based on the financial patient classification. You may select one, multiple, or all patient classifications. If you have not converted the Patient Classification which is stored at the patient level, to the Financial Patient Classification. The following error message is displayed:

Financial Patient Classification conversion (F6587) has not been run

7. PT CLASS ALERT/SUPPRESS (1-A-R)
This field allows you to limit accounts selected for this report based on the financial patient classification alert and suppression indicators. You may select from the values of Alert Only, Suppress, and Clear display. You may select one, multiple, or all

suppression statuses. Selecting all restricts the report to only those accounts that have an alert status defined.

After you complete the information required on the second General Selection screen, the system enables you to accept the screen or edit the field contents. When you accept this screen, the system displays the following prompt:

> *Go to (A)ccount F/Up, (I)nsurance F/Up, (E)xit? [All]--*

To edit only the fields on the Account Selections screen (the fifth screen of this processor), enter **A**. To edit only the fields on the Insurance Selections screen (the sixth screen of this processor), enter **I**. If you enter (E) to exit, the following prompt is displayed:

> *Run Now/Tonight or Define? (N/T/D) [D] --*

If you respond with (A)ccount or [ALL] at the "Go to" prompt, the following Account Selection screen is displayed:

```
                    General Hospital Account Selection Processor
                                            Tue Feb 02, 1999 10:16 am
                    Account Report Selection-Account Selections
( 1)PA F/U Schedule Codes    :
( 2)AR F/U Schedule Codes    : 927
( 3)Agency F/U Schedule Codes:
( 4)# of Patient F/U's = & > : 2
( 5)Next F/U Sequence # = & >: 5
( 6)Patient F/U Hold Flag    : Y
( 7)Schedule type            : GS,GC,GPP,AS
( 8)Include Prelist Accounts?: Include
( 9)Prelisted Indicators     : SH,MH
(10)Collection Agency Code    : CCIM






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

Field Explanations

1. PA F/U SCHEDULE CODES (TABLE LOOKUP)
This field contains the PA follow-up schedules assigned to the guarantor of the accounts that you want to select. You can select up to five schedules from the displayed table. If you do not want to limit the report selection by collection schedules, leave this field blank. This field can only be completed if the location field on the General Information Account Selection screen has been defined for PA or is blank.

NOTE: If the location field is updated and the field value of PA is deleted, the system automatically deletes the follow-up schedule codes defined in the PA F/U Schedule field.

2.   AR F/U SCHEDULE CODES (TABLE LOOKUP)
This field contains the AR follow-up schedules assigned to the guarantor of the accounts that you want to select. You can select up to five schedules from the displayed table. If you do not want to limit the report selection by collection schedules, leave this field blank. This field can only be completed if the location field on the General Information Account Selection screen has been defined for AR or is blank.

NOTE: If the location field is updated and the field value of AR is deleted, the system automatically deletes the follow-up schedule codes defined in the AR F/U schedule field.

3.   AGENCY F/U SCHEDULE CODES (TABLE LOOKUP)
This field contains the agency follow-up schedules assigned to the guarantor of the accounts that you want to select. You can select up to five schedules from the displayed table. If you do not want to limit the report selection by collection schedules, leave this field blank. This field can only be completed if the location field on the General Information Account Selection screen has been defined for BD or is blank.

NOTE: If the location field is updated and the field value of BD is deleted, the system automatically deletes the follow-up schedule codes defined in the Agency F/U Schedule Codes field.

The following fields can work together or independently of the PA, AR and Agency Schedule Code fields:

4. # of Patient F/Us

5. Next F/U Sequence #

6. Patient F/U Hold Flag

7. Schedule Type

These fields may be used for accounts in PA, AR and BD. The system determines the schedule to check based on the current location of the patient's account. Users may want to specify the Account Locations in the Account Selection Report Definition to further restrict the search and selection of accounts. These fields select accounts in AR, PA, and BD if the PA follow-up, AR follow-up, or Agency follow-up criteria on the account matches the entry in one of the fields listed above.

4.   # OF PATIENT F/Us = & > (3-N-O)
This field contains the number of patient follow-ups already performed on each of the accounts that you want to select. The entry range is 1 to 999. The system uses the value entered and all greater values (up to 999) for this report.

5. NEXT F/U SEQUENCE # = & > (3-AN-O)

This field contains the number of the next follow-up sequence that you want to use to select accounts. Entry options are 1 through 999 or the default response of all follow-up sequence numbers. The number entered here prompts the system to use this value and any values that are greater, up to 999.

6.   PATIENT F/U HOLD FLAG (TABLE LOOKUP)

This field allows you to report on accounts that are on follow-up hold or exclude accounts that are on hold. Valid table selections are Yes, No Hold, and Both. If you do not want to limit the report selection, leave this field blank. The Both selection, in effect, removes the F/U hold flag from account selection criteria.

7.   SCHEDULE TYPE (TABLE LOOKUP)

This field contains the schedule types assigned to the account (if the patient is on a separate schedule) or to the guarantor of the account that you want to select. You can select to include accounts having one or more of the following schedule types:

GUARANTOR STANDARD   SEPARATE
GUARANTOR CUSTOM   ACCOUNT CUSTOM
GUARANTOR PAYMENT PLAN ACCOUNT PAYMENT PLAN

If you do not want to limit the report selection to any schedule type, leave this field blank.

8.   INCLUDE PRELIST ACCOUNTS? (1-A-R)

This field determines whether the report should include, exclude, or contain only accounts that have been prelisted for bad debt. Valid responses are:

* **O** (only) - include only prelisted accounts. If you enter **O**, an account must have a user or system hold flag to be considered for inclusion on the report.

* **I** (include) - include prelisted accounts as well as accounts that are not prelisted.

* **E** (exclude) - exclude prelisted accounts from this report. If you enter **E**, an account ID not considered for inclusion if it has a user or system hold flag.

The default response is Include.

9.   PRELISTED INDICATORS (TABLE LOOKUP)

This field enables you to select prelist indicators to refine the selection of prelist accounts if you are including prelisted accounts in this report. You must make your selections from the displayed table. Entry options are

* System Selected
* User-flagged
* Account Not Selected
* System Hold
* Manual Hold.

If the Include Prelist Accounts? field contains **E,** you cannot access this field.

10. COLLECTION AGENCY CODE (TABLE LOOKUP)
This field is used to identify the collection agencies assigned to the accounts that you want to select. Select from the table the collection agencies whose accounts you want to include on the report. You can select up to five collection agencies. If you do not want to limit the report selection by collection agencies, leave this field blank.

After you complete the information required on this screen, the system enables you to accept the screen or edit the field contents.

If you responded with (I)nsurance or (A)ll at the "Go to" prompt on the General Selection screen, the following Insurance Selections screen is displayed:

```
                 General Hospital Account Selection Processor
                                            Wed March 26, 2003 10:16 am
                     Account Report Selection-Insurance Selections
( 1)Ins F/U Schedule Codes   :
( 2)# of F/U's = & >         :
( 3)Next F/U Sequence # = & >:
( 4)F/U Hold Flag            :
( 5)Insurance Carriers       :
( 6)Insurance Plans          :
( 7)Custom                   :
( 8)COB 1 Balance            : /
( 9)COB 2 - COB 9 Balances   : /
(10)Individual COB(s) Balance: /




 Select accounts on insurance custom schedule (O)nly, (E)xclude, [Include]--
                  next screen(/) or previous screen(/P)
```

The Insurance Selection field on the first screen is referenced to determine if accounts are to be selected based only on the primary insurance plan or on all insurance plans. If all insurance plans are used, an account can be selected more than one time.

If any of the insurance follow-up selection fields (fields 1-4) are completed, then an account must have a claim to be included on the report. The most recent claim is used.

Field Explanations

1. INS F/U SCHEDULE CODES (TABLE LOOKUP)
This field contains the follow-up schedules assigned to the insurance company. You can select up to five schedules from the displayed table. If you do not want to limit the report selection by schedule code, leave this field blank.

2. # OF F/Us (3-N-O)

This field contains the number of follow-ups already performed on each of the accounts that you want to select. The entry range is 1 to 999. The system uses the value entered and all greater values (up to 999) for this report.

3. NEXT F/U SEQUENCE # = & > (3-AN-O)

This field contains the number of the next follow-up sequence that you want to use to select accounts. Entry options are 1 through 999 or the default response of all follow-up sequence numbers. The number entered here prompts the system to use this value and any values that are greater, up to 999.

4. F/U HOLD FLAG (TABLE LOOKUP)

This field allows you to report on accounts that are on insurance follow-up hold or exclude accounts that are on hold. Valid table selections are Yes and No Hold.

5. INSURANCE CARRIERS (TABLE LOOKUP)

This field is used to identify the insurance carriers of the accounts that you want to select. Insurance carriers are identified by user-defined codes stored in the Insurance Carrier table in the STAR Patient Processing system. When you access this field, the system displays the insurance carriers in your system. You can select one, some, or all carriers. Due to screen limitations, all selected carriers may not display. You can view all selected carriers by looking at the Selection Criteria Report, FARASCx.

6. INSURANCE PLANS (TABLE LOOKUP)

This field is used to identify the insurance plans of the accounts you want to select. You can select one, some or all plans from the displayed table. Plans display for each selected carrier. Due to screen limitations, all selected carriers may not display. You can view all selected carriers by looking at the Selection Criteria Report, FARASCx.

7. CUSTOM (1-A-R)

This field determines whether the report should include, exclude, or only contain accounts that are on a custom insurance schedule. An earlier field on this insurance selection screen must be selected prior to selecting this field. If you have selected this field without selecting further defining criteria in other fields on this screen, you receive the following error message:

Earlier field required to use field!

Valid responses are:

• **O** (only) - only include accounts on a custom insurance schedule.

• **I** (include) - include all accounts, regardless of whether they are on a custom Insurance schedule.

• **E** (exclude) - exclude accounts on a custom insurance schedule.

After you complete the information required on this screen, the system enables you to accept the screen or edit the field contents.

NOTE: If you are using a defined set of selection criteria to create this report, when you accept the screen the system displays the following prompt:

Continue? (Y/N) or Delete? (D) [Y]--

To accept the screen and continue creating the report, enter **Y** or press ENTER to accept the default. To edit the contents of the screen, enter **N**. To delete this defined set of selection criteria, enter **D**.

8. COB 1 BALANCE (15-N-O)
This field allows account selection when a primary insurance has a balance between the values entered in the field. If this field is left blank, the system does not do an account selection per the primary insurance balance. If this field is used, self-pay accounts cannot be selected. When this field is accessed, the following prompts are displayed which allow you to enter a beginning and ending range:

Enter starting COB 1 balance--

Enter ending COB 1 balance--

Enter a starting and ending range between -999999999999999.99 to 999999999999999.99.

9. COB 2-9 BALANCES (15-N-O)
This field allows account selection when at least one of the secondary insurances has a balance between the values entered in the field. When entering in a balance range for the COB 2 through the COB 9 plans, only one of the secondary insurances has to meet the criteria. For example, if you enter $25.00 - $9999999.00, and COB 2 has a balance of $50.00, but COB 3 has a balance of $0.00, the account would still be selected for the report since at least one of the secondary insurances satisfied the balance range. If values are entered for both this field and the COB 1 Balance field, then both criteria have to hold true for the account to be selected on the report.

If this field is left blank, the system does not do an account selection per the secondary insurance balances. If this field is used, self-pay accounts cannot be selected. When this field is accessed, the following prompts are displayed which allow you to enter a beginning and ending range:

Enter starting COB 2 - COB 9 balance--

Enter ending COB 2 - COB 9 balance--

Enter a starting and ending range between -999999999999999.99 to 999999999999999.99.

NOTE: If you only want to report on accounts where the COB 1 plan has paid, but there is a balance on at least one of the secondary insurance plans, then you

should enter in a COB 1 balance range of $0.00 to $0.00, and a COB 2 - COB 9 balance range of $1.00 to $999999999999999.99.

10. INDIVIDUAL COB(S) BALANCE (15-N-O)
This field contains the beginning and ending balances for any COB. When this field is accessed, the following prompt is displayed:

> *Enter starting individual COB(s) balance--*

After the amount is entered, and you press ENTER, the next prompt is displayed:

> *Enter ending individual COB(s) balance--*

The value of valid ranges for both amounts is -99,999,999,999.99 to 99,999,999,999.99.

Printing the Report

When you accept the screen, the system displays the following prompt:

> *Run Now/Tonight/Schedule/Copy or Define? (N/T/S/C/D) [D]--*

Your entry to this field determines when the report is created and what information is displayed on the report:

NOTE: If at any time prior to the display of the exit prompt, you press **ENTER**, the system displays the following prompt:

> *Are you sure you wish to exit without saving the definition? Y/N [N] --*

> **Y** returns the user to the Account Reports menu. **N** returns you to the screen from which you pressed ENTER.

Now - Enter **N**, and the system generates the report now, using the current account balance.

Tonight - Enter **T**, and the system generates the report during the batch run, using the pre-batch balance. This is the balance information as of midnight. To produce a month-end Account Selection report, use this option on the last day of the month.

If you enter **N** or **T** to run the report now or tonight, the system then displays:

> *Delete definition when complete? (Y/N) [N]--*

Enter **Y** to delete the report definition after it has been used to generate a report. To re-use this definition as often as desired, until you manually delete it, enter **N** or press **ENTER** to accept the default.

Define - Enter **D**, and the system saves the report selection criteria and you can run the report at a later time. The system displays defined selection criteria following the facility selection process when you first enter the Account Selection function.

Copy - Enter **C**, and the system makes a copy of the current report definition. For more details, see "Copying Account Selection Report Definitions" on page 2-37.

Schedule - Enter **S** to schedule the report to run. The following screen is displayed:

```
              General Hospital Account Selection Report Processor
                                                   Mon Mar 24, 2003 10:26 am
  1 Report Code    2 Description
    MK1              PA ACCOUNTS
  3 Frequency Type                              4 Starting/Next Date
    One Time Only                                 Cancel
  5 Daily Interval/Day of Month/Day-Week of Month

  6 Use Month End Balances
    No
  7 Edit by                                    8 Edit date
    New, Nancy                                   03/21/2003 4:01 pm
```

Field Explanations

1.   CODE (DISPLAY ONLY)
This field displays the code for this Account Selection Report.

2.   DESCRIPTION (DISPLAY ONLY)
This field displays the description of this Account Selection Report.

3.   FREQUENCY TYPE (1-A-R)
This field contains the frequency type with which the report should be run. Entry options are **I** for interval, **D** for a specified day of the month, **W** for a specified day within a certain week of the month, and **O** for One Time Only. If you select O, you must enter a next starting date for the report to run. The report only runs on the next starting date and is not rescheduled by the system. The next starting date is blank after the report runs for the One Time Only option.

4.   STARTING/NEXT DATE (DATE-R)
This field contains the starting date or the next date on which the report is to be run. This date is automatically incremented after the job is run based on the frequency defined for the job. Enter the starting date to establish the report run. To change the next run date, enter the new date on which the report should be run.

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

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

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

5.   DAILY INTERVAL/DAY OF MONTH/DAY-WEEK OF MONTH (3-AN-R)
Entry options for this field are determined based on the frequency type selected.

- If you selected Interval, you are prompted to enter a daily interval from 1-365. An entry of **1** means that the report will run every day.

- If you selected Day of Month, you are prompted to enter the day of the month from 1-28 or L for the last day of the month. An entry of **15** means that the report will run on the 15th of every month.

- If you selected Day- Week of Month, you are first prompted to enter the day of the week (1=Sun, 2=Mon, for example), and then for the week of the month from 1-4 or L for the last week of the month. For example, an entry of **2** for the day of the week and L for the week of the month means that the report will run on the last Monday of the month.

6.   USE MONTH END BALANCES (1-A-R)
This field indicates whether month end balances should be used. If the field is completed with **Y(es)**, month end balances are used, if present. If the field is completed with **N(o)**, current balances are used.

7.   EDIT BY (DISPLAY ONLY)
This field contains the name of the person who performed the last edit.

8.   EDIT DATE (DISPLAY ONLY)
This field contains the date and time this job was last edited.

COPYING ACCOUNT SELECTION REPORT DEFINITIONS

To copy account selection reports from one facility to another, enter **C (Copy)** at the following prompt:

Run Now/Tonight/Schedule/Copy or Define? (N/T/S/C/D) [D]--

The system makes a copy of the current definition, and the following screen is displayed, from which you can select the Copy To Facility.

```
                 General Hospital Account Selection Report Processor
                                                  Mon Mar 24, 2003 12:13 pm
                           Account Selection Report Copy
Page:01                          Copy `TO` Facility
( 1) Model Hospital B
( 2) Model Hospital C
( 3) Model Hospital D
```

The following message displays for single facility sites:

Copy function not valid for single facility

If a multi-facility system exists, you have the option to highlight multiple facility codes to copy to. The facilities to list are determined by the user's CRT definition of valid facilities. If an Account Selection code already exists for one of the facilities, the system displays the message:

Code exists for facility B. Do you want to overwrite? (Y/N) [N] --

If the response is No, then the facility will be unselected. If the response is Yes, the current definition will be overwritten with the copied definition.   After the valid facilities are selected, the system asks for verification with the following prompt:

Copy xyz from facility A to facility(s) B,C (Y/N)-

If you answer No, the system reverts to the prior menu option. If you answer Yes, the following information screen is displayed:

```
            General Hospital Account Selection Report Processor
                                          Mon Mar 24, 2003 03:43 pm
                      Account Selection Report Copy

*****************************************************************************
                                 NOTE

                            SRB-STACEYS TEST
                 Will be copied from Facility A to Facility D
*****************************************************************************





Do you wish to proceed? (Y/N) [Y]--
```

The screen shows the Account Selection definition code and description, and notifies you of the To and From facilities. The following prompt is displayed:

Do you wish to proceed?

If you answer Yes, and the To facility has criteria defined that is different from the criteria defined for the From facility, the table is displayed, highlighted with valid entries for the From facility. You can add or remove items from the table. For example: Facility A has patient types defined of A, B, C, D, and E. Of these items, only B and C are defined for the 'copy to' facility B. The patient type table is displayed with the entries B and C highlighted.

```
            General Hospital Account Selection Report Processor
                                          Mon Mar 24, 2003 03:43 pm
                      Account Selection Report Copy
Facility A Aging Category: 1-F2267
*****************************************************************************
Page:01                     Facility C Aging Categories        ##=Current Choices
( 1) 88-15/30/45
( 2) 99-30/60/90


Enter choice--

```

TRANSACTION HISTORY

The transaction history report contains a complete listing of events for the patient account selected. This information can include adjustments, balance transfers, final billing and claim dates, all payments, refunds, free form notes, phone calls, and statement notations.

After you select this option, the system prompts you to select a facility (if this is a multifacility installation), and then use the standard lookup procedure to select a patient account. When an account is selected, you have the option of printing the report by posting date of the transaction involved (**P**), by transaction type (**T**), by balance transactions (**B**), or include all transactions (**A**). The default is A.

If you want to define the report by posting date (P), the system prompts you to enter a range of dates (begin and end dates). After the dates are entered, the system prompts you to accept or edit the information entered. Accepting the screen completes the transaction and begins the compiling and printing of the report.

If you are defining the report by transaction type, the system displays a list of the transaction summary types established in the system:

- A - Adjustments

- B - Billing/Claims

- C - Cash

- M - Memo

- N - Notes

- R - Refunds

- T - Status Transfers

If you are defining balance transactions, the system displays payment, adjustment and refund transaction history entries.

You can select one, some, or all of these types. Once the type or types are selected, the system automatically begins compiling and printing the report.

PRINT PENDING CLAIMS REPORT

This function enables you to print the Pending Claims report (FCR260). After you select this menu option, the system displays the following prompt:

>   *Do you want to run the Pending Claims Report (N)ow, or (T)onight [T] --*

If you want to run this report during midnight processing, enter **T**. If you want to run this report now, enter **N**.

If you entered T to run the report during midnight processing and you need to cancel this report, then when you reselect this option the following prompt is displayed after you enter in the facilities selection:

>   *(C)ancel tonight's Pending Claims Report, or run (N)ow? --*

Enter **C** to cancel this report from midnight processing. Enter **N** to run this report now.

CLAIMS TO BE SUBMITTED

This function enables you to print the Claims To Be Submitted report (FCR300).

NOTE: Submission of claims starts insurance follow-up.

After you select this menu option, the system displays the following prompt.

Do you want to run the Claims Gen Not Sub Report (N)ow, or (T)onight [T] --

If you want to run this report during midnight processing, enter **T**. If you want to run this report now, enter **N**.

If you entered T to run the report during midnight processing and you need to cancel this report, then when you reselect this option the following prompt is displayed after you enter in the facilities selection:

(C)ancel tonight's Claims Generated Not Submitted Report, or run (N)ow? --

Enter **C** to cancel this report from midnight processing. Enter **N** to run this report now.

UNPAID CLAIMS REPORT

This function enables you to print the Unpaid Claims report (FCR280). After you select this menu option, the system displays the following prompt.

Do you want to run the Unpaid Claims Report (N)ow, or (T)onight [T] --

If you want to run this report during midnight processing, enter **T**. If you want to run this report now, enter **N**.

If you entered T to run the report during midnight processing and you need to cancel this report, then when you reselect this option the following prompt is displayed after you enter in the facilities selection:

(C)ancel tonight's Unpaid Claims Report, or run (N)ow? --

Enter **C** to cancel this report from midnight processing. Enter **N** to run this report now.

PROVINCIAL CLAIMS REPORTS (CN ONLY)

This function enables you to print the Bill Summary, Production, Diskette Submission Reprint, and Reconciliation reports for OHIP claims. Refer to the *Canadian Claims Processing Volume* of the *STAR Patient Accounting Reference Guide* for details on these reports.

PATIENT CLASS SUPPRESSED ACCOUNTS REPORT

The screen below is used to define the selection and sort criteria for the Patient Classification Suppressed Accounts report and to request the report to be generated either immediately or during midnight processing.

```
          General Hospital Pt Class Suppressed Accts Report Processor
                                            Thu Feb 04, 1999 10:21 am


 1 Include AR Accounts?                  2 Include PA Accounts?
   Yes                                     No
 3 Accounts with no Insurance Balance    4 Suppress Zero Balance Accts
   Include                                 No
 5 Sort By                               6 Page Break by Pt Class
->
 7 Edit by                               8 Edit date

Page:01                     Report Sort Options
( 1) 1-Account Name
( 2) 2-Account Number
( 3) 3-Acct Bal and Name
( 4) 4-Ins Balance and Name
( 5) 5-Pt Class and Acct Name
( 6) 6-Pt Class and Ins Bal



Enter choice--
```

Field Explanations

1. INCLUDE AR ACCOUNTS? (1-A-R)
This field defines whether or not accounts in the location AR are included in the report. **Y** indicates that AR accounts are included on the report. **N** indicates that AR accounts are not included on the report. The default is **Y**.

2. INCLUDE PA ACCOUNTS? (1-A-R)
This field defines whether or not accounts in the location PA are included on the report. **Y** indicates that PA accounts are included on the report. **N** indicates that PA accounts are not included on the report. The default is **Y**.

3. ACCOUNTS WITH NO INSURANCE BALANCE (1-A-R)
This field defines whether to include, exclude or only include accounts with no insurance balance on the report. The system selects accounts based on the account balance minus the patient balance. The system displays the following prompt:

(I)nclude, (E)xclude, or (O)nly include accounts with $0.00 insurance balance?

(**I**)nclude indicates that accounts are included on the report if the insurance balance is $0.00. (**E**)xclude indicates that accounts are excluded from the report if the insurance balance is $0.00. (**O**)nly indicates that the report only includes accounts where the insurance balance is $0.00, excluding all accounts with an insurance balance. The default is (I)nclude.

4. SUPPRESS ZERO BALANCE ACCOUNTS (1-A-R)
This field defines whether to suppress accounts with a $0.00 account balance. **Y** indicates accounts with $0.00 account balances do not print on the report. **N** indicates accounts with $0.00 account balances print on the report. The default is **N**.

5. SORT BY (TABLE - R)
This field defines the sort of the report as one of the following options:

•   Account Name - alphabetical order by the patient's last name

•   Account Number - numerical order by the patient's account number

•   Acct Bal and Name - primary sort by the patient's account balance in descending order with a secondary sort by the patient's last name.

•   Ins Balance and Name - primary sort by the patient's insurance balance in descending order with a secondary sort by the patient's last name

•   Pt Class and Acct Name - primary sort by patient classification with a secondary sort by the patient's last name

•   Pt Class and Ins Bal - primary sort by patient classification with a secondary sort by the account's insurance balance in descending order. This option groups accounts with no insurance balance together on the report

6. PAGE BREAK BY PT CLASS (1-A-C)
If the primary sort that is by patient classification, then you may also specify whether or not to insert a page break for each change in patient classification. If a page break is defined, the system provides subtotals by patient classification.

If the response to the sort by field is either Pt Class and Acct Name or Pt Class and Ins Bal, then the following prompt is displayed:

Insert page break by Patient Classification? (Y/N) [N] - -

Y indicates a page break is inserted. **N** indicates a page break is not be inserted. The default is **N**.

Upon exiting the processor screen, the following error message appears, and the screen is displayed again if **N** was indicated for Include AR Accounts and for Include PA Accounts.

Inclusion of PA or AR accounts must be indicated!

You can then go back and change field 1 and field 2, but if these fields are not changed the following message is displayed when NL is pressed:

No changes to report parameters recorded. Press NL.

This indicates that the changes to the screen have not been accepted by the system. If you press NL again, the following prompt is displayed:

Run the Pt Class Suppressed Accts Report (N)ow, or (T)onight? [T] - -

(N)ow generates the report immediately. (T)onight generates the report during midnight processing even if it is not set up as an optional batch job. The report that is generated is based on the parameters that are stored in the system and not necessarily what is displayed on the screen.

If the report is already scheduled to run tonight, the following prompt is displayed:

(C)ancel tonight's Pt Class Suppressed Accts Report, or run (N)ow? - -

(N)ow generates the report immediately. (C)ancel withdraws the request to run the report during midnight processing.

Generating the Report

The report may be generated in three different ways:

- immediately on demand

- during midnight processing on demand

- during midnight processing as a regularly scheduled optional batch job

In all three methods, the Request Patient Classification Accounts Report screen is referenced to determine the sort and selection criteria for the report.

To obtain the report immediately, you must complete the Request Patient Classification Suppressed Accounts Report screen and respond (N)ow to the run prompt upon exiting the function.

To obtain the report on demand during the next midnight processing run, you must complete the Request Patient Class Suppressed Accounts Report screen and respond (T)onight to the run prompt upon exiting the function.

To obtain the report on a regularly scheduled frequency during midnight processing, you must complete the Optional Batch Job for the Patient Class Suppressed Accounts Report. An optional batch job for the new report must be added to the system.

PRINT CLAIM DISPOSITION FORMULAS

This function enables you to print the Claim Disposition Forumlas report (FTFACF). This report lists of the McKesson pre-defined formulas that can be associated with the Claim Disposition Rules table. The report also lists any criteria that must be met in order to use the rule.

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

Do you want a printed list for Claim Disposition Formulas? (Y/N) [N]--

Enter **Y** to print the report and **N** to return to the Account Transaction Reports menu. If a Y for Yes is entered the system prompts you to print either in Claim Disposition Code or alphabetic sequence.

Enter code(C) sequence or alphabetic(A) [A]-- |

You can enter C for sequence or A for Alphabetic. The system displays the following message:

Compiling and Printing Report FTFACF!

Chapter 3 - OTHER ACCOUNT MANAGEMENT FUNCTIONS

STAR Patient Accounting Reference Guide - Account Transactions Volume
October 2012   *Release 18.0*   *3–1*
Proprietary to McKesson - Subject to Confidentiality Agreement

STAR Patient Accounting Reference Guide - Account Transactions Volume
3–2   *Release 18.0*   *October 2012*
Proprietary to McKesson - Subject to Confidentiality Agreement

INSURANCE MANAGEMENT

Insurance Management allows Patient Accounting users to delete insurance plans on PA and AR accounts with financial activity and outstanding claims. Insurance Management also provides you with a way to bill and prorate the affected accounts during the same processing day.

Insurance Management is a four step process:

1. Delete Financial Insurance Activity
2. Insurance Revision
3. Instant Adjustment Bill
4. Add Claim to Insurance

Delete Financial Insurance Activity is used to notify you of financial activity, remove the insurance balance and delete insurance claims for the COB. Accounts appear on the Insurance Management Insurance Changes Report (FBR320), when Insurance Revision is used under the Delete Financial Insurance Activity option.

Insurance Revision allows you to delete the insurance plan and update the MPI with insurance changes. You can also add new insurance plans, modify existing insurance plan coverage and resequence the insurance plans on the account. Accounts appear on the Insurance Management Insurance Changes Report (FBR320), when Insurance Revision is used.

Instant Adjustment Bill allows you to create a new bill sequence for the account and re-prorate the charges based on the remaining insurance plans. Only charges are re-prorated. The Instant Adjustment Bill does not move activity such as a Balance Transfer, Payment, Adjustment, or Refund amount from one insurance or patient to another insurance or patient. You can also have the STAR Patient Accounting system recalculate the reimbursement amount and post a contractual adjustment on the account.

Add Claim to Insurance allows you to add selected claims to the insurance plans on the account after using the Instant Adjustment Bill function.

When the Insurance Management option is selected, the Insurance Management menu is displayed:

```
                    General Hospital Insurance Management Processor
                                                  Thu Apr 22, 1999 01:10 pm
     Insurance Management Input Options


               Option No.  Option
               ---------------------------------------
                   1       Delete Financial Insurance Activity
                   2       Insurance Revision
                   3       Instant Adjustment Bill
                   4       Add Claim to Insurance
                   5       Single Bill

                   6       Account Inquiry
                   7       Account Revision
                   8       Approve Refunds
                   9       Maintain Claims by Account
                  10       Balance Transfer & Claim Disposition
                  11       Demand Bill






     Enter option number--
```

Delete Financial Insurance Activity

This function allows authorized STAR Patient Accounting users to:

- delete insurance plans with financial activity and outstanding claims from within Insurance Management without having to wait for Midnight Processing to complete the deletion.

- handle financial activity or be advised of processes to be done outside of the Delete Financial Insurance Activity processor before the insurance plan can be deleted.

- delete outstanding claims for the insurance plan to be deleted.

- update the MPI with insurance deletions.

In the Delete Financial Insurance Activity function, deletion of financial insurance activity is allowed on PA and AR accounts if the account has billed. Bad Debt accounts must be transferred from BD to AR in order to use the function. If the selected account has no insurance, the following message is displayed:

Error: Account has no insurance!

If the selected account is in PA and has not billed, the following message is displayed:

Account has not billed. Use Account Revision or Revise Admission.

After selecting an account that has been billed and has insurance, the following screen is displayed, providing a summary of the activity on the insurance plans for the account:

```
     General Hospital Delete Financial Insurance Activity Processor
                                     Mon Mar 13, 2006 11:59 am
Account       Name               FC Typ Admit    Disch       Balance Loc
A9929900001   FESLER,DANIEL      M  O/P 10/26/99 10/26/99      0.00   AR/FCRV


COB    Code Insurance Name                  Bal  Pay Adj Ref  Xfer Clm/EP Logs

#1  100100 MEDICARE PART A                  Yes  No  No  No   No   Yes/1  No
#2  100200 MEDICARE PROFESSIONAL COMPONENT  No   No  No  No   No   Yes/1  No
#3  100200 MEDICARE PROFESSIONAL COMPONENT  No   No  No  No   No   No     No







 Select COB to delete financial insurance activity--
```

Field Explanations

The following fields are displayed up to nine times, once for each insurance plan on the account.

COB
This field contains the insurance coordination of benefits indicator.

CODE
This field contains the insurance carrier/plan code.

INSURANCE NAME
This field contains the insurance plan name.

BAL
This field indicates whether financial insurance balance information exists for the insurance plan that prevents it from being deleted. Yes indicates that a financial balance exists and that the plan cannot be deleted. No indicates that a financial balance does not exist and the plan can be deleted. Balance is No if the payment balance is zero, the adjustment balance is zero, the refund balance is zero and if the net balance of transfers to and transfers from is zero.

PAY
This field indicates whether or not payments exist for this insurance. This field displays either Yes or No. Payments must be reversed in the Post Cash function before deleting the COB.

ADJ

This field indicates whether or not adjustments exist for this insurance. This field displays either Yes or No. The Delete Financial Insurance Activity function can be used to reverse contractual adjustments. Other adjustment amounts must be reversed in the Post Adjustments function.

REF

This field indicates whether or not refunds exist for this insurance. This field displays Hold, App, or Yes.

Hold indicates a refund has been selected and is on hold. A refund on hold may be deleted in the Approve Refunds function. App indicates that a refund is approved but not printed. An approved refund may also be deleted in the Approve Refunds function. Yes indicates a refund to the carrier has been approved and printed. Printed refunds cannot be reversed, and therefore, an insurance plan with a printed refund cannot be deleted. In this situation, you need to resequence the insurance plan to the last COB position.

XFER

This field indicates whether balance transfers exist for this insurance. This field displays either Yes or No. Deletion of financial insurance activity on a plan with transfers is allowed in the Delete Financial Insurance Activity function. Balance transfers can be performed from within the Delete Financial Insurance Activity function.

CLAIMS

This field indicates whether claims exist for this insurance. This field displays either Yes or No. Deletion of claims is allowed within the Delete Financial Insurance Activity function.

LOGS

This field indicates whether log entries exist for this insurance. This field displays either Yes or No and is informational only. The presence of log entries does not prevent the deletion of an insurance plan. Log entries are deleted when the insurance plan is deleted in the Insurance Revision, Account Revision, and Revise Admission functions.

After entering the Delete Financial Insurance Activity screen, the following prompt may be displayed:

> *COBs do not match last proration. Press NL.*

This informational message indicates that the account has not been prorated since an insurance change occurred. This is not necessarily an error condition. This message is displayed when you modify more than one insurance plan on an account prior to requesting an Instant Adjustment Bill. You may continue with the Delete Financial Insurance Activity function; just remember to request an Instant Adjustment bill when you have completed the insurance deletions and additions required for the account.

The following message is displayed:

Select COB to delete financial insurance activity--

Enter the COB number for which the deletion of financial insurance activity is being requested. If you enter a COB number that is not on the account, the following message is displayed:

Error: Selected COB does not exist.

Financial insurance information for the COB is displayed in the following screen:

```
     General Hospital Delete Financial Insurance Activity Processor
                                           Mon Mar 13, 2006 11:59 am
Account      Name                     FC Typ Admit    Disch      Balance Loc
A9929900001  FESLER,DANIEL            M  O/P 10/26/99 10/26/99     0.00    AR/FCRV

Prorated:    8,047.28 at 11/17/99 9A Last Pay:      Tot chg:      $0.00 *

COB 1-4      XI/100-100  BO/100-200  BO/100-200              Third Party Excess
                8047.28        0.00        0.00
COB 5-9


COB 1        XI/100-100  MEDICARE PART A                 Patient       Account
                         --------------------------------------------------------
#Clm/LCS/EP:     1/2/1   Act. Liab      8047.28            0.00
Submit Dt:               -Payment          0.00            0.00           0.00
Est Amt Due:  8047.28    +Adjust           0.00            0.00           0.00
Amt Paid:        0.00    +Refund           0.00            0.00           0.00
Dsp/Date:                +Bal Trf          0.00            0.00           0.00
Logs:              No    ====================================================
                         =Balance       8047.28            0.00           0.00

Continue for COB 1 or key T for trans history (Y/N/T) [Y]--
```

The system checks for the existence of financial insurance activity on the selected COB. Financial insurance activity exists if the insurance payment, adjustment, refund, and balance transfer "buckets" are not zero and/or claims exist. The system displays the following prompt:

Continue for COB # or key T for trans history (Y/N/T) [Y]--

If T, transaction history is displayed as it is under Account Inquiry. This provides you the ability to review the past transactions on the account all at one time in order to plan the steps you need to take to remove the existing financial insurance activity on the plan or plans to be deleted. After completing the viewing of Transaction History, you are returned to this screen and prompt.

If N, the system exits the function and returns to the patient lookup prompt.

If Y, the system begins the evaluation of the selected plan for existing financial insurance activity that prevents its deletion.

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The system first checks for the existence of insurance payments and refunds for the selected insurance plan. The following screen is displayed if error conditions exist:

```
        General Hospital Delete Financial Insurance Activity Processor
                                        Mon Mar 13, 2006 11:59 am
Account       Name                 FC Typ Admit    Disch       Balance Loc
A9900100042  PETERSON,IRENE         O  ER  01/01/99 01/01/99    300.00 AR/FCRV

 Prorated:         0.00 at 04/15/99 1P Last Pay:01/01/99 Tot chg:    $100.00 *




 Refund request of status Approve must be removed.
 Refund requests must be removed.
 Insurance activity cannot be removed if refund balance exists.








 Insurance activity cannot be removed due to reasons listed above. Press NL.
```

If the payment or adjustment transaction has not been posted, you cannot delete the insurance selected for the transaction. One of the following messages is displayed if the insurance should not be deleted due to un-posted activity (xx signifies the batch number):

If an un-posted payment transaction exists in a batch for an account's insurance plan and you attempt to delete the account's insurance plan, the following message is displayed:

Un-posted cash transaction exists in batch xx!

If the un-posted payment is displayed in a cross-facility batch, the following message is displayed:

Un-posted cash transaction exists in cross facility batch xx!

If an un-posted adjustment exists in a batch for an account's insurance plan and you attempt to delete the account's insurance plan, the following message is displayed:

Un-posted adjustment exists in batch xx!

If the un-posted adjustment is displayed in a cross-facility batch, the following message is displayed:

Un-posted adjustment appears in cross facility batch xx!

If an insurance refund balance exists with a refund status of approved, the following messages are displayed:

Refund request of status Approve must be removed.
Refund requests must be removed.

If an insurance refund balance exists with a refund status of hold, the following messages are displayed:

Refund request of status Hold must be removed.
Refund requests must be removed.

The refund errors may be cleared by accessing the Approve Refunds function and entering (D)elete in the Action field. This changes the status of the refund to Deleted.

If an insurance payment balance exists, the following error message is displayed:

Insurance payment balance must be zero.

The insurance payment must be reversed in the Post Cash function by posting a negative payment to offset the insurance payment balance and force the payment "bucket" to zero.

If any of the above errors exist, all error messages that apply are displayed, and the deletion of financial insurance activity is denied.

Insurance activity cannot be removed due to reasons listed above. Press NL.

Pressing NL exits the function and returns you to the patient lookup prompt.

If an insurance refund balance exists and the refund has been printed, then the refund cannot be reversed. The following message is displayed:

Insurance activity cannot be removed if refund balance exists.

In this situation, the insurance plan cannot be deleted; however, the plan can be resequenced to the last COB position.

If a contractual adjustment balance exists and the insurance plan is for the primary COB, the following prompt is displayed:

Contractual adjustment of $99,999.99 will be posted. Continue? (Y/N)--

The actual dollar amount of the existing contractual adjustment is displayed in the prompt. Responding **Y** automatically posts to the account a contractual adjustment reversal of the amount displayed. Responding **N** returns the message:

Insurance adjustment amount must be zero. Press NL.

The insurance plan cannot be deleted if an adjustment balance exists. Pressing NL exits the function and returns you to the patient lookup prompt.

If a contractual adjustment amount exists, but a variance adjustment has also been posted to the insurance by the Electronic Payments module, then the following message is displayed:

> *Final ERA payment posted using variance method. No contractual adjustment will be removed. Press NL.*

This contractual adjustment amount is not automatically removed in the Delete Financial Insurance Activity function but can be removed in the Post Adjustments function.

If an insurance adjustment balance exists that is not a contractual adjustment, then the following prompt is displayed:

> *Insurance adjustment amount must be zero. Press NL.*

You cannot continue and must press NL to exit the function. An adjustment must be placed on the account using the Post Adjustments function to reverse the existing adjustment.

If an insurance balance transfer balance exists the following prompt is displayed:

> *Balance transfer exists. Use Bal Transfer and Claim Disposition? (Y/N) [Y]--*

You cannot delete an insurance with a balance transfer balance. You must respond either **Y**, **N**, or accept the default of **Y**. **Y** invokes the Balance Transfer and Claim Disposition function in which you can move the remaining balance transfer amount to the patient or to another carrier. If the remaining balance transfer amount is negative, you need to transfer money from the patient or another insurance to the insurance being evaluated. N exits the function and returns you to the patient lookup prompt.

If the insurance to be deleted has outstanding claims, the following prompt is displayed:

> *Claims exist. EP=1 Do you want to delete? (Y/N)--*

You must respond either **Y** or **N**. There is no default. **N** returns you to the next selected COB without deleting financial insurance activity for the current COB. **Y** deletes the claims on the selected insurance plan. If one or more claims require a background job, the system displays the following message:

> *Starting background job to delete claims!*

When this message is displayed, the account lock established by the Delete Financial Insurance Activity function has been removed so the deletion of claims in background

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processes can occur. The system monitors the completion of claim deletion because it can't continue until claims for the insurance plan have been deleted and a lock on the account can be established again. At two-second intervals, the system displays the following prompt:

Background job deleting claims is incomplete. Continue waiting (Y/N)--

If you do not respond with Yes, the system displays the message *Complete this process later!* and you are prompted for another account. You can use Insurance Revision, Single Bill, and Instant Adjustment Bill as needed to complete this process.

If the system determines that all claims for the insurance plan have been deleted, it locks the account again so processing can continue. Two events can occur causing the system to terminate processing for the account and to provide the chance to select an account. If one of these scenarios occurs, you can use Insurance Revision, Single Bill, and Instant Adjustment Bill as needed to complete this process.

If the lock on the account can't be established because another process is using the account, the system displays the following prompt:

Account in use. Retry (Y/N)?--

If the response is Yes, the system waits one second and tries to lock the account again. The prompt is repeated if the lock is not established. If the response is not Yes, the system prompts for another account after displaying the following message:

Complete this process later!

If a patient merge or transfer visit occurred before the lock on the account could be established, the following prompt is displayed:

Patient for visit has changed. Select patient again to continue this process. Press NL.

After pressing ENTER, you can select another account.

If a change was made to the list of insurance plans for the account before the lock on the account could be established, the system displays the following prompt:

Insurance for visit has changed. Select patient again to continue this process. Press NL.

After pressing ENTER, you can select another account.

If the deletion of claims requires the lock of the account, you must exit the Delete Financial Insurance Activity function to release the lock and then re-enter the Delete Financial Insurance Activity function to delete the insurance plan, or later delete the plan using the Insurance Revision function. The system displays the following prompt:

Claim deletion requires account lock. Access the account again to refresh. Press NL.

After the payment, refund, adjustment, and balance transfer balances and claims have been cleared, the system displays the following prompt:

Delete ALL remaining financial insurance activity before deleting the insurance plan (Y/N) [N]--

This is the step that actually deletes the insurance balance internal control totals for the selected COB and deletes all of the associated proration information. Once you respond **Y** to this prompt, you need to delete the insurance plan in Insurance Revision or Account Revision, and subsequently request an Instant Adjustment Bill or a Single Bill Request for an adjustment bill for the account. Prior to deleting the insurance plan and requesting an adjustment bill, you need to delete financial insurance activity on additional insurance plans so that you only generate one adjustment bill.

If any insurance liability remains on the insurance to be deleted, a message similar to the following message is displayed:

Patient liability will change to $253.11 until the account is re-prorated. Continue? (Y/N)--

If **Y**, the system assigns the remaining liability to the patient liability in order to keep the account in balance. Accounts with this temporary liability re-assignment display a "T" beside the patient liability on the Balance Summary screen in Account Inquiry until the account is re-prorated online by either an Instant Adjustment Bill or in midnight processing by a Single Bill Request for an adjustment bill. A response of **Y** displays the following message:

Insurance activity deleted for COB 1. Finish process in Insurance Revision NOW!   Press NL.

You can access the Insurance Revision Processor from within the Delete Financial Insurance Activity function or by selecting the Insurance Revision menu option from the Insurance Management menu.   Before the Insurance Revision function is provided within Delete Financial Insurance Activity, the system displays the following prompt:

Use (I)nsurance Revision, (S)elect another COB, or (E)xit Account [I] --

If you respond with I (Insurance Revision), processing for Insurance Revision starts. For details, see .

If you respond with S (Select another COB,) you are given the opportunity to delete financial insurance activity for another insurance plan. The system displays insurance again and the following prompt:

Select COB to delete financial insurance activity---

You can select another COB or press ENTER to return to the following prompt:

Use (I)nsurance Revision, (S)elect another COB, or (E)xit Account [I] --

If you respond with E (Exit), you can select another account in order to delete financial insurance activity on the account.

Insurance Revision

After the financial insurance activity has been deleted, you may access the Insurance Revision Processor from within the Delete Financial Insurance Activity function or by selecting the Insurance Revision menu option from the Insurance Management menu.

The Insurance Revision function provides direct access to the Account Revision, Admission Information, Insurance Information function. This function is identical to the function found within Account Revision except that it is restricted to billed accounts and that additional messages (reminders) are available to help guide you through the Insurance Management process. Insurance plans may be added, deleted, and resequenced within this function. Insurance demographic and benefit information may also be modified on the insurance plans.

After selecting an account, the following screen is displayed:

```
             General Hospital Insurance Revision Processor
                                    Mon Mar 13, 2006 11:59 am
Account      Name                  FC Typ Admit    Disch       Balance Loc
A9910900007  HENDERSON,BYRON       B  ER  04/19/99 04/19/99     146.57  AR/FCRV

COB  Code Insurance Name                 Policy Number     Ver PreCert FC

#1 500100 COMMERCIAL BASIC PLAN                            No  No      B
#2 500200 1500 BASIC PLAN                                  No  No




Modify FC(M), select plan, (D)elete, (A)dd, MPI (T)able or (R)esequence--
   MSP(Q), (N)otes, (E)ligibility, next screen(/) or previous screen(/P) [/]
```

The insurance plans for which the financial activity has been cleared should be deleted. New insurance plans may be added, and existing plans may be resequenced as necessary. Benefit and demographic information on all of the plans may be modified.

If an insurance plan is deleted from the patient's record, all remaining insurance plans move up one position in COB order. If a primary plan is being deleted and the

secondary plan cannot become a primary plan, the system displays the following error message:

COB2 cannot be primary.

The deletion is not performed. The insurance plans must be resequenced or a new primary plan entered in order to complete the deletion process prior to deleting the primary plan. You may want to delete the non-primary plans before deleting the primary plan to facilitate the deletion process. Upon successful deletion, the system displays the following prompt:

Delete this plan from the MPI Master Insurance Table? (Y/N) [N]--

If you enter **Y** for Yes, the system deletes the insurance plan from the patient's MPI. If you enter **N** for No, the insurance plan for the patient's MPI Insurance Master Table remains in the system. For either a **Y** or **N** entry, the system deletes the plan for the current active visit.

The reclassification of revenue and the ability to modify the financial class is available.

Updates to Transaction History are made for additions, deletions and resequencing of insurance through the Delete Financial Insurance Activity function.

After insurance revisions are completed, the following message is displayed:

Pausing for updates

The system waits three seconds after displaying the message, so the network has the opportunity to update insurance information in Patient Accounting per changes which were made in Patient Processing during insurance revision.

If financial activity was deleted, the following prompt is displayed:

Re-prorate by doing a bill request.   Financial insurance activity was
deleted on 07/23/01. Press NL.

This is a reminder to re-prorate the account using either the Single Bill Request or the Instant Adjustment Bill functions. Use Single Bill to produce an adjustment bill during midnight processing. This causes Pathways Contract Management to be updated, if appropriate, and claims to be replaced if new claims are loaded. Use Instant Adjustment Bill to re-prorate the account. If claims are needed or reimbursement for the primary insurance is Pathways Contract Management, it is recommended that Single Bill be used to request an adjustment bill after the results from proration are confirmed in Instant Adjustment Bill.

The system must establish a lock on the account again before further processing can continue. If the lock cannot be placed, the following prompt is displayed:

Account in use. Retry (Y/N)?

If you answer Y (Yes), the system waits one second and tries to lock the account again. The prompt is repeated if the lock is not established. If the response is N (No), the system prompts for another account.If a patient merge or transfer visit has occurred since the start of this process, the following prompt is displayed:

Patient for visit has changed. Request bill later to complete this process. Press NL.

The list of insurance plans per Patient Accounting is displayed under on the Insurance Information per Patient Accounting screen. This screen should be examined to confirm that all insurance changes have been networked from STAR Patient Processing to STAR Patient Accounting. A bill should not be requested until that update occurs.

If the account is an AR account or a PA account with cycle bills, the system displays the following prompt:

Request (I)nstant Adjustment Bill, (S)ingle Bill, (B)oth, (N)o Bill, or (W)ait for Insurance Change--

The billing options for PA accounts include Instant Adjustment Bill only if the account has cycle bills and the cycle adjustment bill indicator is set to Yes for the account. The options are as follows:

Wait for Insurance Change (W)—If the list of insurance plans is incorrect because all insurance changes have not been networked from Patient Processing, **Wait for Insurance Change** can be entered. If this option is entered, the lock on the account is released so any pending updates from the network for the account can be accomplished; the system pauses for two seconds and then attempts to re-establish the lock on the account. If the account can be locked, the list of insurance plans per Patient Accounting is displayed again, followed by the prompt to request a bill.

Instant Adjustment Bill (I)—If this option is entered, the process to request an instant adjustment bill begins, and you are given the opportunity to request a single bill if the reimbursement type for the primary carrier is Pathways Contract Management. Typically, an Instant Adjustment Bill would be requested if you wanted to review the results from the latest proration before requesting an adjustment bill in Midnight Processing. Once the Instant Adjustment Bill function is completed, you will no longer be reminded to re-prorate the account in Delete Financial Insurance Activity or Insurance Revision unless Delete Financial Insurance Activity is used again to remove financial insurance activity. For details on the Instant Adjustment Bill function, see "Instant Adjustment Bill" on page 3-17. For details on the Single Bill function, see "Single Bill Request" on page 3-32.

CN Only: If the creation of an Instant Adjustment Bill is requested during the Delete Financial Insurance Activity function, the account qualifies for financial class repricing, and the financial class repricing is incomplete, the following prompt is displayed:

Financial class repricing is incomplete. Wait for repricing (Y/N)?--

If you enter N for No, the system requests another account. If you enter Y for Yes, the system releases the lock on the account for two seconds so charges can be repriced and then displays the following prompt. This can happen several times before financial class repricing completes.

Request (I)nstant Adjustment Bill, (S)ingle Bill, (B)oth, (N)o Bill, or (W)ait for Insurance Change--

For details on the Instant Adjustment Bill function, see "Instant Adjustment Bill" on page 3-17. For details on the Single Bill function, see "Single Bill Request" on page 3-32.

Single Bill (S)—If this option is entered, you are given the opportunity to request an adjustment bill to be produced during Midnight Processing and to select claims to be loaded for the insurance plans. If the reimbursement method for the primary insurance plan is Pathways Contract Management, an adjustment bill should be requested and a claim should be loaded for the primary insurance to insure Pathways Contract Management is updated properly. If a request for an adjustment bill exists after Single Bill is used in this process, you will no longer be reminded to re-prorate the account in Delete Financial Insurance Activity or Insurance Revision unless Delete Financial Insurance Activity is used again to remove financial insurance activity.

Both (B)—If this option is entered, the Instant Adjustment Bill process begins, you are given the opportunity to request an adjustment bill to be produced during Midnight Processing and to select claims to be loaded for the insurance plans. It is recommended that this option be employed, if you want to check the results from proration before requesting the production of an adjustment bill during Midnight Processing. For details on the Instant Adjustment Bill function, see "Instant Adjustment Bill" on page 3-17. When this option is employed, one of the following events can occur:

- If Instant Adjustment Bill is completed and billing starts, the system displays the message: *Billing and Claims is running. Please continue later!* You are exited from the processor.

- If the system can't lock the account again after Instant Adjustment Bill is used, the system displays the following prompt:

  Account in use. Retry (Y/N)?--

- If the response is Yes, the system waits one second and tries to lock the account again. The prompt is repeated if the lock is not established. If the response is not yes, the system prompts for another account after displaying the message: *Request a bill to complete this process!*

- If a patient merge or transfer visit occurs after Instant Adjustment Bill is used, the system displays the following prompt:

Patient for visit has been changed. Request bill later to complete this process. Press NL

When ENTER is pressed, you are prompted for another account.

• If the response is No, you are prompted for another account.

Upon exiting the function, the following screen is displayed if un-prorated insurance management accounts exist:

```
        General Hospital Delete Financial Insurance Activity Processor
                                             Tue Apr 20, 1999 03:16 pm




Account#              Name                                  Last Deletion

A9910900007           HENDERSON,BYRON                       04/20/99








Financial insurance activity was deleted but account was not re-prorated using
Instant Adjustment Bill. Delete these reminders? (Y/N) [N]--
```

After requesting adjustment bills on all accounts as needed, all remaining reminders displayed on this screen may be deleted by responding **Y**. Adjustment bills can be requested by the Instant Adjustment Bill or the Single Bill Request function. Only Instant Adjustment Bill requests clear the reminder message for the account.

Instant Adjustment Bill

This function must be used after the insurance changes have updated the Patient Accounting System to re-prorate the account using the new insurance information, calculate a new reimbursement and contractual adjustment amount, assign a new bill sequence number, obtain a copy of the adjustment bill, and to review the results of the online proration. Claims can also be produced in this function. Only charges are re-prorated with an Instant Adjustment Bill. The Instant Adjustment Bill will not move activity such as Balance Transfer, Payment, Adjustment, or Refund amount from one insurance or patient to another insurance or patient.

After the Instant Adjustment Bill option is selected from the menu, the function cannot be used if one of the following is occurring:

- The UB Split Claims Criteria Table is being used.

- A background job is running to create indexes for split claims criteria.

- UB Charge Control Parameters are being maintained.

If any of these is occurring, the system displays the following message:

UB Split Claim Criteria in use by Job 123, User,Name. Please try later!

If you don't receive this message, the system prompts you to select the desired facility (if this is a multi-facility installation) and then select a patient and account. Depending on the status of the account, the following warning and error messages may be displayed:

- If a selected account has no insurance, the following message is displayed:

Account has no insurance. Continue? (Y/N)--

You can continue and generate an adjustment bill and new bill sequence by entering **Y**. A response of **N** returns you to the patient lookup prompt.

- If a selected account has unbilled cycle charges or credits, the system displays the following warning message:

Unbilled cycle charges exist. Press ENTER.

You can press ENTER and proceed with the Instant Adjustment Bill process.

- If the selected account is flagged as prelisted for bad debt, the following warning message is displayed:

Account's pre-list status is User Flagged. Do you want to continue? (Y/N) [Y]--

You can press ENTER and proceed with the Instant Adjustment Bill process.

- If the selected account is on hold for billing, the following message is displayed:

Error: Account on billing hold!

If the account is on bill hold, you would need to remove the bill hold before continuing with the Instant Adjustment Bill request.

- If the selected account is on hold for DRG Payment Window (DPW) billing, the following message is displayed:

Error: Account on DPW billing hold

If the account is on bill hold, you would need to remove the bill hold before continuing with the Instant Adjustment Bill request.

• If a cycle, final, adjustment, or late bill request exists on the account, the following message is displayed:

Bill request for (Bill Type) Bill will be deleted. Continue? (Y/N)

Bill Type in the prompt may be cycle, final, adjustment, or late. A response of **Y** deletes the existing bill request and continues with the Instant Adjustment Bill process. A response of **N** exits the function and returns you to the patient lookup prompt.

The Balance Summary screen is displayed next, as shown below:

```
              General Hospital Instant Adjustment Bill Processor
                                              Mon Mar 13, 2006 11:59 am
Account      Name                    FC Typ Admit    Disch      Balance  Loc
C0315300002  McCrae, Bobby           C  O/P 06/02/03 06/02/03   70904.32 AR/FCRV
Prorated:    76,321.60 at 09/05/03 1P Last Pay:06/20/03 Tot chg:   $76321.60
             XI/500-999 XE/100-100 XI/300-100 BO/500-200     Patient     Account
-Non Cvrd         0.00    1321.60        0.00   75000.00
+Room Cvrd        0.00       0.00        0.00       0.00
+Anc Cvrd     76321.60   75000.00    76321.60    1321.60
-Lim Exces        0.00       0.00        0.00       0.00
- Deduct        100.00      10.00        0.00       0.00
- Coins       15244.32       0.00        0.00       0.00
- COB Adj         0.00   60967.28    75000.00    1321.60
=Est Liab     60977.28   14022.72     1321.60       0.00       0.00
--------------------------------------------------------------------------
Act. Liab     60977.28   14022.72     1321.60       0.00       0.00
-Payment       5417.28       0.00        0.00       0.00       0.00    5417.28
+Adjust           0.00       0.00        0.00       0.00       0.00       0.00
+Refund           0.00       0.00        0.00       0.00       0.00       0.00
+Bal Trf          0.00       0.00        0.00       0.00       0.00       0.00
==========================================================================
=Balance      55560.00   14022.72     1321.60       0.00       0.00   70904.32
Press NL--
```

If there are unprorated charges, the Balance Summary screen displays an unprorated charge amount. If the account hasn't been updated, the following message is displayed:

Chgs and COB list are unchanged since last proration. Do you still want to re-prorate all charges and re-bill (Y/N)?--

If you enter **N** for No, the patient/guarantor lookup is displayed. If you enter **Y** (Yes), the system displays the Instant Adjustment Bill Criteria screen:

```
               General Hospital Instant Adjustment Bill Criteria
                                       Mon Jun 12, 2012 11:24 pm
Account      Name                  FC Type Admit   Disch       Balance Loc
A0601800002  NILES, BOB            O   SER 01/18/06            $11857.60 PA/ND
1 Bill Type    2 CycA Chg/Cr/Dys Override for Subs Bills    3 Reprint/Adjustment of
   Z  CycA      No                                             1,2,3,4,5
 4 Bill From Date                  5 Bill Through Date
   01/18/06                          01/20/06
 6 Perform Edits                   7 Requested By
   No                                Smith, Nancy M.
 8 Comment                         9 # of Copies of Bills to Print
                                     1-Dtl
10 Printer for FBR901             11 CycA Suppress Subsequent Bills/ Do Not Load
  Clms
     FINA                             No
12 Produce Claims?

13 UB Loc 4 Last Digit            14 1500 Type of Bill

15 PCON Send



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

Field Explanations

1.   BILL TYPE (1-A-R)
This field contains the type of adjustment bill that you are requesting. The options, depending on the account's status, are **A** (adjustment) or **Z** (cycle bill adjustment). All options are not available for every account, and the fields on this screen that can be edited vary with the bill type requested.

Adjustment - Only the Comment, Produce Claim, # of Copies of Bills to Print, and Perform Edits fields can be edited. All other fields are completed by the system. Only final bills can be adjusted.

Cycle Bill Adjustment - Only the Comment, Produce Claim, # of Copies of Bills to Print, CycA Suppress Subsequent Bills/ Do Not Load Clms, and Perform Edits fields can be edited. All other fields are completed by the system. When the bill type is cycle bill adjustment, the Cycle Adjustment Bill Selection screen is displayed. This screen displays all of the associated bills for the account. The screen is displayed only if there are cycle bills associated with the account and cycle adjustment processing is allowed, if cycle adjustment parameters exist for the account, and if the account is not on bill hold. If a cycle adjustment bill can't be processed for the account because no cycle adjustment parameters are defined, the following error message is displayed:

Cycle Adjustment parameters no longer exist for this account. Therefore a Cycle Adjustment Bill cannot be processed. Press Enter.

After you press ENTER, the system displays the patient lookup screen. If a cycle adjustment bill can be processed, the system displays the following screen.

```
Cycle Adjustment Bill Selection


     BS    BT   Bill     Bill     Bill     Bill      Unbill          Unbill
                Date     From     Thru     Amount    Chg Amt/#       Cr Amt/#
( 1)  1    C    01/18/06 01/18/06 01/18/06 $400.84   $1000.00/1      40.00-/1
( 2)  4/2  Z    01/20/06 01/19/06 01/21/06 $700.00
( 3)  5/3  A    01/30/06 01/22/06 01/22/06 $864.16


Select Cycle Bill to be Adjusted--


```

Select the bill that you want to request a cycle adjustment for. Only bills with a bill type of cycle or cycle adjustment can be selected.

Field Explanations

BS (DISPLAY ONLY)
This field displays the current bill sequence number associated with the bill concatenated with the replaced bill sequence number. An example of this is: 4/2.

BT (DISPLAY ONLY)
This field displays the bill type code.

BILL DATE (DISPLAY ONLY)
This field displays the bill date.

BILL FROM (DISPLAY ONLY)
This field displays the bill from date.

BILL THRU (DISPLAY ONLY)
This field displays the bill through date.

BILL AMOUNT (DISPLAY ONLY)
This field displays the bill amount.

UNBILL CHG AMT/# (DISPLAY ONLY)
This field displays the total amount and number of unbilled charges associated with the bill.

UNBILL CR AMT/# (DISPLAY ONLY)
This field displays the total amount and number of unbilled credits associated with the bill.

You can select a bill sequence from this screen. For example, if bill sequence 1 is selected, the system rebills bill sequence 1 and all subsequent bills. All bills that are to

be rebilled are displayed in the *Adjustment of* field. For example, if bills 1, 2, 3, 4 and 5 are being rebilled, the system displays *1, 2, 3, 4, 5.*

After selecting the bill on the Cycle Adjustment Selection screen, the fields on the Instant Adjustment Request Criteria screen must be completed.

2. CYCA CHG/CR/DYS OVERRIDE FOR SUBSEQUENT BILLS (1-A-O)
This field indicates whether the system, when producing subsequent cycle adjustment bills, should override the minimum number and amount for unbilled charges/credits defined in the Min Unbilled Charges, Min Unbilled Charge Amt, Min Unbilled Credits, Min Unbilled Credit Amt, and CycA Max Days Since Service fields (on the Cycle Adjustment Parameters screen). A subsequent cycle adjustment bill is one that is loaded automatically as a result of a manual or automatic cycle adjustment bill request. When requesting a cycle adjustment bill for a bill period, all billing periods following the one selected have to be rebilled in order for the selected bill to be processed. For example, if a manual cycle adjustment bill request is made for a cycle adjustment bill on the Single Bill Request or Instant Adjustment Bill functions, new charges or credits are not added for subsequent cycle adjustment bills unless the criteria for the minimum number and amount for unbilled charges or credits and the CycA Max Days Since Service are satisfied for the billing event. When this field is accessed, the following prompt is displayed:

> *Override Min Chg/Cr/Dys for manual subsequent CycA bills? (Y)es or (N)o*

If you enter **Y** (Yes), the system overrides the maximum days since service and the minimum number and amount for unbilled charges and credits when producing subsequent cycle adjustment bills, so that the constraint is removed for the subsequent adjustment bills and any new charge/credits are included. If you enter **N** (No), the system won't override the maximum days since service and the minimum number and amount for unbilled charges/credits when producing subsequent cycle adjustment bills Any new charges/credits must meet the defined number/amount to be included on the cycle adjustment bill. The system uses the value of this field as the default on the Single Bill Request and the Instant Adjustment Bill screens.

NOTE: If there are no charge/credit numbers/amounts indicated and the Manual CycA Chg/Cr Override field isn't set to Yes, new charges/credits are never loaded for a subsequent cycle adjustment bill.

3. REPRINT/ADJUSTMENT OF (TABLE LOOKUP)
This field determines which bill associated with this account is reprinted if you want to reprint a bill. If the Bill Type field contains R (Reprint), the system displays a list of bills associated with this account. You can select one or more bills from this list. If the Bill Type field contains A (Adjustment), the system displays the final bill.

4. BILL FROM DATE (DISPLAY ONLY)

This field contains the beginning billing date for the selected bill. If this account has been cycle billed, the system displays its previous cycle bill through date. If the account has not been cycle billed, the admission or registration date is displayed. If this is a single reprint bill, the original bill from date is displayed. If multiple reprint bills have been selected, this field displays: *See Reprint/Adjustment of field.*

5. BILL THROUGH DATE (6-N-C)

This field contains the cutoff date for recording charges on this bill, entered in the format MMDDYY or MM/DD/YY. The default entry is the current system date. If the requested bill is a final, late, reprint, or adjustment bill, this field is completed by the system and cannot be edited. If multiple reprint bills have been selected, this field displays: *See Reprint/Adjustment of field.* If the requested bill is a cycle bill, you can complete this field.

6. PERFORM EDITS (1-A-C)

This field indicates whether bill edits can be performed on this bill. If you are requesting a cycle, reprint, or late bill, this field is completed by the system and cannot be edited. This field must be completed when a final bill is requested. When this field is accessed, the following prompt is displayed:

> *Perform bill edits (Y/N)--*

You can enter **Y** (Yes) to allow the system to edit the adjustment bill or **N** (No) to prevent the system from editing the adjustment bill. Adjustment bills can be edited if the Edit Adj Bill field on the PAAR Control Maintenance screen is set to Yes. If an adjustment bill is requested automatically after a Change Patient Type After Final Bill (CPTAFB) transaction, the Perform Edits field defaults to Yes, according to the Edit Adjustment Bill and Edit Adjustment Bill for CPTAFB parameters on PAAR Control. This field can be defined manually for an adjustment bill, regardless of the settings on the PAAR Control Maintenance screen.

NOTE: Automatic adjustment bills due to late charges/credits or a change in DRG, diagnosis code, or procedure code, are not produced if an account is on CPTAFB hold.

7. REQUESTED BY (DISPLAY ONLY)

This field contains the name of the user requesting this single bill.

8. COMMENT (30-C-O)

This field contains the comment associated with this request. Generally this field is used to explain the reason for requesting an instant adjustment bill. The system stores the comment in the biller's workfile and maintains it for display in the account's transaction history.

9. # OF COPIES OF BILLS TO PRINT (1-N-O)

This field contains the number of copies and the bill types that you want to print. When this field is accessed, the following prompt is displayed:

Enter # of Copies of Bills to Print? [1]--

You can enter a number from **0** to **9**. If you enter 0, the bill is loaded during Midnight Processing, but no copy of it is printed. The field displays either 1 Copy, X Copies, or None. After you enter the number of copies to print, the system displays a list of bill types that can be printed. You can select one or more of the following bill types: detail, summary, series (only displays if series is a valid bill associated with your billing parameters), or prorated. After you make your selections, the system displays the number of copies to print and the bill type(s) in the field. An example of this is: 1-Dtl/ Summ/Pro/Series.

10. PRINTER FOR FBR901 (TABLE LOOKUP-R)
This field contains the name of the printer for the instant adjustment bill. When this field is accessed, a list of printers assigned to Report FBR901 is displayed. You can select the appropriate printer.

11. CYCA SUPPRESS SUBSEQUENT BILLS/ DO NOT LOAD CLMS (1-A-O)
This field indicates, for subsequent cycle adjustment bills, whether bills should be suppressed and claims not loaded if there are no new/qualifying charges for subsequent cycle adjustment bills. If a bill is suppressed because there are no new charges, the billing, proration, and reimbursement information is maintained, but the bill is not printed and no claims are loaded for the bill. The default value in this field is populated by the value in the corresponding field on the Cycle Bill Parameters or Patient Bill Format. This field is only valid if the bill type is Z for Cycle Adjustment. When this field is accessed, the following prompt is displayed:

Suppress Subsequent Bill/ Do Not Load Clm for Cycle Adj if there are no new Charges? (Y)es, (N)o [N]

You can enter **Y** (Yes), to suppress the bills and not load claims for cycle adjustments, or **N** (No), not to suppress bills and to load claims. This field is only used if cycle adjustment bills are allowed per the setting on the Cycle Adj Bill Ind field in the Cycle Billing Parameters and the Patient Bill Format Processor.

If a Y for Yes, Suppress subsequent bills and Don't Load claims for cycle adjustments is entered, the field displays *Yes*. If N for No is selected, the field displays *No*.

A subsequent cycle adjustment bill is one that is loaded automatically as a result of a manual or automatic cycle adjustment bill request. When requesting a cycle adjustment bill for a bill period, all billing periods following the one selected have to be rebilled in order for the selected bill to be processed. If there are new charges for the subsequent cycle adjustment bill that are eligible to be rebilled, the bill won't be suppressed, and claims are loaded. If there are new unbilled charges but they don't qualify for the bill (for example, if they don't meet the minimum charge amount), the bill is suppressed and claims are not loaded, if this field is set to Yes.

12. PRODUCE CLAIMS? (1-A-R)

This field indicates whether the claim form should be produced, either electronically or as a printed claim. This field displays the insurance carrier/plan followed by the Produce Claim and Suppress indicators:

- The insurance carrier/plan code is displayed as follows: CBx stands for COB x, where the x is COB 1-9..

- When there is a value in x/x format, the x before the slash (/) represents the Produce Claim indicator. A *P* means Produce, and an *N* means do Not Produce. The x after the slash (/) represents the Suppress indicator. If the Produce indicator is *N* for Do Not Produce, the Suppress indicator is not displayed. If the Produce indicator is *P* for Produce, the Suppress indicator is displayed. An *N* means No Suppression, and an *S* means Suppress.

When this field is accessed, the system displays insurance plans for the account:

```
Page:01                       Account Insurance Plans         ##=Current Choices
( 1) COB 1-918100 NEW PLAN
( 2) COB 2-500200 1500 BASIC PLAN

Highlight all insurances that should load a claim or `-` to remove selection --
```

The following prompt is displayed on the screen:

> *Highlight insurances that should load claims or key N for Do Not Load Claims--*
> *end select (NL)*

The system displays the settings of the Produce Claim and Suppress Claim fields for each insurance selected.

COB 1 500999 GENERAL COMMERCIAL

> *Produce Claim is YES and Suppress Claim is NO. Override? (Y/N) [N]-- |*

If you press ENTER, the settings are retained and copied to the claim. If you enter Yes, you can override the settings as follows:

- If the Produce Claim field is set to Yes, and it is updated to No, the system sets the Suppress field to Yes (since the system does not print the claim regardless of balance) and displays the following message:

> *Produce Claim flag set to No and Suppress Claim flag set to Yes for Claim!*

- If the Produce Claim field is set to No, and it is updated to Yes, the system displays the following message:

> *Produce Claim flag set to Yes for Claim!*

• If the Produce Claim flag is not updated, one of the following messages is displayed, depending on the setting of the current Produce Claim flag. Even if the current setting is not updated, if the Produce Claim flag is set to No at the insurance level, the Produce Claim flag is set to No, and the Suppress Claim flag is set to Yes for the claim.

   Produce Claim flag set to No and Suppress Claim flag set to Yes for Claim!

   Produce Claim flag set to Yes for Claim!

One of the following prompts is displayed if the Produce Claim flag is Yes. The system displays the Suppress prompts only if the Produce Claim flag is set to Yes.

• Suppress Claim is Yes. Update for claim to No? (Y/N) [N]

   Enter Y for Yes to update the Suppress Claim flag to No. The system displays the following message:

   Suppress Claim flag set to No for Claim!

• If the Suppress Claim flag is No, the following prompt is displayed:

   Suppress Claim is No. Update for claim to Yes? (Y/N) [N]

   Enter Y for Yes to update the Suppress Claim flag to Yes.The following prompt is displayed:

   Suppress Claim flag set to Yes for Claim!

• If the Suppress Claim flag is not updated for the claim, the system displays one of the following messages depending on the current setting of the field:

   Suppress Claim flag set to No for Claim!

   Suppress Claim flag set to Yes for Claim!

The system displays the Suppress Suppress prompts only if the Produce Claim flag is set to Yes.

13. UB LOC 4 LAST DIGIT (1-N-R)
This field contains the last digit of the UB Locator 4. You can access this field only if the Bill Type is Adjustment (A for final adjustment or Z for cycle adjustment) and the Produce Claims field is completed with Produce Claims or Suppress Claims. For each UB insurance loading a claim (this includes both primary and split UB claims) as specified in the Produce Claims field, the system displays the following prompt:

   For plan 500999 load UB Locator 4 last digit of 1 (admit-disch), 2 (interim-first), 3 (interim-continue), 4 (interim-last), 6 (adj), 7 (replace), 8 (void) $[2,3,4]$ *--*

You can enter one of the folowing:

- 1 - Admit-Disch

- 2 - Interim-first

- 3 - Interim - continue

- 4 - Interim - Last

- 6 - Adjustment

- 7 - Replace

- 8 - Void

When requesting a cycle bill adjustment, all subsequent bills are also adjustment billed. Therefore, the system prompts for type of bill for the selected bill and the bills that come after. One of the following prompts is displayed, depending on the account location (AR or PA) and based on which cycle bill is selected to load the claim:

- If the account is in the AR file, and the first cycle bill is selected when requesting a Cycle Adjustment bill, the system prompts as follows:

  For plan 500100 load UB Locator 4 last digit for first cycle, interim cycles, and final (e.g., 2,3,4) of 1 (admit-disch), 2 (interim-first), 3 (interim- continue), 4 (interim-last), 6 (adj), 7 (replace), or 8 (void) [2,3,4] -- |

  You can take the default or enter the choices for the first cycle, continuing cycles, and the final, each separated by a comma.

- If the account is in the AR file, and the second or subsequent cycle bill is selected when requesting a Cycle Adjustment bill, the system prompts as follows:

  For plan 500100 load UB Locator 4 last digit for interim cycles and final (e.g., 3,4) of 1 (admit-disch), 2 (interim-first), 3 (interim-continue), 4 (interim-last), 6 (adj), 7 (replace), or 8 (void) [3,4] --

  You can take the default or enter the choices for the continuing cycles and the final, separated by a comma.

- If the account is in the PA file, and the first cycle bill is selected when requesting a Cycle Adjustment bill, the system prompts as follows:

  For plan 500100 load UB Locator 4 last digit for first cycle and interim cycle (e.g., 2,3) of 1 (admit-disch), 2 (interim-first), 3 (interim-continue), 4 (interim-last), 6 (adj), 7 (replace), or 8 (void) [2,3] -- |

You can take the default, or enter the choices for the first cycle and continuing cycles, separated by a comma.

- If the account is in the PA file, and the second or subsequent cycle bill is selected when requesting a Cycle Adjustment bill, the system displays the following prompt:

  For plan 500100 load UB Locator 4 last digit for interim cycles (e.g., 3) of 1 (admit-disch), 2 (interim-first), 3 (interim-continue), 4 (interim-last), 6 (adj), 7 (replace), or 8 (void) [3] -- |

  You can can take the default, or enter the choice for the continuing cycles.

- If the account is in the PA file, and the last cycle bill is selected when requesting a Cycle Adjustment bill, the system displays the following prompt:

  For plan 500100 load UB Locator 4 last digit of 1 (admit-disch), 2 (interim-first), 3 (interim-continue), 4 (interim-last), 6 (adj), 7 (replace), 8 (void) [3] -- |

  You can take the default, or enter the choice for the cycle bill selected.

STAR Patient Accounting does not actually delete or void a claim with the type of bill last digit of 8. This claim is treated as another claim for the payor. Pathways Contract Management processes claims with a type of bill last digit of 8 (Void) the same as a final claim.

14. 1500 TYPE OF BILL (1-A-O)
This field allows you to select the type of bill that prints on the top of the 1500 and Non Pro Fee 1500 adjustment claim. This is used when adding a 1500 or Non Pro Fee 1500 once the account is already in AR.

The top of the 1500 and Non Pro Fee 1500 claim form can print the Account number, the COB of the insurance, the claim sequence, and the bill type of Cycle, Final, Adjustment, or Late. When using Instant Adjustment Bill, Single Bill Request, or Add Claim to Insurance to add a 1500 or Non Pro Fee 1500 adjustment claim, you can select the 1500 "type of bill" that prints on the top of the claim form. The default is Adjustment.

Note that in order for the 1500 or Non Pro Fee 1500 to print the type of bill on the top of the paper claim form, the Claim Load Edit Parameter assigned to the insurance must NOT have the field "Top Line Blank?" set to Yes. If set to Yes, the information will not print, regardless how the prompts are answered in Instant Adjustment Bill, Single Bill Request or Add Claim to Insurance.

NOTE: The following only affects what is printed in the top of the claim in the print spoolfile and what is sent to the Electronic Claim System. Changing the bill type that prints on the form does not change how the bill and claim appear when accessing Account Inquiry, Billing Information or Claim Information. In other words, if an Adjustment Bill is used or created in order to load a 1500/Non Pro Fee 1500 claim, and the user overrides the type of bill for the claim so that it prints FINAL on the top of the

claim, the claim is still tied to the adjustment bill internally (and not to the Final), and will load the charges that were reflected on that adjustment bill.

If either an Adjustment (A) or Cycle Adjustment (CycA) is requested, then for each 1500 insurance (claim type B), or Non Pro Fee 1500 (claim type Z), the system will prompt as follows in the field (where xxxxxx is the carrier and plan code).

- When the account has not cycle billed (where xxxxxx is the carrier and plan code), the prompt is:

    For plan xxxxxx load 1500 type of bill of Cycle (C), Final (F), Adjustment (A), or Late (L)
    [Adjustment] -- |

- When requesting a Cycle Adjustment bill, where there are cycles and a final, the prompt is:

    For plan xxxxxx load 1500 type of bill of Cycle (C), Final (F), Adjustment (A), or Late (L)
    (First response is for all cycle bills) [Cycle,Adjustment]-- |

The first response applies to all Cycle Adjustment claims loaded, and the last response applies to the Final Adjustment claim. In other words, if the field was answered with C,F and the account had three cycle bills and a final bill, the claims for the cycle adjustment bills would all have CYCLE and the claim for the final adjustment bill would have FINAL.

After answering the prompt for each 1500/Non Pro Fee 1500 insurance, the field will display the one character alpha values, starting with the highest COB, and with a space between the values for the different insurances. For example, if the field was answered with Adjustment for COB 2, and with Final for COB 4, the field would display:

A F

If the field was answered with Cycle and Adjustment for COB 2, and Cycle and Final for COB 4, the field would display:

CA CF

This value will print on the top of the 1500/Non Pro Fee 1500 claim form (in the Print image only) as long as the Claim Load Edit Parameter for the insurance does not have the "Top Line Blank?" field set to Yes on the header screen of the parameter. The format of the top line has NOT changed. The system now simply allows the user to override the system calculated value with a different value.

15. PCON SEND (1-A-R)
This field determines if primary UB claims whose reimbursement method is Pathways Contract Management should be queued for processing at the time of claim load, claim release or both claim load and claim release. When this field is accessed, the following prompt is displayed:

Send PCON UB claims at (L)oad, (R)elease or (B)oth --

If you choose **L** (Load), claims are queued to be sent to Pathways Contract Management at the time they are loaded. If you choose **R** (Release), claims are queued to be sent to Pathways Contract Management at the time they are released on STAR. If you choose **B** (Both), claims are queued to be sent to Pathways Contract Management at the time they are loaded and at the time they are released. If this field is blank, the system uses the values contained in the Pathways Contract Management screen in the Reimbursement Master to determine when to queue claims to Pathways Contract Management. For Bill Types of Cycle and Final, if the PCON Send field is blank, the system uses the value associated with the PCON Send for Cycle/Final field from the Pathways Contract Management screen in the Reimbursement Master. For Bill Types of Adjustment and Late, if the PCON Send field is blank, the system uses the value associated with the PCON Send for Adj/Late from the Pathways Contract Management screen in the Reimbursement Master.

After the Instant Adjustment Bill criteria screen is accepted, the system processes the request and produces bills and claims. The system displays messages to indicate if the bills and claims were prorated, loaded, and printed. The first message is as follows:

Prorating

After the bills are prorated and loaded, the system displays the following message:

Proration complete. Bill Sequence(s) 6- 8 added. Enter to Continue.

After each claim is loaded, the system displays a message indicating the claims that were loaded, such as the following:

Loading Claim 4 $5564.00   COB 1

After all of the claims are loaded, the system displays the following message to indicate that claims are being edited:

Editing Claim

The system then returns you to the account lookup prompt:

Patient (P) or guarantor (G) lookup? [P]--

Add Claim to Insurance

This function is used to add a claim record to an account for a new insurance. This function is used to add claims to an insurance plan in the Insurance Management process after an Instant Adjustment Bill has been completed. Another 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. For detailed information regarding this function, refer to the Add Claim to Insurance section in the *Billing and Claims Volume* of the *STAR Patient Accounting Reference Guide*.

Account Inquiry

This function enables you to view a patient's admission, medical and financial information. For detailed information regarding this function, refer to the Account Inquiry section in the *Account Inquiry and Revision Volume* of the *STAR Patient Accounting Reference Guide*.

Account Revision

This function enables you to view and edit a patient's admission and financial information, including patient financial class, patient biographics, guarantor information, and insurance information. For detailed information regarding this function, refer to the Account Revision section in the *Account Inquiry and Revision Volume* of the *STAR Patient Accounting Reference Guide*.

Approve Refunds

This function allows you to approve, delete, hold, or exclude refunds on an account basis for both guarantors and carriers. For detailed information regarding this function, refer to the Approve Refunds section in the *General Information Volume* of the *STAR Patient Accounting Reference Guide*.

Maintain Claims by Account

This function 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. For detailed information regarding this function, refer to the Claim Status Information section in the *Billing and Claims Volume* of the *STAR Patient Accounting Reference Guide*.

Balance Transfer & Claim Disposition

This function enables you to transfer account balance liability amounts between one or more carriers and the patient balance for an account, disposition claims, and change the financial class of an account in accounts receivable and bad debt. For detailed information regarding this function, refer to the Balance Transfer/Claim Disposition

section in the *Billing and Claims Volume* of the *STAR Patient Accounting Reference Guide*.

Demand Bill

This function enables you to print an account's bill on demand. It does not rely on midnight processing but prints the bill immediately. A demand bill does not replace a final or cycle bill. It is simply a list of current charges and transaction activity. Demand bills are not edited, do not generate claims, and do not update the account's transaction history. For detailed information regarding this function, refer to the Demand Bill section in the *Billing and Claims Volume* of the *STAR Patient Accounting Reference Guide*.

Single Bill Request

This function generates a request for a single account rather than a batch of accounts, enabling you to reprint a bill and rebill an account. It can be used in several situations. For example, an inpatient's account balance has quickly reached a considerable dollar amount. The account's cycle bill parameters are based on 30 days since admission but you need to generate a cycle bill now. This function permits you to do this. For details on the Single Bill Request option, refer to the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide*.

ADD AR MASTER

The Add AR Master function reinstates an account that has either been archived or was not initially converted to STAR Financials when the system was installed. In order to reinstate a patient account to accounts receivable, the patient must have a related visit in the MPI (master patient index). If the account does not have a corresponding visit, the MPI record must be created before the AR add can be accomplished. Only accounts resident in the STAR Patient Care MPI are eligible for addition.

During the add process, it is very important that you enter as much information as possible about this account. For example, claim information is essential if you intend to post insurance payments. Once the add is accomplished, you complete the process by placing a balance forward adjustment on the reinstated account. Balances need to be adjusted through an adjustment, refund, or cash transaction. The account is added with a zero balance.

NOTE: The visit that is added must have a financial class or insurance, medical service, attending physician, and guarantor. This information is added through the STAR Patient Care system.

There are four screens used to add an account to the AR master:

• Selected admitting information

• Edit/confirm billing information

• General claims information

• Carrier-specific claims information

Once the fourth and final screen has been completed, you are prompted to enter notes on this visit.

After this function is selected, the system prompts you to select a facility (if this is a multi-facility installation) and select the desired inactive patient account using the standard lookup procedure. When an account is selected, this screen containing selected admitting information is displayed. The account must be in the location HS in order to be added as an AR account.

Selected Admitting Information

```
                    General Hospital Add AR Master Processor
                                              Mon Mar 13, 2006 11:59 am
Account       Name                    FC Typ Admit    Disch       Balance Loc
00001-02782   SCHMALTER,MICKEY           AAA 08/01/88 08/01/88     866.15

1 Patient Type   2 Account#       3 Admit Date    4 Dsch Date
   I/P              00001-02782      07/01/88        07/03/88
 5 Service                 6 Financial Class       7 Admitting Physician
   CCU CORONARY CARE       S SELF PAY                32 ADAIR,FRANK C
 8 Attending Physician      9 Primary Diagnosis
   32 ADAIR,FRANK C            001.0-CHOLERA D/T VIB CHOLERAE
10 Guarantor
   BARKLEY,ELIZABETH T




Do you wish to add this account to AR? (Y/N) [N]--
```

Field Explanations

The information on this screen is taken from the visit-specific portion of the MPI and cannot be edited. Its purpose is to help identify this account. At the bottom of this screen, the system prompts you to confirm the addition of this account to AR. If you enter Y for Yes, the system displays billing information associated with this account.

Billing Information

```
                General Hospital Add AR Master Processor
                                        Mon Mar 13, 2006 11:59 am
Account        Name                  FC Typ Admit    Disch       Balance Loc
00001-02782  SCHMALTER,MICKEY          AAA 08/01/88 08/01/88     0.00
                          BILLING INFORMATION
 1 Final Bill Date        2 Final Bill Amount       3 Last Bill #
   08/01/88                  $9,999,999.00            1
 4 Last Pay Date          5 Total Payments          6 Last ADJ Date
   08/01/88                  $9,999,999.00            08/01/88
 7 Total Adjustments      8 Last Refund Date        9 Total Refunds
   $9,999,999.00             08/01/88                  $9,999,999.00
10 Last F/U Date         11 Last F/U Type          12 Last F/U Msg #
   08/01/88                 11                        1
13 Total Amount of Charges                         14 Last Rebill Date
   $9,999,999.00
15 Collector Name                                  16 Collection Schedule
   Smith, J H                                         9



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

Field Explanations

1. FINAL BILL DATE (6-N-O)
This field contains the date on which the final bill was generated for this account. The system completes this field with the discharge date and you can edit it if you desire.

2. FINAL BILL AMOUNT (9-N-R)
This field contains the amount of the final bill. The entry limit is $9,999,999.99.

3. LAST BILL # (DISPLAY ONLY)
This field contains the number one at all times.

NOTE: You can enter data in fields 4 through 14 if you want to have past history of this information available for the account.

4. LAST PAY DATE (6-N-O)
This field contains the date of the most recent payment received for this account, entered in the format MMDDYY or MM/DD/YY.

5. TOTAL PAYMENTS (9-N-O)
This field contains the total amount of all payments made on this account. The entry limit is $9,999,999.99

6. LAST ADJ DATE (6-N-O)
This field contains the date of the most recent adjustment made to this account's balance, entered in the format MMDDYY or MM/DD/YY.

7. TOTAL ADJUSTMENTS (9-N-O)
This field contains the total amount of any adjustments made to this account's balance. The entry limit is $9,999,999.99.

8. LAST REFUND DATE (6-N-O)
This field contains the date of the most recent refund (if any) on this account. This date is entered in the format MMDDYY or MM/DD/YY.

9. TOTAL REFUNDS (9-N-O)
This field contains the total dollar amount of all refunds issued for this account. The entry limit is $9,999,999.99.

10. LAST F/U DATE (6-N-O)
This field contains the date of the last scheduled follow-up for this account. This date is entered in the format MMDDYY or MM/DD/YY.

11. LAST F/U TYPE (1-A-O)
This field contains the last type of follow-up (either phone, letter, or detail statement) received by this account.

12. LAST F/U MESSAGE # (4-N-C)
This field contains the number of the last follow-up message received by this account. If the Last F/U Type field is completed, the system prompts you to enter a number in this field.

13. TOTAL AMOUNT OF CHARGES (9-N-O)
This field contains the total amount of all charges made to this account. The entry limit is $9,999,999.99.

14. LAST REBILL DATE (6-N-O)
This field contains the date of the last rebill for this account. The date is entered in the format MMDDYY or MM/DD/YY.

Fields 15 and 16 display the current follow-up schedule number and collector if there is an existing guarantor. If there is a new guarantor, the information in both field is assigned based on the financial class of the account.

15. COLLECTOR NAME (DISPLAY ONLY)
This field contains the name of the collector assigned to this account through the Collector table.

16. COLLECTION SCHEDULE (DISPLAY ONLY)
This field contains the sequence number of the last follow-up schedule used for this account.

When these fields are completed, the system displays a third screen containing general claims information about this account.

General Claims Information

If the patient has insurance in the MPI, a generic claim sequence of 1 is created for each insurance resident in the MPI. If it is necessary to enter an insurance balance

through cash posting, adjustment posting, or refund processing, you must do it manually.

```
                   General Hospital Add AR Master Processor
                                              Mon Mar 13, 2006 11:59 am
Account        Name                   FC Typ Admit    Disch       Balance Loc
00001-02781    SCHMALTER,GUY             AAA 07/01/88 07/05/88      0.00
                         GENERAL CLAIMS INFORMATION
 1 Claim Seq #            2 Claim Type       3 Biller
   1                        B-1500             86 Quesy,Curtis
 4 Claim Work Status      5 Claim Amount     6 Paper Claim Produced
   M-Manually Released      $0.00              YES
 7 Electronic Media
   T-Tape
_____
(1) 200001  HBO & CO - MEDICAL 100




 Enter option number--
```

Field Explanations

1. CLAIM SEQ # (DISPLAY ONLY)
This field contains the number assigned for all the insurances.

2. CLAIM TYPE (1-A-R)
This field contains the type of form used for this claim. Entry options are B (1500), X (UB), or U (UB82). The entry in this field is based on the claim type of the primary insurance.

3. BILLER (DISPLAY ONLY)
This field contains the biller that is assigned to the claim based on the patient's primary carrier.

4. CLAIM WORK STATUS (1-A-O)
This field contains the status of Manually Released. It can be modified to another status but it is suggested that it remain as Manually Released.

5. CLAIM AMOUNT (9-N-O)
This field contains the amount of this claim. The entry limit is $9,999,999.99.

6. PAPER CLAIM PRODUCED (1-A-R)
This field indicates whether a paper claim form has been produced for this claim? Entry options are Y for Yes or N for No; the default is Y.

7. ELECTRONIC MEDIA (1-A-O)
This field indicates the type of electronic media that is used to submit this claim. Entry options are:

- **A** (electronic media A)

- **B** (electronic media B)

- **C** (electronic media C, formerly CPU-to-CPU)

- **D** (electronic media D)

- **E** (electronic media E)

- **T** (electronic media T, formerly magnetic tape)

If this field is left blank, the system spools the claim to the paper spool file.

When these fields are completed, the system displays a list of the carriers associated with this account. The purpose is to enable you to select a carrier to display/edit additional, carrier-specific claim information. Selecting a carrier prompts the system to display this screen. You can also update the billing and claim information and not display the following screen by entering **U** (update).

```
                 General Hospital Add AR Master Processor
                                        Mon Mar 13, 2006 11:59 am
 Account       Name                FC Typ Admit    Disch       Balance Loc
 00001-02781  SCHMALTER,GUY            AAA 07/01/88 07/05/88     0.00
                       GENERAL CLAIMS INFORMATION
  1 Claim Seq #          2 Claim Type       3 Biller
    1                      B-1500             86 Quesy,Curtis
  4 Claim Work Status    5 Claim Amount     6 Paper Claim Produced
    M-Manually Released    $0.00              YES
  7 Electronic Media
    T-Tape
                     200001-HBO & CO - MEDICAL 100
                         CLAIM INFORMATION
  1 Claim Loaded      2 Claim Generated    3 Payment Amount
    07/05/88            07/05/88             ->
  4 Claim Submitted   5 Last Payment       6 Claim Disposition
    07/05/88


 Enter claim payment amount--
```

Field Explanations

1. CLAIM LOADED (6-N-O)
This field displays the patient's discharge date. This field can be edited or left blank.

2.   CLAIM GENERATED (6-N-O)
This field displays the patient's discharge date. This field can be edited; the date is entered in the format MMDDYY or MM/DD/YY.

3.   PAYMENT AMOUNT (9-N-O)
This field can be updated with the amount paid on this claim. The entry limit is $9,999,999.99.

4.   CLAIM SUBMITTED (6-N-O)
This field displays the patient's discharge date. This field can be edited; the date is entered in the format MMDDYY or MM/DD/YY.

5.   LAST PAYMENT (6-N-O)
This field contains the patient's discharge date. This field can be edited; the date is entered in the format MMDDYY or MM/DD/YY.

6.   CLAIM DISPOSITION (1-A-O)
This field contains the claim's disposition (A - adjusted to zero, D - denied, F - final payment, P - partial payment, R - replaced, T - transfer). This field is loaded with F but can be edited.

When these fields are complete, you are prompted to accept or edit the information on the screen. Accepting the screen completes the transaction. You then have the option of selecting another carrier associated with this account, adding another account to AR, or returning to the initial menu. If you enter U, the system updates all billing and claim information.

TRENDSTAR/Horizon Performance Manager AR Information

The information on this screen is used for TRENDSTAR and Horizon Performance Manager User Defined fields. Since User Defined Fields (UDFs) can only be replaced on TRENDSTAR and Horizon Performance Manager, it is important that this information is completed if you are planning to send payment and adjustment data as UDFs. If these UDFs are sent and the following screen is not complete, only the payments and adjustments which occurred after the account was added to AR or Bad Debt are sent in the UDF and it overwrites the amounts which were previously sent for these accounts.

The following screen is displayed:

```
              General Hospital Add AR Master Processor
                                          Mon Mar 13, 2006 11:59 am
Account        Name                     FC Typ Admit    Disch      Balance Loc
A0000056783   Bass, Karen                  I/P 01/01/00  01/03/00   0.00    AR/FCRV
 1 Payments COB 1    2 Payments COB 2     3 Payments COB 3    4  Payments COB 4

 5 Payments COB 5    6 Payments COB 6     7 Payments COB 7    8  Payments COB 8

 9 Payments COB 9   10 Patient Payments  11 Adj COB 1       12 Adj COB 2

13 Adj COB 3        14 Adj COB 4         15 Adj COB 5       16 Adj COB 6

17 Adj COB 7        18 Adj COB 8         19 Adj COB 9       20 Patient Adj

21 Refunds COB 1    22 Refunds COB 2     23 Refunds COB 3   24 Refunds COB 4

25 Refunds COB 5    26 Refunds COB 6     27 Refunds COB 7   28 Refunds COB 8

29 Refunds COB 9    30 Patient Refunds


Enter the total payments for COB 1---
```

Field Explanations

1. PAYMENTS COB1 (9-N-O)
The amount entered in this field is used for payment UDFs and Summarized Payment amounts in record 6.04 in TRENDSTAR. It is also used for the Actual Payment Field in the ENCPAYOR record and for UDA's in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total payments for COB1 --

Enter the total payments for COB1 which occurred before the accounts were added back into AR.

2. PAYMENTS COB2 (9-N-O)
The amount entered in this field is used for payment UDFs and Summarized Payment amounts in record 6.04 in TRENDSTAR. It is also used for the Actual Payment Field in the ENCPAYOR record and for UDA's in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total payments for COB2 --

Enter the total payments for COB2 which occurred before the accounts were added back into AR.

3. PAYMENTS COB3 (9-N-O)
The amount entered in this field is used for payment UDFs and Summarized Payment amounts in record 6.04 in TRENDSTAR. It is also used for the Actual Payment Field in the ENCPAYOR record and for UDA's in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total payments for COB3 --

Enter the total payments for COB3 which occurred before the accounts were added back into AR.

4. PAYMENTS COB4 (9-N-O)

The amount entered in this field is used for payment UDFs and Summarized Payment amounts in record 6.04 in TRENDSTAR. It is also used for the Actual Payment Field in the ENCPAYOR record and for UDA's in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total payments for COB4 --

Enter the total payments for COB4 which occurred before the accounts were added back into AR.

5. PAYMENTS COB5 (9-N-O)

The amount entered in this field is used for payment UDFs and Summarized Payment amounts in record 6.04 in TRENDSTAR. It is also used for the Actual Payment Field in the ENCPAYOR record and for UDA's in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total payments for COB5 --

Enter the total payments for COB5 which occurred before the accounts were added back into AR.

6. PAYMENTS COB6 (9-N-O)

The amount entered in this field is used for payment UDFs and Summarized Payment amounts in record 6.04 in TRENDSTAR. It is also used for the Actual Payment Field in the ENCPAYOR record and for UDA's in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total payments for COB6 --

Enter the total payments for COB6 which occurred before the accounts were added back into AR.

7. PAYMENTS COB7 (9-N-O)

The amount entered in this field is used for payment UDFs and Summarized Payment amounts in record 6.04 in TRENDSTAR. It is also used for the Actual Payment Field in the ENCPAYOR record and for UDA's in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total payments for COB7 --

Enter the total payments for COB7 which occurred before the accounts were added back into AR.

8. PAYMENTS COB4 (9-N-O)
The amount entered in this field is used for payment UDFs and Summarized Payment amounts in record 6.04 in TRENDSTAR. It is also used for the Actual Payment Field in the ENCPAYOR record and for UDA's in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total payments for COB8 --

Enter the total payments for COB8 which occurred before the accounts were added back into AR.

9. PAYMENTS COB9 (9-N-O)
The amount entered in this field is used for payment UDFs and Summarized Payment amounts in record 6.04 in TRENDSTAR. It is also used for the Actual Payment Field in the ENCPAYOR record and for UDA's in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total payments for COB9 --

Enter the total payments for COB9 which occurred before the accounts were added back into AR.

10. PATIENT PAYMENTS (9-N-O)
The amount entered in this field is used for payment UDFs and Summarized Payment amounts in record 6.04. After you enter this option, the following prompt is displayed:

Enter total payments for patient --

Enter the total payments for patients which occurred before the accounts were added back into AR.

11. ADJUSTMENTS COB1 (9-N-O)
The total adjustments for COB1 should be entered in this field. This value is used for adjustment UDFs in TRENDSTAR and UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total adjustments for COB1--

Enter the total adjustments for COB1 which occurred before the accounts were added back into AR.

12. ADJUSTMENTS COB2 (9-N-O)
The total adjustments for COB2 should be entered in this field. This value is used for adjustment UDFs in TRENDSTAR and UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total adjustments for COB2--

Enter the total adjustments for COB2 which occurred before the accounts were added back into AR.

13. ADJUSTMENTS COB3 (9-N-O)
The total adjustments for COB3 should be entered in this field. This value is used for adjustment UDFs in TRENDSTAR and UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total adjustments for COB3--

Enter the total adjustments for COB3 which occurred before the accounts were added back into AR.

14. ADJUSTMENTS COB4 (9-N-O)
The total adjustments for COB4 should be entered in this field. This value is used for adjustment UDFs in TRENDSTAR and UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total adjustments for COB4--

Enter the total adjustments for COB4 which occurred before the accounts were added back into AR.

15. ADJUSTMENTS COB5 (9-N-O)
The total adjustments for COB4 should be entered in this field. This value is used for adjustment UDFs in TRENDSTAR and UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total adjustments for COB5--

Enter the total adjustments for COB5 which occurred before the accounts were added back into AR.

16. ADJUSTMENTS COB6 (9-N-O)
The total adjustments for COB6 should be entered in this field. This value is used for adjustment UDFs in TRENDSTAR and UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total adjustments for COB6--

Enter the total adjustments for COB6 which occurred before the accounts were added back into AR.

17. ADJUSTMENTS COB7 (9-N-O)
The total adjustments for COB7 should be entered in this field. This value is used for adjustment UDFs in TRENDSTAR and UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total adjustments for COB7--

Enter the total adjustments for COB7 which occurred before the accounts were added back into AR.

18. ADJUSTMENTS COB8 (9-N-O)
The total adjustments for COB8 should be entered in this field. This value is used for adjustment UDFs in TRENDSTAR and UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total adjustments for COB8--

Enter the total adjustments for COB8 which occurred before the accounts were added back into AR.

19. ADJUSTMENTS COB9 (9-N-O)
The total adjustments for COB9 should be entered in this field. This value is used for adjustment UDFs in TRENDSTAR and UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total adjustments for COB9--

Enter the total adjustments for COB4 which occurred before the accounts were added back into AR.

20. PATIENT ADJUSTMENTS (9-N-O)
The total adjustments for the patient should be entered in this field. This value is used for adjustment UDFs in TRENDSTAR and UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total adjustments for patient--

Enter the total adjustments for patient which occurred before the accounts were added back into AR.

21. REFUNDS COB1 (9-N-O)
The total refunds for COB1 should be entered in this field. This value is used for Refund UDFs and Summarized Payments (6.04) in TRENDSTAR if parameter to send refunds with summarized payments is set to Yes. It is also used for the Actual Payment field in the ENPAYOR record and for UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total refunds for COB1--

Enter the total refunds for COB1 which occurred before the accounts were added back into AR.

22. REFUNDS COB2 (9-N-O)
The total refunds for COB2 should be entered in this field. This value is used for Refund UDFs and Summarized Payments (6.04) in TRENDSTAR if parameter to send refunds with summarized payments is set to Yes. It is also used for the Actual Payment field in

the ENPAYOR record and for UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total refunds for COB2--

Enter the total refunds for COB2 which occurred before the accounts were added back into AR.

23. REFUNDS COB3 (9-N-O)
The total refunds for COB3 should be entered in this field. This value is used for Refund UDFs and Summarized Payments (6.04) in TRENDSTAR if the parameter to send refunds with summarized payments is set to Yes. It is also used for the Actual Payment field in the ENPAYOR record and for UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total refunds for COB3--

Enter the total refunds for COB3 which occurred before the accounts were added back into AR.

24. REFUND COB4 (9-N-O)
The total refunds for COB4 should be entered in this field. This value is used for Refund UDFs and Summarized Payments (6.04) in TRENDSTAR if parameter to send refunds with summarized payments is set to Yes. It is also used for the Actual Payment field in the ENPAYOR record and for UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total refunds for COB4--

Enter the total refunds for COB4 which occurred before the accounts were added back into AR.

25. REFUND COB5 (9-N-O)
The total refunds for COB5 should be entered in this field. This value is used for Refund UDFs and Summarized Payments (6.04) in TRENDSTAR if parameter to send refunds with summarized payments is set to Yes. It is also used for the Actual Payment field in the ENPAYOR record and for UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total refunds for COB5--

Enter the total refunds for COB5 which occurred before the accounts were added back into AR.

26. REFUND COB6 (9-N-O)
The total refunds for COB6 should be entered in this field. This value is used for Refund UDFs and Summarized Payments (6.04) in TRENDSTAR if parameter to send refunds with summarized payments is set to Yes. It is also used for the Actual Payment field in

the ENPAYOR record and for UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total refunds for COB6--

Enter the total refunds for COB6 which occurred before the accounts were added back into AR.

27. REFUND COB7 (9-N-O)
The total refunds for COB7 should be entered in this field. This value is used for Refund UDFs and Summarized Payments (6.04) in TRENDSTAR if parameter to send refunds with summarized payments is set to Yes. It is also used for the Actual Payment field in the ENPAYOR record and for UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total refunds for COB7--

Enter the total refunds for COB7 which occurred before the accounts were added back into AR.

28. REFUND COB8 (9-N-O)
The total refunds for COB8 should be entered in this field. This value is used for Refund UDFs and Summarized Payments (6.04) in TRENDSTAR if parameter to send refunds with summarized payments is set to Yes. It is also used for the Actual Payment field in the ENPAYOR record and for UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total refunds for COB8--

Enter the total refunds for COB8 which occurred before the accounts were added back into AR.

29. REFUND COB9 (9-N-O)
The total refunds for COB9 should be entered in this field. This value is used for Refund UDFs and Summarized Payments (6.04) in TRENDSTAR if parameter to send refunds with summarized payments is set to Yes. It is also used for the Actual Payment field in the ENPAYOR record and for UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total refunds for COB9--

Enter the total refunds for COB9 which occurred before the accounts were added back into AR.

30. PATIENT REFUNDS (9-N-O)
The total refunds for the patient should be entered in this field. This value is used for Refund UDFs and Summarized Payments (6.04) in TRENDSTAR if parameter to send refunds with summarized payments is set to Yes. It is also used for the Actual Payment

field in the ENPAYOR record and for UDAs in Horizon Performance Manager. After you enter this option, the following prompt display:

Enter total refunds for patient--

Enter the total refunds for patients which occurred before the accounts were added back into AR.

ADD BD MASTER

Add BD Master reinstates an account that has either been archived and purged or was not initially converted to STAR Financials when the system was installed. In order to reinstate a patient account to bad debt, the patient must have a related visit in the MPI (master patient index). If the account does not have a corresponding visit, the MPI record must be created before the BD add can be accomplished. Only accounts resident in the STAR Patient Care MPI are eligible for addition.

During the add process, it is very important that you enter as much information as possible about this account. For example, claim information is essential if you intend to post insurance payments. Once the add is accomplished, you complete the process by placing a balance forward adjustment on the reinstated account. Balances need to be adjusted through an adjustment, refund, or cash transaction. The account is added with a zero balance.

NOTE: The visit that is added must have a financial class or insurance, medical service, attending physician, and guarantor. This information is added through the STAR Patient Care system.

There are four screens used to add an account to the BD master. The first displays selected admitting information; the second is used to edit/confirm billing information; the third contains general claims information, and the fourth displays carrier-specific claims information. Once the fourth and final screen has been completed, you are prompted to enter notes on this visit.

After this function is selected, the system prompts you to select a facility (if this is a multi-facility installation) and the desired patient account using the standard lookup procedure. The account must be in account location HS in order to be added as a BD account. After you select an account, the system displays the following screen, which contains selected admitting information.

The following screen is displayed:

```
              General Hospital Add BD Master Processor
                                        Mon Mar 13, 2006 11:59 am
 Account        Name                  FC Typ Admit    Disch      Balance Loc
 00001-02782   SCHMALTER,MICKEY         AAA 08/01/88 08/01/88      866.15
  1 Patient Type   2 Account#        3 Admit Date    4 Dsch Date
    I/P              00001-02782        07/01/88        07/03/88
  5 Service              6 Financial Class        7 Admitting Physician
    CCU CORONARY CARE      S SELF PAY               32 ADAIR,FRANK C
  8 Attending Physician      9 Primary Diagnosis
    32 ADAIR,FRANK C            001.0-CHOLERA D/T VIB CHOLERAE
 10 Guarantor
    BARKLEY,ELIZABETH T




 Do you wish to add this account to BD? (Y/N) [N]--
```

Field Explanations

The information on this first screen cannot be edited. Its purpose is to help identify this account as the one you want to add before the process is begun. At the bottom of this screen, the system prompts you to confirm the addition of this account to BD. If you enter **Y** for yes, the system displays the following screen, which contains billing information associated with the selected account.

Billing Information

```
                    General Hospital Add BD Master Processor
                                              Mon Mar 13, 2006 11:59 am
Account        Name                  FC Typ Admit      Disch        Balance Loc
00001-02781  SCHMALTER,GUY              AAA 07/01/88 07/05/88      0.00
                            BILLING INFORMATION
 1 Final Bill Date           2 Final Bill Amount        3 Last Bill #
   07/05/88                    $100.00                    1
 4 Last Pay Date             5 Total Payments           6 Last ADJ Date
   07/07/88                    $12.00
 7 Total Adjustments         8 Last Refund Date         9 Total Refunds

10 Last F/U Date            11 Last F/U Type           12 Last F/U Msg #
   07/08/88                    PHONE                      1
13 Total Amount of Charges                             14 Last Rebill Date
    $9,999,999.99
15 Collector Name                                      16 Collection Schedule
   Smith, J H                                             9
```

Field Explanations

1. FINAL BILL DATE (6-N-O)
This field contains the date on which the final bill was generated for this account. The system completes this field with the discharge date and you can edit it if you desire.

2. FINAL BILL AMOUNT (9-N-R)
This field contains the amount of the final bill. The entry limit is $9,999,999.99.

3. LAST BILL # (DISPLAY ONLY)
This field contains number 1 at all times.

NOTE: You can enter data in fields 4 through 14 if you want to have past history of this information available for the account.

4. LAST PAY DATE (6-N-O)
This field contains the date on which the most recent payment was received for this account, entered in the format MMDDYY or MM/DD/YY.

5. TOTAL PAYMENTS (9-N-O)
This field contains the total amount of all payments made on this account. The entry limit is $9,999,999.99

6. LAST ADJ DATE (6-N-O)
This field contains the date on which the most recent adjustment was made to this account's balance, entered in the format MMDDYY or MM/DD/YY.

7. TOTAL ADJUSTMENTS (9-N-O)
This field contains the total amount of any adjustments made to this account's balance. The entry limit is $9,999,999.99.

8. LAST REFUND DATE (6-N-O)
This field contains the date on which the most recent refund (if any) was made on this account. This date is entered in the format MMDDYY or MM/DD/YY.

9. TOTAL REFUNDS (9-N-O)
This field contains the total dollar amount of all refunds issued for this account. The entry limit is $9,999,999.99.

10. LAST F/U DATE (6-N-O)
This field contains the date on which the last scheduled follow-up occurred for this account. This date is entered in the format MMDDYY or MM/DD/YY.

11. LAST F/U TYPE (1-A-O)
This field contains the last type of follow-up (either phone, letter, or detail statement) received by this account.

12. LAST F/U MESSAGE # (DISPLAY ONLY)
This field contains number of the last follow-up message received by this account.

13. TOTAL AMOUNT OF CHARGES (9-N-O)
This field contains the total amount of all charges made to this account. The entry limit is $9,999,999.99.

14. LAST REBILL DATE (6-N-O)
This field contains the date of the last rebill for this account. The date is entered in the format MMDDYY or MM/DD/YY.

Fields 15 and 16 display the current follow-up schedule number and collector if there is an existing guarantor. If there is a new guarantor, the information in both field is assigned based on the financial class of the account.

15. COLLECTOR NAME (DISPLAY ONLY)
This field contains the name of the collector assigned to this account through the Collector table.

16. COLLECTION SCHEDULE (DISPLAY ONLY)
This field contains the sequence number of the last follow-up schedule used for this account.

When these fields are completed, the system displays a third screen containing collection agency information about this account.

Collection Agency Information

```
                     General Hospital Add BD Master Processor
                                          Mon Mar 13, 2006 11:59 am
 Account        Name                     FC Typ Admit    Disch       Balance Loc
 00001-02781  SCHMALTER,GUY                 AAA 07/01/88 07/05/88     0.00

                        Collection Agency Information
  1 Agency
    HSI HEALTHCARE COLLECTIONS
  2 Transfer Amount          3 Transfer Date
    900.00                     08/08/88











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

Field Explanations

1.   AGENCY (DISPLAY ONLY)
This field contains the code and description of the collection agency assigned to this account based on the guarantor follow-up schedules collection agency group code.

2.   TRANSFER AMOUNT (9-N-O)
This field can be updated to contain the amount of the final account balance transferred to the collection agency. The entry limit is $9,999,999.99.

3.   TRANSFER DATE (6-N-O)
This field can be updated to contain the date on which this amount was transferred to this collection agency. This date is entered in the format MMDDYY or MM/DD/YY.

When these fields are completed, the system displays the following screen containing general claims information about this account.

General Claims Information

If the patient has insurance in the MPI, a generic claim sequence of 1 is created for each insurance resident in the MPI. If it is necessary to enter an insurance balance, enter the balance through cash posting, adjustment posting, or refund processing.

The following screen is displayed:

```
                General Hospital Add BD Master Processor
                                        Mon Mar 13, 2006 11:59 am
Account        Name                   FC Typ Admit    Disch       Balance Loc
00001-02781  SCHMALTER,GUY              AAA 07/01/88 07/05/88     0.00
                        GENERAL CLAIMS INFORMATION
 1 Claim Seq #          2 Claim Type        3 Biller
   1                      B-1500               86 Quesy,Curtis
 4 Claim Work Status    5 Claim Amount      6 Paper Claim Produced
   M-Manually Released    $0.00               YES
 7 Electronic Media
   T-Tape
_____
(1) 200001  HBO & CO - MEDICAL 100




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

Field Explanations

1. CLAIM SEQ # (DISPLAY ONLY)
This field contains the number assigned for all the insurances.

2. CLAIM TYPE (1-A-R)
This field contains the type of form used for this claim. Entry options are B (1500) or X (UB). The entry in this field is based on the claim type of the primary insurance.

3. BILLER (DISPLAY ONLY)
This field contains the biller that is assigned to the claim based on the patient's primary carrier.

4. CLAIM WORK STATUS (1-A-O)
This field contains the status of Manually Released. It can be modified to another status but it is suggested that it remain as Manually Released.

5. CLAIM AMOUNT (9-N-O)
This field contains the amount of this claim. The entry limit is $9,999,999.99.

6. PAPER CLAIM PRODUCED (1-A-R)
This field indicates whether a paper claim form has been produced for this claim. Entry options are Y for Yes or N for No; the default is Y.

7.   ELECTRONIC MEDIA (1-A-O)
This field indicates the type of electronic media that is used to submit this claim. Entry options are:

- **A** (electronic media A)

- **B** (electronic media B)

- **C** (electronic media C, formerly CPU-to-CPU)

- **D** (electronic media D)

- **E** (electronic media E)

- **T** (electronic media T, formerly magnetic tape)

If this field is left blank, the system spools the claim to the paper spool file.

When these fields are completed, the system displays a list of the carriers associated with this account. The purpose is to enable you to select a carrier to display/edit additional, carrier-specific claim information. Selecting a carrier prompts the system to display this screen. You can also update the billing and claim information and not display the following screen by entering **U** (update).

```
                 General Hospital Add BD Master Processor
                                            Mon Mar 13, 2006 11:59 am
 Account        Name                 FC Typ Admit     Disch       Balance Loc
 00001-02781  SCHMALTER,GUY             AAA 07/01/88 07/05/88      0.00
                        GENERAL CLAIMS INFORMATION
  1 Claim Seq #          2 Claim Type       3 Biller
    1                      B-1500              86 Quesy,Curtis
  4 Claim Work Status    5 Claim Amount      6 Paper Claim Produced
    M-Manually Released    $0.00               YES
  7 Electronic Media
    T-Tape
                      200001-HBO & CO - MEDICAL 100
                          CLAIM INFORMATION
  1 Claim Loaded        2 Claim Generated    3 Payment Amount
    07/05/88              07/05/88            ->
  4 Claim Submitted     5 Last Payment       6 Claim Disposition
    07/05/88


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

Field Explanations

1.   CLAIM LOADED (6-N-O)
This field displays the patient's discharge date. This field can be edited or left blank.

2. CLAIM GENERATED (6-N-O)
This field displays the patient's discharge date. This field can be edited; the date is
entered in the format MMDDYY or MM/DD/YY.

3. PAYMENT AMOUNT (9-N-O)
This field can be updated with the amount paid on this claim. The entry limit is
$9,999,999.99.

4. CLAIM SUBMITTED (6-N-O)
This field displays the patient's discharge date. This field can be edited; the date is
entered in the format MMDDYY or MM/DD/YY.

5. LAST PAYMENT (6-N-O)
This field displays the patient's discharge date. This field can be edited; the date is
entered in the format MMDDYY or MM/DD/YY.

6. CLAIM DISPOSITION (1-A-O)
This field contains the claim's disposition (A - adjusted to zero, D - denied, F - final
payment, P - partial payment, R - replaced, T - transfer, or C - clear disposition). The
default is F (final payment).

When these fields are complete, you are prompted to accept or edit the information on
the screen. Accepting the screen completes the transaction. You then have the option
of selecting another carrier associated with this account, adding another account to
BD, or returning to the initial menu. If you enter U, the system updates all billing and
claim information.

TRENDSTAR/Horizon Performance Manager BD Information

The information on this screen is used for TRENDSTAR and Horizon Performance
Manager User Defined fields. Since User Defined Fields (UDFs) can only be replaced
on TRENDSTAR and Horizon Performance Manager, it is important that this
information is completed if you are planning to send payment and adjustment data as
UDFs. If these UDFs are sent and the following screen is not complete, only the
payments and adjustments which occurred after the account was added to AR or Bad
Debt are sent in the UDF and it overwrites the amounts which were previously sent for
these accounts.

```
              General Hospital Add BD Master Processor
                                          Mon Mar 13, 2006 11:59 am
Account       Name                  FC Typ Admit    Disch     Balance Loc
A0000056783   Bass, Karen              I/P 01/01/00  01/03/00   0.00    BD/FCRV
 1 Payments COB 1    2 Payments COB 2     3 Payments COB 3    4  Payments COB 4

 5 Payments COB 5    6 Payments COB 6     7 Payments COB 7    8  Payments COB 8

 9 Payments COB 9   10 Patient Payments  11 Adj COB 1        12 Adj COB 2

13 Adj COB 3        14 Adj COB 4         15 Adj COB 5        16 Adj COB 6

17 Adj COB 7        18 Adj COB 8         19 Adj COB 9        20 Patient Adj

21 Refunds COB 1    22 Refunds COB 2     23 Refunds COB 3    24 Refunds COB 4

25 Refunds COB 5    26 Refunds COB 6     27 Refunds COB 7    28 Refunds COB 8

29 Refunds COB 9    30 Patient Refunds


Enter the total payments for COB 1---
```

1. PAYMENTS COB1 (9-N-O)
The amount entered in this field is used for payment UDFs and Summarized Payment
amounts in record 6.04 in TRENDSTAR. It is also used for the Actual Payment Field
in the ENCPAYOR record and for UDA's in Horizon Performance Manager. After you
enter this option, the following prompt is displayed:

   Enter total payments for COB1 --

Enter the total payments for COB1 which occurred before the accounts were added
back into AR.

2. PAYMENTS COB2 (9-N-O)
The amount entered in this field is used for payment UDFs and Summarized Payment
amounts in record 6.04 in TRENDSTAR. It is also used for the Actual Payment Field
in the ENCPAYOR record and for UDA's in Horizon Performance Manager. After you
enter this option, the following prompt is displayed:

   Enter total payments for COB2 --

Enter the total payments for COB2 which occurred before the accounts were added
back into AR.

3. PAYMENTS COB3 (9-N-O)
The amount entered in this field is used for payment UDFs and Summarized Payment
amounts in record 6.04 in TRENDSTAR. It is also used for the Actual Payment Field
in the ENCPAYOR record and for UDA's in Horizon Performance Manager. After you
enter this option, the following prompt is displayed:

   Enter total payments for COB3 --

Enter the total payments for COB3 which occurred before the accounts were added back into AR.

4. PAYMENTS COB4 (9-N-O)

The amount entered in this field is used for payment UDFs and Summarized Payment amounts in record 6.04 in TRENDSTAR. It is also used for the Actual Payment Field in the ENCPAYOR record and for UDA's in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total payments for COB4 --

Enter the total payments for COB4 which occurred before the accounts were added back into AR.

5. PAYMENTS COB5 (9-N-O)

The amount entered in this field is used for payment UDFs and Summarized Payment amounts in record 6.04 in TRENDSTAR. It is also used for the Actual Payment Field in the ENCPAYOR record and for UDA's in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total payments for COB5 --

Enter the total payments for COB5 which occurred before the accounts were added back into AR.

6. PAYMENTS COB6 (9-N-O)

The amount entered in this field is used for payment UDFs and Summarized Payment amounts in record 6.04 in TRENDSTAR. It is also used for the Actual Payment Field in the ENCPAYOR record and for UDA's in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total payments for COB6 --

Enter the total payments for COB6 which occurred before the accounts were added back into AR.

7. PAYMENTS COB7 (9-N-O)

The amount entered in this field is used for payment UDFs and Summarized Payment amounts in record 6.04 in TRENDSTAR. It is also used for the Actual Payment Field in the ENCPAYOR record and for UDA's in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total payments for COB7 --

Enter the total payments for COB7 which occurred before the accounts were added back into AR.

8. PAYMENTS COB4 (9-N-O)
The amount entered in this field is used for payment UDFs and Summarized Payment amounts in record 6.04 in TRENDSTAR. It is also used for the Actual Payment Field in the ENCPAYOR record and for UDA's in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total payments for COB8 --

Enter the total payments for COB8 which occurred before the accounts were added back into AR.

9. PAYMENTS COB9 (9-N-O)
The amount entered in this field is used for payment UDFs and Summarized Payment amounts in record 6.04 in TRENDSTAR. It is also used for the Actual Payment Field in the ENCPAYOR record and for UDA's in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total payments for COB9 --

Enter the total payments for COB9 which occurred before the accounts were added back into AR.

10. PATIENT PAYMENTS (9-N-O)
The amount entered in this field is used for payment UDFs and Summarized Payment amounts in record 6.04. After you enter this option, the following prompt is displayed:

Enter total payments for patient --

Enter the total payments for patients which occurred before the accounts were added back into AR.

11. ADJUSTMENTS COB1 (9-N-O)
The total adjustments for COB1 should be entered in this field. This value is used for adjustment UDFs in TRENDSTAR and UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total adjustments for COB1--

Enter the total adjustments for COB1 which occurred before the accounts were added back into AR.

12. ADJUSTMENTS COB2 (9-N-O)
The total adjustments for COB2 should be entered in this field. This value is used for adjustment UDFs in TRENDSTAR and UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total adjustments for COB2--

Enter the total adjustments for COB2 which occurred before the accounts were added back into AR.

13. ADJUSTMENTS COB3 (9-N-O)

The total adjustments for COB3 should be entered in this field. This value is used for adjustment UDFs in TRENDSTAR and UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total adjustments for COB3--

Enter the total adjustments for COB3 which occurred before the accounts were added back into AR.

14. ADJUSTMENTS COB4 (9-N-O)

The total adjustments for COB4 should be entered in this field. This value is used for adjustment UDFs in TRENDSTAR and UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total adjustments for COB4--

Enter the total adjustments for COB4 which occurred before the accounts were added back into AR.

15. ADJUSTMENTS COB5 (9-N-O)

The total adjustments for COB4 should be entered in this field. This value is used for adjustment UDFs in TRENDSTAR and UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total adjustments for COB5--

Enter the total adjustments for COB5 which occurred before the accounts were added back into AR.

16. ADJUSTMENTS COB6 (9-N-O)

The total adjustments for COB6 should be entered in this field. This value is used for adjustment UDFs in TRENDSTAR and UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total adjustments for COB6--

Enter the total adjustments for COB6 which occurred before the accounts were added back into AR.

17. ADJUSTMENTS COB7 (9-N-O)

The total adjustments for COB7 should be entered in this field. This value is used for adjustment UDFs in TRENDSTAR and UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total adjustments for COB7--

Enter the total adjustments for COB7 which occurred before the accounts were added back into AR.

18. ADJUSTMENTS COB8 (9-N-O)
The total adjustments for COB8 should be entered in this field. This value is used for adjustment UDFs in TRENDSTAR and UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total adjustments for COB8--

Enter the total adjustments for COB8 which occurred before the accounts were added back into AR.

19. ADJUSTMENTS COB9 (9-N-O)
The total adjustments for COB9 should be entered in this field. This value is used for adjustment UDFs in TRENDSTAR and UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total adjustments for COB9--

Enter the total adjustments for COB4 which occurred before the accounts were added back into AR.

20. PATIENT ADJUSTMENTS (9-N-O)
The total adjustments for the patient should be entered in this field. This value is used for adjustment UDFs in TRENDSTAR and UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total adjustments for patient--

Enter the total adjustments for patient which occurred before the accounts were added back into AR.

21. REFUNDS COB1 (9-N-O)
The total refunds for COB1 should be entered in this field. This value is used for Refund UDFs and Summarized Payments (6.04) in TRENDSTAR if parameter to send refunds with summarized payments is set to Yes. It is also used for the Actual Payment field in the ENPAYOR record and for UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total refunds for COB1--

Enter the total refunds for COB1 which occurred before the accounts were added back into AR.

22. REFUNDS COB2 (9-N-O)
The total refunds for COB2 should be entered in this field. This value is used for Refund UDFs and Summarized Payments (6.04) in TRENDSTAR if parameter to send refunds with summarized payments is set to Yes. It is also used for the Actual Payment field in

the ENPAYOR record and for UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total refunds for COB2--

Enter the total refunds for COB2 which occurred before the accounts were added back into AR.

23. REFUNDS COB3 (9-N-O)
The total refunds for COB3 should be entered in this field. This value is used for Refund UDFs and Summarized Payments (6.04) in TRENDSTAR if the parameter to send refunds with summarized payments is set to Yes. It is also used for the Actual Payment field in the ENPAYOR record and for UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total refunds for COB3--

Enter the total refunds for COB3 which occurred before the accounts were added back into AR.

24. REFUND COB4 (9-N-O)
The total refunds for COB4 should be entered in this field. This value is used for Refund UDFs and Summarized Payments (6.04) in TRENDSTAR if parameter to send refunds with summarized payments is set to Yes. It is also used for the Actual Payment field in the ENPAYOR record and for UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total refunds for COB4--

Enter the total refunds for COB4 which occurred before the accounts were added back into AR.

25. REFUND COB5 (9-N-O)
The total refunds for COB5 should be entered in this field. This value is used for Refund UDFs and Summarized Payments (6.04) in TRENDSTAR if parameter to send refunds with summarized payments is set to Yes. It is also used for the Actual Payment field in the ENPAYOR record and for UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total refunds for COB5--

Enter the total refunds for COB5 which occurred before the accounts were added back into AR.

26. REFUND COB6 (9-N-O)
The total refunds for COB6 should be entered in this field. This value is used for Refund UDFs and Summarized Payments (6.04) in TRENDSTAR if parameter to send refunds with summarized payments is set to Yes. It is also used for the Actual Payment field in

the ENPAYOR record and for UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total refunds for COB6--

Enter the total refunds for COB6 which occurred before the accounts were added back into AR.

27. REFUND COB7 (9-N-O)
The total refunds for COB7 should be entered in this field. This value is used for Refund UDFs and Summarized Payments (6.04) in TRENDSTAR if parameter to send refunds with summarized payments is set to Yes. It is also used for the Actual Payment field in the ENPAYOR record and for UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total refunds for COB7--

Enter the total refunds for COB7 which occurred before the accounts were added back into AR.

28. REFUND COB8 (9-N-O)
The total refunds for COB8 should be entered in this field. This value is used for Refund UDFs and Summarized Payments (6.04) in TRENDSTAR if parameter to send refunds with summarized payments is set to Yes. It is also used for the Actual Payment field in the ENPAYOR record and for UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total refunds for COB8--

Enter the total refunds for COB8 which occurred before the accounts were added back into AR.

29. REFUND COB9 (9-N-O)
The total refunds for COB9 should be entered in this field. This value is used for Refund UDFs and Summarized Payments (6.04) in TRENDSTAR if parameter to send refunds with summarized payments is set to Yes. It is also used for the Actual Payment field in the ENPAYOR record and for UDAs in Horizon Performance Manager. After you enter this option, the following prompt is displayed:

Enter total refunds for COB9--

Enter the total refunds for COB9 which occurred before the accounts were added back into AR.

30. PATIENT REFUNDS (9-N-O)
The total refunds for the patient should be entered in this field. This value is used for Refund UDFs and Summarized Payments (6.04) in TRENDSTAR if parameter to send refunds with summarized payments is set to Yes. It is also used for the Actual Payment

field in the ENPAYOR record and for UDAs in Horizon Performance Manager. After you enter this option, the following prompt display:

Enter total refunds for patient--

Enter the total refunds for patients which occurred before the accounts were added.

BD TO AR TRANSFER

This transaction enables you to transfer an account with a location of bad debt to a location of AR.

After this function is selected, the system prompts you to select a facility (if this is a multi-facility installation) and then the desired bad debt account using the standard lookup procedure.

If you select an account scheduled to be archived, the system displays the following prompt:

> *Account to be archived. Do you want to continue? (Y/N) [N] --*

Enter **Y** to continue the process; the system cancels the archive request when the transfer is processed. Enter **N** or press ENTER to return and select another account.

The system creates a transaction history entry using the transaction code as defined in the PAAR Control Parameters for the User Removed Archive Prelist Transaction Code. If the BD to AR request is deleted and the request to transfer AR to BD is cancelled, you need to manually prelist the Bad Debt account in order for the account to qualify for archiving.

After you select an account, the system displays the following screen:

```
              General Hospital BD to AR Transfer Processor
                                        Mon Mar 13, 2006 11:59 am
 Account        Name                    FC Typ Admit    Disch        Balance Loc
 00101-02784   SCHMALTER,MICKEY         BC AAA 01/01/88 01/10/88      0.00    BD/FCRV
  1 Financial Class     2 Transaction Code
    T BLUE CROSS          S0003
```

Field Explanations

The system displays the account number, patient name, patient type, admit date, discharge date, account balance, and account location/sub location.

1. FINANCIAL CLASS (1-A-R)

This field contains the financial class currently assigned to this account. You can modify the financial class if necessary.

2. TRANSACTION CODE (4-N-R)

This field contains the transaction code (up to four digits) that is used to record the transfer in this account's transaction history. The transaction type associated with this code is always S (status transfer). You can enter the code or a hyphen (-) to display a list of valid codes. The list of codes includes the transaction type, code, description, account types for which the code is valid, whether the code prints, and whether it is combined with any other transaction type/code.

When these fields are completed, the system prompts you to accept or edit the entered information. Accepting the screen completes the transaction. The request is filed and then processed during the next midnight processing run. All necessary GL entries are posted at this time.

BAD DEBT PRE-LIST

This function allows you to manually select or unselect accounts in account location AR for transfer to Bad Debt. It also allows the hospital to prevent the account transfers to Bad Debt for accounts that have already been selected by a user or the system for transfer.

A guarantor who reaches the end of his follow-up schedule and meets the dollar and insurance outstanding criteria, is eligible for system prelisting. System prelisting is an optional batch job requested by the hospital. Accounts are prelisted by running this optional batch job or setting the status manually via this function.

The system generates a prelist report which lists all accounts prelisted by the system, user and all accounts currently on hold. You should review this report before requesting AR to BD transfer. From reviewing this report, the hospital can remove accounts from the prelist or place accounts on hold.

If the system has selected accounts for prelisting to Bad Debt that the hospital does not want to go to Bad Debt, you can put these accounts on prelist hold. When you remove the prelist flag, the account is selected for the prelist at its next eligible time. Accounts on hold cannot be sent to Bad Debt until the hold flag is removed.

The system automatically places an account on prelist hold if:

• A payment or adjustment is received after prelist but before the account is transferred from AR to BD, or

• The account has a credit balance.

Posting cash or an adjustment to an account that causes the account balance to become zero changes the prelist status to *Unprelisted* (the account is no longer selected for Bad Debt Prelist).

If a payment or adjustment is received on one account that has been prelisted, then the system places all accounts prelisted for that guarantor on prelist hold. Prelisted accounts with the same guarantor that are on a separate or account custom schedule are not placed on hold by the payment or adjustment. If an account is placed on hold due to a payment or adjustment, the system displays a reference to the account number that received the payment/adjustment in the Transaction History comment.

If a guarantor with multiple accounts is prelisted and then one of the accounts is placed on a custom schedule, if the guarantor is removed from the prelist only the guarantor's standard accounts is unprelisted. The accounts on the custom schedule remain on the BD Prelist. To remove these accounts, you must choose selected guarantor accounts at the prompt displayed after you select the Bad Debt Pre-List function.

When you manually prelist an account, the system assigns the account to the collection agency specified through this function or to a collection agency based on the

Collection Agency Group table specified through this function. It is possible for a guarantor to have accounts sent to two or more agencies if the accounts have different financial classes. If the account that you are manually prelisting has a pending adjustment or late bill request, the system issues one of the following warnings:

Account has a pending adjustment bill request. Do you want to continue? Y/N [Y]

or

Account has a pending late bill request. Do you want to continue? Y/N [Y]

Press ENTER to accept the default of Yes and continue with the bad debt prelist request. Enter **N** to return to the patient lookup prompt.

Finally, this function also enables you to modify the Collection Agency assignment on accounts prior to their transfer. You can modify the agency for all of the guarantor's standard accounts or for selected accounts. Selected accounts do not have to be on a custom follow-up schedule for the system to handle them differently than it does other guarantor's accounts regarding bad debt prelisting and AR to BD transfer.

After you select this function, the system prompts you to specify whether the account lookup is for all accounts by guarantor (all regular accounts), selected accounts by guarantor, or by patient. The following prompt is displayed:

(A)ll accounts controlled by guarantor, (S)elected accounts by guarantor, or
        (P)atient lookup [A]?--

A, All accounts controlled by guarantor, is the default and allows you to pre-list all regular accounts associated with a guarantor for transfer to bad debt. The lookup is by guarantor. **S**, Selected accounts by guarantor, allows you to choose an individual account from the list of guarantor's accounts for the Bad Debt pre-list. This lookup is also by guarantor. **P**, Patient lookup, also allows you to choose an individual account for the Bad Debt pre-list, but this lookup is by patient instead of by guarantor. To locate an account for transfer to bad debt by account number, use the Patient lookup option.

After a guarantor or an account is selected, the system displays the following screen:

```
              General Hospital Bad Debt Pre-List Processor
                                           Sun Jul 16, 2006 04:07 pm
Sun Jul 16, 2006 04:07 pm


  Corporate    Type    Guarantor Name
  00005231    (G)     BOONE, MIKE      (all reg. accts)
 1 Schedule # 2 Days After Ins    3 Bad Debt Transfer Trans Code/Desc

 4 Group/Code      5 Collection Agency Group/Code          6 BD Pre-List Flag
                                                             Acct Not Selected
 7 BD Prelist Trans Code/Desc      8 Comments
   M0003-BAD DEBT PRELIST
 9 Healthcare Score/Desc - Date          10 Invalid Address/Phone Flag


 * * * * * * * * * * * *   Last Follow Up Information  * * * * * * * * * * *
11 Last Follow-up           12 Last Seq #          13 Last F/U Type

14 Last Message




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

Field Explanations

If all accounts for a single guarantor are selected, the system displays the guarantor's corporate number, the account type (in this case G - guarantor), the guarantor's name, and whether all accounts for this guarantor are included in this transaction. The system does not display a default in the Collection Agency Code field, since system-assignment of a collection agency is based on patient financial class.

If a single account is selected, the system displays the account number of the patient selected, the account type (in this case A - account), the patient's name, and a statement identifying this patient as a single account of the listed guarantor.

NOTE: If the selected account has insurance pending, the system displays a warning and asks if you wish to continue. Enter **N** to return to the Account Selection screen. Enter **Y** to continue this process.

1. SCHEDULE # (DISPLAY ONLY)
This field contains the follow-up schedule number assigned to the guarantor or account.

2. DAYS AFTER INS (DISPLAY ONLY)
This field contains the number of days after insurance payment that this guarantor or account would be automatically prelisted. This entry is loaded from the guarantor's or account's follow-up schedule.

3. BAD DEBT TRANSFER TRANS CODE/DESC (4-N-R)

This field contains the transaction code (up to four digits) that records the transfer to Bad Debt in the account's or guarantor's account transaction history. Transaction type S (status transfer) is always used in this field. You can enter a code or a hyphen (-) to display a list of valid codes. This update occurs when AR to BD transfer is run. This entry is loaded from the follow-up schedule for the account or guarantor but you can edit the field for bad debt if all other qualifications for the guarantor or account have been met (for example: end of follow-up schedule, no other accounts with insurance, meets balance check).

4. GROUP/CODE (1-A-R)

This field is used to define the collection agency group or collection agency the account is sent to when the AR to BD transfer runs. When this field is accessed, the following prompt is displayed:

Select from a Collection Agency (G)roup or (C)ode (G/C)--

If you enter **G** (Group) or **C** (Code), the cursor goes to the next field, Collection Agency Group/Code. If you entered G (Group), you can select the bad debt collection agency group. If you entered C (Code), you can select a collection agency. For details, see the Collection Agency Group/Code field.

5. COLLECTION AGENCY GROUP/CODE (1-A-R)

This field contains the code and description of the collection agency or collection agency group to which the account is sent when the AR to BD transfer runs.This field can be accessed after you enter either a G (Group) or C (Code) in the Group/Code field. If you entered G (Group) in that field, the system displays a list of collection agency groups for this account. You can enter a hyphen (-) to select the collection agency group. If you entered C (Code) in that field, the system displays a list of collection agencies for this account. You can enter a hyphen (-) to select the collection agency.

6. PRE-LIST FLAG (TABLE LOOKUP)

This field contains the Prelist Status and indicates whether the guarantor or account is sent to Bad Debt. The status codes are as follows:

- Account not Selected

- Flagged for Prelist

- User Hold

- System Hold (user is not allowed to enter this status)

- System Selected (user is not allowed to enter this status)

If you want to prelist an account, use the Flagged for Prelist status. If you want to hold an account, use the User Hold status. If you want to remove the account from the prelist function, use the Account not Selected status.

An account that does not have a current prelist status has an Account not Selected status when the user accesses this function.

Accounts are placed on system hold if a payment is received on the account, and the account has a prelist value of System Selected or Flagged For Prelist.

A System Selected status indicates guarantor met qualifications for prelisting and an optional batch job has selected the guarantor for transfer.

7. BD PRELIST TRANS CODE/DESC (4-N-O)
This field contains the transaction code for the prelist status that is used to update the account's transaction history of the event. This field defaults from the Bad Debt Prelist Transaction Code field from the Facility Information - PAAR Control function. You can override this code to indicate whether the guarantor or custom account is being removed or placed on hold. You can enter a code or a hyphen (-) to display a list of valid codes under transaction type M (memo).

8. COMMENTS (40-C-O)
This field contains comments relating to this account. These comments display in the account's transaction history. You can include the reason for adding or changing the prelist status.

9. HEALTHCARE SCORE/DESC-DATE (DISPLAY ONLY)
This field contains the most recently received healthcare score, its description, and the date it was received. The Healthcare Score table (controlled by STAR Patient Processing) designates definitions for healthcare scores or healthcare score ranges. A healthcare score is received in response to a credit check request on a guarantor.

10. INVALID ADDRESS/PHONE FLAG (DISPLAY ONLY)
This field contains the code for the invalid address flag and a description.

Fields 11 through 14 are related to the most recent follow-up information for this guarantor or specific account.

11. LAST FOLLOW-UP (DISPLAY ONLY)
This field contains the date of the last follow-up event.

12. LAST SEQ # (DISPLAY ONLY)
This field contains the number of the last follow-up event from the follow-up schedule.

13. LAST F/U TYPE (DISPLAY ONLY)
This field contains the last follow-up type (telephone, letter, detail statement).

14. LAST MESSAGE (DISPLAY ONLY)

This field contains the last message for this account. This message is tied to the last follow-up type.

NOTE: If the entry in the BD Pre-list Flag field is User Hold or Account Not Selected (if account has been previously prelisted), the system displays a section at the bottom of this screen that has the following two fields:

1.   NEXT FOLLOW-UP DATE (6-N-R)

This field contains the date the next follow-up event is selected for the guarantor or account. It allows the follow-up to be restarted. It is required that this date be reset.

2.   SEQUENCE # (2-N-R)

This field contains the sequence number of the next follow-up event that you want to assign to this account. It is required that this date be reset.

When these fields are completed, you have the option of accepting or editing the information entered. Accepting the screen completes the transaction. You can select another guarantor or specific guarantor account to work with or return to the Account Management menu.

BAD DEBT DEMAND FOLLOW-UP

This function displays the accounts that are in a Bad Debt location and have an Internal Bad Debt follow-up schedule. Refer to the *Follow-Up Functions Volume* in the *STAR Patient Accounting Reference Guide* for a description of bad debt demand follow-up.

INSURANCE AGENCY PROCESS STATUS

This function is used to display and update the insurance agency collection data for insurance. The insurance collection data can be updated only for accounts in an Accounts Receivable location. This function can be accessed through the Pending/ Candidate Workfile, AR Agency Workfile, Account Inquiry Snap Shot function, and the Bad Debt Management menu.

For more information on this function, see the Collector Functions chapter in the *Follow-Up Functions Volume* of the *STAR Financials Patient Accounting Reference Guide.*

AGENCY PROCESS STATUS

This function is used to display and update the agency collection data for accounts. The agency collection data can only be updated for accounts in an Accounts Receivable location. This function can be accessed through the Pending/Candidate Workfile, AR Agency Workfile, Account Inquiry Snap Shot function, and the Bad Debt Management menu.

For more information on this function, see the Collector Functions chapter in the *Follow-Up Functions Volume* of the *STAR Financials Patient Accounting Reference Guide.*

COLLECTION AGENCY FUNCTIONS

This option provides the following collection agency-related functions:

- Collection Agency Transfer

- Collection Agency Tape/Report

- Collection Agency Payment File

Collection Agency Transfer is used to transfer bad debt and internal collection accounts from one collection agency to another in the system.

Collection Agency File/Report electronically transfers bad debt accounts from the hospital's system to a collection agency file. Two printed reports of the accounts transferred to the specified agency are available.

Collection Agency Payment File electronically records payments received by the agency and submitted to the hospital for collected accounts. Reports detailing the payments made and any posting errors are generated.

Collection Agency Transfer

This process is used to transfer accounts from one collection agency to another with the transfer automatically recorded in the account's transaction history. When the screen is accepted, transfers occur immediately. In addition, a report (FFR340) is generated during the midnight processing which details every transfer. This process is for accounts at internal collection or in bad debt.

For internal collection, the collection agency transfer process:

- Updates the next follow-up date, type, and step for the accounts that transfer to a new internal agency. Accounts resequence to step 1 of their new Follow-up Schedule, and they receive a new follow-up schedule according to what is attached to the Collection Agency Code parameters.

- Deletes any existing workfile entries for the old agency.

- Verifies that the accounts are at Internal collection before transferring them to another Internal collection agency.

- Is not valid for transferring to or from a CCI Collection Agency.

For bad debt agencies, the collection agency transfer process:

- Updates the next follow-up date, type and step for the accounts that receive a new collection agency. Accounts resequence back to the first step of their new follow-up schedule.

- Assigns the accounts a new follow-up schedule according to what is in the Collection Agency Code parameters.

- Updates the Collection Agency File with the New Agency.

- Deletes any existing workfile entries for the old agency.

- Only transfers accounts in Bad Debt to Internal or External Bad Debt agencies.

- Updates the Agency Tran Date field on the Account Follow-up processor through Account Inquiry.

After this function is selected, the system displays the following screen:

```
              General Hospital Collection Agency Transfer Processor
                                             Thu Jan 27, 2000 02:28 pm


  1 Collection Agency Type

  2 All Agency Accounts/Guarantor Accounts/Specific Account

  3 Old Agency                          4 New Agency

  5 Transfer Transaction Code
    S0004-KEY DATA CHANGED




 Enter (B)ad Debt or (P)re-Collect agency transfer (B/P) [B]?--  |
```

Field Explanations

1. COLLECTION AGENCY TYPE
This field determines if the collection agency transfer is for bad debt or internal per-collect agencies. Enter a B for Bad Debt or a P for Pre-Collect.

2. ALL AGENCY ACCOUNTS/GUARANTOR ACCOUNTS/SPECIFIC ACCOUNT (1-A-R)
Entry options are:

- A (all guarantors and associated accounts assigned to this agency).

- G (all accounts for a specific guarantor assigned to this agency).

- C (an individual account assigned to this agency).

The default is G. If you enter A, the system proceeds to field 3. All accounts associated with the agency are transferred to the new agency.

If you enter G, the standard lookup procedure is used to select a guarantor. The system proceeds to field 3. All accounts for a specific guarantor that are assigned to the agency are transferred to the new agency.

If you enter C, the individual account selected is transferred from the old agency to the new agency.

3. OLD AGENCY (6-A-C)
This field contains the code and description of the collection agency from which accounts are being transferred. This field is dependent on the Collection Agency Type field. If the Collection Agency Type Field is completed with a B for Bad Debt, only bad debt agencies can be selected. If the Collection Agency Type field is completed with a P for Pre-collect, only internal collection agencies can be selected. You can enter the code or a hyphen (-) to display a list of valid codes. If you enter C in field 1, this field is automatically completed.

4. NEW AGENCY (6-A-R)
This field contains the code and description of the collection agency to which the account(s) is being transferred. This field is dependent on the Collection Agency Type field. If the Collection Agency Type Field is completed with a B for Bad Debt, only bad debt agencies can be selected. If the Collection Agency Type field is completed with a P for Pre-collect, only internal agencies can be selected. You can enter the code or a hyphen (-) to display a list of valid codes.

5. TRANSFER TRANSACTION CODE (4-N-R)
This field contains the transaction code (up to four digits) used to record this transfer in the account's transaction history and on associated reports. This field defaults to the transaction code that is entered in the Facility Options PA/AR Control - Key Data Revision Transaction Code field. You can override this entry and enter the code or a hyphen (-) to display a list of valid codes under transaction type S (status change).

When these fields are completed, you have the option of accepting, editing or deleting this information. Accepting the screen causes the selected accounts to be transferred. While the system updates, the following message is displayed:

Updating .... Please Wait.

When the transfer is completed, the transaction is completed and the system displays the Collection Agency Functions submenu.

Collection Agency File/Report

This function is used to generate a PC, UNIX, or tape file of accounts transferred to a bad debt collection agency. If an agency is unable to accept a file, you can choose to produce a report detailing transfers. This function does not actually transfer accounts from AR to BD; AR to BD transfer is a function of an optional batch function. The Collection Agency File/Report function is a mechanism that provides each collection agency with a listing of the accounts that have been transferred to the agency. The

Collection Agency PC, UNIX, and tape files are formatted according to defined specifications (See Section 2 of the *General Information Volume* of the *STAR Patient Accounting Reference Guide*). Before submitting a PC, UNIX, or tape file to a collection agency for processing, you should consult with your McKesson installation or customer support representative to obtain a copy of the current format document. There are two Bad Debt COB formats. The four format sends insurance information for the first four insurances. The nine format sends up to nine insurances. Please specify which format you want to use. The Bad Debt COB format is controlled by the BD COB Format field on the Collection Agency Code table. Generally, collection agency files are created in conjunction with AR to BD account transfer, but this is not mandatory. For example, a hospital can transfer accounts from AR to BD twice a month and create a collection agency transfer file at the end of the month.

After this function is selected, you are asked to select the collection agency or agencies for which you are generating the file and reports. You can enter the agency code or a hyphen (-) to display a list of valid codes. You can select one, some, or all agencies available.

After you select the agency or agencies, the system asks if you only want to produce a report of accounts being transferred:

Produce only a Report for Selected Agency(s) (Y/N)[N]--

The options are:

Y for Yes produce the Collection Agency report (FXPCAT4) without generating an agency transfer file for each agency selected.

N for No produces the Collection Agency Report (FXPCAT4), the Collection Agency Interface Report (FXPCAT5), and an agency transfer file for each agency selected.

The default is N. If you enter N, you are then prompted for the accounts to be included. The following prompt is displayed on your screen:

Select all accounts that have not been sent to the current agency? (Y/N) [Y]--

Enter **N** to generate specific dates. You are prompted to enter the beginning and end dates. Enter **Y** to select all accounts that have not been sent. After completing these selections, the following prompt is displayed:

Download COLLECTION AGENCY NAME to (P)C, (U)NIX, or (T)ape (P/U/T) [T]--

NOTE: Enter **P** to create a PC file, **U** to create a UNIX file, or **T** to create a tape. The default is T.

CN: Enter **P** to create a PC file, **U** to create a UNIX file, and **T** to create a tape. The default is P.

DOWNLOADING A PC FILE

If you select **P**C, you are prompted for the drive. The default drive is A, but any drive can be entered. After you enter the drive, you are prompted to name the PC file. The following prompt is displayed:

> *PC File Name [AGENCY223.410]*

The system automatically names the collection agency file. The naming convention is the name of the agency concatenated with the STAR system ID and the date the file is generated. For example, if the file name is AGENCY1.407, the collection agency name is called AGENCY; the STAR system ID is 1, and the date the file was generated was April 7. The name of the file can be overwritten by typing in a new file name. If the month the file is generated is 10, 11, or 12, it is represented by A, B, or C respectively. For example, if the file is created on October 10 in ID 1 for collection agency code AGENCY, the default file name is AGENCY1. A10.

After you enter the file name, you are prompted to confirm the download:

> *Download interface for COLLECTION AGENCY NAME? (Y/N) [Y]*
>   *PC file name: AGENCY.MDD*

Enter **Y** to begin the download. Enter **N** if you do not want to proceed. The default is **Y**. If you select Yes, the system processes the selected records and writes them to the collection agency under the PC file name specified.

While the system is gathering records for the file, it deletes accounts from the collection agency file whose collection agency transfer date is older than a year from the date the agency file was requested. Accounts that are deleted still remain in bad debt and associated with the agency, but they do not remain in the collection agency file that the system uses to determine which accounts are included on a collection agency transfer file. when the system is done reviewing accounts for deletion, the following message is displayed:

> *XX Records deleted prior to XX/XX/XX --*

After the file is produced, the following messages are displayed:

> *Collection Agency (Name of Agency) download successful--*

> *Records written to (PC, UNIX, Tape) verified--*

If there are not any more agency files to download, the system returns to the Collection Agency Functions Processor screen.

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DOWNLOADING A UNIX FILE

If you select **U**NIX, the system generates a collection agency file and writes the file to UNIX. The UNIX Directory Path that the system uses is the one that is defined in the Directory Path Processor table. After you select U, the following prompt is displayed:

> *UNIX File Name [AGENCY1.121]*

The system automatically names the collection agency file. The naming convention is the name of the agency concatenated with the STAR system ID and the date the file is generated. For example, if the file name is AGENCY1.121, the collection agency name is AGENCY; the STAR system ID is 1, and the date the file was generated was January 21. The file name can be overwritten by typing a new file name. After you enter the file name, you are prompted to confirm the download:

> *Download interface for COLLECTION AGENCY NAME? (Y/N) [Y]--*
> *UNIX File Name: /hbo/tmp/AGENCY223.410*

Enter **Y** to begin the download. Enter **N** if you do not want to proceed. The default is **Y**. If you select Yes, the system processes the selected records and writes them to the collection agency under the UNIX file name specified.

While the system is gathering records for the file, it deletes accounts from the collection agency file whose collection agency transfer date is older than a year from the date the agency file was requested. Accounts that are deleted still remain in bad debt and associated with the agency, but they do not remain in the collection agency file that the system uses to determine which accounts are included on a collection agency transfer file. when the system is done reviewing accounts for deletion, the following message is displayed:

> *XX Records deleted prior to XX/XX/XX --*

After the file is produced, the following messages are displayed:

> *Collection Agency (Name of Agency) download successful--*

> *Records written to (PC, UNIX, Tape) verified--*

If there are not any more agency files to download, the system returns to the Collection Agency Functions Processor screen.

DOWNLOADING A TAPE FILE

If you select **T**ape, you are prompted for the tape drive. After you select the appropriate tape drive, you are prompted to mount the tape. The following is displayed:

> *Please mount (ABC collection agency's) interface tape. Enter tape ready (R) or bypass (B)-*
> *-*

Enter **R** (tape ready) or **B** (bypass). If you enter R, you are then prompted for the density of the tape.

Do you want high (6250 BPI) density or low (1600 BPI) density tape? (H/L)--

Enter **H** for a high (6250 BPI) density tape. Enter **L** for a low (1600 BPI) density tape. After you make the selection, the system processes and writes the selected records to the collection agency interface tape.

While the system is gathering records for the file, it deletes accounts from the collection agency file whose collection agency transfer date is older than a year from the date the agency file was requested. Accounts that are deleted still remain in bad debt and associated with the agency, but they do not remain in the collection agency file that the system uses to determine which accounts are included on a collection agency transfer file. when the system is done reviewing accounts for deletion, the following message is displayed:

XX Records deleted prior to XX/XX/XX --

After the file is produced, the following messages are displayed:

Collection Agency (Name of Agency) download successful--

Records written to (PC, UNIX, Tape) verified--

If there are not any more agency files to download, the system returns to the Collection Agency Functions Processor screen.

GENERATING MULTIPLE AGENCIES

If you have selected multiple agencies to process, the system creates separate reports and interfaces for each agency. The following prompt is displayed for each agency selected:

Download COLLECTION AGENCY NAME to (P)C, (U)NIX, or (T)ape (P/U/T) [T]--

After you select P, U, or T, the system displays the prompts that correspond to generating the selected file.

When generating tapes for multiple agencies, tape density and mounting of tapes are required for each agency selected.

PRINTING THE REPORT ONLY

After you enter Y to produce the report only, the system asks if you want to select all accounts that have not been sent to the current agency. The entry options are **Y** for Yes or **N** for No; the default is Y.

ACCOMPANYING REPORTS

> The Collection Agency Report(FXPCAT4) and Collection Agency Interface Report (FXPCAT5) are generated as a result of the Collection Agency File/Report function. The FXPCAT4 report is generated if you produce a report only and do not generate a file. The FXPCAT4 and FXPCAT5 reports are generated if you produce an agency file. For a detailed explanation of these reports, refer to the *Reports Volume* of the *STAR Patient Accounting Reference Guide*.

Collection Agency Payment File

> This function enables the hospital to automatically post payments received by the collection agency for bad debt accounts. To use this function, create an agency cash posting batch. In order to be processed by STAR Financials, the agency must format the payments on the file according to defined specifications, refer to Interface File Functions in the Financial System Management section in the *General Information Volume* of the *STAR Patient Accounting Reference Guide*.

> Using this function creates a batch of agency cash that is handled in same way as regular agency cash. The payments received in this process do not immediately update the account. They are held in the agency cash batch until the batch is balanced and approved. This enables the hospital to verify the cash and correct any errors before posting to individual accounts.

> Refer to the Posting Agency Cash transaction in the *Account Transactions Volume* of the *STAR Patient Accounting Reference Guide* for more information.

> After this function is selected, the system prompts you to select a facility (if this is a multi-facility installation). You are then prompted to enter a batch code or hyphen (-) to display a list of valid batch codes or have the system assign a code to this batch of agency cash.

After you enter or select a batch code, the system displays the following screen:

```
         General Hospital Agency Cash Posting Setup Processor
                                            Thu Dec 08, 1988 02:58 pm

 1 Batch Code        2 Batch Description                      3 # of Trans
   22                  NATIONAL HEALTHCARE COLLECTIONS
 4 Agency Code/Description              5 Total Entered
   NHC-National Health                    220.00
 6 Check Amount       7 Agency Fees      8 Batch Total      9 Variance
   200.00               20.00              220.00
10 Posting Date      11 Payment Date     12 Remittance #
   12/08/88             12/08/88             Tape Number 22, NHC
13 Trans Code/Description
   E8020-PATIENT PAYMENT-NHC




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

Field Explanations

1. BATCH CODE (DISPLAY ONLY)
This field contains the code assigned to this batch. If the batch code is assigned by the system, NEW is displayed in this field until the batch screen is completed and accepted.

2. BATCH DESCRIPTION (30-AN-R)
This field contains the description of this batch. It is suggested that you include as much information as possible regarding the payment type (for example, Natal Healthcare Coll - Nov payment).

3. # OF TRANS (DISPLAY ONLY)
This field contains the number of accepted transactions on the tape once the agency tape is processed. Only payments accepted into this batch are included. Payments that are rejected appear on a separate error report.

4. AGENCY CODE/DESCRIPTION (6-A-R)
This field contains the code identifying this collection agency. You can enter the code or a hyphen (-) to display a list of valid codes. The payment transaction code associated with this transaction code is displayed in the Transaction Code/Description field.

5. TOTAL ENTERED (DISPLAY ONLY)
This field contains the total amount of payments accepted into the batch once the agency tape is processed. Any additional entries are reflected as well.

6. CHECK AMOUNT (11-N-R)

This field contains the total amount of the payments from the collection agency. The entry range is 0 to $9,999,999.99. If the check amount plus the agency fees does not equal the batch total, the system displays a warning at the bottom of the screen but accepts the amount entered. This occurs if a batch total was calculated previously and you are now changing the check amount or agency amount.

7. AGENCY FEES (11-N-R)

This field contains the fee charged by the agency for collecting this debt. The entry range is 0 to $9,999,999.99. If the check amount plus the agency fee does not equal the batch total, the system displays a warning at the bottom of the screen but accepts the amount entered. This occurs if a batch total was calculated previously and you are now changing the check amount or agency amount. Agency fees are posted using a separate transaction code and type and can be posted to a different GL account. The transaction code is maintained on the Collection Agency Code table and is not displayed here. The transaction type for agency fees is V. This amount is supplied to the hospital by the collection agency.

8. BATCH TOTAL (DISPLAY ONLY)

This field contains the calculated batch total. This field is the sum of the amounts entered in the Check Amount and Agency Fees fields.

9. VARIANCE (DISPLAY ONLY)

This field contains the difference, if any, between the batch total and the total entered. If there is a variance, the batch is unbalanced. A batch must be balanced before it can be approved and posted. If you are creating a batch, this field is blank.

10. POSTING DATE (6-N-R)

This field contains the date that is used for posting this batch to each account and the general ledger. This field defaults to the current date when the batch is created but can be changed to a previous date.

11. PAYMENT DATE (6-N-R)

This field contains the payment date. The system uses the current date but it can be changed to a previous one.

12. REMITTANCE # (12-C-O)

This field contains the check or remittance advice number. If the agency did not provide a remittance number, enter some other information pertaining to the payment. This information is maintained in the account's transaction history.

13. TRANS CODE/DESCRIPTION (DISPLAY ONLY)

This field contains the transaction code (up to four digits) and description that is used to record this payment in the account's transaction history and in the general ledger. The system automatically completes this field based on the Collection Agency code entered in the Agency Code/Description field.

After these fields are completed and you press ENTER to accept the screen, the system displays the following prompt:

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> *Upload from (P)C, (U)NIX, or (T)ape (P?U?T) [T] --*

Uploading a PC File

If you select **P**, the system displays the following prompt:

> *Enter the drive [A] --*

The system is prompting for the drive where your collection agency payment file is located. The default drive is A, but you can override this by typing in the alpha character identifying the drive where the collection agency payment file resides. The system then displays the following prompt:

> *Enter the directory [\] --*

Enter the directory path for the PC file. You are then prompted for the file name:

> *Enter the file name to upload --*

Enter the name of the collection agency payment file. The system then displays the following prompt:

> *Upload interface file (Y?N) [Y] --*
> *PC File Name: [PC file name]*

Enter **Y** for Yes to upload the collection agency payment file. The system displays the following messages:

> *Please wait - Files are being transferred*

> *# Records received from PC!*

If you do not wish to upload the collection agency payment file, select **N** for No, and the system returns to the prompt where you are asked to enter the drive.

Uploading a UNIX File

If you select **U** for UNIX, the system displays the following prompt:

> *Enter the file name to upload --*

Enter the name of the collection agency payment file that you want to upload. The file must reside in the directory path that was specified in the Collection Agency Directory Path Processor. The following prompt is displayed:

> *Upload interface file? (Y?N) [Y] --*
> *UNIX File Name: /hbo/tmp/name of UNIX file*

Enter **Y** for Yes to upload the interface file. The system displays the name of the file that you are requesting to upload and the following messages:

Please wait - Files are being transferred

 # Records received from UNIX!

Uploading a Tape File

If you select **T**, the system displays the available tape units. After selecting a tape unit, the system displays the following prompt:

Please mount the collection agency interface tape.

Enter tape ready(R) or skip(S) --

Enter **R** (ready) or **S** (skip) to bypass the process if you are not ready and want to wait. If R is selected, the system uploads the tape. When the tape process is complete, the system displays the number of records received from the tape. Once the tape is finished processing (or if you decided to skip the tape process), the system displays the following screen:

```
        General Hospital Agency Cash Posting Exit Batch Processor
                                            Thu Dec 08, 1988 04:35 pm

 1 Batch #             2 Batch Description                  3 # of Trans
   22                     Nat'l Healthcare Coll - Nov pymnt      131
CASH   4 Starting Balance  5 Total Entered   6 Batch Total    7 Variance
                                                1.00
CONTRACTUAL ADJUSTMENTS     8 Total Entered  9 Batch Total   10 Variance

11 Batch Status
   Unbalanced




Batch is balanced - Approve (A), Hold (H), Print (P) or Edit (E)?--
```

Field Explanations

1. BATCH # (DISPLAY ONLY)
This field contains the number identifying this batch.

2. BATCH DESCRIPTION (DISPLAY ONLY)
This field contains the description assigned to this batch.

3. # OF TRANS (DISPLAY ONLY)
This field contains the number of transactions added to this batch. This field entry cannot equal the number of records on the tape since some payments may have errors.

CASH

4. STARTING BALANCE (DISPLAY ONLY)
This field contains the batch starting balance. This field is always blank since there is no starting batch for agency cash.

5. TOTAL ENTERED (DISPLAY ONLY)
This field contains the total dollar amount of the payments in the batch based on the information contained on the tape and any charges or additions you entered.

6. BATCH TOTAL (DISPLAY ONLY)
This field contains the estimated total of the batch. This is the sum of the check amount and the agency fees amount. This figure cannot be changed using this function. Once calculated, the batch total is never recalculated. The actual batch total can only be changed through the Agency Cash Posting function in Account Transactions. This field is controlled by security and can only be changed by a user who has the proper security level.

7. VARIANCE (DISPLAY ONLY)
This field indicates the difference between the actual batch total (the Total Entered field) and the batch total entered. The system completes this field by calculating the difference between the two fields and uses the resulting value to assign the batch a status of Balanced or Unbalanced.

CONTRACTUAL ADJUSTMENTS

8. TOTAL ENTERED (DISPLAY ONLY)
This field displays the total amount entered into the batch.

9. BATCH TOTAL (10-N-O)
This field contains an amount for Contractual Adjustments.

10. VARIANCE (DISPLAY ONLY)
This field is a calculation of Batch Total less the Total Entered.

11. BATCH STATUS (DISPLAY ONLY)
This field indicates the batch status--balanced or unbalanced--based on the variance. The prompt at the bottom of the screen varies depending on whether the batch is balanced or unbalanced. If a batch is in balance, you can post it, print it, edit it, or put it on hold. If a batch is unbalanced, you can accept the batch, print the batch detail, edit the information entered, or put the batch on hold.

If a batch is balanced, the options are to approve, hold, print, or edit.

- **A** (approve) causes each batch entry to post to the patient account and the general ledger. Account balances and transaction history are updated immediately to reflect the payment amount. The general ledger is updated during the next midnight processing.

- **H** (hold) causes the batch to remain in the cash file until further action is taken.

- **P** (print) causes every batch entry to print on the designated printer.

- **E** (edit) enables you to edit or delete individual batch entries.

If the batch is unbalanced, the options are to accept, print, or edit. Unbalanced batches remain on the system until they are balanced and approved.

- **A** (accept) is different from the approve option in that batch entries are not posted. You use this option when you want to acknowledge that the batch is unbalanced and you plan to make corrections at a later time.

- **P** (print) causes every batch entry to print on the designated printer.

- **E** (edit) enables you to edit or delete individual batch entries.

If the batch is unbalanced, it must be reconciled before it can be posted. To reconcile the batch, you should verify all entries in the batch and post any rejected payments into the batch. If you want to post the payments that were originally processed by the tape and make corrections in a separate batch, you can edit your check amount to reflect only those entries in the batch and then create a new batch for any additional postings. This is especially true if the account has been transferred to accounts receivable or to a different agency. Creating a separate batch enables you to post the agency payment without affecting the current status of the account. In these instances, you need to change your check amount on the original agency cash batch to reflect the new totals. Payment records not accepted by the system are listed on the Collection Agency Error report. Possible reasons for this are:

- The patient account is not assigned to this agency. This can occur if the hospital has transferred the account back to AR or transferred the account to another collection agency.

- The patient account is not in the system. This can occur if the patient account number on the payment record does not exist in STAR Financials. If the account has been archived or purged, the payment is rejected.

Payment errors can be manually corrected by adding rejected payments to the batch through the Post Agency Cash function. It may be necessary to correct or recreate the account before posting the payment. When the batch is balanced and approved, it is processed like all other cash batches. If you process the same payment report more than one time, the payment records are duplicated in the batch. If you believe there are too many errors to correct manually and you want to reprocess the payment tape after correcting the errors listed, you must first delete each entry from the batch.

Accepting or posting the batch enables you to work with another agency's tape or exit the transaction.

ACCOMPANYING REPORTS

Two reports are produced as a result of this transaction:

- Collection Agency Payment report (FXPCPTP)

- Collection Agency Error report (FXPCPTE)

The Agency Payment report contains the patient account number, patient name, date paid, and payment amount for each record on the tape. The total amount of payments in the batch is included. This report provides a written record of the accounts included on the payment tape.

The Agency Error report contains the same information for accounts whose payments are not accepted by the system and is used in reconciling the batch. An error message is provided for each account listed.

BD ARCHIVE PRE-LIST

This function is used to manually select BD accounts for account archive or to override the system-assigned prelist status. As BD accounts reach the end of their collection agency follow-up schedules, they are considered for account archive. Accounts can be prelisted for account archive manually or by running the optional batch job. In addition, you can manually prelist accounts for archive. The account archive prelist should always be selected and reviewed prior to running the account archive optional batch job. This gives the hospital an opportunity to review all BD accounts eligible for account archive and make any changes to the account status if necessary.

NOTE: It is not required that accounts appear on the BD Archive Prelist Report before they are archived. The account archive process selects and archives all eligible accounts in BD, regardless as to whether or not they have appeared on the BD Archive Prelist Report. Therefore, it is recommended that the hospital develop a procedure to produce and review the BD Archive Prelist Report prior to running the account archive optional batch job.

To be automatically prelisted for account archive, the account must meet the following criteria:

• The account must be in account location BD.

• The last step in the assigned collection agency follow-up schedule must have occurred.

• The account balance cannot exceed the maximum deletion balance indicated on the Collection Agency Follow-up Schedule.

Bad Debt accounts that are on archive hold status are also excluded. You can override these criteria and manually prelist any account in bad debt or remove previously prelisted accounts.

After you select this option, the system prompts you to select a facility (if this is a multi-facility installation). The system then presents the standard account lookup prompt. Only accounts in Bad Debt can be selected.

After you select an account, the system displays the following screen:

```
               General Hospital BD Archive Pre-List Processor
                                              Mon Mar 13, 2006 11:59 am
 Account       Name                    FC Typ Admit    Disch      Balance Loc
 00015-68      LOWMAN,SUSAN L          BC PSY 11/01/89 11/03/89    8.00-   BD/FCRV

  1 Collection Agency Code                   2 Archive Pre-List Flag
    CBI-CBI COLLECTION AGENCY                  User Hold
  3 Archive Prelist Transaction Code/Description
    M0084-BD ARCHIVE PRE-LIST HOLD
  4 Comments
    PUT ACCOUNT ON HOLD-PENDING GUAR. CALL






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

Depending on the current archive prelist status, fields 2 through 4 may already be completed. No field can be accessed without changing the Archive Prelist Flag.

The patient account number, patient type, admission date, discharge date, account balance, and account location/sub location are displayed at the top of the screen.

Field Explanations

1.   COLLECTION AGENCY CODE (DISPLAY ONLY)
This field contains the collection agency code and description assigned to this account.

2.   ARCHIVE PRE-LIST FLAG (1-A-R)
This field contains the prelist status of the account. If the account has not been previously selected, this field contains Account Not Selected. You can enter a hyphen (-) to display a list of valid codes. Depending on your selection, a different transaction code is displayed in field 3. The possible prelist codes are:

• User Hold

  The account is not archived until the hold flag is removed manually. This flag is for accounts that have been previously prelisted or that may be eligible for archive prelisting in the future.

• User Removed

  If an account was previously prelisted for account archiving, this code removes the account from the prelist file. Accounts are considered for selection again the next time the archive prelist is processed.

• User Selected

   This code is for accounts that are not currently on the archive prelist that you want to archive in the next archive process.

3. ARCHIVE PRELIST TRANS CODE/DESCRIPTION (DISPLAY ONLY)
This field displays a code based on the entry in field 2. If the selected account already has a prelist status, the current status is displayed. The transaction code and type is loaded from the corresponding entry in the PAAR Control of the Facility Information function. There is a separate field on the PAAR Control for each selection to allow the hospital to differentiate and maintain statistics on each different process. The transaction type is M (memo) and the fields are defined as follows:

• User Hold Archive Prelist

• User Remove Archive Prelist

• User Archive Prelist

For detailed information on how to complete PAAR Control refer to the *General Information Volume* of the *STAR Patient Accounting Reference Guide.*

4. COMMENTS (76-C-O)
This field contains a free form comment regarding the actions taken on this account. This comment is maintained in account's transaction history. You can only access this field if you change the current prelist status.

Accepting the screen completed the transaction. The account's transaction history is updated to reflect the entered archive prelist status.

MPI INQUIRY

This function is a STAR Patient Care function. Refer to the *Patient Processing Module* of the *STAR Patient Care Reference Guide*.

CHANGE PT AFTER DISCHARGE/FINAL BILL

This function is a STAR Patient Care function. It allows you to make changes to the patient type after final billing. For details, refer to the *Patient Processing Module* of the *STAR Patient Care Reference Guide*.

UNAPPLIED CASH LOG

The designation of unapplied cash is recorded in the Unapplied Cash Log. For cash transactions, the designation is recorded when the money is transferred. For a refund, the designation is recorded when the refund check is produced. The information in the Unapplied Cash Log supplements the information recorded in transaction history. The log is indexed by date of receipt, payment date, and post date. The retention of this data is optional and is determined per the number of days indicated for the Unapplied Cash Log field found on the Data Retention Parameters screen.

The Unapplied Cash Log contains the following elements:

*   Date/time unapplied cash was received

*   ID of user recording the transaction in unapplied cash

*   Payment By

*   Payment For

*   Address Line 1

*   Address Line 2

*   City

*   State

*   Zip

*   Payment Amount

*   Remittance/Check/Card #

*   Carrier if designated insurance payment

*   Plan if designated insurance payment

*   Agency if designated agency payment

*   Contract code if designated contract payment

*   Entity code if designated miscellaneous cash

*   Department # if designated miscellaneous cash

*   Subaccount # if designated miscellaneous cash

- Miscellaneous Cash Code if designated miscellaneous cash

- Payment Date if designated miscellaneous cash or refund

- Post Date if designated miscellaneous cash or refund

- User ID if designated miscellaneous cash

The Unapplied Cash Log can be viewed by selecting the following options:

Account Management/Account Transactions/Unapplied Cash Log

After this processor is selected and the facility is selected if need be, the following screen is displayed which is used to filter the selection list for viewing the Unapplied Cash Log:

```
                    General Hospital Unapplied Cash Log Processor
                                              Wed Jun 23, 2010 07:58 pm


 1 Sort Date                            2 Start Date for Display
->
                    Selection Criteria for Unapplied Activity Log
 3 Transaction Type(s)

 4 Carrier

 5 Plan

 6 Agency

 7 Contract

 8 Miscellaneous Cash Code




Select (R)eceived, P(A)yment, or P(O)st date for sort of Unapplied Activity
Log--  |
```

Field Explanations

1. SORT DATE (1-A-R)

This is the only field which is required, and it determines which of the three index dates is used to find and sort transactions. The prompt for this field is as follows:

Select (R)eceived, P(A)yment, or P(O)st date for sort of Unaplied Activity Log--

2. START DATE FOR DISPLAY (6-AN-O)

The start date for the display can be indicated in this field. The index date selected in the field labeled Sort Date is used. The prompt for this field is as follows:

Enter start date for display or press ENTER to view all activity in log--

3. TRANSACTION TYPE(S) (3-A-O)
The transactions listed can be limited per the cash type used when the use for the unapplied cash was defined. You can enter the code or a hyphen (-) to display a list of valid codes, or enter A (All). Cash types are as follows:

A-Agency

C-Contract

G-Guarantor

I-Insurance

M-Miscellaneous

P-Patient

R-Refund

4. CARRIER (3-A-O)
The insurance payments displayed in the list can be limited by carrier. If insurance plans are selected also in the field labeled Plan, a transaction is included if it matches per carrier or plan. It does not need to match an entry in each list. You can enter the code or a hyphen (-) to display a list of valid codes, or enter A (All)

5. PLAN (5-A-O)
The insurance payments displayed in the list can be limited by insurance plan. If insurance carriers are selected in Carrier field, a transaction is included if it matches per carrier or plan. It does not need to match an entry in each list. You can enter the code or a hyphen (-) to display a list of valid codes, or enter A (All)

6. AGENCY (5-A-O)
The agency payments displayed in the list can be limited by agency. You can enter the code or a hyphen (-) to display a list of valid codes, or enter A (All).

7. CONTRACT (5-A-O)
The contract (vendor) payments displayed in the list can be limited by contract code. You can enter the code or a hyphen (-) to display a list of valid codes, or enter A (All).

8. MISCELLANEOUS CASH CODE (3-A-O)
The entries for miscellaneous cash displayed in the list can be limited by miscellaneous cash code. You can enter the code or a hyphen (-) to display a list of valid codes, or enter A (All).

After accepance of the screen used to define any selection criteria for entries in the Unapplied Cash Log, qualfying transactions are displayed as follows:

```
                 General Hospital Unapplied Cash Log Processor
                                           Sun Jun 27, 2010 02:59 pm


      Seq  Rcv Dt      Payment By                 Payment For
             Amount  Remittance/Check/Card #      Type of Cash
        1  04/30/10    J.R. SMITH                  AMY JONES
             $10.00  CK 233                        Refund
        2  06/07/10    ALLIED SERVICES             B. JOHNSON
             $10.00  CK 3125                       Contract
        3  06/07/10    BLUE CROSS                  C. DOBSON
             $20.00  REMIT NO 239485025            Insurance
        4  06/07/10    ABC COMPANY                 MED REC FEES
             $25.00  CK 2245                       Miscellaneous
        5  06/07/10    J.B. FORD                   J. MATHERS
             $10.00  MASTERCARD                    Patient
        6  06/07/10    ABC AGENCY                  R. BARONE
              $5.00  CK 984                        Agency




         F1Prev Page F2Next Page F5Dsp Transc F6 Reset  F7  E
```

Field Explanations

SEQ
This field contains the line number assigned to the transaction.

RCV DT
This field contains the date the payment was received.

PAYMENT BY
This field contains any information about how the payment was received. Information entered here could include the carrier name, or the name on the check.

PAYMENT FOR
This field contains information regarding the purpose of the payment (that is, for or to whom the payment was made).

AMOUNT
This field contains the amount of the transaction when unapplied activity was indicated.

REMITTANCE/CHECK/CARD #
This field contains the identification number for transaction.

TYPE OF CASH
This field identifies the type of cash selected when the payment was transferred from Unapplied Activity. For refunds, the designation is assigned by the system after the refund check prints. The values which can be displayed in this field are as follows:

• Agency

- Guarantor

- Insurance

- Contract

- Miscellaneous

- Patient

- Refund

The F5 key, which is labeled Dsp Trans, can be used to display a screen with more information about the unapplied cash transaction. For details on this screen, please refer to "Unapplied Cash" on page 1-58 in Chapter 1: Posting Transactions, in the *Account Transactions Volume.*

POST PAYMENT EVALUATION OPTIONS

This option is used to create custom reports which analyze impacts on the prompt receipt of expected reimbursement and on the amount of the reimbursement. The analysis is performed on payment information. Payments are selected for evaluation per the posting date for the transaction. Admitting, HIM, Patient Accounting, Payment Transactions, Business Analysis, Charge, ERA, and Denial data can be used to select payments of interest and to report information. The reported data can be spooled for download to Excel and/or can be saved as SQL records available for queries in STAR. Another option provides a report containing one line per selected record which can be printed in a landscape set-up. One of three types of records can be created, and they are payment, CAS code within payment, or high dollar CAS code within payment. Of particular interest is the ability to select high dollar CAS codes, to select high dollar remark codes, and to analyze data per the department with the higher charge totals for an account with a selected payment. The tool can be used to identify payments of interest for follow-up and to select data for any trending analysis.

There are eleven options for Post Payment Evaluation, as follows. Each option is discussed in detail on the following pages.

• Maintain Post Payment Evaluation Table

  Used to maintain entries in the Post Payment Evaluation Table. This can be done in Financial Table Maintenance also.

• Maintain Post Payment Evaluation Batch Jobs

  Used to view jobs for Post Payment Evaluation and to stop, re-start, or clear jobs. These include jobs scheduled to run in the future, jobs in progress, recently completed jobs, and stopped jobs. Jobs not creating SQL data are removed during midnight processing for the date that the job ended. Jobs creating SQL data are removed when the SQL data is removed automatically or manually.

• Remove Post Payment Evaluation SQL Data

  Used to remove SQL data for a Post Payment Evaluation before the data are purged by the system automatically. When the data are purged, run information for the job is removed if the job completed on a previous day.

• Set Stop Time for MNP Post Payment Evaluation Jobs

  Used to set a stop time for Midnight Processing of Post Payment Evaluation Jobs.

• View Post Payment Evaluation Table

  Used to view entries in the Post Payment Evaluation Table. This can be done in Financial Table Maintenance - View also.

- View Post Payment Evaluation Batch Jobs

  Used to view jobs for Post Payment Evaluation. These include jobs scheduled to run in the future, jobs in progress, recently completed jobs, and stopped jobs. Jobs not creating SQL data are removed during midnight processing for the date that the job ended. Jobs creating SQL data are removed when the SQL data is removed automatically or manually.

- View Post Payment Evaluation Jobs with SQL Data

  Used to review jobs with SQL data for a Post Payment Evaluation before the data are purged by the system automatically or manually. When the data are purged, run information for the job is removed if the job completed on a previous day.

- View Post Payment Evaluation Dictionary

  Used to view the data elements used in Post Payment Evaluation. The data elements can be used to select payments and to provide fields for the record created.

- Report Post Payment Evaluation Dictionary

  Used to report the data elements used in Post Payment Evaluation. The data elements can be used to select payments and to provide fields for the record created.

- Perform Post Payment Evaluation for Posted Batch

  Used to perform a Post Payment Evaluation for a batch posted during the current day.

- Post Payment Evaluation Worklist

  This option is used to create a worklist of selected payments. This enables you to 'work' the accounts in a timely fashion. The worklist can be purged when the user exits this function. In the Post Payment Evaluation Table, if the code is setup in field 3 for Worklist or Both, when the job completes, a worklist of the selected accounts is created.

Maintain Post Payment Evaluation Table

This table is used to define set-up criteria for selecting payments and to choose data elements to be used in the record built for the report and/or SQL data.

When this option is selected from the menu, the following screen is displayed:

```
          General Hospital Maintain Post Payment Evaluation Table Processor
                                              Wed Apr 27, 2011 01:23 pm

Post Payment Evaluation Table
 1 Evaluation Code          2 Evaluation Description
   TST                        Test 1
 3 Report/Worklist
   Worklist
 4 ERA/Manual Batch         5 Include Facilities         6 Selection Criteria
   ERA                        A                            9
 7 Report Options           8 Type of Record for Data Selection
   SQL Record                 Payment
Daily           9 Schedule                             10 Retain SQL Data
                  After Each Batch Posts
Weekly/Monthly  11 Schedule                             12 Retain SQL Data

One-Time        13 Start/End Dates       14 Run Date   15 Retain SQL Data

16 Elements     17 Max Record Length
   5               86
18 Edit by                        19 Edit date             20 Status
   New, Nancy                        04/12/11 08:03pm          Active
Enter field number or '/' starting field number--
```

Field Explanations

1. EVALUATION CODE (AN-20-R)
This field contains the user-defined code for this set-up for Post Payment Evaluation.

2. EVALUATION DESCRIPTION (AN-30-R)
This field contains the user-defined code for this set-up for Post Payment Evaluation.

3. REPORT/WORKLIST (1-A-R)
This field defines whether you want to create a report, a worklist, or both.When this field is accessed, the following prompt is displayed:

Create (R)eport, (W)orklist, or (B)oth-

4. ERA/MANUAL CASH BATCH (1-A-R)
This field is used to limit the selection to payments posted in an ERA batch or a manual cash batch. For example, if you are selecting payments for analysis using CAS codes there is no need to include batches manually created. When this field is accessed, the following prompt is displayed:

Use (E)RA Batches, (M)anual Batches, or (B)oth Type of Batches-

5. INCLUDE FACILITIES (1-A-R)
This table is not split by facility. This field is used if the evaluation should be limited by facility. Cross Facility Batches can be selected also.   When this field is accessed, the following screen is displayed:

```
Page:01                        Facilities                 ##=Current Choices
( 1) *-Cross Facility Batches
( 2) A-Model Hospital A
( 3) B-Model Hospital B
( 4) C-Model Hospital C
( 5) D-Cloned Facility from A




Select facilities to be included or press ENTER for ALL--
                              end select(NL)
```

- If all batches should be evaluated, you can press ENTER to select all facilities on the screen.

- If a facility is included, a batch for the included facility is evaluated after it posts. If Cross Facility Batches are included, cross facility batches are evaluated when the batch posts.

6. SELECTION CRITERIA
The criteria used to select payments are defined in this field. If the field is accessed and criteria have been defined previously, a scrolling screen is displayed, which lists the criteria. If the field is accessed and no criteria were defined previously, the following screen is displayed:

```
              General Hospital Maintain Post Payment Evaluation Table Processor
                                           Wed Apr 27, 2011 02:43 pm

Selection Criteria for Payments
 1 Criteria#     2 Field Name                          3 Type of Field
   1
 4 Field Description

 5 Criteria

 6 Operator                 7 Value

 8 Table Selection

 9 Indicator

10 From/Thru Dates

11 Comment1

12 Comment2

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

Field Explanations

1.   CRITERIA# (DISPLAY ONLY)
This field contains a sequence number for the criteria and is supplied by the system when the criteria is added.

2.   FIELD NAME (TABLE LOOKUP-R)
This field contains a Field Name from the Post Payment Evaluation Data Dictionary. This field is used to select a field identifying a criteria for selecting a payment. Fields for High Dollar and Table for Column can be selected up to five times. Other fields can be selected once. When this field is accessed, the following prompt is displayed:

>   *Key Field name or use `-` for a table lookup-*

If a Field Name is selected, the Type of Field field is populated.

The declaration of the search criteria is based on the data schema of the selected field. The data schemas for payment selection are as follows:

Number

Table to Filter

Indicator

From/Thru Dates

If the field name is changed, the rest of the fields on this screen are removed so the user may start over with a new selection.

3. TYPE OF FIELD (1-A-O)
This optional field can be used before a Field Name is selected. If a Type of Field is selected, any table lookups in Field Name are limited by Type of Field. The fields in the Post Payment Evaluation Data Dictionary are organized by type, and these are as follows:

- Patient Processing

- HIM

- Patient Accounting

- Payment Transactions

- Business Analysis

- Charge

- ERA

- Denial

The prompt for this field is as follows:

Select (A)dm, (H)IM, (P)t Acct, Pymt Transc(T), (B)us Anal, (C)hg, (E)RA, or (D)enial-

If the Type of Field is changed and Field Name has a value, it is removed, as are any selection criteria, the Field Description, and comments.

4. FIELD DESCRIPTION (DISPLAY ONLY)
This is display only field of the description per the item selected in Field Name.

5. CRITERIA (DISPLAY ONLY)
This field defines how payments are selected per the field selected from the Post Payment Evaluation Data Dictionary. This is a display only field formatting the search criteria for the field per responses in fields 6-10.

6. OPERATOR (TABLE LOOKUP-R)
This field contains operators used when the Data Schema is for a number. The Operator is selected from the following table lookup.

- BE-Between or Equal

- BT-Between

- EQ-Equal

- GE-Greater Than or Equal

- GT-Greater Than

- LE-Less Than or Equal

- LT-Less Than

- NBE-Not Between or Equal

- NBT-Not Between

- NE-Not Equal

7. VALUE (TABLE LOOKUP-R)

This field is used when the Data Schema is for a number. One or two numbers are keyed for Value depending upon the Operator selected in the Operator field. The potential prompts are as follows. The prompts are listed in the order of the table lookup for the Operator field.

Enter value 1, value 2 for Between or Equal Comparison-

Enter value 1, value 2 for Between Comparison--

Enter value for Equal Comparison-

Enter value for Greater Than or Equal Comparison-

Enter value for Greater Than Comparison-

Enter value for Less Than or Equal Comparison-

Enter value for Less Than Comparison-

Enter value 1, value 2 for Not Between or Equal Comparison-

Enter value 1, value 2 for Not Between Comparison-

Enter value for Not Equal Comparison--

8. TABLE SELECTION (TABLE LOOKUP-CONDITIONAL)

This field is required when the Data Schema is for table. The prompt for the field is as follows where xx is the table name.

Key entries for xx separated by commas or use `-` to select from table lookup-

If entries are keyed, any previous entries in the field are removed. If entries are selected from the table lookup, they are added to previous entries in the field.

9. INDICATOR (1-A-CONDITIONAL)
This field is required when the Data Schema is for an Indicator. The prompt is dependent upon the Indicator. For example if the Indicator is for First/Last Payment Indicator, the prompt is as follows:

Enter (F)irst Payment for Insurance, (L)ast Payment for Insurance, or (B)oth--

10. FROM/THRU DATES (N-8-CONDITIONAL)
This field is required when the Data Schema is for From/Thru Dates. The time frame for payment selection is defined by answering the following prompt where xx is the field name. The time frame for the payment posting date is used also. The four-digit year is required for each of the two dates and the end date cannot follow the current date.

Enter From Date-Thru Date for xx using the MM/DD/YYYY format for the two dates-

11. COMMENT1 (DISPLAY ONLY)
This field displays hints for the field displayed in Field Name.

12. COMMENT2 (DISPLAY ONLY)
This field displays hints for the field displayed in Field Name.

Maintain Post Payment Evaluation Table - Field Explanations Continued

7. REPORT OPTIONS (1-A-R)
This field contains output options for the report from the following:

- Create (D)ownload Report, (S)QL Record, (B)oth, or Report for (P)rinting.

- **D** (Download) - The download report is available for exporting into Excel or the report can be spooled to FAR900x

- **S** (SQL Record) - The SQL record option creates the SQL index for SQL reporting.

- **P** (Printing) - The option for printing spools a 132 character report to the spooler. If the Report for (P)rinting option is selected the report is spooled to FAR901x.

8. TYPE OF RECORD (1-A-R)
When this field is accessed, the following prompt is displayed:

Create records for each (P)ayment or each selected (C)AS Code in a payment?--

One of two types of records can be created:

- A record can be created for each payment.

- A record can be created for each CAS code displayed in the payment and displayed in one of the following selection lists. Note that all entries can be selected from the selection list in the Elements field.

    - CAS Codes for CAS Record Type

    - Group/CAS Codes for CAS Record Type

- A record can be created for the High Dollar CAS code displayed in the payment. The High Dollar CAS code is not limited by a selection list although the selection of a payment can be limited by the existence of a CAS code within the payment.

NOTE: If Cross Facility batches are selected in the Facilities field, the following error is displayed:

Error: Must select After Each Batch Posts for Cross Facility!

In order to run a Post Payment Evaluation against a Cross Facility batch, the Criteria field must be set to include *Cross Facility batches*, and the Daily Schedule Field must be set to run *After Each Batch Posts.*

9. DAILY SCHEDULE (1-A-O)
This optional field is used if the output from the evaluation should be performed immediately after the batch posts or during Midnight Processing for all batches posted during the day.

- The prompt for the field is as follows if SQL Tran Hist Index is employed:

    Run after each batch (P)osts or daily during (M)NP for all batches posted during the day?-

- The prompt for the field is as follows if SQL Tran Hist Index is not employed:

    Run after each batch (P)osts?--

If the evaluation is performed during Midnight Processing, it is done during the step titled PA Uptime Rpts.

10. RETAIN SQL DATA (2-N-O)
If a SQL Record is being created per the Report Options field, and the Schedule field was used to schedule daily runs, the Retain SQL Data field can be used to indicate how long the SQL Record should be retained. If the Retain SQL Data field has no value, the SQL Record is retained until the next run of Midnight Processing occurs and the Post Payment Evaluation is performed. The prompt for the field is as follows and the maximum value is 99:

Enter number of days to retain SQL data for daily runs-

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The data is purged automatically when (run end date for evaluation) - (midnight processing date) > number of days in the Retain SQL Data field.

11. WEEKLY/MONTHLY SCHEDULE
This field cannot be accessed unless SQL Tran Hist Index is employed. This optional field is used if the output from the evaluation should be produced for batches posted in the previous week or month. The first prompt for the field is as follows:

Schedule (W)eekly or (M)onthly Run?-

- If W for Weekly Run is keyed, the day of the week for the run is selected by answering the below prompt. The selection is done during midnight processing for the selected date for batches posted in the previous 7 day, meaning data for the date of midnight processing is not included. For example, if 2 for Monday is keyed, the analysis is done during Midnight Processing for Monday and payments posted for the previous Monday thru Sunday are analyzed. The day of the week for the midnight processing run matches the start day for the seven days of data being evaluated.

  Enter day of week (1=Sun,2=Mon etc.) to run evaluation for previous 7 days during MNP-

- If M for Monthly Run is keyed, then the day of the month for the run is selected by answering the following prompt. During midnight processing for the selected date in the month, payment transactions posted in the previous month are analyzed.

  Enter day of month to run evaluation for previous month (1-28)--

12. RETAIN SQL DATA FOR WEEKLY/MONTHLY RUNS (2-N-O)
If a SQL Record is being created per the Report Options field, and the Weekly/Monthly Schedule field was used to schedule weekly/monthly runs, the Retain SQL Data for Weekly/Monthly Runs field can be used to indicate how long the SQL Record should be retained. If this field has no answer, then the SQL Record is retained until the next run of PA's MNP occurs. The prompt for the field is as follows and the maximum value is 99:

Enter number of days to retain SQL data for weekly/monthly runs-

The data is purged automatically when (run end date for evaluation) - (midnight processing date) > number of days in field 12.

13. ONE-TIME START/END DATES (8-AN-O)
This optional field is used to schedule a one-time run selecting data per the criteria in this Evaluation Criteria. The time frame for the selection is defined by answering the following prompt. The four-digit year is required for each of the two dates and the end date cannot follow the current date.

Enter Start Date-End Date for One-Time Run using the MM/DD/YYYY format for the two dates-

14. RUN DATE (1-A-O)
This optional field is used to indicate when the run defined in the One-Time Run Start/
End Dates field should be performed. The prompt is as follows:

Key N to run Now or enter MNP run date [T]-

15. RETAIN SQL DATA FOR ONE-TIME RUNS (2-N-O)
If a SQL Record is being created per field 7 (Report Options) and field 14 (Run Date
for One-Time Run) was used to schedule one-time runs, then field 15 can be used to
indicate how long the SQL Record should be retained. If field 15 has no answer, the
SQL Record is retained until the next run of PA's MNP occurs. The prompt for the field
is as follows and the maximum value is 99:

Enter number of days to retain SQL data for one-time runs-

The data is purged automatically when (run end date for evaluation) - (midnight
processing date) > number of days in field 15.

16. ELEMENTS (TABLE LOOKUP-R)
The data elements to be included in the record created from the Reimbursement
Evaluation are selected in this field via the following screen:

```
              General Hospital Maintain Post Payment Evaluation Table Processor
                                               Tue May 03, 2011 03:51 pm

 Fields to be Included                                            Length: 299
 Seq#  Field Code          Type      Sel#  Order  Len  Table Selection
       Description
   1  Act                 Pt Proc            1    13
       Account Number
   2  PSq                 PA                 2     7
       Payment Sequence Number
   3  LQ@                 ERA        1       3     7  M3
       LQ Remark Code @ Equals
   4  LQAmt@              ERA        1       4    15
       Total Charge Amount for LQ Remark Code Equals
   5  LQPAmt@             ERA        1       5    15
       Total Payment Amount for LQ Remark Code Equals
   6  LQ@                 ERA        2       6     7  M4
       LQ Remark Code @ Equals
   7  LQAmt@              ERA        2       7    15
       Total Charge Amount for LQ Remark Code Equals
   8  LQPAmt@             ERA        2       8    15
       Total Payment Amount for LQ Remark Code Equals


 F1Prev Page F2Next Page F3 Insert  F4 Delete  F5View Dtl F6 Reset  F7  Exit   ?
```

Field Explanations

LENGTH (DISPLAY ONLY)
The current record length is maintained and updated as the list of data elements
changes.

SEQ# (DISPLAY ONLY)
Seq# is the order of the field in the record.

FIELD CODE (TABLE LOOKUP-O)
This field is used to select one data element. You can enter a hyphen (-) to select from a list of data elements. This field is not required so the field can be bypassed temporarily to use the Type field to limit the lookup list to fields of a particular type. You can select a type in the Type field, then return to the Field Code field to select a data element.

There are several fields related to selecting a High Dollar item. These fields are referred to as *High Dollar* fields. If the High Dollar item is found, the code for the qualifying item is displayed in the field. If the High Dollar item is not found, the field is blank. Subsequent related fields can be selected, and the fields are populated if the High Dollar item is found. For example if the High Dollar SIM Dept # is selected for the first High Dollar SIM Dept #, this is the SIM department with the highest charge total for the account, and the SIM department is displayed in the field. Up to five fields can be selected in any of these field types meaning the first thru fifth high dollar items can be identified. These field types include the following:

- High Dollar SIM Dept #

- High Dollar Rev Code #

- High Dollar ERA HCPCS #

- High Dollar ERA Rev Code #

- High Dollar CAS Code #

- High Dollar Group/CAS Code #

- High Dollar LQ Remark #

- High Dollar Denial Code #

The Table for Column fields are related to populating a field if the value matches the selected value. If the item is found, the code for the qualifying item is displayed in the field. If the item is not found, the field is blank. Subsequent related fields can be selected, and the fields are populated if the item is found. For example if Charge SIM Dept @ Equals is used to determine if a charge exists for SIM department RAD and the account has a charge for SIM department RAD, then the SIM department RAD is displayed in the field. Up to five fields can be selected in any of these field types. These field types include the following:

- Charge SIM Dept @ Equals

- Rev Code @ Equals

- CAS Code @ Equals

- Group/CAS Code @ Equals

- LQ Remark @ Equals

- Denial Code @ Equals

If a field is selected, the length displayed above the header line is updated. If the new field would cause the length to exceed the allowed length for the type of output, the selected field is disallowed and the edit message is as follows:

Record length exceeds xx!

If records are being selected to print a report, then xx equals 132. Otherwise xx equals 1023.

FIELD TYPE (1-A-O)
This field can be used to limit the fields displayed in the lookup list for the Field Code field. If a Field Code exists or is selected in Field 2, Field Type is populated automatically. The types of fields are as follows:

- A Adm

- H HIM

- P Patient Accounting

- T Payment Transactions

- B Business Analysis

- C Charge

- E ERA

- D Denial

The prompt for this field is as follows:

(A)dm, (H)IM, (P)t Acct, (T)Pmt Tx, (B)us Anal, (C)harge, (E)RA, (D)enial

SEL# (DISPLAY ONLY)
This field is populated when the field selected in Field 2 (Field Code) is one of the fields for High Dollar or Table for Column. The next unused number is assigned and the maximum number of selections for a given field is five.

ORDER (1-A-O)
The order of fields is determined by the order of appearance in the scrolling screen unless this field is used. If the field is used, the order in which fields are stored is changed. Fields for which Order is indicated are stored first, and they are sorted by Order followed by Seq#. Fields for which Order is not indicated are stored next and they are sorted by Seq#.

LEN (DISPLAY ONLY)
This field is populated with the length for the field selected in the Field Code field.

FIELD DESCRIPTION (DISPLAY ONLY)
This field is populated with the description for the field selected in Field 2 (Field Code).

Maintain Post Payment Evaluation Table - Field Explanations Continued

17. MAX RECORD LENGTH (DISPLAY ONLY)
This field displays the current record length per the fields selected in Data Elements. The length in this field cannot exceed 1023 if Download Rpt/SQL/Rpt to Prt equals Download Report, SQL Record or Both. The length in this field cannot exceed 132 if Download Rpt/SQL/Rpt to Prt equals Report for Printing.

18. EDIT BY (DISPLAY ONLY)
This field contains the name of the last person updating information for the entry in the table.

19. EDIT DATE (DISPLAY ONLY)
This field contains the last date for updating information for the entry in the table.

20. STATUS (DISPLAY ONLY)
Indicates whether an entry is Active or Inactive.

Maintain Post Payment Evaluation Batch Jobs

This option can be used to view a li'st of batch jobs sorted by scheduled start time of the following types:

- Scheduled for today or in the future

- Completed today

- Running Currently

- Incomplete

- SQL Data has not been removed

The list of jobs is provided in a scrolling screen and the details of a particular job can be requested. The screen can be used to stop a run, to re-start a run, or to clear a run.

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The list can be limited per Post Payment Evaluation codes, completion date, and facility.

When this option is selected, the system prompts you to select a facility, then displays the following prompt:

Key Post Payment Evaluation Code, use `-` for table selection, or press ENTER for All--

After you enter a post payment evaluation code or press ENTER for all, the following prompt is displayed:

Select (A)ll jobs, (S)cheduled jobs, (I)ncomplete Jobs, or (C)ompleted jobs [A]--

After you select the type of jobs (all, scheduled, incomplete, or completed) you want to maintain and enter a starting date, the following screen is displayed:

```
                    General Hospital Maintain Post Payment Evaluation Batch Jobs Processor
                                        Wed May 11, 2011 02:04 pm
Maintain Post Payment Evaluation Batch Jobs
    Rn#        Code                 Description                         Page:01
    Type/BN         Sched Start   Started      Ended       Last Check Point
( 1) 1         JAPMT               JA PMT VARIANCE
    After Pstd/ 3   05/02/11 1417 05/02/11 1417 05/02/11 1417
( 2) 3         JAHD                JA HIGH DOLLAR HCPCS
    After Pstd/ 4   05/06/11 MNP 05/06/11 0934 05/06/11 0934
( 3) 4         JAHD                JA HIGH DOLLAR HCPCS
    After Pstd/J2   05/06/11 MNP 05/06/11 1120 05/06/11 1120
( 4) 5         JAHD                JA HIGH DOLLAR HCPCS
    After Pstd/J1   05/06/11 MNP 05/06/11 1139 05/06/11 1139
( 5) 6         JAHD                JA HIGH DOLLAR HCPCS
    After Pstd/J1   05/06/11 MNP 05/06/11 1151 05/06/11 1151
( 6) 7         JAHD                JA HIGH DOLLAR HCPCS
    After Pstd/J2   05/06/11 MNP 05/06/11 1200 05/06/11 1200
```

Field Explanations

RN
This field contains the run number.

CODE
This field contains the code from Post Payment Evaluation table for the job.

DESCRIPTION
This field contains the description for Code from Post Payment Evaluation table.

TYPE/BN
If the run is for one batch, the batch number is displayed in this field. Otherwise the values are as follows:

- Daily - The run is performed during Midnight Processing for Patient Accounting using all insurance cash batches posted that day.

- Weekly - The run is performed weekly during Midnight Processing for Patient Accounting for all insurance payments posted in the previous seven days. The end date for the week would be one day before the date for midnight processing. If the run is occurring for a Midnight Processing run on Monday, the selection dates are for the preceding Sun thru Sat.

- Monthly - The run is performed monthly during midnight processing for Patient Accounting for the previous month.

- One Time - The run was scheduled with user-selected start and end dates.

SCHED START
This field contains the expected start date and time for the job. If the job is running during midnight processing, the Midnight Processing date for the run is displayed followed by MNP.

STARTED
If the job has started, the start date and time appear. The start date and time appear even if the job started but is not running currently.

ENDED
If the job completed, the end date and time are displayed.

LAST CHECK POINT
If the job is not executing for a specific batch, check points of the job occur periodically. This allows the job to be re-started and continued.

The following screen is displayed:

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```
              General Hospital (Maintain Post Payment Evaluation Batch Jobs Processor
                                        Tue Sep 20, 2011 01:57 pm
Maintain Post Payment Evaluation Batch Jobs
 1 Run#       2 Evaluation Code       3 Evaluation Description
   964          JAHD                    JA HIGH DOLLAR HCPCS
 4 Sched Start     5 Type/BN              6 Start/End Dates        7 Report/Work
   09/20/11 MNP      Daily                  09/20/11-09/20/11        Both
 8 ERA/Manual       9 Report Options     10 Type of Record      11 SQL
   Both              Report for Printing    Payment                  No/7
12 Run Started     13 Run Completed     14 Last Check Point    15 MNP Job Stopped

16 Stop Requested 17 Run Stopped        18 Run Re-started       19 Run Cleared

20 Stop Requested By      21 Re-start Requested By  22 Cleared By

23 Job Running Since      24 Restart Information Exists

25 Payments Evaluated     26 Payments Selected        27 Records Created

28 SQL Data Removed       29 SQL Data Removed By


(E)xit or (R)eview Selection Details--
```

Field Explanations

1. RUN # (DISPLAY ONLY)
This field contains the run number.

2. EVALUATION CODE (DISPLAY ONLY)
This field contains the code for the Post-Payment Evaluation setup used.

3. EVALUATION DESCRIPTION (DISPLAY ONLY)
This field contains the description for the Post-Payment Evaluation setup used.

4. SCHED START (DISPLAY ONLY)
This field contains the expected start date and time for the job. If the job is running during midnight processing, the Midnight Processing date for the run is displayed followed by MNP.

5. TYPE/BN (DISPLAY ONLY)
If the run is for one batch, the batch number is displayed in this field. Otherwise the values are as follows:

* Daily - The run is performed during Midnight Processing for Patient Accounting using all insurance cash batches posted that day.

* Weekly - The run is performed weekly during Midnight Processing for Patient Accounting for all insurance payments posted in the previous seven days. The end date for the week would be one day before the date for midnight processing. If the

run is occurring for a Midnight Processing run on Monday, the selection dates are
for the preceding Sun thru Sat.

- Monthly - The run is performed monthly during midnight processing for Patient
  Accounting for the previous month.

- One Time - The run was scheduled with user-selected start and end dates.

6. START/END DATES (DISPLAY ONLY)
The start and end dates for the record selection are displayed. Selection is per the
posting date for the insurance cash transaction.

7. REPORT/WORK (DISPLAY ONLY)
This field indicates whether the job creates a report, worklist, or both.

8. ERA/MANUAL (DISPLAY ONLY)
This field indicates whether the job selects payments posted to an ERA batch or a
manual cash batch.

9. REPORT OPTIONS (DISPLAY ONLY)
This field indicates the report option: Download Report, SQL Record, Both, or Report
for Printing.

10. TYPE OF RECORD (DISPLAY ONLY)
One of two record types can be created and they are as follows:

- Payment. A record is created for each qualifying Payment.

- CAS Code within Pymt. A record is created for each CAS Code within a qualifying
  Payment. The CAS Codes can be limited using the selection lists CAS Codes for
  Rec Type CAS Code within Pymt or Group/CAS Codes for Rec Type Group/CAS
  Code within Pymt.

11. SQL (DISPLAY ONLY)
This field indicates if the SQL Data is retained and if so, displays the number of days
the SQL Data is retained.

12. RUN STARTED (DISPLAY ONLY)
This field contains the date/time for start of job execution.

13. RUN COMPLETED (DISPLAY ONLY)
This field contains the date/time for completion of job execution.

14. LAST CHECK POINT
This field contains the date/time the last check point was taken to record re-start
information. Re-start information is retained for runs not being performed for one batch.

15. MNP JOB STOPPED (DISPLAY ONLY)
This field contains the stop time for the job if the job was stopped in MNP due to a cutoff time based on the stop time parameter.

16. STOP REQUESTED (DISPLAY ONLY)
If a user requested stoppage of the batch job, the requested date/time are displayed here.

17. RUN STOPPED (DISPLAY ONLY)
If a user requested stoppage of the batch job, the date/time of the stoppage are displayed here.

18. RUN RE-STARTED (DISPLAY ONLY)
If a user requested a re-start of the batch job, the re-start date/time are displayed here.

19. RUN CLEARED (DISPLAY ONLY)
If a user requested a previously stopped job be cleared meaning the job can no longer be restarted, the date/time of the clearance of data are displayed here.

20. STOP REQUESTED BY (DISPLAY ONLY)
The last user requesting the job be stopped is displayed here.

21. RE-START REQUESTED BY (DISPLAY ONLY)
The last user requesting the job be re-started is displayed here.

22. CLEARED BY (DISPLAY ONLY)
The user requesting a previously stopped job be cleared is displayed here.

23. JOB RUNNING SINCE (DISPLAY ONLY)
This field contains the date/time for the beginning of the run of the job. If a job was re-started, this is the date/time of the job re-start.

24. RESTART INFORMATION EXISTS (DISPLAY ONLY)
This field contains Yes if re-start information exists for the evaluation.

25. PAYMENTS EVALUATED (DISPLAY ONLY)
The number of payments reviewed for the evaluation is displayed.

26. PAYMENTS SELECTED (DISPLAY ONLY)
The number of payments selected for the evaluation is displayed. If the type of record is 'CAS Code within Pymt', the Payments Selected may not match Records Created.

27. RECORDS CREATED (DISPLAY ONLY)
The number of records created for the evaluation is displayed. This should match Payments Selected when the type of record is Payment or High Dollar CAS Code. If the type of record is 'CAS Code within Pymt', Records Created may not match Payments Selected.

28. SQL DATA REMOVED (DISPLAY ONLY)
If the SQL Data was removed by user request, the date/time of the request is displayed in this field.

29. SQL DATA REMOVED BY (DISPLAY ONLY)
If the SQL Data was removed by user request, the user name is displayed in this field. If the user elects to review selection details, the following screen is displayed. It documents the contents in the Post Payment Evaluation table when the job ran.

- You can press F5 to view details about a specific job.

- If there are no processes to be performed for the job, the following prompt is displayed:

  (E)xit or (R)eview Selection Details--

- One of the following prompts can be displayed below the screen if appropriate:

  Job is not running. Do you want to (R)estart job from where it stopped or (C)lear this job?-

  Job is running. Do you want to stop this job? (Y/N)--

- If the previous prompt was not answered, a response of N was keyed, or no prompt was displayed, the following prompt is displayed.

   (E)xit or (R)eview Selection Details--

Remove Post Payment Evaluation SQL Data

This option can be used to view a list of completed batch jobs with SQL information sorted by scheduled start time. The list of jobs is provided in a scrolling screen and the details of a particular job can be requested. The screen can be used to remove SQL information for the job before it is scheduled to be purged automatically.

The list can be limited per Post Payment Evaluation codes, start date, and facility.

A job is listed in this index until the SQL information is removed manually in this option or automatically by purging.

After this option is selected, the following prompts are displayed.

  *Select facility or * for cross facility batches--Key Post Payment Evaluation Code or use `-` for table selection or press Enter for All-*

If ENTER is pressed, you are prompted to enter a Starting Date.

A facility lookup is displayed with the following prompt.. Cross Facility appears if Cross Facility is activated for the site.

The following screen is displayed:

```
              General Hospital Remove Post Payment Evaluation SQL Data Processor
                                          Sun Jul 31, 2011 09:26 pm
Remove Post Payment Evaluation SQL Data
     Rn#        Code                  Description                          Page:01
     Type/BN           Sched Start    Started      Ended      Last Check Point
( 1) 538        PMTRS                 PM SQL TRS
     Daily              07/23/11 MNP 07/24/11 0211 07/24/11 0211
( 2) 540        PMPA                  PM SQL PA
     Daily              07/24/11 MNP 07/25/11 0211 07/25/11 0211
( 3) 541        PMTRS                 PM SQL TRS
     Daily              07/24/11 MNP 07/25/11 0211 07/25/11 0211
( 4) 543        PMPA                  PM SQL PA
     Daily              07/25/11 MNP 07/26/11 0211 07/26/11 0211
( 5) 544        PMTRS                 PM SQL TRS
     Daily              07/25/11 MNP 07/26/11 0211 07/26/11 0211
```

For field explanations, see .

If a specific job is selected the following screen appears providing more information about the job.

```
              General Hospital Remove Post Payment Evaluation SQL Data Processor
                                          Sun Jul 31, 2011 09:26 pm
Remove Post Payment Evaluation SQL Data
 1 Run#        2 Evaluation Code       3 Evaluation Description
   538          PMTRS                    PM SQL TRS
 4 Sched Start    5 Type/BN           6 Start/End Dates       7 Report/Work
   07/23/11 MNP    Daily                07/23/11-07/23/11        Both
 8 ERA/Manual     9 Report Options     10 Type of Record      12 SQL
   Both            Both                    Payment               Yes/6
11 Run Started    13 Run Completed     14 Last Check Point     15 MNP Job Stopped
   07/24/11 02:11    07/24/11 02:11
16 Stop Requested 17 Run Stopped       18 Run Re-started       19 Run Cleared

20 Stop Requested By       21 Re-start Requested By   22 Cleared By

23 Job Running Since       24 Restart Information Exists
   07/24/11 02:11
25 Payments Evaluated      26 Payments Selected         27 Records Created

28 SQL Data Removed        29 SQL Data Removed By


Do you want to remove the SQL information for this run? (Y/N)--
```

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For field explanations, see "Maintain Post Payment Evaluation Batch Jobs" on page 3-112.

The following prompt is displayed:

Do you want to remove the SQL information for this run?

If Y for Yes is keyed, SQL information for the job is removed, the user exits the option, and the job ceases to be displayed in the list of Post Payment Evaluation jobs with SQL files.

View Post Payment Evaluation Table

This option allows you to view the Post Payment Evaluation Table. The table can be viewed but not updated.

For details, see "Maintain Post Payment Evaluation Table" on page 3-100.

View Post Payment Evaluation Batch Jobs

This option is used to view jobs for Post Payment Evaluation. These include jobs scheduled to run in the future, jobs in progress, recently completed jobs, and stopped jobs. Jobs not creating SQL data are removed during midnight processing for the date that the job ended. Jobs creating SQL data are removed when the SQL data is removed automatically or manually.

This option is used to view, but not to update post payment evaluation batch jobs. For details, see "Maintain Post Payment Evaluation Batch Jobs" on page 3-112.

View Post Payment Evaluation Jobs with SQL Data

This option is used to view but not update jobs with SQL data for a Post Payment Evaluation before the data are purged by the system automatically or manually. When the data are purged, run information for the job is removed if the job completed on a previous day.

For details, see "Remove Post Payment Evaluation SQL Data" on page 3-118.

View Post Payment Evaluation Dictionary

This option is used to view information on an element used in Post Payment Evaluation. Elements are used to select payments and/or to provide data related to the selected payment.

When this option is selected, the following prompt is displayed:

Enter code for field name or use `-` for table lookup--

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You can enter a code or hyphen for a table lookup. If a hyphen is entered, the following screen is displayed:

```
                General Hospital View Post Payment Evaluation Dictionary Processor
                                       Thu Aug 04, 2011 12:20 am


Page:01                     Post Payment Evaluation Fields
( 1) ActBal-Account Balance
( 2) Act-Account Number
( 3) Adj-Adjustment Amount
( 4) AdmDt-Admit Date
( 5) AdmDr-Admitting Doctor
( 6) PAdmDr-Admitting Doctor per PA
( 7) AttDr-Attending Doctor
( 8) PAttDr-Attending Doctor per PA
( 9) BT-Bill Type for Claim Paid
(10) BLR-Biller for Account
(11) CASAmt@-CAS Amount for CAS Code @ Equals
(12) CASAmt!-CAS Amount for CAS Code Record
(13) GASAmt!-CAS Amount for Group and CAS Cod
(14) HCASAmt#-CAS Amount for High Dollar CAS
(15) HGASAmt#-CAS Amount for High Dollar Grou
(16) CAS@-CAS Code @ Equals
```

After an element is chosen from the list, the following screen is displayed:

```
                General Hospital View Post Payment Evaluation Dictionary Processor
                                       Thu Aug 04, 2011 12:20 am


 1 Field Name              2 Format              3 Type of Data   4 Data Schema
   ActBal                    Money                 Patient           Number
 5 Field Description
   Account Balance
 6 Use to Select Payment                          7 Maximum Occurrences
   Yes
 8 Use to Report Data?   9 Maximum Length      10 Example Col Header
   Yes                     15
11 Comment1

12 Comment2

13 Prior Field Required

14 Related Fields

15 SQL Table Name                    16 SQL Column
   FPE_PPE_PA_TRS_BA_SEL_INFO            CURR_ACCT_BAL
```

Field Explanations

1.   FIELD NAME (DISPLAY ONLY)
This field contains the name of the data element.

2.   FORMAT (DISPLAY ONLY)
This field contains the format for the data. The values for this field are as follows:

Date

Date with Century

Text

Numeric

Money

If the format is Date, the data is translated for a format of MM/DD/YY. If the format is Date with Century, the data is translated for a format of MM/DD/YYYY. If the format is Text or Numeric, the data is sent as is. If the format is Money, then the data is sent with two decimal places meaning a value of 100 is sent as 100.00.

3.   TYPE OF DATA (DISPLAY ONLY)
The fields in the Post Payment Evaluation Data Dictionary are organized by type and these are as follows:

Adm

HIM

Patient Accounting

Payment Transaction

Business Analysis

Charge

ERA

Denial

The Type of Field is display only and correlates to the data that is selected as the Field Name. If the Type of Field is changed and Field Name has a value, it is removed, as are any selection criteria, the Field Description, and comments.

4. DATA SCHEMA (DISPLAY ONLY)
The data elements for selection criteria and data inclusion can be filtered per one of the following formats:

From/Thru Dates. The From and Thru Dates are keyed to provide a time frame for date selection.

Indicator. An indicator is a flag for data. An example would be that the selection could be limited to the first or last payment for a claim.

Number. For a numeric field, any of the following operators can be used to select a payment for inclusion:

BE-Between or Equal

BT-Between

EQ-Equal

GE-Greater Than or Equal

LE-Less Than or Equal

LT-Less Than

NBE-Not Between or Equal

NBT-Not Between

NE-Not Equal

5. POST PYMT EVALUATON ITEM FIELD DESCRIPTION (DISPLAY ONLY)
This field contains a description of the item.

6. USE TO SELECT PAYMENTS (DISPLAY ONLY)
If Yes is displayed in this field, this element can be used to select payments.

7. MAXIMUM OCCURRENCES (DISPLAY ONLY)
This is the maximum number of occurrences where this data element may be selected and/or displayed.

8. USE TO REPORT DATA (DISPLAY ONLY)
If Yes is displayed in this field, this element can be reported.

9. MAXIMUM LENGTH (DISPLAY ONLY)
This is the maximum column length for the element for reporting. This value is the maximum of the maximum length of the element and the column label. In some instances, the length of the column label exceeds the length of the data element.

10. EXAMPLE COL HEADER (DISPLAY ONLY)
This field provides an example of the column header for the field. In most instances it matches Code/Col Label. The label can be created from the instance of the data element. For example, the first time that High Dollar SIM Dept # is selected, the column label will be HSM01.

11. COMMENT (DISPLAY ONLY)
This field provides the first line of any documentation for the field.

12. COMMENT 2 (DISPLAY ONLY)
This field provides the second line of any documentation for the field.

13. PRIOR FIELD REQUIRED (DISPLAY ONLY)
If a field cannot be selected for inclusion until a previous field is selected, the field name is displayed in this column.

14. RELATED FIELDS (DISPLAY ONLY)
For some fields such as High Dollar fields or fields for Table for Column, the selection of a field for inclusion indicates related fields can be selected. This column contains the field names for those related fields.

15. SQL TABLE NAME (DISPLAY ONLY)
This field displays the SQL Table Name where the data is stored in SQL.

16. SQL COLUMN (DISPLAY ONLY)
This field displays the SQL Column where the data is stored in SQL.

Report Post Payment Evaluation Dictionary

This option is used to request a report of elements in the Post Payment Evaluation Dictionary. The report spools to FTFARC.

When this option is selected, the following prompt is displayed:

Sort Post Payment Eval Dictionary Rpt by (C)ode or (A)lphabetic?--

The user determines if the report is sorted by code or alphabetic sequence and then chooses if the report is spooled via the standard or download format. Select the download format if the report will be exported to Excel or another format.

Use (S)tandard or (D)ownload Format?-

After the format is selected, the following message is displayed:

Background job started to produce FTFARC!

Perform Post Payment Evaluation for Posted Batch

This option is used to request the run of a Post Payment Evaluation code for a batch posted in the current day.

When the option is selected, you can choose from a list of facilities. After a facility is selected, a list of batches is displayed, as follows:

```
            General Hospital Perform Post Payment Evaluation for Posted Batch Processor
                                       Sun Jul 31, 2011 09:26 pm
Perform Post Payment Evaluation for Posted Batch
    Batch Stat Type Creation Date        By  Description/Comment
( 1)   2  Ubal  P   Aug 23, 0323pm       T J TRISH TEST
( 2)   3  Ubal  I   May 11, 0638pm       P M A/PM ANSI/Unmatched Pymt
( 3)   7  Bal   I   May 11, 0638pm       P M A/PM ANSI/TRN1
( 4)  10  Ubal      Apr 03, 1130am       J A F9532 INS CASH HEADER
( 5)  11  Ubal      Feb 23, 0943am       JAK TEST REMIT
```

Post Payment Evaluation Worklist

This option is used to create a worklist of selected payments. This enables the user to work the accounts in a timely fashion. The worklist can be purged by the user upon exiting.

In the Post Payment Evaluation Table, if the code is setup in field 3 for Worklist or Both, when the job completes, a worklist of the selected accounts is created.

Once the worklist menu item is selected, you can select the facility (via the facility lookup screen) and then select to access the worklist by Batch Number or Post Payment Evaluation Code.

> *Select by (B)atch or (P)ost Payment Evaluation Code-*

If Batch is selected, the screen displays up to 15 cash batches per screen. The sort order is by post date and the batch number within post date.

For cross facility batches, the accounts displayed are limited to accounts from that facility. The batch does not clear from the worklist until all facilities are analyzed.

If Post Payment Evaluation Code is selected, the screen displays all defined Post Payment Evaluation Codes. The user selects a code, and the worklist displays up to 15 accounts per screen.

For batches, the following screen is displayed with batches for review:

```
                    General Hospital Post Payment Evaluation Worklist Processor
                                                    Tue Sep 20, 2011 03:30 pm


   Page:03                               Posted Cash Batches
      Batch Num  Post Dt  Batch Description
   ( 1)     A00   Aug 04  A/835
   ( 2)     A05   Aug 04  A/835
   ( 3)     A11   Aug 04  A/835
   ( 4)     A12   Aug 04  A/835
   ( 5)     A14   Aug 04  A/835
   ( 6)     A15   Aug 04  A/835




   Select batch to be reviewed--
                                previous pg(/P or PG UP)
```

You can select the batch number, and the actual worklist entries are displayed (shown below). If a payment was selected per different evaluation codes, an entry appears for each code.

```
                              General Hospital Post Payment Worklist Processor
                                                    Wed Mar 02, 2011 03:28 pm

   SQ  Account        Name                Pymt Amt Cd Eval               BN ( 1)
   A0516600004     TENN,TONY              1000.00  P   CAS31x            A01
   ( 2) A0516600004 TENN,TONY             1000.00  P   CAS42x            A01
   ( 3) A0611400007 TEST,BKB               125.00  P   CAS31x            A01
   ( 4) A0615200004 TAYLOR,ANDY              0.00  D   CAS31x            A01
```

If the user selects to view the worklist by Post Payment Evaluation Code, the following screen is displayed with all defined Post Payment Evaluation Codes:

```
                  General Hospital Post Payment Evaluation Worklist Processor
                                            Tue Sep 20, 2011 03:33 pm


Page:01                       Post Payment Evaluation Table      ##=Current Choices
( 1) A1-PAYMENT VARIANCE
( 2) A2-ERA HCPCS
( 3) A3-ERA CAS CODES
( 4) A4-HIGH DOLLAR CAS CODES
( 5) HAC-HAC DOLLARS
( 6) MR1-HIM DX AND PX
```

Once the Post Payment Evaluation Code is selected, the worklist displays the entry for each selected account.

```
Page:01                       Post Payment Worklist
 SQ  Account        Name                   Pymt Amt Cd Eval            BN
( 1) A1113100004    ADAMS,JANE               100.00  P JACAS          J44
( 2) A1117200002    ADAMS,ANNIE            1,000.00  P JACAS          J44
( 3) A1117300004    ADAMS,ANNIE            1,100.00  P JACAS          J44
( 4) A1117300005    ADAMS,BEN                800.00  P JACAS          J44
( 5) A1117300005    ADAMS,BEN                800.00  P JACAS          J44
( 6) A1117300005    ADAMS,BEN                800.00  P JACAS          J44
( 7) A1117300005    ADAMS,BEN                800.00  P JACAS          J44
( 8) A1115100004    KESLER,KURT               55.55  P JACAS          P1I
( 9) A1113100001    ADAMS,ANNIE              100.00  F JACAS          J06
(10) A1113100001    ADAMS,ANNIE              100.00  F JACAS          J06
(11) A1113100002    ADAMS,BEN                399.00  F JACAS          J06
(12) A1113100002    ADAMS,BEN                399.00  F JACAS          J06
(13) A1113100001    ADAMS,ANNIE              100.00  F JACAS          J08
(14) A1113100002    ADAMS,BEN                399.00  F JACAS          J08
(15) A1114500001    ADAMS,JUDY                 5.00  P JACAS          J44


Enter choice--
                     next pg(/ or PG DN)  Search(TAB)
```

Once an entry is selected, the screen below is presented with details about the cash payment that was just posted and then from there the user has the ability to access other functions (see next 2 screens):

```
                General Hospital Post Payment Evaluation Worklist Processor
                                           Mon Mar 07, 2011 04:13 pm
Account       Name                 FC Typ Admit    Disch        Balance Loc
A1023000003  ADAMS,BEN             JA ER  08/18/10 08/18/10      1250.00 AR
1 Posting Date   2 Trans Amount   3 Carrier/Plan            4 BS/CS
   05/05/10            $500.00      750/200-JULIE'S SECONDARY 150   1/1
5 Coin/Ded/Co-Pay/Pat Resp                          6 Clm Disp/Pymt Ind
  500/250/100/                                        Partial
7 Adjustmt Amount  8 High $ CAS code      9 CAS amount
         500.00            CO/97              750.00
10 Total Charges    11 Total Adj      12 Total Payments
        $400.00            $120.00-          $350.00
13 Ins Liability    14 Ins Adj        15 Ins Payments
        $20.00-            $120.00-          $100.00
16 Pt Liability     17 Patient Adj    18 Pt Payments    19 Last Pt Payment
        $50.00-            $0.00             $250.00    10/05/10   $250.00
20 # Unpaid Claims  21 Batch Num
    2          123
22 Post Payment Evaluation Codes
  CAS31x,CAS42x



Press NL for worklist, enter code, or `-` for list--
```

1. POSTING DATE
This field contains the date the payment was posted.

2. TRANS AMOUNT
This field contains the total dollar amount of the transaction posted for this account.

3. CARRIER/PLAN
This field contains the insurance carrier and plan for the account.

4. BS/CS
This field contains the bill sequence and claim sequence numbers.

5. COIN/DED/CO-PAY/PAT RESP
This field contains the amounts for the coinsurance, co-payment, deductible, and patient responsibility.

6. CLM DISP/PYMT IND
This field contains the current disposition of this claim. Possible claim dispositions are:

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 will also require 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.

7. ADJUSTMENT AMOUNT
This field contains the adjustment amount.

8. HIGH $ CAS CODE
This field contains the high dollar CAS code.

9. CAS AMOUNT
This field contains the CAS amount.

10. TOTAL CHARGES
This field contains the total charges for the account.

11, TOTAL ADJ
This field contains the total adjustments for the account.

12. TOTAL PAYMENTS
This field contains the total payments for the account.

13. INS LIABILITY
This field contains the total insurance liability.

14. INS ADJ
This field contains the insurance adjustment.

15. INS PAYMENTS
This field contains the total insurance payments.

16. LAST PT PYMT DATE
This field contains the date of the last patient payment.

17. PT LIABILITY
This field contains the total patient liability.

18. PATIENT ADJ

This field contains the total patient adjustments.

19. PT PAYMENTS

This field contains the total patient payments

20. LAST PT PAYMENT

This field contains the date of the last patient payment.

21. # UNPAID CLAIMS

This field contains the total number of unpaid claims on the account.

22. BATCH NUM

This field contains the batch number.

23. POST PAYMENT EVALUATION CODES

This field contains the post payment evaluation codes for the account.

24. ACCOUNT BALANCE

This field contains the total account balance for the account.

25. INSURANCE BALANCE

This field contains the total insurance balance for the account.

26. PATIENT BALANCE

This field contains the total patient balance for the account.

Set Stop Time for MNP Post Payment Evaluation Jobs

This option is used to set a time when Midnight Processing stops running the post payment evaluation jobs. For example, a facility may want to stop all Post Payment Evaluation jobs when users logon to the system for the business day.

When this option is selected, the following prompt is displayed:

Enter the stop time for MNP Post Payment Evaluations Job--

You can enter the time as in the following example: 7:00 am.

Details can be viewed in the Maintain Post Payment Evaluation Batch Jobs. See .

Chapter 4 - RETIRED ACCOUNTS MODULE

STAR Patient Accounting Reference Guide - Account Transactions Volume
October 2012   *Release 18.0*   *4–1*
Proprietary to McKesson - Subject to Confidentiality Agreement

INTRODUCTION

The activation of the Retired Accounts Module requires McKesson Implementation Services for implementation. Please contact the Customer Satisfaction team at CustomerSatTeam@McKesson.com for more information.

The Retired Accounts Module provides an alternative to archiving/purging accounts with a zero balance and to posting the small balance write off for qualifying BD accounts. If an account is retired, it cannot be archived/purged. There is no relationship between account retirement and claim archive/purge other than no claims can exist which are archived and not purged.

If the functionality is used to retire accounts, the STAR Patient Accounting system can continue to be used to view account and claim information but the account no longer appears in the indexes used for many batch processes in the system. The (C)Prc information is removed for OPPS and EAPG claims when an account is retired. This is information about the status of the account in the OPPS or EAPG Interface, and the information returned from 3M is not removed when an account is retired. Also, pre-bill edit status Information is removed when an account is retired. The OBJ used to retire accounts can be used to place BD accounts with a balance qualifying for a write off on the BD Archive Pre-List so the write off can be taken with another OBJ. An account can be "unretired" if a subsequent need arises to perform further processing. This can be done by an optional batch job, upon user request, or can be done automatically in some scenarios as the need arises. Two account locations are used which are ARR (Retired from AR) and BDR (Retired From BD). Whenever an account is retired or un-retired, a message is placed in transaction history.

There are exceptions that prevent an account from retirement. They are listed below,

Claim Exceptions

- Archived and Not Purged

- Appeal Schedule

- Carrier Pay Days Remaining (Does not qualify for claim archive/purge)

- F/U Scheduled for Replaced Claim

- F/U Scheduled for Claim

NOTE: Claim disposition and claim disposition date are not examined

Claim exceptions are reported by claim but tallied by exception for transaction history.

Account Exceptions

- Account Status is On Hold

- Account Has No Discharge Date

- Archive Status is Archived

- Balance but Zero Bal Date

- Balance=0 but No Zero Bal Date

- BD Pre-Listed is User Hold

- BD Pre-Listed is System Hold

- BD Pre-Listed is System Flagged

- BD Pre-Listed is User Flagged

- F/U Schedule is Not Complete

- Account on F/U Hold

- Future F/U Date

- BD to AR Transfer Request Exists

- Patient Balance Exists

- Guarantor Refund Exists

BD Account Exceptions

- BD Archive Pre-List Entry Created

- BD Auto Write-Off Not Reported

- BD Account Balance Qualifies for Auto Write-Off (Not posted yet)

Insurance Exceptions

- Insurance Refund Exists

- Insurance Balance Exists

When an account is retired, it is available for inquiry features, but it is not available for features adding/revising information for the account. That means the account does not appear in the list of accounts for a person in features adding/revising information. The header line for the person contains *Ret* if a person has retired accounts. If a desired account is not visible in a processor used to maintain information, the account can be

unretired by using the Un-Retire Account (Move to AR/ BD) processor. This returns the account to location AR or BD, and the account can be accessed.

In the GUI applications for Patient Accounting, the retired accounts do not appear in any of the selection lists for accounts, and a retired account cannot be selected by account number.

Moving retired accounts to different indexes means processes executed during Midnight Processing such as Daily Bal PA and Account Selection Reports will require less time to complete.

Trigger events for the TRENDSTAR and Horizon Performance Management interfaces allow retired and/or un-retired accounts to be sent to those interfaces. For Patient Compass v 2.0, retired accounts are handled as if the account has been archived, and unretired accounts are handled as if the account was unarchived. Patient Compass Classic has not been updated for the Retired Accounts Module.

Optional Batch Jobs

The following optional batch jobs are used in the Retired Accounts Module. For detailed information on these optional batch jobs, refer to *General Information Volume* in the *STAR Patient Accounting Reference Guide,* Chapter 2: Financial System Management.

- Retire Zero Balance AR/BD Accounts (Optional Batch Job 130)

Optional batch job 130 (Retire Zero Balance AR/BD Accounts) can be used to produce reports on accounts to be retired and to retire the accounts. The job can be run in a report mode before using the optional batch job to retire accounts. If a BD account with a balance qualifies for BD Archive Pre-List, the account is pre-listed for archive, so optional batch job 132 can be used to write off the small balance. This happens when OBJ 130 is running in the report mode or is being used to retire accounts, unless the parameter *Exclude BD Accnts with Bal* is set to Yes.

- Return ARR/BDR (Retired) Accounts to AR/BD (OBJ 131)

Optional batch job 131 (Retire Zero Balance AR/BD Accounts) can be used to produce reports on accounts to be un-retired and to un-retire them. When an account is un-retired, it is returned to the location from which it was retired. The intent of the job is allowing accounts to be returned to AR and BD which were retired previously. The job can be run in a report mode before using the optional batch job to un-retire accounts.

- Process BD Accnts with Bal Pre-Listed for Archive (OBJ 132)

Optional batch job 132 (Process BD Accnts with Bal Pre-Listed for Archive) can be used to process accounts in the BD Archive Pre-List with a balance qualifying for the small balance write-off. The qualifying balance for the small balance write-off is determined from Max Delete Bal in the Agency Follow-up Schedule. The qualifying

accounts can be reported or the job can be used to write off the remaining balance. When the remaining balance is written off, a zero balance date is assigned, which is one of the criteria for retiring an account. The job can be run in a report mode before using the optional batch job to write off the small balance. Also, the job can be parameterized so the amount is not written off until the account is selected to appear in the report produced by this job which is FBRRTB. The logic assumes that the detail report is being produced.

Secondly, the OBJ can be used to count the current number of accounts in the BD Archive Pre-List.

- Reverse SMB Write-Off Posted by Job 132 (Optional Batch Job 133)

 The OBJ 133 can be used to reverse the small balances that were written off with OBJ code 132. If the user wishes to reverse the small balance write offs then the parameters for OBJ 133 would be filled in based upon how OBJ 132 was run.

If the account is in BDR, the account is returned to BD first. The reversal is done for the write-offs done per the From SMB W/O Date and To SMB W/O Date. The most recent adjustment for the account must be used and that must be a BD SMB W/O. The Report Only and Reverse Balance? fields must be answered for the reversal to occur.

- Estimate Accounts to be Retired (OBJ 134)

This optional batch job can be used to estimate the number of accounts qualifying to be retired in AR and BD and satisfying the following criteria which are used to select accounts for retirement.

- Discharge date does not follow 12/31 of the preceding year

- Number of days beyond the Zero Balance Date is greater than 180

The following numbers are provided by year of discharge for AR accounts:

- Number of Accounts

- Number of Accounts Not Qualifying to be Retired

The following numbers are provided by year of discharge for BD accounts:

- Number of Accounts

- Number of Accounts Qualifying to be Retired

- Number of Accounts Qualifying to be Retired after Small Balance W/O

- Number of Accounts Not Qualifying to be Retired

MANUALLY RETIRING AND UN-RETIRING ACCOUNTS

This section contains information about using the processors in the Retired Accounts Module to manually retire and un-retire accounts and to view online statistics for retired and unretired accounts. These processors are as follows:

Manually Retiring an Account

*   Retire Account (Move to ARR/BDR) - moves an account from AR to ARR or from BD to BDR. It operates like the AR to ARR Transfer and BD to BDR functions, except accounts in both AR and BD locations can be selected.

*   AR to ARR Transfer- transfers an account to location ARR, and a note is made in Transaction History.

*   BD to BDR Transfer - transfers an account to location BDR, and a note is made in Transaction History.

Manually Un-Retiring an Account

*   Unretire Account (Move to AR/BD) - moves an account from ARR to AR or from BDR to BD. It operates like the ARR to AR Transfer and BDR to BD functions, except accounts in both ARR and BDR locations can be selected.

*   ARR to AR Transfer- transfers an account to location AR, and a note is made in Transaction History.

*   BDR to BD Transfer - transfers an account to location BD, and a note is made in Transaction History

Online Statistics

*   This processor is used to review statistics for retired and unretired accounts.

Menu options for these processors are under Account Management on the menu titled Zero Balance Retired Account Options. Following is a sample of the screen:

```
                    General Hospital Zero Balance Retired Account Options Processor
                                            Fri Apr 01, 2011 02:13 pm
        Zero Balance Retired Account Options Input Options

                 Option No.  Option
                 ----------------------------------------
                     1       Un-Retire Account (Move to AR/BD)
                     2       ARR to AR Transfer
                     3       BDR to BD Transfer

                     4       Retire Account (Move to ARR/BDR)
                     5       AR to ARR Transfer
                     6       BD to BDR Transfer

                     7       Statistics for Retired Account Module
```

Retire Account (Move to ARR/BDR)

This processor can be used to move an account from AR to ARR or from BD to BDR. It operates like the AR to ARR Transfer and BD to BDR functions, except accounts in both AR and BD locations can be selected. One use of this processor would be to examine accounts of interest to determine if the account can be retired. This means accounts can be examined without running the OBJ because the same program is used.

If the account does not qualify per the current criteria in OBJ 130, the reason is noted on the screen, in transaction history, and on the FBRRTE report. Otherwise, the following prompt requires a response of Yes before the account is retired immediately:

Account qualifies to be retired. Do you want to retire the account? (Y/ N)--:

After you enter Yes to retire the account, one of the following messages is displayed on the screen:

Account Moved to Location ARR

Account Moved to Location BDR

AR to ARR Transfer

This processor is used to move an account from location AR to ARR. The account is then evaluated to see if it qualifies for retirement based upon parameters in the OBJ 130. The Report Only field in OBJ 130 must be set to 'No' in order to manually retire an account. If the account does not qualify per the current criteria in OBJ 130, the reason is noted on the screen and in transaction history. If the account qualifies per the current criteria in OBJ 130, the following message is displayed:

Account qualifies to be retired. Do you want to retire the account? (Y/ N)--

After you enter **Yes** to retire the account, the following message is displayed on the screen:

Account Moved to Location ARR

The account is manually transferred to location ARR, and a note is made in Transaction History.

BD to BDR Transfer

This processor is used to move an account from location BD to BDR.If the account balance is non-zero and the account has not been added to the BD Archive Pre-List, the following prompt is displayed:

Account needs to be added to Archive Pre-List for required processing before Retirement. Do you want to do that now? (Y/N)-

If a response of Y for Yes is keyed, the account is added to the BD Archive Pre-List. For a zero balance BD account, the user is given the opportunity to retire it.If the account does not qualify per the current criteria in OBJ 130, the reason is noted on the screen, in transaction history, and on the FBRRTE report. Otherwise, the following prompt requires a response of Y before the account is retired immediately:

Account qualifies to be retired. Do you want to retire the account? (Y/ N)--:

After you enter Yes to retire the account, the following message is displayed on the screen:

Account Moved to Location BDR

Un-Retire Account (Move to AR/BD)

This processor can be used to move an account from ARR to AR or from BDR to BD. One of the following prompts is displayed:

Account does not qualify to be un-retired per system parameters. Do you want to un-retire the account? (Y/N)-

Account qualifies to be un-retired per system parameters. Do you want to un-retire the account? (Y/N)-

After you enter Yes to un-retire the account, one of the following messages is displayed on the screen:

Account Moved to Location AR

Account Moved to Location BD

If the user enters No, the account is not un-retired.

ARR to AR Transfer

This processor can be used to move an account from location ARR to AR.

- If the account qualifies per the current criteria in OBJ 131, the following prompt requires a response of Y before the account is returned to location AR.

    Account qualifies to be un-retired. Do you want to un-retire the account? Y/N)--

    If Yes is entered, the account is moved back to location AR and a note is made in Transaction History.

- If the account does not qualify per the current criteria in OBJ 131, the following prompt requires a response of **Yes** before the account is returned to location AR.

    Account does not qualify to be un-retired per system parameters. Do you want to un-retire the account? (Y/N)--

BDR to BD Transfer

This processor is used to move an account from location BDR to BD.If the account does not qualify per the current criteria in OBJ 130, the following prompt requires a response of Y before the account is returned to location BD.

    Account qualifies to be un-retired. Do you want to un-retire the account? Y/N)--

If the account does not qualify per the current criteria in OBJ 131, the following prompt requires a response of Y before the account is returned to location BD.

    Account does not qualify to be un-retired per system parameters. Do you want to un-retire the account? (Y/N)--

On-Line Statistics

Statistics are kept online for users to view the number of accounts retired and unretired by facility. The below screen may be accessed via the menu option 'Statistics for Retired Account Module'.When this screen is accessed, the following prompt is displayed:

    Select first date for 180 entries in the stat file--

After the date is entered, the following screen is displayed:

```
     General Hospital Statistics for Retired Account Module Processor
                                          Fri Nov 12, 2010 12:58 pm


                              * Indicates some/all accounts reported only
              To ARR To BDR   To AR   To BD AR Exc  BD Exc  BD W/O
Page:01          Statistics for Retired Accounts Module
( 1) 09/11/10-     0      0      0      0       0       0       0
( 2) 09/12/10-     0      0      0      0       0       0       0
( 3) 09/13/10-     0      0      0      0       0       0       0
( 4) 09/14/10-     0      0      0      0       0       0       0
( 5) 09/15/10-     0      0      0      0       0       0       0
( 6) 09/16/10-     0      0      0      0       0       0       0
( 7) 09/17/10-     0      0      0      0       0       0       0
( 8) 09/18/10-     0      0      0      0       0       0       0
( 9) 09/19/10-     0      0      0      0       0       0       0
(10) 09/20/10-     0      0      0      0       0       0       0
(11) 09/21/10-     0      0      0      0       0       0       0
(12) 09/22/10-     0      0      0      0       0       0       0
(13) 09/23/10-     0      0      0      0       0       0       0
(14) 09/24/10-     0      0      0      0       0       0       0

Press ENTER or E to Exit--
                next pg(/ or PG DN)  Search(TAB)
```

Chapter 5 - PATIENT PAYMENT/ADJUSTMENT INTERFACE

OVERVIEW

This interface is for posting patient payments, adjustments and agency fees. Payments/Adjustments may be posted to accounts in location PA, AR, BD. This interface has its own file specifications, menu, screens and reports. Payments and adjustments posted through the Patient Payment/ Adjustment interface will also be incorporated on existing cash/adjustments reports. The Cash Type of Z will display in the existing Type field in Patient Accounting when the associated payment/adjustment batch is from the patient payment adjustment interface.

When the Patient Payment/Adjustment Interface is selected from the Account Transactions menu, the following options are displayed:

1	Upload Patient Payment/Adjustment Interface File	
2	Post Patient Payment Interface Cash	
3	Post Patient Adjustment Interface Cash	
4	Patient Pymt/Adj Interface Parameters Table	

Each of these options is discussed below. See "POST PATIENT PAYMENT INTERFACE CASH" on page 5-4.

The patient cash and adjustment batches that are generated from the interface will be included on reports as follows:

- FAR180 Patient Payment/Adjustment Interface Upload report. This report is automatically generated when a Payment/Adjustment Interface file is uploaded.

- FAR181 Patient Payment/ Adjustment Interface Summary Upload report. This report is automatically generated after a file is uploaded through the Payment/ Adjustment Interface.

- FAR182 Payment/Adjustment Interface Error report. This report contains all of the accounts where the payment or adjustment couldn't post because it was missing required information.

The patient payment transactions are included on:

- FAR120-Cash Posting Batch Audit

- FAR130-Cash Posting Batch Detail

- FAR140- Cash Posting Exception Report

- FAR150- Collection Agency Cash Adjustment Report

- FAR160- Cash/Adjustment Report

- FAR801- Daily Cash Posting Audit

The patient adjustment transactions will be included on:

- FAR200- Adjustment Posting Batch Audit

- FAR210-Adjustment Posting Detail Report

- FAR220- Adjustment Posting Exception Report

- FAR802- Daily Adjustment Posting Audit Report

- FAR160- Cash/Adjustment Report

The options on the Patient Payment/Adjustment Interface menu are discussed on the following pages.

POST PATIENT PAYMENT INTERFACE CASH

The Post Patient Payment Interface Cash option is used to approve an uploaded file, edit a batch, post patient payments, put a batch on hold, and print reports.

Editing a Batch

After selecting the Post Patient Payment Interface Cash option, the system prompts for a facility (if multifacility). After you select the facility, you are prompted to enter in the batch number to directly access the batch or enter a '-' to view a list of all the batches and then select a batch. If a hyphen is entered, the following screen is displayed:

```
        Patient Payment Posting Int Batches
Batch Stat Type Creation Date By Description/Comment
( 1) 306 Ubal Z Apr 26, 1448 PMR Pat Int pt0426c
( 2) 307 Ubal Z Apr 26, 1500 PMR Pat Int pt0426f
( 3) 308 Ubal Z Apr 26, 1511 PMR Pat Int pt0426h
( 4) 309 Ubal Z Apr 26, 1516 PMR Pat Int pt0426i
( 5) 310 Ubal Z Apr 27, 1023 PMR Pat Int pt0427
( 6) 311 Ubal Z Apr 27, 1041 PMR Pat Int pt0427a
( 7) 312 Ubal Z Apr 27, 1222 PMR Pat Int pt0427
```

Field Explanations

BATCH (DISPLAY ONLY)
This field contains the batch number.

STAT (DISPLAY ONLY)
This field contains the batch status. Valid values are Ubal for Unbalanced, Bal for Balanced, Pstd for Posted and Hold for Hold.

TYPE (DISPLAY ONLY)
This field contains the batch type. The batch type associated with the patient payment/ adjustment interface is Z.

CREATION DATE (DISPLAY ONLY)
This field contains the date/time the batch was created.

BY (DISPLAY ONLY)
This field contains the initials of the person uploading the file.

DESCRIPTION/COMMENT (DISPLAY ONLY)
This field contains the name of the file. The name of the file will always begin with Pat Int for Patient Interface and then the name of the uploaded file.

After selecting a batch, the next screen displays basic information about this batch. Most of the values for the fields on this screen come from the patient payment/ adjustment interface file. The hospital can update values on this screen and must verify the batch is in balance so that when they access the exit batch processor they will be prompted to approve the batch.

```
            General Hospital Patient Payment Posting Int Setup Processor
                                             Thu Sep 20, 2012 10:34 pm



 1 Batch Code        2 Batch Description                     3 # of Trans
     9                 Pat Int pk0625forpat                      1
 4 Posting Date      5 Payment Date      6 Agency
   06/25/12            06/25/12             RELAYH-RELAY HEALTH
 7 Default Patient Cash Tran Code
->
 8 Agency Fees Tran Code                  9 Agency Cash Tran Code
   V0001-COLLECTION AGENCY FEES             P0007-code 7
10 Agency Batch Total      11 Agency Fees        12 Fees Variance
   80.00                      10.00                  .00
13 Total Entered           14 Batch Total         15 Variance
   10.00                      70.00                  60.00
16 Batch Created By                    17 Batch Approved By
   New, Nancy




Enter transaction code, or '-' for list --      |
```

BATCH CODE (DISPLAY ONLY)
This field contains the batch number that was assigned automatically by the system.

BATCH DESCRIPTION (30-C-R)
This field contains the name of the patient payment batch. This field is automatically generated and contains the words "Pat Int" for patient interface followed by the file name. For example, if the file name was empdisc0503 then the batch description would be Pat Int empdisc0503. This field can be manually updated.

 # OF TRANSACTIONS (DISPLAY ONLY)
This is a calculated field and the system uses the entries that were uploaded into the batch to determine the number of transactions. This field is updated if entries are added or deleted from the batch.

POSTING DATE (6-N-R)
This field contains the date on which the batch is posted. The date the file was uploaded is the default date. This field can be updated to a prior date or the current date.

PAYMENT DATE (6-N-R)

This field contains the date on which the payment is made. The system uses the date of the upload to populate this field. This field can be updated. A prior date can be entered.

AGENCY (DISPLAY ONLY)

This field contains the agency that is uploaded in the 00 record from the patient payment/adjustment interface file.

DEFAULT PATIENT CASH TRAN CODE (5-AN-O)

This field contains the patient payment transaction code in the 00 record from the patient payment/adjustment interface file. This field can be manually updated.

AGENCY FEES TRAN CODE (5-AN-C)

This field contains the agency fee transaction code that is associated with the agency code that is uploaded in the patient payment/adjustment interface file. This field can be manually updated. If an agency fee trans code is present then an agency code must also be present on the screen.

AGENCY CASH TRAN CODE (5-AN-C)

This field contains the agency cash transaction code from the 00 record in the patient payment/adjustment interface file. This field isn't required unless an agency fee exists. This field can be edited.

AGENCY BATCH TOTAL (11-N-C)

This field contains the agency batch total from the 00 record in the patient payment/ adjustment interface file. This field can be updated.

The batch total plus the agency fees must equal the agency batch total or there will be a fee variance.

AGENCY FEES (10-N-C)

This field contains the agency fee that is uploaded from the 00 record in the patient payment/adjustment interface file. If this is present in the file then an agency code must also be in the file and an agency fee transaction code must be associated with the collection agency code. This field can be edited.

FEES VARIANCE (DISPLAY ONLY)

This field contains the fees variance. This is a calculated field and contains a value if the batch total plus the agency fees don't equal the agency batch total.

TOTAL ENTERED (DISPLAY ONLY)

This field contains the total amount of all of the transactions in the batch.

BATCH TOTAL (11-N-R)

This field contains the value in the total payment amount field in the 00 record of the interface file. This field must equal the total entered field or a variance will be calculated. This field can be edited.

VARIANCE (DISPLAY ONLY)

This field contains the batch variance. This field contains a value if the total entered field doesn't equal the batch total field.

BATCH CREATED BY (DISPLAY ONLY)

This field contains the person who created the batch.

BATCH APPROVED BY (DISPLAY ONLY)

This field contains the person who approved the batch. This field doesn't contain a value if the batch posts correctly but there is a problem with the batch and it is partially posted the hospital can determine who approved the batch when they access the screen.

Next the system displays the Patient Payment Posting Interface Processor where you can add entries to the batch. If you elect to add an entry to the batch, select the account from the lookup screen and then the Patient Payment Posting Interface Posting screen will display to enter payment information for the selected account. When you are finished adding entries or if you do not need to add an entry to the batch press ENTER to return to the Patient Payment Posting Interface Exit Batch Processor.

```
                General Hospital Patient Payment Posting Int Processor
                                              Fri Sep 21, 2012 12:43 am




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

The Patient Payment Posting Interface processor contains the following information:

```
            General Hospital Patient Payment Posting Int Processor
                                      Thu Aug 30, 2012 01:05 pm
Account      Name                 FC Typ Admit    Disch      Balance Loc
A11277-00001 CRANE, TOM           C  O/P 10/04/11 10/04/11     510.75 PA /DNFB
 1 Patient Balance    2 Last Payment Date     3 Collection Agency
   226.72
 4 # of Payments      5 Total Payments              6 Account Balance
                                                      510.75
 7 Seq#   8 Pt Class                            9 New Account Balance
   3                                              410.75

10 Payment Amount     11 Receipt #
   100.00
12 Payment Date       13 Posting Date    14 Trans Code/Description
   11/28/11              11/28/11            P0001-PERSONAL PAYMENT-CHECK

15 Comments
-> 01
   02
   03


Enter comments (C) or notes (N)--
```

FIELD EXPLANATIONS

1. PATIENT BALANCE (DISPLAY ONLY)
This field contains the patient balance associated with the account.

2. LAST PAYMENT DATE (DISPLAY ONLY)
This field displays the last payment date associated with the account.

3. COLLECTION AGENCY (DISPLAY ONLY)
This field displays the bad debt collection agency associated with the account. (Note this is not the agency that is in the 00 record of the interface).

4. # OF PAYMENTS (DISPLAY ONLY)
This field displays the total number of payments that have been posted for the account.

5. TOTAL PAYMENTS (DISPLAY ONLY)
This field displays the total amount of payments that have been posted for the account.

6. ACCOUNT BALANCE (DISPLAY ONLY)
This field displays the account balance associated with the account.

7. SEQ # (DISPLAY ONLY)
This field displays the sequence # of the payment.

8. PT CLASS (DISPLAY ONLY)

This field displays the patient class code associated with the account.

9. NEW ACCOUNT BALANCE (DISPLAY ONLY)

This field displays the account balance with the new payment applied to it.

10. PAYMENT AMOUNT (11-N-R)

This field contains the payment amount that is entered for the account. This field is populated with the value in field 9 in the Patient Payment/Adjustment Interface.

11. RECEIPT # (DISPLAY ONLY)

This field is not used in the Patient Payment/Adjustment Interface.

12. PAYMENT DATE (6-N-R)

This field contains the payment date.This field is populated with the value from field 8 in the 01 record of the patient payment/adjustment interface.

13. POSTING DATE (DISPLAY ONLY)

This field contains the posting date.

14. TRANS CODE/DESCRIPTION (5-N-R)

This field contains the transaction code associated with the payment. This field contains the value in field 14 in the 01 record if it is present. If it is not present then it will use the value in field 6 in the 00 record.This field can be manually updated.

15. COMMENTS (40-AN-O)

This field allows the user to enter patient comments and notes. This field is populated with fields 11-13 in the 01 record. The first line comes from field 11. The second line comes from field 12. The third line comes from field 13. If field 10 in the interface is an A then the system will populate line one in the Comments field with Acct Holder: (this contains what is in field 11).

For example:

Acct Holder: testacctholder name

02

03 Comment: comment for interface from field 13

 If field 10 in the interface is a C then the system will populate line one in the comments field with Card Holder. Line 2 of the comments field will contain Payment Type Desc: (and the value of field 12). Line 3 of the comments field will contain Comment: (and the value in field 13).

For example:

card Holder: testcreditcard name

02 Payment Type Desc: payment type desc for xxxx

03 Comment: comment line 1

You can change an entry to a batch by pressing ENTER to return to the Patient Payment Exit Processor. Accessing the Edit function and selecting an entry in the batch will display the Patient Payment Posting Interface Revision Processor.

.

```
        General Hospital Patient Payment Posting Int Exit Batch Processor
                                         Mon Sep 24, 2012 11:54 am

* = Pt Class - a Alert, s Suppressed F/U, c Cleared
Page:01     Batch 122 - Pat Int pk0918143a                 ##=Current Choices
  Seq#   Type            Amount        C/A Amt  *  Account      Name
( 1) 1   Pat Pmt Pst      60.00           .00       1214300002 CRANE, BOB














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

```
               General Hospital Patient Payment Posting Int Revision Processor
                                                   Mon Sep 24, 2012 11:49 am
Account        Name                  FC Typ Admit    Disch      Balance Loc
A1214300002  CRANE,BOB               O  O/P 05/22/12 05/22/12      369.00 AR /ACCF
 1 Patient Balance     2 Last Payment Date     3 Collection Agency
   2.87                  09/18/12
 4 # of Payments       5 Total Payments              6 Account Balance
   4                     31.00                          369.00
 7 Seq#   8 Pt Class                               9 New Account Balance
   1                                                   309.00

10 Payment Amount     11 Receipt #
   60.00
12 Payment Date       13 Posting Date    14 Trans Code/Description
   04/21/12              09/18/12            P0001-PERSONAL PAYMENT-CHECK

15 Comments
   01 Card Holder: testcreditcard name
   02 Payment Type Desc: paymenttypedesc for xxxx
   03 Comment: comment line 1


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

FIELD EXPLANATIONS

1. PATIENT BALANCE (DISPLAY ONLY)
This field contains the current patient balance for this account.

2. LAST PAYMENT DATE (DISPLAY ONLY)
This field contains the last date on which the payment was received for this account.

3. COLLECTION AGENCY (DISPLAY ONLY)
This field contains the code of the collection agency assigned to this account if the account is in account location Bal.

4. # OF PAYMENTS (DISPLAY ONLY)
This field contains the number of payments (either insurance or patient) made on this account.

5. TOTAL PAYMENTS (DISPLAY ONLY)
This field contains the total dollar amount of all patient and insurance payments made on this account.

6. ACCOUNT BALANCE (DISPLAY ONLY)
This field contains the current account balance.

7. SEQ #- (DISPLAY ONLY)
This field displays the sequence # of payment.

8. PT CLASS (DISPLAY ONLY)
This field displays the patient class code associated with the account.

9.   NEW ACCOUNT BALANCE (DISPLAY ONLY)
This field displays the account balance with the new payment applied to it.

10. PAYMENT AMOUNT (6-N-O)
This field contains the amount of this payment. This field is populated with the value in field 9 in the Patient Payment/Adjustment Interface.

11. RECEIPT # (DISPLAY ONLY)
This field is not used in the Patient Payment/Adjustment Interface.

12. PAYMENT DATE (DISPLAY ONLY)
This field contains the date on which this payment was made. This field is populated with the value from field 8 in the 01 record of the patient payment/adjustment interface.

13. POSTING DATE (DISPLAY ONLY)
This field contains the date on which this payment was posted.

14. TRANS CODE/DESCRIPTION (5-N-R)
This field contains the transaction type and code used to record this payment in this account's transaction history. This field contains the value in field 14 in the 01 record if it is present, if it is not present then it will use the value in field 6 in the 00 record to populate this field.This field can be manually updated. You can enter the code or a hyphen (-) to display and select from a list of valid codes under transaction type P (cash payment). This field is required.

15. COMMENTS (40-N-
This field allows the user to enter patient comments and notes. This field is populated with fields 11-13 in the 01 record. The first line comes from field 11. The second line comes from field 12. The third line comes from field 13. If field 10 in the interface is an A then the system will populate line one in the Comments field with Acct Holder: (this contains what is in field 11).

For example:

Acct Holder: testacctholder name

02

03 Comment: comment for interface from field 13

If field 10 in the interface is a C then the system will populate line one in the comments field with Card Holder. Line 2 of the comments field will contain Payment Type Desc: (and the value of field 12). Line 3 of the comments field will contain Comment: (and the value in field 13).

For example:

card Holder: testcreditcard name

02 Payment Type Desc: payment type desc for xxxx

03 Comment: comment line 1

After you accept this screen and press ENTER, the Patient Posting Int Exit Batch Processor screen is displayed.

```
        General Hospital Patient Payment Posting Int Exit Batch Processor
                                              Thu Sep 20, 2012 10:34 pm


 1 Batch Code        2 Batch Description                       3 # of Trans
    9                  Pat Int pk0625forpat                        1
 4 Posting Date      5 Payment Date       6 Agency
   06/25/12            06/25/12             RELAYH-RELAY HEALTH
 7 Default Patient Cash Tran Code
->
 8 Agency Fees Tran Code                   9 Agency Cash Tran Code
   V0001-COLLECTION AGENCY FEES              P0007-code 7
10 Agency Batch Total      11 Agency Fees      12 Fees Variance
   80.00                      10.00               .00
13 Total Entered           14 Batch Total      15 Variance
   10.00                      70.00               60.00
16 Batch Created By                        17 Batch Approved By
   New, Nancy




Batch is out of balance - (A)ccept, (P)rint, (E)dit, or (R)eturn? --

```

For field descriptions, see "POST PATIENT PAYMENT INTERFACE CASH" on page 5-4, the Post Patient Payment Int Setup Processor.

The Patient Payment Posting Interface Exit Batch Processor indicates that the batch is either in or out of balance with the following prompt:

    Batch is out of balance - (A)ccept, (P)rint, (E)dit, or (R)eturn? --

    Batch is balanced - (A)pprove, (H)old, (P)rint Batch, (E)dit, or (R) eturn?

•   Batch is balanced - (A)pprove, (H)old, (P)rint Batch, (E)dit, or (R) eturn?

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- A (Approve) - Enter A to approve the batch. The following message is displayed:

  Batch Approved.

  Approving a balanced batch posts the batch and updates account balances, last payment dates, transaction history, and follow-up information. When a batch is posted, the patient account is updated immediately. The General Ledger is updated during midnight processing.

  Approving the batch causes the following reports to be generated during midnight processing:

  Cash Posting Detail report (FAR130)

  Cash Posting Exception report (FAR140)

- H (Hold) - Enter H to put the batch on hold. The following message is displayed:

  Batch Status is Hold

- P (Print Batch) - Enter P to print the FAR120, Cash Posting Batch Audit Report.

- E (Edit) - Enter E to edit payments. See "Editing a Batch" on page 5-4.

- R (Return) - Returns the user to the Patient Payment Posting Interface Setup Processor to review/update the batch.

- Batch is out of balance - (A)ccept, (P)rint, (E)dit, or (R)eturn? --

  - A (Accept) - Enter A to accept, but not approve, a batch.

  - P (Print Batch) Enter P to print the FAR120, Cash Posting Batch Audit Report.

  - E (Edit) - Enter E to edit payments. See "Editing a Batch" on page 5-4.

  - R (Return) - Returns the user to the Patient Payment Posting Interface Setup Processor to review/update the batch.

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POST PATIENT ADJUSTMENT INTERFACE CASH

The Post Patient Adjustment Interface Cash option is used to approve an uploaded file, edit a batch, post patient adjustments, put a batch on hold, and print reports. The patient adjustment transactions will be included on FAR200, Adjustment Batch Audit Report.

Editing a Batch

After selecting the Post Patient Adjustmentt Interface Cash option, the system prompts for a facility (if multifacility). After you select the facility, you are prompted to enter in the batch number to directly access the batch or enter a '-' to view a list of all the batches and then select a batch. If a hyphen is entered, the following screen is displayed:

```
                General Hospital Patient Adjustment Int Posting Setup Processor
                                         Fri Sep 21, 2012 03:13 am


 Page:01                 Patient Adjustment Int Posting Batches
   Batch Status  Type Creation Date  By  Description/Comment
 ( 1)  22 Unbalanced Z Jun 25, 1452 PMK Pat Int pk0625143c
 ( 2) 102 Unbalanced Z Jun 27, 1455 PMK Pat Int pk0628143a
 ( 3) 113 Unbalanced Z Jul 12, 737 PMK Pat Int pk0712143b
 ( 4) 114 Unbalanced Z Jul 12, 1018 PMK Pat Int pk0712143c
 ( 5) 115 Unbalanced Z Jul 18, 1352 PMK Pat Int pk0718143
 ( 6) 116 Unbalanced Z Jul 18, 1437 PMK Pat Int pk0718143a
 ( 7) 121 Unbalanced Z Sep 18, 1654 PMK Pat Int pk0918143a
 ( 8)  21 Unbalanced Z Jun 25, 1431 PMK Pat Int pk0625
 ( 9)  22 Unbalanced Z Jun 25, 1452 PMK Pat Int pk0625143c
 (10)  23 Unbalanced Z Jun 25, 1715 P M Pat Int pk0625forpat
 (11)  26 Unbalanced Z Jun 27, 1440 PMK Pat Int pk0628143




 Enter choice--
```

Field Explanations

BATCH (DISPLAY ONLY)
This field contains the batch number.

STATUS (DISPLAY ONLY)
This field contains the batch status. Valid values are Ubal for Unbalanced, Bal for Balanced, Pstd for Posted and Hold for Hold.

TYPE (DISPLAYONLY)

This field contains the batch type. The batch type associated with the patient payment/ adjustment interface is Z.

CREATION DATE (DISPLAY ONLY)

This field contains the date/time the batch was created.

BY (DISPLAY ONLY)

This field contains the initials of the person uploading the file.

DESCRIPTION/COMMENT (DISPLAY ONLY)

This field contains the name of the file. The name of the file will always begin with Pat Int for Patient Interface and then the name of the uploaded file.

After selecting a batch, the next screen displays basic information about this batch. Most of the values for the fields on this screen come from the patient payment/ adjustment interface file. The hospital can update values on this screen and must verify the batch is in balance so that when they access the exit batch processor they will be prompted to approve the batch.

```
              General Hospital Patient Adjustment Int Posting Setup Processor
                                                   Fri Sep 21, 2012 03:16 am


    1 Batch #                  2 Batch Description                3 # of Trans
      22                         Pat Int pk0625143c                   1
    4 Posting Date             5 Default Patient Adjustment Tran Code
      06/25/12                   A0003-O/P M'CARE B PRO FEES ALLOW
    6 Total Entered            7 Batch Total                      8 Variance
      100.00-                    300.00-                             200.00-




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

1. BATCH # (DISPLAY ONLY)

This field contains the batch number that was assigned automatically by the system.

2. BATCH DESCRIPTION (30-C-R)

This field contains the name of the patient adjustment batch. This field is automatically generated and contains the words "Pat Int" for patient interface followed

by the file name. For example, if the file name was empdisc0503 then the batch description would be Pat Int empdisc0503.

This field can be manually updated.

3. # OF TRANSACTIONS (DISPLAY ONLY)

This is a calculated field and the system uses the entries that were uploaded into the batch to determine the number of transactions. This field is updated if entries are added or deleted from the batch.

4. POSTING DATE (6-N-R)

This field contains the date on which the batch is posted. The date the file was uploaded is the default date. This field can be updated to a prior date or the current date.

5. DEFAULT PATIENT ADJ TRAN CODE (5-AN-O)

This field contains the patient adjustment transaction code in the 00 record from the patient payment/adjustment interface file. This field can be manually updated.

6. TOTAL ENTERED (DISPLAY ONLY)

This field contains the total amount of all of the transactions in the batch.

7. BATCH TOTAL (11-N-R)

This field contains the value in the total adjustment amount field in the 00 record of the interface file. This field must equal the total entered field or a variance will be calculated. This field can be edited.

VARIANCE (DISPLAY ONLY)

This field contains the batch variance. This field contains a value if the total entered field doesn't equal the batch total field.

Next the system displays the Patient Adjustment Posting Interface Processor where you can add entries to the batch. If you elect to add an entry to the batch, select the account from the lookup screen and then the Patient Adjustment Posting Interface screen will display to enter adjustment information for the selected account. When you are finished adding entries or if you do not need to add an entry to the batch, press ENTER to return to the Patient Adjustment Posting Interface Exit Batch Processor.

```
                    General Hospital Patient Adjustment Posting Int Processor
                                                 Fri Sep 21, 2012 12:43 am








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

The Patient Adjustment Posting Interface processor contains the following information:

```
                  General Hospital Patient Adjustment Int Posting Processor
                                                 Fri Sep 21, 2012 03:19 am
Account      Name                   FC Typ Admit    Disch        Balance Loc
A1217300002  SMITH,BOB     O  NEW 06/21/12             59931.71 PA /INSR
 1 Patient Balance    2 Adjustments        3 Payments
   679.29
 4 Account Balance    5 Last Adjustment Date   6 Last Payment Date
   59,931.71
 7 Batch Seq #        8 Pt Class
   2

 9 Adjustment Date   10 Posting Date   11 Trans Code/Description
 ->                      06/25/12          A0003-O/P M'CARE B PRO FEES ALLOW
12 Adjustment Amount                   13 New Balance

14 Comments
   01
   02
   03



 Enter payment date  [09/21/12]--
```

FIELD EXPLANATIONS

1. PATIENT BALANCE (DISPLAY ONLY)
This field contains the patient balance associated with the account.

2. ADJUSTMENTS (DISPLAY ONLY)
This field contains the total adjustment amount made to the patient's portion of this account.

3.   PAYMENTS (DISPLAY ONLY)

This field contains the total payment amount made to the patient's portion of this account.

4.   ACCOUNT BALANCE (DISPLAY ONLY)

This field contains the current account balance.

5.   LAST ADJUSTMENT DATE (DISPLAY ONLY)

This field contains the date on which the last adjustment was made on the patient's portion of this account.

6.   LAST PAYMENT DATE (DISPLAY ONLY)

This field contains the date on which the last payment was made on the patient's portion of this account.

7.   BATCH SEQ # (DISPLAY ONLY)

This field contains the sequence number of this adjustment within the batch.

8.   PT CLASS (DISPLAY ONLY)

This field displays the financial patient classification combined with the alert and suppression indicators associated with the financial patient classification. The three character patient classification code is displayed if a patient classification has been assigned to the account. Leading and trailing asterisks (**) display when the assigned patient classification has an alert designation. Finally, the follow-up suppression indicator is displayed as the final character in the field:

  a = alert only; follow-up is not suppressed

  c = suppression of follow-up has been cleared by a user

  s = follow-up is currently being suppressed

9.   ADJUSTMENT DATE (6-N-R)

This field contains the date on which this adjustment is entered.

10.POSTING DATE (6-N-R)

This field contains the date on which this adjustment is posted.

11.TRANS CODE/DESCRIPTION (5-AN-R)

This field contains the transaction code associated with the adjustment. This field contains the value in field 14 in the 01 record if it is present, if it is not present then it will use the value in field 9 in the 00 record. This field can be manually updated.

12. ADJUSTMENT AMOUNT (11-N-R)

This field contains the adjustment amount.

13.NEW BALANCE (DISPLAY ONLY)

This field contains the account's new balance based on the beginning balance. It displays what the balance is when the adjustment is applied.

14. COMMENTS

This field allows the user to enter patient comments and notes. This field is populated with fields 11-13 in the 01 record. The first line comes from field 11. The second line comes from field 12. The third line comes from field 13. If field 10 in the interface is an A then the system will populate line one in the Comments field with Acct Holder: (this contains what is in field 11).

For example:

Acct Holder: testacctholder name

02

03 Comment: comment for interface from field 13

If field 10 in the interface is a C then the system will populate line one in the comments field with Card Holder. Line 2 of the comments field will contain Payment Type Desc: (and the value of field 12). Line 3 of the comments field will contain Comment: (and the value in field 13).

For example:

card Holder: testcreditcard name

02 Payment Type Desc: payment type desc for xxxx

03 Comment: comment line 1

You can change an entry to a batch by pressing ENTER to return to the Patient Adjustment Exit Processor. Accessing the Edit function and selecting an entry in the batch will display the Patient Adjustment Posting Interface Revision Processor.

```
                General Hospital Patient Adjustment Int Posting Exit Batch Processor
                                                 Mon Sep 24, 2012 12:03 pm

* = Pt Class - a Alert Only, s Suppressed F/U, c Cleared
Page:01      Batch 102 - Pat Int pk0628143a                    ##=Current Choices
    Seq#  Type              Amount  *    Account     Name
( 1) 1    Pat Adj Pst       100.00-      1213900002 SMITH,BOB












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

.

```
                General Hospital Pat Adj Pst Adjustment Revision Processor
                                                 Mon Sep 24, 2012 12:04 pm
Account        Name                  FC Typ Admit    Disch        Balance Loc
A1213900002  SMITH,BOB               O  O/P 05/18/12 05/18/12      209.90 AR /ACCF
 1 Patient Balance    2 Adjustments              3 Payments
   81.13-               100.00-
 4 Account Balance    5 Last Adjustment Date    6 Last Payment Date
   209.90               06/27/12
 7 Batch Seq #        8 Pt Class
   1

 9 Adjustment Date   10 Posting Date    11 Trans Code/Description
   04/24/12             06/27/12            A0001-I/P MEDICARE PART A ALLOWANCE
12 Adjustment Amount                    13 New Balance
   100.00-                                 220.00
14 Comments
   01 comment line 1
   02
   03



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

FIELD EXPLANATIONS

1. PATIENT BALANCE (DISPLAY ONLY)
This field contains the patient balance associated with the account.

2. ADJUSTMENTS (DISPLAY ONLY)

This field contains the total adjustment amount made to the patient's portion of this account.

3. PAYMENTS (DISPLAY ONLY)

This field contains the total payment amount made to the patient's portion of this account.

4. ACCOUNT BALANCE (DISPLAY ONLY)

This field contains the current account balance.

5. LAST ADJUSTMENT DATE (DISPLAY ONLY)

This field contains the date on which the last adjustment was made on the patient's portion of this account.

6. LAST PAYMENT DATE (DISPLAY ONLY)

This field contains the date on which the last payment was made on the patient's portion of this account.

7. BATCH SEQ # (DISPLAY ONLY)

This field contains the sequence number of this adjustment within the batch.

8. PT CLASS (DISPLAY ONLY)

This field displays the financial patient classification combined with the alert and suppression indicators associated with the financial patient classification. The three character patient classification code is displayed if a patient classification has been assigned to the account. Leading and trailing asterisks (**) display when the assigned patient classification has an alert designation. Finally, the follow-up suppression indicator is displayed as the final character in the field:

  a = alert only; follow-up is not suppressed

  c = suppression of follow-up has been cleared by a user

  s = follow-up is currently being suppressed

9. ADJUSTMENT DATE (6-N-R)

This field contains the date on which this adjustment is entered.

10.POSTING DATE (6-N-R)

This field contains the date on which this adjustment is posted.

11.TRANS CODE/DESCRIPTION (5-AN-R)

This field contains the transaction code associated with the adjustment. This field contains the value in field 14 in the 01 record if it is present, if it is not present then it will use the value in field 9 in the 00 record. This field can be manually updated.

12. ADJUSTMENT AMOUNT (11-N-R)

This field contains the adjustment amount.

13.NEW BALANCE (DISPLAY ONLY)

This field contains the account's new balance based on the beginning balance. It displays what the balance is when the adjustment is applied.

14. COMMENTS

This field allows the user to enter patient comments and notes. This field is populated with fields 11-13 in the 01 record. The first line comes from field 11. The second line comes from field 12. The third line comes from field 13. If field 10 in the interface is an A then the system will populate line one in the Comments field with Acct Holder: (this contains what is in field 11).

For example:

Acct Holder: testacctholder name

02

03 Comment: comment for interface from field 13

 If field 10 in the interface is a C then the system will populate line one in the comments field with Card Holder. Line 2 of the comments field will contain Payment Type Desc: (and the value of field 12). Line 3 of the comments field will contain Comment: (and the value in field 13).

For example:

card Holder: testcreditcard name

02 Payment Type Desc: payment type desc for xxxx

03 Comment: comment line 1

After you accept this screen and press ENTER, the Patient Adjustment Int Exit Batch Processor screen is displayed.

```
                    General Hospital Patient Adjustment Int Posting Exit Batch Processor
                                      Fri Sep 21, 2012 03:24 am


   1 Batch #            2 Batch Description                     3 # of Trans
     22                   Pat Int pk0625143c                      2
   4 Batch Status       5 Total Entered      6 Batch Total      7 Variance
     Unbalanced           99.00-                300.00-           201.00-












   Batch is out of balance - Accept (A), Print (P) or Edit (E)? [E]--
```

For field descriptions, see "POST PATIENT ADJUSTMENT INTERFACE CASH" on page 5-15.

The Patient Adjustment Posting Interface Exit Batch Processor indicates that the batch is either in or out of balance with the following prompt:

Batch is out of balance - Accept (A), Print (P) or Edit (E)? [E]--

Batch is balanced - (A)pprove, (H)old, (P)rint Batch or (E)dit?

- Batch is balanced - (A)pprove, (H)old, (P)rint Batch, (E)dit?

    - A (Approve) - Enter A to approve the batch. The following message is displayed:

      Batch Approved.

      Approving a balanced batch posts the batch and updates account balances, last payment dates, transaction history, and follow-up information. When a batch is posted, the patient account is updated immediately. The General Ledger is updated during midnight processing.

      Approving the batch causes the following reports to be generated during midnight processing:

      FAR210, Adjustment Batch Posting Detail Report.

- H (Hold) - Enter H to put the batch on hold. The following message is displayed:

  Batch Status is Hold

- P (Print Batch) - Enter P to print the FAR200, Adjustment Posting Batch Audit Report.

- E (Edit) - Enter E to edit adjustments. See "Editing a Batch" on page 5-15.

- Batch is out of balance - (A)ccept, (P)rint, (E)dit, or (R)eturn? --

  - A (Accept) - Enter A to accept, but not approve, a batch.

  - P (Print Batch) - Enter P to print the FAR200, Adjustment Posting Batch Audit Report.

  - E (Edit) - Enter E to edit adjustments. See "Editing a Batch" on page 5-15.

UPLOAD PATIENT PAYMENT/ADJUSTMENT INTERFACE FILE

This function is used to upload a payment or adjustment interface file. Payments and adjustments may be posted to accounts in location PA, AR, BD. When this function is accessed, the system prompts for a facility to be selected. It then displays the Patient Pymt/Adj Upload Files screen.This screen contains the files that are available to upload for the selected facility. Files must have a file extension of .pmn and should be located in UNIX directory defined in the Patient Payment/ Adjustment Interface Parameters table.

When this function is selected, the following screen is displayed:

```
Page:01 Patient Pymt/Adj Upload Files
     ( 1) /hbo/tmp/patpay.pmn
```

After a file is selected, the following prompt is displayed:

Are you sure you want to process this file? (Y/N) [Y]--

  File Name: /hbo/tmp/patpay.pmn

The directory of the file is displayed (in the above example it is / hbo/tmp) and then the name of the file (which is patpay.pmn in the above example).

After the file is uploaded a message will display on the screen indicating the payment batch number and/or the adjustment batch number that was created. The user should press enter for the process to continue and automatically return to the patient payment/ adjustment interface main menu.

Example of Message:

Batch 343 created for payment transactions. Press ENTER.

 Batch 287 created for adjustment transactions. Press ENTER.

A payment and/or an adjustment batch will be created. The batch numbers that were created (in the above example it was batches 343 and 287) can be accessed by selecting the menu option of Post Patient Payment Interface Cash for a payment batch and Post Patient Adjustment Cash for an adjustment batch. To post a patient payment or adjustment interface batch the Post Patient Payment Interface Cash or Post Patient

Adjustment Interface Cash options must be used. If the hospital tries to access a patient payment or patient adjustment interface cash batch in the Post Cash or Post Adjustment functions (not through the Post Patient Payment/Adjustment Interface

menu) the system will display an error message. The error message will indicate the batch number followed by a message stating that batch is either a Patient Payment Interface or Patient Adjustment Interface batch. Following is an example error message:

Error: Batch 287 is Patient Payment Posting batch

A report of the uploaded file information will automatically be generated called FAR180, Payment/Adjustment Interface Upload report. If there are no batches created due to errors that prevent a batch from being uploaded, then the FAR180 will not be generated. During the upload process the user will see the message:

Error: Process stopped due to errors in header record. Consult FAR182A!

If the interface process stopped due to errors it still renames the file to .pmo extension. After the errors are fixed then a new file should be put out in the unix directory with a .pmn extension.

The FAR181, Patient Payment/Adjustment Interface Summary report is also generated when the interface file is uploaded. The FAR181, Patient Payment/ Adjustment Interface Summary report contains patient payment and adjustment batch totals.

Also, the FAR182 Payment/Adjustment Interface Error report will be automatically generated when the file is uploaded. This report contains error and warning messages when accounts have problems in the 00 header record and 01 detail record interface file.

REPORTS

Patient Payment/Adjustment Interface Upload Report (FAR180)

Description/Purpose

This report is automatically generated when a Payment/Adjustment Interface file is uploaded. If there are no batches created due to errors that prevent a batch from being uploaded, the FAR180 will not be generated. During the upload process the user will see the message:

Error: Process stopped due to errors in header record. Consult FAR182A!

If the interface process stopped due to errors it still renames the file to .pmo extension. After the errors are fixed, a new file should be put out in the UNIX directory with a .pmn extension.

This report contains the information in the uploaded file from the 00 and 01 records.

Following is a sample of the report.

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Figure 5.1 Patient Payment/Adjustment Interface Upload Rpt (FAR180)

```
Date: 09/24/12                                    General Hospital                                    Page  : 1
Time: 8:24                          Patient Payment/Adjustment Interface Upload Rpt                    Report: FAR180A
                                             /hbo/tmp/relay0924143f.pmn/RELAYH
                                                   Payment Batch 126
                                                   Adjustment Batch 122


Record 00- Header Record

Record Type   Agency Code   Agency Fee    Agy Bch Tot    Total # of Pymt    Total Pymt Amt    Pymt Trans Code  Pymt Bch Tot
  Total # of Adj   Total Adj Amt   Adj Trans Code    Adj Bch Tot   Agency Cash Tran Code
---------------------------------------------------------------------------------------------------------------------------
00           RELAYH         $100.00        $11.11               50         $12,345.00      P0001                124.10
             10        $22.00    A0001                   10.10  P0001

<Page Break>
Date: 09/24/12                                    General Hospital                                    Page  : 2
Time: 8:24                          Patient Payment/Adjustment Interface Upload Rpt                    Report: FAR180A
                                             /hbo/tmp/relay0924143f.pmn/RELAYH
                                                   Payment Batch 126
                                                   Adjustment Batch 122


Record 01- Detail Record
Patient Name                      Patient Acct #   Rec Type   Adm Dt      DC Dt      FC   PT    Trans Type   Trans Code  LOC
  Date Paid           Pymt Amt         Adj Amt   Pymt Type  Pymt Desc                    CC or Bank Name
    Comment
---------------------------------------------------------------------------------------------------------------------------
SMITH, SSN                        A1217300003      01         06/21/12   06/21/12   S2   O/P   P            P0001       AR
  09/02/11           $104.00                      A
     test msg                     P0002

SMITH, PATRICE                    A1218400003      01         07/02/12   07/02/12   S2   O/P   P            P0001       AR
  09/30/11           $10.00                       A
     TESTMSG2                      P0002

SMITH, TESTB                      A1214300003      01         05/22/12   05/22/12   O    ER    P            P0001       AR
  09/01/11           $10.10                       C
     CONFMSG                       P0003

SMITH, TESTC                      A1213900004      01         05/18/12   05/18/12   O    O/P   A            A0001       AR
  09/01/11                         $10.10  C
     CONFMSG                       P0003

Totals
Total Transaction   Total Amount   Total # Pymts   Total Payments   Total # Adjs   Total Adjustments
            4         $134.20             3           $124.10            1              $10.10

                                                   End of Report
```

Field Descriptions

Following is the information related to the 00 header record:

RECORD TYPE
This field contains the record type in the 00 record. This field should contain a 00.

AGENCY CODE
This field contains the agency code in the 00 record.

AGENCY FEE
This field contains the agency fee in the 00 record.

AGY BCH TOT
This field contains the agency batch total in the 00 record.

TOTAL # OF PYMT
This field contains the value in the Total Number of Payments field in the 00 record.

TOTAL PYMT AMT
This field contains the value in the Total Payment Amount field in the 00 record.

PYMT TRANS CODE
This field contains the payment transaction code in the 00 record.

PYMT BCH TOT
This field contains the payment batch total in the 00 record.

TOTAL # OF ADJ
This field contains the value in the Total Number of Adjustments field in the 00 record.

TOTAL ADJ AMT
This field contains the value in the Total Adjustment Amount field in the 00 record.

ADJ TRANS CODE
This field contains the adjustment transaction code in the 00 record.

ADJ BCH TOT
This field contains the value in the adjustment batch total field in the 00 record.

AGENCY CASH TRAN CODE
This field contains the agency cash transaction code in the 00 record.

Next is the information from the 01 detail record display. Note the source of information for the fields on the report in the 01 section are from the interface file unless the field is preceded with an asterisk.

The fields are:

PATIENT NAME

This field contains the patient name from the 01 record.

PATIENT ACCT #

This field contains the account number from the 01 record. The upload process validates that the account number in the 01 record matches an account number on the STAR system.

REC TYPE

This field contains the record type contained in the file.

*ADM DT

This field contains the admit date associated with the account on STAR.

*DC DT

This field contains the discharge date associated with the account on STAR.

*FC

This field contains the financial class associated with the account STAR.

*PT

This field contains the patient type associated with the account on STAR.

TRANS TYPE

This field contains the transaction type in the 01 record. Valid values are P for Payment and A for Adjustment.

TRANS CODE

This field contains the transaction code associated with the payment or adjustment for the account. The value is either from the 01 or 00 record. The system uses what is in the 01 record and if that is blank it will use what is in the 00 record.

*LOC

This field contains the location associated with the account on STAR.

DATE PAID

This field contains the date associated with the payment. This field comes from field 8 in the 01 record.

PYMT AMT

This field contains the amount of the payment from the 01 record.

ADJ AMT

This field contains the amount of the adjustment from the 01 record.

PYMT TYPE

This field contains the payment type that is in the 01 record, field 10.

PYMT DESC

This field contains the value in field 11 in the 01 record. This field provides a payment description.

CC OR BANK NAME

This field contains the value in field 12 of the 01 record if field 10 equals a "C or an "A". If field 10 = "C", this is the Credit Card Owner's name and if Field 10 = "A", then this is the Bank Account Owner's name.

COMMENT

This field contains the value in field 13 in the 01 record.

A Totals Section is included at the end of the FAR180 after the 01 records. These totals include:

TOTAL TRANSACTION

This field contains the total number of transactions in the file.

TOTAL AMOUNT

This field contains the total amount of the transactions in the file.

TOTAL # OF PYMTS

This field contains the total number of payments in the file.

TOTAL PAYMENTS

This field contains the total amount of payments in the file.

TOTAL # OF ADJUSTMENTS

This field contains the total number of adjustments in the file.

TOTAL ADJUSTMENTS

This field contains the total number adjustments in the file.

Patient Payment/Adjustment Interface Summary Rpt (FAR181)

Description/Purpose

This report contains the following summary/total information about the patient payment and adjustment batches:

- Payment Batch Totals

- Adjustment Batch Totals

- Totals for Payments and Adjustment Batches

- Totals by Transaction Codes for Payments and Adjustments.

This report is automatically generated after a file is uploaded through the Payment/Adjustment Interface.

Following is a sample of the report.

Figure 5.2 Patient Payment/Adjustment Interface Summary Upload Rpt (FAR181)

```
Date: 09/24/12                             General Hospital                          Page  : 1
Time: 8:24              Patient Payment/Adjustment Interface Summary Upload Rpt      Report: FAR181A
                                    /hbo/tmp/relay0924143f.pmn/RELAYH
                                          Payment Batch 126
                                         Adjustment Batch 122

Payment Batch Totals

Batch #    Number of Transactions     Transaction Amt     Agy Bch Tot        Agency Fee

   126                     3              $124.10           $11.11            $100.00


Adjustment Batch Totals

Batch #    Number of Transactions     Transaction Amt

   122                     1               $10.10


Totals for Payments and Adjustment Batches

Number of Transactions for Payments and Adjustments          Transaction Amount
                                    4                               $134.20

Totals by Transaction Codes for Payments and Adjustments

Transaction Code            Number of Transactions             Transaction Amount
A0001                                  1                              $10.10
P0001                                  3                             $124.10

                                    End of Report
```

Field Explanations

The Payment Batch Totals section of the report contains:

BATCH #
This field contains the batch number associated with the uploaded payment batch.

NUMBER OF TRANSACTIONS
This field contains the total number of payment transactions in the uploaded batch.

TRANSACTION AMT
This field contains the total amount of payment transactions in the batch.

AGENCY BATCH TOTAL
This field contains the amount in the agency batch total field in the 00 record.

AGENCY FEE
This field contains the amount in the agency fee field in the 00 record.

The Adjustment Batch Totals section of the report contains:

BATCH #
This field contains the batch number.

 # OF TRANSACTIONS
This field contains the total number of adjustment transactions in the batch.

TRANSACTION AMOUNT
This field contains the total amount of adjustment transactions in the batch.

The Totals for Payments and Adjustments section of the report contains:

 # OF TRANSACTIONS FOR PAYMENTS AND ADJUSTMENTS
This field contains the total number of payment and adjustment transactions in the file.

TRANSACTION AMOUNT
This field contains the total amount of payment and adjustments transactions in the file.

The Totals by Transaction Codes for Payments and Adjustments contains:

TRANSACTION CODE
This column lists all of the transaction codes in the file.

 # OF TRANSACTIONS
This column lists the total number of instances for each transaction code in the file.

TRANSACTION AMOUNT

This column displays the total amount for each of the transaction codes in the file.

Patient Payment/Adjustment Interface Error Rpt (FAR182)

Description and Purpose

This report generates when the interface file is uploaded. This report contains all of the accounts where the payment or adjustment couldn't post because it was missing required information.

Note if a batch couldn't be created due to an error then the following message displays on the screen in the upload processor.

 Error: Process stopped due to errors in header record. Consult FAR182A!

The FAR182 will also generate and could contain errors even if batches were created successfully. The error message to indicate the process was stopped doesn't appear on the screen when uploading the file if the file does successfully complete uploading but there could be errors on accounts in the 01 record in the interface file. It is a good process to always check the FAR182 report after uploading a file.

In the header of the report the name of the report displays followed by the directory of the uploaded file, the name of the file and an agency code if there was one associated with it. Next displays the payment and adjustment batch numbers that are created.

 Patient Payment/Adjustment Interface Error Rpt

 /hbo/tmp/ pk0503b.pmn/RELAYH

Following is a sample of the report.

Figure 5.3 Patient Payment/Adjustment Interface Error Rpt (FAR182)

```
Date: 09/24/12                                   Model Hospital A                                     Page  : 1
Time: 8:24                          Patient Payment/Adjustment Interface Error Rpt                    Report: FAR182A
                                            /hbo/tmp/relay0924143f.pmn/RELAYH
                                                  Payment Batch 126
                                                  Adjustment Batch 122


Record 00- Header Record

Record Type    Agency Code    Agency Fee     Agy Bch Tot    Total # of Pymt      Total Pymt Amt     Pymt Trans Code  Pymt Bch Tot
  Total # of Adj    Total Adj Amt    Adj Trans Code     Adj Bch Tot  Agency Cash Tran Code
   Error/Warning Message
------------------------------------------------------------------------------------------------------------------------------------
00          RELAYH          $100.00         $11.11                  50         $12,345.00     P0001                     124.10
            10        $22.00    A0001                    10.10  P0001
      Warning-Number of Pymts does not equal # of Trans in Uploaded Batch
      Warning-Total Payment Amount field in file does not equal Total Entered field in batch
      Warning-Number of Adjs does not equal # of Trans in Uploaded Batch
      Warning-Total Adjustment Amount field in file does not equal Total Entered field in batch


Total Header Error Messages:

Total Header Warning Messages:     4
<Page Break>
Date: 09/24/12                                   Model Hospital A                                     Page  : 2
Time: 8:24                          Patient Payment/Adjustment Interface Error Rpt                    Report: FAR182A
                                            /hbo/tmp/relay0924143f.pmn/RELAYH
                                                  Payment Batch 126
                                                  Adjustment Batch 122


Record 01- Detail Record

Patient Name                       Patient Acct #    Rec Type    Adm Dt      DC Dt     FC   PT     Trans Type     Trans Code  LOC
  Date Paid                          Pymt Amt                      Adj Amt
   Error/Warning Message


Totals for Errors
Total Transactions   Total Amount   Total # Pymts    Total Payments   Total # Adjs   Total Adjustments
             0          $0.00                          $0.00                          $0.00

                                                  End of Report


<Page Break>
```

FIELD DESCRIPTIONS

Following is the information related to the 00 header record. The source for all of the data in the 00 section of the report comes from the interface file.

RECORD TYPE
This field contains the record type associated with the record. The 00 record should contain a value of 00.

AGENCY CODE
This field contains the agency code in the 00 record.

AGENCY FEE
This field contains the agency fee in the 00 record.

AGY BCH TOT
This field contains the agency batch total in the 00 record.

TOTAL # OF PYMT
This field contains the value in the Total Number of Payments field in the 00 record.

TOTAL PYMT AMT
This field contains the value in the Total Payment Amount field in the 00 record.

PYMT TRANS CODE
This field contains the payment transaction code in the 00 record.

PYMT BCH TOT
This field contains the payment batch total in the 00 record.

TOTAL # OF ADJ
This field contains the value in the Total Number of Adjustments field in the 00 record.

TOTAL ADJ AMT
This field contains the value in the Total Adjustment Amount field in the 00 record.

ADJ TRANS CODE
This field contains the adjustment transaction code in the 00 record.

ADJ BCH TOT
This field contains the value in the adjustment batch total field in the 00 record.

AGENCY CASH TRAN CODE
This field contain the agency cash transaction code in the 00 record.

ERROR/WARNING MESSAGE
This field contains the error/warning messages associated with the 00 record.

Totals at the end of the Record 00 section list the totals for the errors and warnings in the 00 record. For example if there were no error messages but two warnings, the report would list as follows:

Total Header Error Messages:

Total Header Warning Messages: 2

Warning-Number of Pymts does not equal # of Trans in Uploaded Batch Warning-Total Payment Amount field in file does not equal Total entered field in batch

Next the information from the 01 detail record displays. Note the source of information for the fields on the report in the 01 section are from the interface file unless the field is preceded with an asterisk.

The fields are:

PATIENT NAME
This field contains the patient name from the 01 record.

PATIENT ACCT #
This field contains the account number from the 01 record. Note, if the patient account number doesn't exist on the STAR system then an error message will generate. The upload process validates that the account number in the 01 record matches an account number on the STAR system.

REC TYPE
This field contains the record type contained in the file.

*ADM DT
 This field contains the admit date associated with the account on STAR.

*DC DT
 This field contains the discharge date associated with the account on STAR.

*FC
 This field contains the financial class associated with the account STAR.

*PT
This field contains the patient type associated with the account on STAR.

TRANS TYPE
This field contains the transaction type in the 01 record. Valid values are P for Payment and A for Adjustment.

TRANS CODE

This field contains the transaction code associated with the payment or adjustment for the account. The value is either from the 01 or 00 record. The system uses what is in the 01 record and if that is blank it will use what is in the 00 record.

*LOC

This field contains the location associated with the account on STAR.

DATE PAID

This field contains the date associated with the payment. This field comes from field 8 in the 01 record.

PYMT AMT

This field contains the amount of the payment from the 01 record.

ADJ AMT

This field contains the amount of the adjustment from the 01 record.

ERROR/WARNING MESSAGE

This field contains any error or warning messages associated with the account.

After uploading a file the system will generate a message on the screen indicating the file couldn't upload and refer to the FAR182, Patient Payment/Adjustment Interface Error Report. If a file did upload, the message won't display on the screen regarding the FAR182. Accounts can still appear on the FAR182 even if the file uploaded if there is a problem with the 01 record for an account. Also, warning messages can display if there is a problem with the 00 record even if the file did upload.

PATIENT PAYMENT/ADJUSTMENT INTERFACE RECORD LAYOUT

This record layout consists of two records: the 00 record and the 01 record. There can be multiple 01 records. The extension for the input file should be pmn and it is automatically renamed to an extension of pmo after it is processed. If the interface process stopped due to errors it still renames the file to.pmo extension. After the errors are fixed then a new file should be put out in the UNIX directory with a.pmn extension.

The specification contains the following information for both the 00 and 01 records:

- Field

- Description

- Size

- Columns

- Value/Format

- Required (Y=Yes, N=No, C=Conditional)

- Notes

For example the first field in the 00 record is as follows:

Field #=1, Description=Record Type, Size=2, Columns=1-2, Value/ Format=00 and Required=Y.

00 Record

Field #	Description	Size	Columns	Value/ Format	Required (Y/N)	Comment
1	Record Type	2	1-2	00	Y	Header record- one per file
2	Agency Code	6	3-8	Left Justified, Alpha	C- Required if populating Agency Fee field in file. If present the code must appear in the Collection Agency Table and not be filed as deleted	

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Field #	Description	Size	Columns	Value/ Format	Required (Y/N)	Comment
3	Agency Fee	10	9-18	Right Justified/ Zero Filled, No Decimal (two places assumed)	C This is only uploaded into a cash batch. If this is present in the file then an agency code must also be in the file and an agency fee transaction code must be associated with the collection agency code	
4	Total Number of Payments	6	19-24	Right Justified/ Zero Filled	N Field is not edited unless payments exist in file	
5	Total Payment Amount	11	25-35	Right Justified/ Zero Filled, No Decimal (two places assumed) Byte 25 equals "-" if the number is negative.	C-Payments must exist in file. Field is not edited unless payments exist in file.	

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Field #	Description	Size	Columns	Value/ Format	Required (Y/N)	Comment
6	Patient Payment Transaction Code	5	36-40	P####	N - The interface uses the transaction code in the 01 record and if that doesn't exist it will use what is in this field. Field is not edited unless payments exist in file without a payment transaction code.	
7	Total Number of Adjustments	6	41-46	Right Justified/ zero filled	N Field is not edited unless adjustments exist in file.	
8	Total Adjustment Amount	11	47-57	Right Justified/ Zero Filled, No Decimal (two places assumed.) Byte 47 equals "-" if the number is negative	**C** Field is not edited unless adjustments exist in file.	

Field #	Description	Size	Columns	Value/ Format	Required (Y/N)	Comment
9	Patient Adjustment Transaction Code	5	58-62	A####	N The interface uses the transaction code in the 01 record and if that doesn't exist it will use what is in this field. Field is not edited unless adjustments exist in file without an adjustment transaction code	
10	Agency Batch Total	11	63-73	Right Justified/ Zero Filled No decimal (two places assumed) Byte 63 equals "-" if the number is negative	C This is only uploaded into a cash batch and is only required if there is an agency fee in the file.	
11	Agency Cash Transaction Code	5	74-78	Left Justified	N Field is not edited unless agency fee exists in header record.	
12	Filler	172	79-250		Y	

01 Record

Field #	Description	Size	Columns	Value/Format	Required (Y/N)	Comment
1	Record Type	2	1-2	01 - Transaction record, one or more per file	Y	
2	Patient Account Number	10	3-12	Right Justified/ Zero Filled	Y	
3	Facility Indicator	1	13	Upper Case alpha	Y Must match facility selected for processor.	
4	Patient Last Name	15	14-28	Left Justified/ Alpha Numeric	N	
5	Patient First Name	12	29-40	Left Justified/ Alphanumeric	N	
6	Patient Middle Initial	1	41	Alphanumeric	N	
7	Transaction Type	1	42	"P"=Payment "A"=Adjustment	Y (need to have a type for each entry	
8	Date Paid	6	43-48	MMDDYY	Y	
9	Payment/ Adjustment Amount	11	49-59	Right Justified/ Zero Filled, No Decimal (two places assumed). Byte 49 equals "-" if the number is negative.	Y	
10	Payment Type	1	60	"C"=Credit Card "A"=ACH e-check	N	
11	Credit Card or Bank Account Owner Name 40 61-100	40	61-100	If Field 10 = "C", this is Credit Card Owner's name If Field 10 = "A", this Bank Account Owner's name Left Justified/ Alphanumeric	N	

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Field #	Description	Size	Columns	Value/Format	Required (Y/N)	Comment
12	Payment Type Description	25	101-125	If Field 10 = "C", this is Credit Card Type Left Justified/ Alphanumeric	N	
13	Comment Line 1	60	126-185	Left Justified/ Alphanumeric	N	This field is only used if field 10 contains a C or an A
14	Payment/ Adjustment Transaction Code	5	186-190	Left Justified	C- If this is blank then the transaction code in the header 00 record is used.	
15	Filler	60	191-250			

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We value your suggestions for improving our documentation. Please use this form to evaluate the Account Transactions Volume of the *STAR Patient Accounting Reference Guide* for Release 18.0.

Topic	Poor	Fair	Good	Excellent
Organization of information	❑	❑	❑	❑
Accuracy of information	❑	❑	❑	❑
Completeness of information	❑	❑	❑	❑
Clarity of information	❑	❑	❑	❑
Amount of overview information	❑	❑	❑	❑
Explanation of processes	❑	❑	❑	❑

Are there parts of this manual that could be made more helpful to you? Please explain.

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Other Comments:

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Thanks for your help in improving the documentation.

Your Name and Position

_____

Hospital/Organization
Name

_____

Telephone Number

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May we contact you?   Yes or No (circle one)

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